Statewide Substance Use Response Working Group (SURG)

2023 Prevention and Harm Reduction Recommendations: Summary

1. (#1 in Annual Report Rankings) Recommend to DHHS/DPBH/the Bureau of Behavioral Health Wellness and Prevention to double the amount of investment in SAPTA primary prevention programming (i.e., increase from current $12 million to $24 million for this biennium) for ages 0-24 and review the funding allocations annually. This funding should not be at the expense of existing programming.

2. (#3 in Annual Report Rankings) Expand Medicaid billing opportunities for preventive services and allow blended and braided funding to facilitate services to expand access to care for youth and adults.

3. (#5 in Annual Report Rankings) Create a bill draft request to amend the NRS for a 15 percent set aside of tobacco control and prevention funds from the Fund for a Healthy Nevada. This would be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.

4. (#7 in Annual Report Rankings) Support Harm Reduction through: Make a recommendation to DHHS to utilize opioid settlement dollars to designate a baseline level of identification and overdose reversal medication for the next 10 years in Nevada (base this on the state naloxone saturation plan) to create a stable, sustainable source of overdose reversal medication throughout the state.

5. (#8 in Annual Report Rankings) Support Harm Reduction through: Implement changes to recruitment, retention, and compensation of health and behavioral health care workers and enhance compensation in alignment with the Commission on Behavioral Health Board's letter to the Governor of June 22nd. Additionally, continue to sustain and expand investment in Community Health Workers, Peer Recovery Specialists, and Certified Prevention Specialists by implementing changes to recruitment, retention, and compensation.

6. (#10 in Annual Report Rankings, **Harm Reduction)** Create a bill draft request at the legislature to change the Nevada paraphernalia definition as it relates to smoking supplies. (See proposed draft language change to N.R.S. 453.554 in justification.)

7. (#13 in Annual Report Rankings, **Harm Reduction)** Establish a statewide initiative for community drug checking that incorporates qualitative and quantitative drug checking and includes the following parameters:

- Work with harm reduction community to identify partners/ locations and provide guidance and training.
- Start all sites with mail-based testing while piloting on-site drug checking in a subset of early adopters to refine implementation needs.
- Standardize the data collection, entry, testing, mailing, analysis, reporting as a best practice. Make this as transparent of a process as possible.
- Articulate principles and plans for what will happen to the data.

8. (#14 in Annual Report Rankings, **Harm Reduction)** Harm Reduction Shipping Supply: Provide for shipping costs for evidence-based harm reduction supplies (e.g., naloxone, sharps, fentanyl test strips, etc.) and for travel costs for the pickup of used sharps products to be returned for destruction. Increase advertising about shipping programs to rural Nevada. In collaboration with local agencies and through community conversations, establish local support for harm reduction efforts. Establish an alternative strategy for harm reduction supply delivery if people can't receive delivery of the supplies directly.

9. (#15 in Annual Report Rankings, **Harm Reduction)** Recommend a bill draft request to equalize PRSS so it is equal to or exceeds CHW reimbursement. Add an educational requirement around evidence-based harm reduction to both PRSS and CHW certification.

10. (#18 in Annual Report Rankings) Support Harm Reduction through: Create a recommendation to the legislature modeled on Maryland's STOP Act which authorizes certain emergency medical services providers to dispense naloxone to individuals who received treatment for a nonfatal drug overdose or were evaluated by a crisis evaluation team, and requires certain community services programs, certain private and public entities, and hospitals to have a protocol to dispense naloxone to certain individuals free of charge under certain circumstances.

11. (Unranked in Annual Report Rankings) Recommendation to the DHHS (Office of Analytics/or the appropriate entity) to create a data dashboard or other type of regularly updated report on alcohol outlet, tobacco outlet, and cannabis outlets density.

Detailed Recommendations

Recommendations are numbered according to their ranking in the 2023 Annual Report.

Recommendation #1 (Prevention)

Recommend to DHHS/DPBH/the Bureau of Behavioral Health Wellness and Prevention to double the amount of investment in SAPTA primary prevention programming (i.e., increase from current $12 million to $24 million for this biennium) for ages 0-24 and review the funding allocations annually. This funding should not be at the expense of existing programming.

- Justification/Background:
  - While there are strong, evidence-based primary prevention programs that are in place in Nevada along with a robust coalition network, there is not enough financial support to reach all students with primary prevention programming. The most effective interventions target salient risk and protective factors at the individual, family, and/or community levels and are guided by relevant psychosocial theories on substance use. This funding should be allocated on a per pupil basis to ensure maximum reach within the state.

    Nevada was not selected for the Strategic Prevention Framework – Partnership for Success funding from SAMHSA this year, which historically has provided funding for primary prevention (Nevada received an annual $2,260,000 award for the past five years).

