Statewide Substance Use Response Working Group (SURG)

Summary of 2022-2023 Response Recommendations

- Evaluate current availability and readiness to provide comprehensive behavioral health services to include but not limited to screening, assessment, treatment, recovery support, and transitions for reentry in local and state carceral facilities (for example implement follow up and linkage to care for individuals leaving the justice system).

  Recommend the allocation of funding to support the development of a Medicaid Reentry Section 1115 Waiver to Increase Health Care For People Leaving Carceral Facilities and to support readiness of carceral facilities to implement the 1115 waiver.

  Recommend legislation to require DHCFP to apply for and implement the 1115 Waiver to Increase Health Care For People Leaving Carceral Facilities and ensure there is an evaluation of readiness for planning and implementation. (#9 in 2023 Annual Report Rankings)

- Recommend the Nevada System of Higher Education (NSHE) conduct a feasibility study to understand the true cost of implementing wastewater-based epidemiology (WBE) in Nevada and its ability to support community response plans. Funding for this study may be available through the Fund for a Resilient Nevada. (Unranked in 2023 Annual Report Rankings)

- Leverage existing programs and funding to develop outreach response provider(s) and/or personnel that can respond to any suspected overdose or to those who are provided treatment for an overdose in a hospital/emergency room/EMS and offer follow-up support, referrals, and services to the individual and those impacted by the overdose (for example, other persons with a personal and/or emotional connection to the victim, surviving family members and/or postmortem services for families) following an overdose. Provider(s) and/or personnel to be deployed to anyone being released from institutional and community settings (e.g., hospitals, carceral facilities, and other institutional settings) who is being discharged post overdose or suspected overdose. Ensure this recommendation is included as the build out of Nevada's Crisis Response System is occurring so that tailored intervention for individuals who have survived a non-fatal overdose is included. (#14 in 2023 Annual Report Rankings, revised from 2022)

- Review the operations and lessons learned from Clark County's Overdose Fatality Review Task Force when that body's report is released in December 2024 and take this into account when supporting legislation to establish regional Overdose Fatality Review (OFR) Committees allowing flexibility as to the makeup and practice and for the OFR to remain at the county or regional level, as needed, to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies in accordance with established best practices such as the Bureau of Justice Assistance's Overdose Fatality Review: A Practitioner's Guide to Implementation. (See also Overdose Fatality Review for additional resources.) (Revised from 2022 and removed from 2023 Annual Report Rankings for further consideration in 2024)

- Recommend that a compliance study be completed on NRS 259.050 (number 3) and 259.053.

  Provide adequate funding for medical examiner offices to include death scene investigations, forensic pathologists, forensic epidemiologists, and toxicology testing to determine specific cause of death. (#12 in 2023 Annual Report Rankings)

- Revise penalties based on the quantity of Fentanyl, analogs, or other synthetic drugs of high potency that are trafficked. (NRS 453.3385, NRS 453.336, 453.339, 453.3395). (2022 Annual Report)

- Fund personnel and resources for independent medical examiner(s) for investigations and reports to specify the cause of death in overdose cases. (2022 Annual Report)

2022-2023 Detailed Response Recommendations

Recommendation #1 (2023)

Evaluate current availability and readiness to provide comprehensive behavioral health services to include but not limited to screening, assessment, treatment, recovery support, and transitions for reentry in local and state carceral facilities (for example implement follow up and linkage to care for individuals leaving the justice system).

Recommend the allocation of funding to support the development of a Medicaid Reentry Section 1115 Waiver to Increase Health Care For People Leaving Carceral Facilities and to support readiness of carceral facilities to implement the 1115 waiver.

Recommend legislation to require DHCFP to apply for and implement the 1115 Waiver to Increase Health Care For People Leaving Carceral Facilities and ensure there is an evaluation of readiness for planning and implementation.

- Justification/Background:
  - The Federal government is encouraging states to apply for the new 1115 waiver. Readiness of the state jails and prisons to implement EHR's, billing systems, services and supports need to be assessed. States must ensure systems are ready to bill for 1115 services. A needs assessment is currently being done to understand the availability and capacity to provide and bill for services.

