Recommendation #1

A retrospective assessment or/ and prospective study would be conducted to assess the outcomes of patients following discharge from detoxification and examine mortality and overdose.

Submission Details

- Submitted by Chelsea Cheatom on 8/20/2025

Justification/Background

Previous studies (Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study; https://doi.org/10.1136/bmj.326.7396.959) have shown that treatment reduces mortality but sometimes increases in mortality are seen when tolerance is reduced and people return to opiate misuse (relapse). This study, either prospective or retrospective, can be used to examine mortality and relapse after opioid detoxification to develop best practices for continued care after treatment within the state. Previous studies have found reduced mortality when individuals received MOUD and or residential treatment.

Associated Research/Links

1) Strang J, McCambridge J, Best D, Beswick T, Bearn J, Rees S et al. Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. BMJ 2003; 326:959 doi:10.1136/bmj.326.7396.959

2) Walley, A. Y., Lodi, S., Li, Y., Bernson, D., Babakhanlou-Chase, H., Land, T., & Larochelle, M. R. (2020). Association between mortality rates and medication and residential treatment after in-patient medically managed opioid withdrawal: A cohort analysis. Addiction, 115(8), 1496-1508. doi: 10.1111/add.14964. https://pubmed.ncbi.nlm.nih.gov/32096908/ which showed that mortality risk was reduced in individuals who received medication treatment (0.81 all-cause deaths & 0.52 opioid-related deaths per 100 person years), residential treatment (1.27 all-cause & 1.06 opioid-related deaths per 100 person years), or a combination of the two (fewer than 1.23 all-cause and opioid-related deaths per 100 person years), relative to those who did not receive treatment (2.04 all-cause deaths & 1.42 opioid-related deaths per 100 person years) within the 12 months following detoxification.

3) Foglia, R., Kline, A., & Cooperman, N. A. (2021). New and Emerging Opioid Overdose Risk Factors. Current addiction reports, 8(2), 319–329. https://pubmed.ncbi.nlm.nih.gov/33907663/

4) Williams A. R. (2022). Commentary on Burns et al: MOUD saves lives, especially after 60 days, and the longer the better. Addiction (Abingdon, England), 117(12), 3089–3090. https://doi.org/10.1111/add.16043

5) Heimer R., Black, A., Hsiuju, L., et al (2024). Receipt of opioid use disorder treatments prior to fatal overdoses and comparison to no treatment in Connecticut, 2016–17. Drug Alcohol Depend. 1:254:111040. https://pubmed.ncbi.nlm.nih.gov/38043226/

AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(c)Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

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(e) Evaluate ways to improve and expand evidence-based or evidence-informed

programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

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(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b)Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1)Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2)Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3)Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4)Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

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(c)Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

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(h)Examine qualitative and quantitative data to understand the risk factors that contribute to substance use and the rates of substance use and substance use disorders, focusing on special populations.

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(q)Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;

(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;

(4) The use of the money described in section 10.5 of this act to improve racial equity; and

(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Focus Population(s)

g. Other populations disproportionately impacted by substance use disorders

Action Steps

- DHHS Policy

Short-Term or Long-Term

- Short-term (Under 2 years)

Fiscal Note Requirement

- Unsure

Impact of Recommendation *(on a scale of 1-3)*

- 2 - This recommendation could expand requirements for service referrals after a patient completes treatment

Urgency of Recommendation *(on a scale of 1-3)*

- 1- This is a study, so it is not urgent

Capacity & Feasibility of Recommendation *(on a scale of 1-3)*

- 3 - Data is currently available that could be reviewed

Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)*

- 3 - This recommendation could help with best practices for referring patients following detoxification

Possible Presenters on this Recommendation

- Possibly: John Hamilton with Liberation Programs, Inc. who presented on this at the RX Summit. *(presented at June 17, 2025 Subcommittee meeting)*

Recommendation #2

Recommend to Nevada Department of Human Services that they financially support the implementation of hospital emergency room-based peer recovery support teams. This could be via dedicated general funds made available to hospitals, or by encouraging applications for use of Fund for Resilient Nevada monies.