The 2022 National Drug Control Strategy report on cost effectiveness of prevention states that "Prevention is not only effective, it is also cost effective approach to prevent later SUD have been identified as an underutilized response to the opioid crisis. The 2016 Surgeon General's Report on Alcohol, Drugs, and Health also noted that prevention science demonstrates that effective prevention interventions exist, can markedly reduce substance use, and evidence-based programs and policies are underutilized. There are multiple examples of cost-effective prevention programs. For example, the average effective school-based prevention program is estimated to save $18 per dollar invested… There are also cost-benefit assessments of individual programs. Too Good for Drugs, a school-based prevention program for students in kindergarten through 12th grade, was designed to increase social competencies (e.g., develop protective factors) and diminish risk factors associated with alcohol, tobacco, and other drug use. It has a benefit-to-cost ratio of + $8.74 and it is estimated that there is a 94-percent chance that benefits will exceed costs. Other effective and cost-effective programs include Botvin Life Skills which has benefit-to-cost ratio of $13.49, and the Good Behavior Game with a benefit-to-cost ratio of $62.80."

- Action Step:
  - Expenditure of Opioid Settlement Funds
  - DHHS Policy
  - Other – Expenditure of other funds/reappropriation of general fund dollars
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: This long-term investment in Nevada's youth can reduce substance use and risk behavior in our state.
  - **Capacity & feasibility of implementation**: We have a strong coalition infrastructure that is already engaging stakeholders and schools in primary prevention programming; additional resources are needed to reach saturation.
  - **Urgency**: This is an emerging crisis and an ongoing need for youth.
  - **Racial and health equity**: Equitable education to learn about substance use and allhealth risk improves opportunities for healthy choices and reduces risk over time.
- Links:

  - SAPTA 9/26/2023 "Funding Update: SPF-PFS Grant for Nevada" email
  - Griffin, K. W., & Botvin, G. J. (2010). Evidence-based interventions for preventing substance use disorders in adolescents. Child and adolescent psychiatric clinics of North America, 19(3), 505–526. https://doi.org/10.1016/j.chc.2010.03.005
  - American Medical Association (AMA) Substance Use and Pain Task Force (2023). *Overdose Epidemic Report 2023*. AMA Overdose Epidemic Report (ama-assn.org), p. 19.

Recommendation #3 (Prevention)

Expand Medicaid billing opportunities for preventive services and allow blended and braided funding to facilitate services to expand access to care for youth and adults.

- Justification/Background:
  - There is a body of research that indicates investing in Tier 1 and Tier 2 services saves money and provides better outcomes and prevents people from needing Tier 3.
- Action Step:
  - Support efforts to expand Provider Type 60 to include reimbursement for preventive services
  - Require DHHS to revise reimbursement rates and utilize expenditure funds to match the national average reimbursement rate for services
  - Require DHHS to identify any gaps in Medicaid reimbursement for the delivery of care to support prevention
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: This would help Medicaid embrace health and wellness alongside the medical model which would give us tools to get ahead of these important issues. We need to have the ability to be proactive. This will have a profound impact in the long term.
  - **Capacity & feasibility of implementation:** Will need to look at different CPT codes/billing options for facilities to exist. Will need to identify where the gaps are, and opportunities will be. There is quite a bit of infrastructure building that will need to take place.
  - **Urgency**: There is a need to continue to work on this, but it will take some time. It is vital to work on this now.
  - **Racial and health equity**: Addressing gaps in provider services can help improve health outcomes.
- Links:
  - American Medical Association (AMA) Substance Use and Pain Task Force (2023). Overdose Epidemic Report 2023. AMA Overdose Epidemic Report (ama-assn.org), p. 19.

Recommendation #5 (Prevention)

Create a bill draft request to amend the NRS for a 15 percent set aside of tobacco control and prevention funds from the Fund for a Healthy Nevada. This would be distributed using a local lead agencies model to reach $2 per capita, a recommended funding goal from the Nevada Tobacco Control & Smoke-free Coalition and subject matter experts.

- Justification/Background:
  - This funding recommendation was recommended and supported by the Nevada Tobacco Control & Smoke-free Coalition. With the $2 per capita support, this brings the total to

$6.2 million for tobacco control and prevention statewide in Nevada. This would move Nevada's national ranking for tobacco control and prevention funding to 24th instead of its current position at 47th in the nation. The CDC recommendation for Nevada Tobacco Control and Prevention is $30 million to mitigate morbidity and mortality (Ahlo, M., (7/17/23). Presentation to the SURG Prevention Subcommittee).

Fifteen percent set aside of the approximate $41 million received annually for the State of Nevada would be about $6.15 million, which gets close to the $2 per capita.

The intent of this recommendation is that it should not be at the expense of current Prevention programming/funding or existing NRS set aside for the millennium scholarship.