    Many individuals with SUD's end up in jail and prison which rarely provide effective treatment of their addiction. AB156 of the 2023 legislative session attempted to mandate treatment but the bill was changed instead to requiring studies and reports of all justice system entities regarding their data and treatment efforts, due June of 2024. Therefore, these reports should be used to design a new bill to again address this problem. Individuals should be inducted and treated in the jail and prison systems with continuity of care prior to and upon release.
- Action Step:

  - Bill Draft Request (BDR)
  - Expenditure of Opioid Settlement Funds
  - Budget request for next biennium

- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: It would be very impactful if individuals in the criminal justice system with SUD's were treated for their substance use problem in the facility and referred to treatment on discharge. This would decrease significantly their risk of relapse, overdose and return to criminal activity.
  - **Capacity & feasibility of implementation**: While feasible as every county has a jail, and some programs have been implemented in Washoe and Clark counties, the capacity to implement in the jails statewide is low and dependent on acceptability and implementation in the jail or prison systems. Caseloads in the jail and prisons is high which is a barrier to moving individuals toward coping skills and recovery in these systems.
  - **Urgency**: An enormous number of people's introduction to treatment happens in the jail.
  - **Racial and health equity**: See disproportionate representative of racial subpopulations in jails and prisons and the impact of incarceration on health equity.
- Links:
  - https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf
  - https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/
  - https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf
  - The Common Wealth Fund: State Pushes for Innovative Ways to Improve Health Outcomes for Justice-Involved Individuals
  - https://legiscan.com/NV/text/AB156/2023
  - https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/FRN/R_Updated%20Nevada%20Opioids%20Needs%20Assessment%20and%20Statewide%20Plan%202022(1).pdf
  - American Medical Association (AMA) Substance Use and Pain Task Force (2023). Overdose Epidemic Report 2023. AMA Overdose Epidemic Report (ama-assn.org), pp 16, 20.

Recommendation #2 (2023)

Recommend the Nevada System of Higher Education (NSHE) conduct a feasibility study to understand the true cost of implementing wastewater-based epidemiology (WBE) in Nevada and its ability to support community response plans. Funding for this study may be available through the Fund for a Resilient Nevada.

- Justification/Background:

- This has been utilized at UNR for COVID on an opt in voluntary basis. This similar technology is being used for tracking substance use at a community/neighborhood level. "Wastewater-based epidemiology (WBE) has emerged as a powerful tool for monitoring public health trends by analysis of biomarkers including drugs, chemicals, and pathogens.

  Wastewater surveillance downstream at wastewater treatment plants provides large-scale population and regional-scale aggregation while upstream surveillance monitors locations at the neighborhood level with more precise geographic analysis.

  WBE can provide insights into dynamic drug consumption trends as well as environmental and toxicological contaminants.

  Applications of WBE include monitoring policy changes with cannabinoid legalization, tracking emerging illicit drugs, and early warning systems for potent fentanyl analogues along with the resurging wave of stimulants (e.g., methamphetamine, cocaine)"

- Action Step:
  - Expenditure of Opioid Settlement Funds
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact and Capacity & feasibility of implementation**: This recommendation was rated lower for impact and capacity due to the potential positive impact but the true outcomes and capacity are unknown which is why the recommendation is to fund a feasibility study.
  - **Urgency**: This recommendation is not immediately urgent but would improve longer term goals of understanding population-level characteristics.
  - **Racial and health equity**: The state may obtain additional data from areas that are currently lacking, such as rural areas, that can serve to understand the impacts of substance use on different communities. There are also recent efforts that could be leveraged.
- Links:
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8366482/pdf/13181_2021_Article_853.pdf

Recommendation #3 (2023, revised from 2022)

Leverage existing programs and funding to develop outreach response provider(s) and/or personnel that can respond to any suspected overdose or to those who are provided treatment for an overdose in a hospital/emergency room/EMS and offer follow-up support, referrals, and services to the individual and those impacted by the overdose (for example, other persons with a personal and/or emotional connection to the victim, surviving family members and/or postmortem services for families) following an overdose. Provider(s) and/or personnel to be deployed to anyone being released from institutional and community settings (e.g., hospitals, carceral facilities, and other institutional settings) who is being discharged post overdose or suspected overdose. Ensure this recommendation is

included as the build out of Nevada's Crisis Response System is occurring so that tailored intervention for individuals who have survived a non-fatal overdose is included.

- Justification/Background:
    - Those released from facilities are at high risk of overdose. It is an evidence-based practice to provide harm reduction supplies to those who have experienced an overdose.
    - The 2018 Overdose Response Strategy Cornerstone Project details Public Safety-Led Linkage to Care Programs in 23 States. Methods and strategies in this project can serve as guidance in how linkage to care can be provided starting at an overdose scene.
- Action Step:
    - Expenditure of Opioid Settlement Funds
    - Collaboration with existing programs such as crisis response
    - DHHS Policy
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
    - **Impact**: The impact of this recommendation would be to provide support, wraparound services, and continuity of care for those who experience an overdose and have contact with Nevada institutions.