Submission Details

- Submitted by Steve Shell on 6/17/2025

Justification/Background

Hospital emergency rooms continue to struggle with a high volume of patients who present with substance misuse and often with co-occurring mental health conditions. A high percentage of these individuals have multiple visits to the ERs for various reasons that are associated with their substance misuse. The ER teams do their best to evaluate, treat and connect to community services, but many of their team members lack the expertise to effectively manage substance misuse and do not have lived experience like peer recovery support specialists. Evidence has shown that connecting individuals with substance misuse to a peer while in the ER leads to better outcomes as the peer can help navigate a transfer to treatment options in the community as well as maintain communication with the individual for a period of time to encourage recovery. Hospitals would be more motivated to establish peer support teams if financial assistance is provided on a long-term basis.

Associated Research/Links

None provided

AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1)Help persons at risk of a substance use disorder avoid developing a substance use disorder;

(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;

(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and

(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

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(c) Assess and evaluate existing pathways to treatment and recovery for persons

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(q) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;

(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;

(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;

(4) The use of the money described in section 10.5 of this act to improve racial equity; and

(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Focus Population(s)

My recommendation does not focus on a special population

Action Steps

- Expenditure of Opioid Settlement Funds

Short-Term or Long-Term

- Short-term (Under 2 years)

Fiscal Note Requirement

- Unsure

Impact of Recommendation *(on a scale of 1-3)*

- 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, establishing peer support teams is the most efficient way to address these individuals to get them connected to community resources as quickly as possible

Urgency of Recommendation *(on a scale of 1-3)*

- 3 - Due to the high volume of patients with substance misuse in hospital emergency rooms around Nevada, it is imperative that we act quickly to establish peer support teams that are extremely effective to connect individuals to treatment and guide them on their path to recovery

Capacity & Feasibility of Recommendation *(on a scale of 1-3)*

- 3 - Due to CASAT's phenomenal certification program for peer recovery support specialists, there are many peers around Nevada who can be hired by hospitals to work in emergency rooms

Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)*

- 2 – None provided

Possible Presenters on this Recommendation

- Sean Hampton with Foundation For Recovery
- A representative from CASAT

Recommendation #3

Contingency Management can be used to support people in recovery through rewards for reaching their recovery goals. Increasing funding to support contingency management could help more providers offer this important support program to patients.

Submission Details

- Submitted by Chelsea Cheatom on 9/25/2025

Justification/Background

Contingency management has been a strategy used to reward people for treatment and recovery goals. While there may be funding in the state to support contingency management, it is not currently covered by Medicaid (as far as I know). Additional support could help to support more treatment providers to incentivize patients reaching their treatment goals

Associated Research/Links

- https://cherishresearch.org/news-and-events/news/incentivizing-recovery-payment-policy-and-implementation-of-contingency-management/
- https://pmc.ncbi.nlm.nih.gov/articles/PMC9045772/
- https://library.samhsa.gov/sites/default/files/contingency-management-advisory-pep24-06-001.pdf

AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

(f) Examine support systems and programs for persons who are in recovery from opioid use disorder and any co-occurring substance use disorder.

AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b)Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;
(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;
(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and
(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(c) Study, evaluate and make recommendations to the Department of Health and Human Services concerning the use of the money described in section 10.5 of this act to address substance use disorders, with a focus on:

(1) The use of the money described in subsections 1, 2 and 3 of section 10.5 of this act to supplement rather than supplant existing state or local spending;
(2) The use of the money described in section 10.5 of this act to support programs that use evidence-based interventions;
(3) The use of the money described in section 10.5 of this act to support programs for the prevention of substance use disorders in youth;
(4) The use of the money described in section 10.5 of this act to improve racial equity; and
(5) Reporting by state and local agencies to the public concerning the funding of programs to address substance misuse and substance use disorders.

Focus Population(s)

My recommendation does not focus on a special population.

Action Steps

- Bill Draft Request (BDR)
- Expenditure of Opioid Settlement Funds
- DHHS Policy

Short-Term or Long-Term

- Long-term (2+ years)

Fiscal Note Requirement

- Unsure

Impact of Recommendation *(on a scale of 1-3)*

- 2 - People in treatment and recovery can gain financial supports to help them stay in recovery

Urgency of Recommendation *(on a scale of 1-3)*

- 1 – N/A

Capacity & Feasibility of Recommendation *(on a scale of 1-3)*

- 2 - We believe that SNHD is supporting this effort currently (perhaps Jessica Johnson could provide detail) and some providers are supporting contingency management in a smaller scale

Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)*

- 2 - This will help to support people in treatment financially

Possible Presenters on this Recommendation

- One of the researchers from the studies attached, Jessica Johnson from SNHD, may have suggestions. I believe that Partida Corona Medical Center may be supporting this effort already

Recommendation #4

Elimination of prior authorizations needed for starting medication assisted therapy with buprenorphine and buprenorphine products of all types for opioid use disorder.