- Other relevant background information:
    - 1 in 6 Nevada teens use electronic vapor products.
    - This is important because we know that tobacco use is the number 1 cause of preventable illness and death in the United States.
    - Tobacco kills more than 480,000 people annually. More than alcohol, car accidents, illegal drugs, murders, suicides, and HIV/AIDS - COMBINED.
    - Use of electronic cigarettes often lead to co-use or commercial tobacco use.
    - Prevention is key. 90% of adult smokers started before the age of 18.
    - Nevada’s Youth Vaping Prevalence Rate:
    - Current ever tried rate for high schoolers 36.7% (2021)
    - Current ever tried rate for middle schoolers 12.6% (2021)
    - Current past 30 days user high school 17.6% (2021)
    - Current past 30 day user middle school 13.4% (2021)
    - (programs were implemented in high schools across Nevada for vaping prevention and demonstrated a reduction on the YRBS between 2019 - 2021 for all groups except middle school 30-day use (group that was not the focus of the intervention)).
    - In 2023, Youth Vaping Prevention Funding was eliminated.
- Nevada Tobacco Revenue
    - The overall total of $231+ Million from Cigarette Taxes, Other Tobacco Taxes and Settlement Funding is broken down below to demonstrate how much is allocated for tobacco control and prevention.
    - $145.2 million of Cigarette Taxes / $0 for tobacco control and prevention
    - $30.8 million of Other Tobacco Taxes / $0 for tobacco control and prevention
    - $14.6 million Juul Settlement / $0 for tobacco control and prevention
    - $41 million Master Settlement Funding / $950,000 for tobacco control and prevention
    - This equals .004% allocated in Nevada to Tobacco Control and Prevention efforts.
- To reiterate: CDC Recommendation for Nevada Tobacco Control and Prevention is $30mil. This ranks Nevada currently as 47th in the country for Tobacco Control and

Prevention funding. According to the CDC, 2.55 million U.S. middle and high school students reported current (past 30-day) e-cigarette use in 2022, which includes 14.1% of high school students and 3.3% of middle school students. Nearly 85% of those youth used flavored e-cigarettes, and more than half used disposable e-cigarettes. In Nevada, funds for youth vaping prevention have been reduced in 2023.

- Action Step:
  - Identifying funding sources alternative to FRN that can support these statewide programs
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: Vaping prevention efforts focus on youth, which is a population of focus for the SURG, and is relevant to the impact of this recommendation.
  - **Capacity & feasibility of implementation**: There is capacity and feasibility to implement this.
  - **Urgency**: This should be considered urgent, given the statistics shared by Malcolm Ahlo, Tobacco Control Coordinator at SNHD:
    - Tobacco kills at a higher rate than alcohol, car accidents, illegal drugs, murders, suicides, and AIDS combined.
    - Tobacco use remains the leading cause of preventable death, even though traditional tobacco or commercial use has declined.
    - Cannabis/marijuana/tobacco and other mechanisms such as vaping.
  - **Racial & health equity**: Many tobacco companies target communities of color.
- Links:
  - Nevada YRBS Data https://www.unr.edu/public-health/research-activities/nevada-youth-risk-behavior-survey
  - CDC Tobacco Funding Recommendations https://www.cdc.gov/tobacco/stateandcommunity/tobacco-control/program-funding/index.html
  - CDC Tobacco Control Best Practices https://www.cdc.gov/tobacco/stateandcommunity/guides/index.html
  - Nevada Legislature 2023 Session
  - From earlier submission: https://www.cdc.gov/media/releases/2022/p1007-e-cigarette-use.html

Recommendation #7 (Prevention)

Support Harm Reduction through: Make a recommendation to DHHS to utilize opioid settlement dollars to designate a baseline level of identification and overdose reversal medication for the next 10 years in Nevada (base this on the state naloxone saturation plan) to create a stable, sustainable source of overdose reversal medication throughout the state.

- Justification/Background:

    - While the Bureau has made strides to utilize grant funding to identify naloxone, fentanyl test strips, and xylazine test strips, it remains imperative that a baseline level of access to overdose reversal medication (such as naloxone) exists in order to meet on-going needs of community members. Reliance on grant funding alone can leave gaps in access to overdose reversal medications and increases risk for fatal overdose. Other states have utilized past distribution efforts, modeling, and other statistical formulas to project estimated number of naloxone doses needed for sustainable overdose reversal planning and engagement.

- Action Step:
    - Expenditure of Opioid Settlement Funds
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
    - **Impact**: Access to opioid overdose reversal medication during time of overdose (like naloxone) is an evidence-based best practice that is associated with saving lives.
    - **Capacity & feasibility of implementation**: This initiative aligns directly with legislation on opioid litigation funds; expertise on overdose reversal medication, purchase, and distribution already exists within DHHS and affiliates; a naloxone saturation plan has been developed for the state.
    - **Urgency**: Moderate urgency - current naloxone access in the state relies solely on grant funding (e.g., SAMHSA State Opioid Response), which creates vulnerability for long-term sustainable access.
    - **Racial & health equity**: Multiple publications have outlined the current system (nationally) inequitably distributing naloxone across populations at risk, however, research on addressing the gaps is limited. One study on the cascade of care for naloxone engagement (and re-engagement) among people who use drugs found disparities in the re-engagement continuum such that White persons who inject drugs (PWID) were most likely to have ever and recently received naloxone, while Latino/a/x and Black PWID were least likely (https://www.sciencedirect.com/science/article/pii/S0376871621002544). Identifying opportunities to engage and re-engage PWID and PWUD in naloxone access with an eye toward reducing disparities, such as using peer networks to distribute naloxone and equitable access across neighborhoods.
- Links:
    - This article summarizes the process for establishing naloxone saturation. Likely underestimates true need as it does not include non-fatal overdoses and drug checking data: https://www.thelancet.com/article/S2468-2667(21)00304-2/fulltext
    - This article summarizes the net benefit of naloxone access over the counter, and highlights the continued barrier of affordability for people at risk of opioid overdose: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7894851/

- Summary from national experts on overdose education and naloxone distribution (OEND) programs on best practices for community based naloxone distribution: https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-022-00639-z

Recommendation #8 (Prevention)

Support Harm Reduction through: Implement changes to recruitment, retention, and compensation of health and behavioral health care workers and enhance compensation in alignment with the Commission on Behavioral Health Board's letter to the Governor of June 22nd (2022). Additionally, continue to sustain and expand investment in Community Health Workers, Peer Recovery Specialists, and Certified Prevention Specialists by implementing changes to recruitment, retention, and compensation.