      From a family member perspective, there are a lot of impacts, including:
        - Ongoing grief counseling/mental health services for all members of the family to deal with the grief and trauma.
        - Grief alone is complicated enough, but there is a lot of trauma associated with this kind of death. Family members often were the ones to find their loved one deceased, and the trauma of seeing them that way runs very deep. There is always ongoing, reoccurring guilt and questions of what one could have done to prevent this from happening.
        - There is ongoing grief and pain with every holiday, significant date such as the deceased loved one's birthday or the date of their passing. It never ends –any family gathering, event or holiday is a constant reminder that one's own family is no longer complete. There is a deep void that can never be filled.
        - Family members should be provided with Narcan kits if they have a family member with a substance use disorder.
        - Some family members have been known to turn to drugs or alcohol themselves as a means of coping (escaping their pain), or some may already suffer with substance use disorders. They need access to mental health services and treatment services, so they do not relapse, and find healthy ways of living with the pain.
        - The incidence of suicide with grief is heightened, and many with substance use disorders have been known to commit suicide. There needs to be preventative mental health services to assist with this.
        - Family members need ongoing support to honor and remember their loved ones, which is one method of helping to cope with such loss. There needs to be funding

to add such things as memorial plaques in the park, and reservations for parks for various memorial events.
    - There needs to be funding for billboards and other campaigns to raise awareness and address the drug crisis both as a preventative measure to hopefully save lives, but also as a means of healing for the family members so they don't feel their loved one died in vain.
    - Family members need to be included on committees and panels designed to develop programs and preventative measures. They have lived with addiction firsthand usually for years, so they know the tiny little details of what occurs and the kind of help that is needed.

- **Capacity & feasibility of implementation**: Not all places throughout the state have the capacity to implement these services while some areas currently do provide these services - multiple areas of the state have already demonstrated how these types of interventions can help connect people to care. A suggestion was made to ensure this is included in the crisis response plan.
- **Urgency**: Post-overdose response teams respond timely to people and we are in the midst of an overdose crisis and need more of these expedited services to people. Many people who leave institutions do not receive support. There are scattered programs throughout the state such as peers in emergency settings to provide this type of assistance. Additionally, the subcommittee chair has been told by a few MOST team members they are not provided information concerning people who experienced an overdose due to HIPAA issues.

- **Racial & health equity**: This would address people who use drugs as well as other populations that disproportionately experience overdose. Additionally, people who use drugs that are released from institutions such as jails/prisons have a higher incidence of overdose death due to decreased tolerance.

  Public safety led outreach programs have been shown to reduce overdose risk for participants through their engagement with health care providers. There is an opportunity to better evaluate how these programs reduce health disparities and improve racial and health equity.

- Links:
    - Post-overdose Response Team (PORT) Toolkit - PHAST
    - Community Paramedicine and Post Overdose Response Teams-Julota
    - Post-Overdose Response Teams (naco.org)
    - Innovations in Overdose Response: Strategies Implemented by Emergency Medical Services Providers (astho.org)
    - Post-Overdose Response Team (PORT) Toolkit | RCORPTA (rcorp-ta.org)
    - Public Health and Public Safety Resources | Drug Overdose | CDC Injury Center
    - Model Substance Use Disorder Treatment in Emergency Settings Act | LAPPA (legislativeanalysis.org)
    - Peer Support and Recovery Services | LAPPA (legislativeanalysis.org)
    - Mobile Outreach Vans | LAPPA (legislativeanalysis.org)

- Connecting Communities to Substance Use Services: Practical Approaches for First Responders (samhsa.gov)
- TIP 64: Incorporating Peer Support Into Substance Use Disorder Treatment Services | SAMHSA
- Advisory: Peer Support Services in Crisis Care | SAMHSA
- Use of Medication-Assisted Treatment in Emergency Departments | SAMHSA
- What Are Peer Recovery Support Services? | SAMHSA
- Innovations in Overdose Response: Strategies Implemented by Emergency Medical Services Providers (astho.org)
- https://www.hidtaprogram.org/pdf/cornerstone_2018.pdf

Recommendation #4 (2023, revised from 2022)

Review the operations and lessons learned from Clark County's Overdose Fatality Review Task Force when that body's report is released in December 2024 and take this into account when supporting legislation to establish regional Overdose Fatality Review (OFR) Committees allowing flexibility as to the makeup and practice and for the OFR to remain at the county or regional level, as needed, to effectively identify system gaps and innovative community-specific overdose prevention and intervention strategies in accordance with established best practices such as the Bureau of Justice Assistance's Overdose Fatality Review: A Practitioner's Guide to Implementation. (See also Overdose Fatality Review for additional resources.)