Submission Details

- Submitted by Jose Maria Partida Corona, MD, FASAM on 3/22/2026

Justification/Background

Prior authorizations present an unnecessary delay in initiation of treatment for opioid use disorder. In the era of fentanyl, this can be a particularly dangerous delay of care, as it can often result in a patient relapsing and dying of an unintended overdose while waiting for the medication to be approved. All of which can be avoided by eliminating the barrier that is prior authorization. The best way is to mandate coverage for any and all buprenorphine products when being used to initiate treatment for opioid use disorder by any insurance, but specifically Nevada Medicaid and all Medicaid products including MCOs, as well as Medicare. As it is, no prior authorization is required to initiate Sublocade or Brixadi, which are injectable versions of buprenorphine and which are the most costly options for treatment, so this change will, in fact, generate savings for Medicaid, as less expensive, but equally effective options may be exercised readily.

Associated Research/Links

- Ferries E, Racsa P, Bizzell B, Rhodes C, Suehs B. Removal of prior authorization for medication-assisted treatment: impact on opioid use and policy implications in a Medicare Advantage population. J Manag Care Spec Pharm. 2021 May;27(5):596-606. doi: 10.18553/jmcp.2021.27.5.596. PMID: 33908274; PMCID: PMC10390915.

AB374 Section 10 Requirement(s) Assigned to the Treatment and Recovery Subcommittee and Align with this Recommendation

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

(e) Evaluate ways to improve and expand evidence-based or evidence-informed programs, procedures and strategies to treat and support recovery from opioid use disorder and any co-occurring substance use disorder, including, without limitation, among members of special populations.

AB374 Section 10 Requirement(s) that are Cross-Cutting and Align with this Recommendation

(b) Assess evidence-based strategies for preventing substance use and intervening to stop substance use, including, without limitation, the use of heroin, other synthetic and non-synthetic opioids and stimulants. Such strategies must include, without limitation, strategies to:

(1) Help persons at risk of a substance use disorder avoid developing a substance use disorder;
(2) Discover potentially problematic substance use in a person and intervene before the person develops a substance use disorder;
(3) Treat the medical consequences of a substance use disorder in a person and facilitate the treatment of the substance use disorder to minimize further harm; and
(4) Reduce the harm caused by substance use, including, without limitation, by preventing overdoses.

(c) Assess and evaluate existing pathways to treatment and recovery for persons with substance use disorders, including, without limitation, such persons who are members of special populations.

Focus Population(s)

My recommendation does not focus on a special population.

Action Steps

- DHHS Policy
- Change Medicaid policy to eliminate prior authorizations for buprenorphine products of all kinds.

Short-Term or Long-Term

- Long-term (2+ years)

Fiscal Note Requirement

- No fiscal note

Impact of Recommendation *(on a scale of 1-3)*

- 3 - It will help prevent delay of care for patients that are actively seeking treatment for opioid use disorder by allowing them access to lifesaving medications in a timely fashion.

Urgency of Recommendation *(on a scale of 1-3)*

- 3 – These are unforced errors that our medical system creates CURRENTLY and on a daily basis.

Capacity & Feasibility of Recommendation *(on a scale of 1-3)*

- 3 - It would really only require Medicaid to change its policy and ban prior authorizations in this, very specific, situation.

Advances Racial and Health Equity due to Recommendation *(on a scale of 1-3)*

- 3 - It would allow much better access to treatment for opioid use disorder, regardless of the patient's current insurance. This would lead to better health equity between those that are privately insured and those that are insured by Medicaid.

Possible Presenters on this Recommendation

- Dr George Kaiser
- Dr Maureen Strohm
- Dr Stephanie Zority
- Dr Brian Kaszuba
- Kate Jessop