- Justification/Background:
  - As detailed in the August 2023 meeting of the SURG Prevention Subcommittee, there has been tremendous movement and momentum for recognizing the important contributions of CHWs by ensuring that the funds (i.e., Medicaid reimbursements) are at a high enough level to provide competitive and livable wages.

    Those working as Peer Recovery Specialists and Certified Prevention Specialists deserve similar compensation levels for their unique and important contributions to supporting our fellow Nevadans.
- Action Step:
  - Bill Draft Request (BDR)
  - There may be pathway for PRSS's and Prevention Specialists in the "slipstream" of the momentum and pathway carved by CHWs in the 2023 legislative session. Perhaps leverage this for the 2025 session.
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: HIGH -- If successful in having PRSSs and Prevention Specialists at parity with CHWs, we would have onboard all of the Big Three paraprofessional professions that are key to building strong, effective, and sustainable strategies for mitigating harm from substance abuse.
  - **Capacity & feasibility of implementation**: Because of the trailblazing done by CHW advocates, there is already demonstrated capacity and feasibility for implementation of incorporating PRSSs and Prevention Specialists.
  - **Urgency**: HIGH -- It is vitally important that we get all of the needed workforce pieces in place so that we don't unintentionally handicap efforts going forward.
  - **Racial & health equity**: These sorts of services advance racial and health equity. This is done in two ways. On the workforce development side, these are considered "attainable" professions for folks who might otherwise want to work in healthcare but feel that the barrier of entry is too high for more traditional points of entry (i.e., nurses, doctors).

Indeed, data from the NV Community Health Worker Association demonstrates that their most recent training cohort are primarily people of color. Secondly, because paraprofessionals are not as expensive as more traditional supports (i.e., masters-level mental health counselors, psychologists), they are more often utilized and deployed to provide services to people of color where funds are not widely available.

- Links:
  - The value of Peer Recovery Specialists is widely acknowledged for the "lived experience" that informs the interactions of each and every Peer Recovery Specialist. According to SAMHSA's "National Model Standards for Peer Support Certification" page on their website, a primary goal of President Biden's 2022 Presidential Unity Agenda (which indicates strategies for addressing the nation's mental health crisis), "A primary goal outlined within this strategy is accelerating the universal adoption, recognition, and integration of the peer mental health workforce across all elements of the healthcare system."
    Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships (Mead & McNeil, 2006). By sharing their own lived experience and practical guidance, peer support workers help people to develop their own goals, create strategies for self---empowerment, and take concrete steps towards building fulfilling, self---determined lives for themselves. (From "Value of Peers", 2017, SAHMSA)
    According to SAHMSA ("Value of Peers," 2017), the Peers appear to provide the following benefits to clients:
    - Increased confidence and self-esteem
    - Increased sense of control and ability to bring about changes in their lives
    - Raised empowerment scores
    - Increased sense that treatment is response and inclusive of needs
    - Increased sense of hope and inspiration
    - Increased empathy and acceptance (camaraderie)
    - Increased engagement in self care and wellness
    - Increased social support and social functioning
    - Decreased psychotic symptoms
    - Reduced hospital admission rates and longer community tenure
    - Decreased substance use and depression

    As for Certified Prevention Specialists, these are folks with specialized training in providing evidence-based curricula and programs for the purposes of dissuading the substance use or abuse. As we move towards acknowledging the importance of offering comprehensive school-based programs that can help to address all factors including those that contribute to elevated ACE scores, it is important that we have a trained workforce able to do this very important work.
    Per the IC&RC's website, "Today’s communities face a myriad of challenges – violence, drug abuse, crime, illness – but those problems, and the long-term damage they can cause, can be prevented, with appropriate education and intervention. Prevention-based

programs are taking that message to schools, workplaces, faith-based organizations, and community centers in the U.S. and 22 countries around the world. The success of these programs relies on a competent, well-trained, ethical and professional workforce of Prevention Specialists.

"The Affordable Health Care for America Act of 2010, Substance Abuse and Mental Health Services Administration's (SAMHSA) "8 Strategic Initiatives," and the 2011 National Drug Control Strategy have placed prevention in the forefront of health care reform efforts across the country. Local, state, and national organizations are struggling to keep up with the tremendous demand for new prevention professionals.

"Credentialed prevention staff ensure that programs and their funders are delivering on their mission of ensuring public safety and well-being. A thorough understanding of prevention and the latest evidence-based practices for treatment is the hallmark of a qualified professional. The Prevention Specialist credential requires professionals to demonstrate competency through experience, education, supervision, and the passing of a rigorous examination.