- Justification/Background:
  - Current systems limit data sharing and often first responders and public health don't fully understand the investigations, procedures, language, and sometimes conflicting priorities of the other discipline. By conducting a series of OFRs, jurisdictions begin to see patterns of need and opportunity, not only within specific agencies, but across systems.
- Action Step:
  - Bill Draft Request (BDR)
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity: **Not applicable; these questions were not included in the 2022 Annual Report.**
- Links:
  - Overdose Fatality Reviews Tools
  - LAPPA Model Overdose Fatality Review Teams Act (legislativeanalysis.org)
  - Overdose Fatality Review Fact Sheet (legislativeanalysis.org)

Recommendation #5 (2023)

Recommend that a compliance study be completed on NRS 259.050 (number 3) and 259.053.

Provide adequate funding for medical examiner offices to include death scene investigations, forensic pathologists, forensic epidemiologists, and toxicology testing to determine specific cause of death.

- Justification/Background:

- District Attorneys want these causation experts to provide reports before they will go forward with prosecution, particularly in cases where there are poly-drugs in the victim's system.

  With input from the Washoe County Medical Examiner, the recommendation was revised to include funding for positions key to determining the cause of death. This information can be used for both public health and law enforcement purposes.

  Funding for these positions will improve real-time reporting capabilities.

  Given differences in resources and approaches across the state, the recommendation was made to study the compliance with specific NRS sections intended to provide more consistency in death investigations.

- Action Step:
  - Bill Draft Request (BDR)
  - Expenditure of Settlement Funds
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: This is rated midlevel.
  - **Capacity & feasibility of implementation**: This recommendation would improve current capacity, which was rated low.
  - **Urgency**: This is rated midlevel.
- **Racial & health equity**: The impact on racial and health equity could be significant on a number of fronts. For example, more timely reporting would be the biggest impact. As outlined by Dr. Knight, the role of the coroner/medical examiner is to find the correct cause of death, regardless how that information is used. If used in the criminal justice system, it could provide for quicker turn around so those in the criminal justice system would not be experience delays due to slower cause of death and toxicology results. The reporting of cause of death also feeds the public health reporting. So, again, more timely reporting would provide for more timely public health reporting/actions. Also, it should not be lost that family/persons of concern may receive death certificates in a timelier manner so this may assist with death benefits/life insurance/referral for services. So, this recommendation would help an array of persons.
- Links:

- CDC's State Unintentional Drug Overdose Reporting System (SUDORS) | Drug Overdose | CDC Injury Center
- Forensic Pathologists Shortage is Worsening Across the U.S. (forensicmag.com)
- Drugs, Death, and Data | CDC
- Death certificates and death investigations in the United States - UpToDate
- A Reference guide for completing the death certificate for drug toxicity deaths (cdc.gov)
- Intentional vs. Unintentional Overdose Deaths | National Institute on Drug Abuse (NIDA) (nih.gov)
- Prosecuting Drug Overdose Cases: A Paradigm Shift - National Association of Attorneys General (naag.org)
- 20210202-Quick-Guide-Opioid-Death-Investigations.pdf (pceinc.org)

Recommendation #6 (2022)

Revise penalties based on the quantity of Fentanyl, analogs, or other synthetic drugs of high potency that are trafficked. (NRS 453.3385, NRS 453.336, 453.339, 453.3395).

- Justification/Background:
  - While the intent of criminal justice reform legislation passed in the 2019 session was to address Nevada's growing prison population and the expense of that growth to Nevada taxpayers, it did not anticipate the public safety threat stemming from increased weights involving deadlier drugs like fentanyl being trafficked in the community and the impact to overdose victims and their families.
- Action Step:
  - Bill Draft Request
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity: **Not applicable; these questions were not included in the 2022 Annual Report.**
- Links:
  - State Laws Are Treating Fentanyl Like the New Crack—And Making the Same Mistakes of the 80s and 90s (yahoo.com)
  - Fentanyl Accountability and Prevention | Colorado General Assembly
  - Synopsis of "The Future of Fentanyl and other Synthetic Opioids," a Report by the RAND Corporation (legislativeanalysis.org)

Recommendation #7 (2022)

Fund personnel and resources for independent medical examiner(s) for investigations and reports to specify the cause of death in overdose cases.

- Justification/Background:
  - By arresting the source of supply dealers and traffickers who bring this into our communities are removed from the streets.

    - District Attorneys want causation experts to provide the reports before they will go forward with prosecution, particularly in cases where there are poly-drugs in the victim's system.

- Action Step:
    - Expenditure of settlement funds to update curriculums and hire, train, and retain staff.
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity: **Not applicable; these questions were not included in the 2022 Annual Report.**
- Links:
    - Enhanced State Opioid Overdose Surveillance