"Adopted in 1994, the Prevention Specialist (PS) is one of the fastest growing credentials in the field of addiction-related behavioral health care. There are now more than 50 U.S. states, territories, and countries that offer a reciprocal PS credential."

Recommendation #10 (Harm Reduction)

Create a bill draft request at the legislature to change the Nevada paraphernalia definition as it relates to smoking supplies. (See proposed draft language change to N.R.S. 453.554 in justification.)

- Justification/Background:
  - Fentanyl has rapidly become a primary opioid in the illicit drug supply. Fentanyl, especially in its pill form, is most often smoked rather than injected, both by individuals who are new to opioid use and by those experienced in injecting black tar heroin. Along with a parallel increase in the use of methamphetamine, which is also commonly smoked, the prevalence of opioid and stimulant smoking is quickly overtaking injection as a primary and frequent route of administration. This strategy is a significantly less risky mode of administration for people who are unwilling or unable to stop using drugs. A person's overall drug-related risk is lowered every time they choose to smoke instead of inject. Studies have found that participants who inject drugs are often willing to switch to smoking or other modes of administration when feasible, and that non-injection routes of administration may pose less risk of overdose. Many of the harms of injection drug use, such as endocarditis, skin infections, and vein damage, are injection specific. In addition to being harmful to individual health, endocarditis, HIV, and HCV are expensive to treat, and place a considerable economic burden on the public health system. Expansion of access to these supplies for public health purposes are additionally important for reducing risk for exposure to tuberculosis outbreaks and COVID-19. Harm reduction services for people who use drugs are almost entirely focused on injection. Access to safer smoking supplies creates safer-use options for people who don't inject, or who prefer stimulants as

a primary drug. This broadens the reach of harm reduction services and offers an additional pathway into care and recovery.

- Proposed draft language to change NRS 453.554:

N.R.S. 453.554

453.554. "Drug paraphernalia" defined

1. Except as otherwise provided in subsection 2, as used in NRS 453.554 to 453.566, inclusive, unless the context otherwise requires, "drug paraphernalia" means all equipment, products and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing or ingesting, a controlled substance in violation of this chapter. The term includes, but is not limited to:

(a) Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

(b) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing or preparing controlled substances;

(c) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance;

(d) Testing equipment, other than testing products, used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness or purity of controlled substances;

(e) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances;

(f) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose and lactose, used, intended for use, or designed for use in cutting controlled substances;

(g) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining marijuana;

(h) Blenders, bowls, containers, spoons and mixing devices used, intended for use, or designed for use in compounding controlled substances;

(i) Capsules, balloons, envelopes and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances; and

(j) Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances.

2. The term does not include:

(a) Any type of hypodermic syringe, needle, instrument, device or implement intended or capable of being adapted for the purpose of administering drugs by subcutaneous, intramuscular or intravenous injection; or

(b) Testing products.

3. As used in this section:

(a) "Fentanyl test strip" means a strip used to rapidly test for the presence of fentanyl or other synthetic opiates.
(b) "Testing product" means a product, including, without limitation, a fentanyl test strip, that analyzes a controlled substance for the presence of adulterants.

- Note that the proposed suggested changes to NRS are based on the changes the Maine legislature made in 2021 to remove many items from the drug paraphernalia law, including smoking equipment.

- Action Step:
  - Bill Draft Request (BDR)
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: Studies have found that participants who inject drugs are often willing to switch to smoking or other modes of administration when feasible, and that non-injection routes of administration may pose less risk of overdose. Many of the harms of injection drug use, such as endocarditis, skin infections, and vein damage, are injection specific. In addition to being harmful to individual health, endocarditis, HIV, and HCV are expensive to treat, and place a considerable economic burden on the public health system. Expansion of access to these supplies for public health purposes are additionally important for reducing risk for exposure to tuberculosis outbreaks and COVID-19.
  - **Capacity & feasibility of implementation**: Nevada already has multiple laws and policies supporting access to harm reduction services, such as syringe services/harm reduction programs and reduced drug-paraphernalia for drug checking equipment for personal overdose prevention (e.g., fentanyl test strips). Making safer smoking equipment more widely available in partnership with harm reduction programs can provide more opportunities for effective health communication. This can reduce health care barriers and improve health outcomes.
  - **Urgency**: Fentanyl has rapidly become a primary opioid in the illicit drug supply. Fentanyl, especially in its pill form, is most often smoked rather than injected, both by individuals who are new to opioid use and by those experienced in injecting black tar heroin. Along with a parallel increase in the use of methamphetamine, which is also commonly smoked, the prevalence of opioid and stimulant smoking is quickly overtaking injection as a primary and frequent route of administration. This strategy is a significantly less risky mode of administration for people who are unwilling or unable to stop using drugs.
  - **Racial & health equity**: Harm reduction services for people who use drugs are almost entirely focused on injection. Access to safer smoking supplies create safer-use options for people who don't inject, or who prefer stimulants as a primary drug. This broadens the

reach of harm reduction services and offers an additional pathway into care and recovery. Harm reduction programs can connect people who smoke drugs (PWSD) to a wider array of harm reduction education, materials, and linkage with health care and substance use treatment. In addition, engaging PWSD, especially with younger adults, may slow the development or escalation of substance use disorder and/or transition into injection.

- Links:
  - Example briefing from Washington State: https://adai.uw.edu/wordpress/wp-content/uploads/SaferSmokingBrief_2022.pdf
  - CDC: Issue Brief: Smoking Supplies for Harm Reduction.
  - Maine legislation: https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0732&item=1&snum=130

Recommendation #13 (Harm Reduction)

Establish a statewide initiative for community drug checking that incorporates qualitative and quantitative drug checking and includes the following parameters:

- ***Work with harm reduction community to identify partners/ locations and provide guidance and training.***
- ***Start all sites with mail-based testing while piloting on-site drug checking in a subset of early adopters to refine implementation needs.***
- ***Standardize the data collection, entry, testing, mailing, analysis, reporting as a best practice. Make this as transparent of a process as possible.***
- ***Articulate principles and plans for what will happen to the data.***

- Justification/Background:
  - There is an increasingly unstable drug supply, and potency can vary significantly from batch to batch. There is a wide range of cutting agents, some of which can be quite harmful, including Xylazine, Levamisole and synthetic opioids. The unpredictability of the drug supply has a direct impact on overdose rates and negative health effects. Currently, people who use drugs in Nevada lack broad access to quantitative drug checking services, which has been shown to prevent overdoses and change drug using behavior. Additionally, collection of this data as a dashboard reported to the public could inform tailored community interventions and resources.
  - This recommendation was workshopped by the Prevention subcommittee from recommendation submissions by Prevention Vice Chair Schoen, Chair Jessica Johnson, and SURG committee member Lisa Lee. (See SURG Prevention and Harm Reduction Recommendations August 2023 for earlier submissions).
- Action Step:
  - Work with harm reduction community to identify partners/ locations and provide guidance and training.
  - Start all sites with mail-based testing while piloting on-site drug checking in a subset of early adopters to refine implementation needs.

- Standardize the data collection, entry, testing, mailing, analysis, reporting as a best practice. Make this as transparent of a process as possible.
- Articulate principles and plans for what will happen to the data.

- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact:** This could have a profound impact for public health and safety. If we provide accessible drug checking services they empower people to make informed decisions and reduce their risk of overdose. At the community level, it would allow public health entities and community based organizations and harm reduction organizations to have a more comprehensive approach to addressing substance use and overdose prevention.
  - **Capacity & feasibility of implementation:** There is an existing infrastructure through harm reduction advocates to implement this. However, due to recent changes to state law that increased penalties for people who possess drugs that contain fentanyl, there is a risk for criminal penalty. One additional challenge is distributing the needed funding to smaller community based harm reduction organizations.
  - **Urgency:** This is urgent, because of escalating overdoses, particularly around fentanyl. These innovative "boots on the ground" approaches are needed to promote evidence-based strategies to keep people safe. This can negate risks associated with substance use and create safer communities.
  - **Racial & health equity:** Offering accessible drug checking services helps to address system inequities by providing a community-based intervention for all people who use drugs to engage in harm reduction measures, and access to information to make an informed choice. BIPOC communities have historically not been connected to the same resources and do not have the same social supports that alleviate substance use related harms within their communities. Involving community members who are harm reductionists in the design and implementation can help make sure this program is attuned to the unique needs and challenges based on disproportionately impacted populations, making it more inclusive and equitable.
- Links:
  - Nextdistro is a national Harm Reduction Program that partners with local programs to ship overdose prevention supplies to individuals that need it. Trac-B/Impact Exchange in Las Vegas is a partner. Www.nextdistro.org
  - American Medical Association (AMA) Substance Use and Pain Task Force (2023). Overdose Epidemic Report 2023. AMA Overdose Epidemic Report (ama-assn.org), pp. 15, 16, 20.

Recommendation #14 (Harm Reduction)

Harm Reduction Shipping Supply: Provide for shipping costs for evidence-based harm reduction supplies (e.g., naloxone, sharps, fentanyl test strips, etc.) and for travel costs for the pickup of used sharps products to be returned for destruction. Increase advertising about shipping programs to rural Nevada. In collaboration with local agencies and through community conversations, establish local support for harm reduction efforts. Establish an alternative strategy for harm reduction supply delivery if people can't receive delivery of the supplies directly.

- Justification/Background:
    - Syringe exchanges and harm reduction programs are not available throughout most of the state and distance should not be a barrier for people to receive harm reduction services and products. Trac-B Exchange has served 13 counties with naloxone shipping and 16 counties with harm reduction supply shipping. They have had 24 reported reversals with shipped naloxone, and over 1100 requests for harm reduction supplies. These efforts could be scaled up to serve more people in all counties.
- Action Step:
    - Expenditure of Opioid Settlement Funds
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
    - **Impact**: Harm reduction shipping will allow people that do not have easy access to life-saving supplies such as fentanyl test strips, naloxone and sterile harm reduction supplies to have them mailed directly to them. Supporting the collection of used sharps focuses on supporting safe disposal and protects individuals and communities. This recommendation supports the scale up of an existing program with an incorporation of working with communities/community coalitions to develop additional strategies for disposal and delivery to people in need of naloxone and other harm reduction items.
    - **Capacity & feasibility of implementation**: Currently, Trac-B Exchange in Las Vegas works with NextDistro and ships supplies, but their efforts could be supported to allow for growth across the state. Shipping from one location costs less than opening a "brick-and-mortar" storefront but allows for clients to receive many of the same services. Because these services exist already in the state, it is possible to expand quickly. Trac-B Exchange has been shipping since February 2019. This would be a scale up of existing operations, funding an unfunded program, and supporting additional syringe disposal.
    - **Urgency**: Getting supplies to people who are currently using substances saves lives. People who use substances are dying of overdose in our communities and naloxone availability would save lives. Syringe disposal would allow people to prevent improperly disposing of sharps.
    - **Racial & health equity**: Shipping is for everyone and would serve populations without the ability to travel to or purchase supplies or get to a public health vending machine, storefront or van syringe exchange or pharmacy. Shipping allows for all people to receive products that can save their life, regardless of location or access to services. With the addition of alternative strategies if people can't receive delivery of supplies, this would expand harm reduction equity statewide. Incorporating community conversations allows for communities to participate.
- Links:

- Nextdistro is a national Harm Reduction Program that partners with local programs to ship overdose prevention supplies to individuals that need it. Trac-B/Impact Exchange in Las Vegas is a partner. Www.nextdistro.org
- American Medical Association (AMA) Substance Use and Pain Task Force (2023). Overdose Epidemic Report 2023. AMA Overdose Epidemic Report (ama-assn.org), pp. 15, 16, 20.

Recommendation #15 (Harm Reduction)

Recommend a bill draft request to equalize PRSS so it is equal to or exceeds CHW reimbursement. Add an educational requirement around evidence-based harm reduction to both PRSS and CHW certification.

- Justification/Background:
  - Nevada has a robust peer recovery specialist credentialing program and the community prevention coalitions utilize both peers and community health workers on staff that provide support to their communities in various ways which could include harm reduction efforts that are for the communities they serve. Peers are every bit as effective as community health workers in providing therapeutic social support(s); as such, it is important for them to be reimbursed through Medicaid at a similar, if not higher, level.
- Action Step:
  - Expenditure of Opioid Settlement Funds
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: HIGH - If there were a contender for "most impactful strategy" with respect to workforce development, the widespread utilization of CHWs (and Peers and Prevention Specialists) would be at the top of the list. From recruitment to sustainability, these paraprofessionals are the most widely accessible and easily deployable -- not to mention the most eager -- members of the workforce to utilize and mobilize in providing Nevadans with the supports they need to mitigate any harm from possible substance use or abuse, including harm reduction efforts.
  - **Capacity & feasibility of implementation**: The good news is that many of the community coalitions throughout Nevada are already utilizing CHWs and Peers in harm reduction efforts like Naloxone training and distribution, and other strategies. These coalitions have also done the hard work of helping the communities they serve be more receptive to the importance of considering and utilizing harm reduction strategies.
  - **Urgency**: HIGH - Time is of the essence -- the longer we delay in standing up this very important strategy, the slower we will be to bring the full benefits to Nevada residents.
  - **Racial & health equity**: The use of paraprofessionals helps to promote diversity within the workforce (according to the NCHWA, the most recent cohort of CHW trainees is more than 50% people of color). As well, they are uniquely positioned to be able to have

an outsize positive influence relative to more traditional professions (i.e., masters-level therapists, psychiatrists, etc.).

- Links:
  - None provided.

Recommendation #18 (Prevention)

Support Harm Reduction through: Create a recommendation to the legislature modeled on Maryland's STOP Act which authorizes certain emergency medical services providers to dispense naloxone to individuals who received treatment for a nonfatal drug overdose or were evaluated by a crisis evaluation team, and requires certain community services programs, certain private and public entities, and hospitals to have a protocol to dispense naloxone to certain individuals free of charge under certain circumstances.

- Justification/Background:
  - While the Bureau has made considerable strides to develop MOST/FAST teams and crisis stabilization centers, there is still considerable work to ensure naloxone is provided to individuals when they are vulnerable to overdose (e.g., when being released from incarceration, being released from the hospital, etc.) Maryland's legislation requires evaluation of individuals experiencing non-fatal overdose at these key junctures and requires dispensation of naloxone to these individuals. Further, exploring how to give medication free of charge (and in-hand from hospital discharge) is imperative to ensure access to people at risk of overdose.

    From the 2022 Annual Report: One harm reduction tool to address the increase in fatal opioid overdoses is naloxone, a safe and highly effective Food and Drug Administration-approved medication that reverses opioid overdoses. In studies, naloxone efficacy has ranged between 75 and 100 percent. One study from Brigham and Women's hospital in Massachusetts concluded that of those individuals given naloxone, 93.5 percent survived opioid overdose.

    In Maryland, the STOP Act legislation expanded access to naloxone in two ways. First, it authorized emergency medical services (EMS) personnel, including emergency medical technicians (EMTs) and paramedics, to dispense naloxone to an individual who experienced a nonfatal overdose or who was evaluated by a crisis response team for possible overdose symptoms. Second, the legislation established that within 2-years of passage, community services programs, including those specializing in homeless services, opioid treatment, and reentry, must develop protocols to dispense naloxone free of charge to individuals at risk of overdose. Both approaches help get naloxone into the hands of those who are most at risk. It is worth noting that Nevada leaders in the legislature and governor's administration have already taken many steps to increase naloxone availability across the state, such as with the passage of The Good Samaritan Drug Overdose Act of 2015 (Senate Bill 459, Chapter 26, Statutes of Nevada 2015 NRS 453C.120). This Act allows greater access to naloxone, an opioid overdose reversal drug

and has saved countless lives across Nevada since its passage. This proposed policy would expand these laws to allow health providers to dispense naloxone "leave-behind" or "take-home" kits so that people who use drugs have ready access to them if needed. Dispensing naloxone into the hands of people who use drugs has been found to be effective. One meta-analysis found that in the case of overdose, a take-home kit reduced fatality to one in 123 cases.

- Action Step:
  - Bill Draft Request (BDR)
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: Access to opioid overdose reversal medication during time of overdose (like naloxone) is an evidence-based best practice that is associated with saving lives.
  - **Capacity & feasibility of implementation**: This initiative aligns directly with legislation on opioid litigation funds; expertise on overdose reversal medication, purchase, and distribution already exists within DHHS and affiliates; DHHS has expanded capacity in 2022/2023 with MOST/FAST and crisis stabilization, these entities can be the first groups to engage in provision of naloxone for non-fatal overdoses.
  - **Urgency**: Opioid overdose reversal medication during time of overdose (like naloxone) is an evidence-based best practice that is associated with saving lives.
  - **Racial & health equity**: Research on addressing gaps in naloxone access is limited. One study on the cascade of care for naloxone engagement (and re-engagement) among people who inject drugs (PWID) found disparities in the re-engagement continuum such that White PWID were most likely to have ever and recently received naloxone, while Latino/a/x and Black PWID were least likely (https://www.sciencedirect.com/science/article/pii/S0376871621002544). Identifying opportunities to engage and re-engage PWID and PWUD in naloxone access with an eye toward reducing disparities, such as using peer networks to distribute naloxone and equitable access across neighborhoods is imperative to save lives. The impact of this recommendation will be dependent on the extent to which these crisis stabilization services have been impactful at addressing racial disparities in their services and programs.
- Links:
  - Link to a copy of the bill (HB0408): https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0408 Copy of the fiscal and policy note: https://mgaleg.maryland.gov/2022RS/fnotes/bil_0008/hb0408.pdf
  - Citations from the "justification" column:
  - [1] Rachael Rzasa Lynn and JL Galinkin, "Naloxone dosage for opioid reversal: current evidence and clinical implications," Therapeutic Advances in Drug Safety, 9:1 (Dec. 13, 2017), pp. 63-88. https://journals.sagepub.com/doi/10.1177/2042098617744161

- [2] Nadia Kounang, "Naloxone reverses 93% of overdoses, but many recipients don't survive a year," CNN Health, Oct. 30, 2017. https://www.cnn.com/2017/10/30/health/naloxone-reversal-successstudy/index.html
- [3] Rebecca McDonald and John Strang, "Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria," Addiction, 111:7 (July 2016), pp. 1177-87. https://onlinelibrary.wiley.com/doi/10.1111/add.13326
- American Medical Association (AMA) Substance Use and Pain Task Force (2023). Overdose Epidemic Report 2023. AMA Overdose Epidemic Report (ama-assn.org), pp. 5, 12.

Recommendation (Unranked) (Prevention)

Recommendation to the DHHS (Office of Analytics/or the appropriate entity) to create a data dashboard or other type of regularly updated report on alcohol outlet, tobacco outlet, and cannabis outlets density.

- Justification/Background:
  - Overall, there is evidence from U.S. studies to suggest that higher outlet density is associated with alcohol-related harm. Greater alcohol outlet density is associated with higher rates of intimate partner violence and child abuse and neglect. There is strong scientific evidence that regulating alcohol outlet density is an effective intervention for reducing excessive alcohol consumption and related harms.
- Action Step:
  - DHHS data recommendation
- Impact, capacity & feasibility of implementation, urgency, and how the recommendation advances racial and health equity:
  - **Impact**: This would provide a baseline of information needed to complement information at the state level to inform better decisions about interventions. This would have a notable impact and is a first step in identifying opportunities for communities to identify additional policies or program/interventions around outlets and how they correlate with other health outcomes.
  - **Capacity & feasibility of implementation**: here is high capacity and feasibility for implementation.
  - **Urgency**: This is urgent.
  - **Racial & health equity**: There is currently no coordinated effort to collect this information on a regular basis and cross-mapping where people live will help to identify if, and to what degree, there are higher alcohol, tobacco, and cannabis density in communities of color relative to other communities. This can help to advance racial and health equity.
- Links:

- Sacks, J. J., Brewer, R. D., Mesnick, J., Holt, J. B., Zhang, X., Kanny, D., Elder, R., & Gruenewald, P. J. (2020). Measuring Alcohol Outlet Density: An Overview of Strategies for Public Health Practitioners. Journal of public health management and practice: JPHMP, 26(5), 481–488. https://doi.org/10.1097/PHH.0000000000001023
- County Health Rankings: https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/alcohol-outlet-density-restrictions