



Opioid Response Summit 2019



# OPIOID RESPONSE SUMMIT

## FINAL REPORT OF NEVADA'S SUMMIT PROCEEDINGS

AUGUST 2019



# Acknowledgments

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# Opioid Response Summit 2019

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# Introduction and Background

The State of Nevada has been working to address the opioid crisis. A proactive response, beginning in 2014 and continuing today, has included strategies at all levels for change, from policies, systems, and programs to services for individuals. Preliminary data suggests that Nevada's efforts are making a difference.

Nevada has employed a cross-sector approach to addressing the opioid crisis. Individuals, community-based organizations, governmental agencies, and businesses have worked together to advance meaningful change.

This document highlights proceedings from Nevada's second statewide opioid summit, Nevada's Opioid Response 2019. It provides an overview of activities that emerged from then Governor Brian Sandoval's 2016 Prescription Drug Summit. It shares both the efforts and results of some of the processes based on the first opioid summit, which launched many efforts throughout the state.

In March 2017, Nevada passed AB 474, making several changes relating to overdose and prescribing of opioids. Passage of this bill precipitated considerable development of processes to provide information and awareness to prescribers, licensing boards, and the public. AB 474 expanded and updated state laws related to the reporting of drug overdoses, provided prescribing protocols for healthcare providers who prescribe controlled substances for the treatment of pain, and enacted the Prescribe 365 initiative. AB 474 also complemented Senate Bill 459, the Good Samaritan Drug Overdose Act, which was passed unanimously in 2015.

Between 2014 and the present, Nevada has received multiple grants to fund efforts to address opioids. In 2017, Nevada received a considerable award of funding, allowing the state to pursue many of the recommendations from the Governor's Opioid Summit in 2016, including expansion of prevention and treatment programs, providing increased access to naloxone to reduce overdose deaths, and education for prescribers on the implementation of medication-assisted treatment (MAT) and Prescribe 365 in AB 474.

In April 2018, Nevada was recognized in *Prescription Nation 2018: Fighting America's opioid epidemic* as one of only two states in the nation to have addressed all six recommendations made by the National Safety Council for addressing the opioid crisis. This recognition was formal and external validation that Nevada has taken a comprehensive and strategic approach to address the crisis.

Since 2016, continuous activity has taken place to improve data infrastructure and sharing, develop new programs and strengthen existing programs, bring new resources to the state to address the crisis, and to communicate – across silos – toward shared results. The 2019 Opioid Response Summit convened August 14-15, 2019 in Las Vegas, Nevada to highlight progress made to date and plans for the future.

The response to the opioid crisis has shown that people in Nevada share the responsibility to find solutions and that their partnerships are a pathway to more collaborative systems that have helped people with opioid use disorder, as well as other substance use disorders (SUD) while combatting this public health crisis.



# Plenary and Keynote Sessions

## Welcome and Overview

Richard Whitley, Director of the Nevada Department of Health and Human Services welcomed participants and introduced the Honorable Steve Sisolak, Governor of the State of Nevada. Governor Sisolak welcomed participants to Nevada's Opioid Response Summit and made the following remarks:

*As we all know and have seen first-hand, opioid misuse is a serious issue negatively impacting families and hurting communities all across our state. But there is hope and it's because all of you, and the organizations you represent, who have dedicated yourselves to the fight. I thank you for your commitment to this serious issue.*

*This Summit is an opportunity to learn, share, and make connections that will help you to better serve Nevadans. Over the next two days, you will hear from many speakers who will share their stories and expertise. These are the law enforcement and medical professionals, the judges, attorneys, and representatives of diversion programs, and, most importantly, the families and the individuals who have experienced addiction firsthand.*

*Some stories are heart-breaking, and some provide hope and a light at the end of a dark tunnel. This summit has the opportunity to be life-changing as you learn and share ideas to help our fellow Nevadans. Throughout this Summit, you will hear the progress that has been made, and the work that is being done on the state and local level. The ideas that you bring forward will have an opportunity to grow and evolve as the next steps in this important fight are discussed. I encourage you all to share what you've seen in the field, listen to your fellow attendees, and learn from the many experiences that you will hear about over the next two days.*

*In the Silver State, we are moving the dial on opioid addiction – we know this from the numbers -- the data that is gathered from all of you. The use of the Prescription Drug Monitoring Program, which is now required by law, has dramatically increased the amount of data the state has available to develop a focused response for Nevada communities. In early 2014, there were about 121,000 queries of this system. In 2018 that number had jumped to more than 700,000 queries—a nearly 500% increase over 4 years. This change is a huge step to ensure that prescriptions are being made available to those who need them, while keeping them out of the hands of those who may be looking to merely make a profit from these powerful drugs.*

*Another notable change is the significant decrease – 57% overall since 2017 – in people who were prescribed both benzodiazepines and opioids in the same month, a combination that we know is a leading cause of accidental overdose. This availability of data is critical. As we fight this epidemic, obtaining reliable information is a key piece of this conversation.*

*These are all great steps in combating opioid abuse, and each change represents a mom, dad, daughter, son, or friend, who is now a healthier part of our community. Nevadans from Las Vegas, to Sparks, to Elko and everywhere in between, have been touched by this epidemic. The improvements and understanding of treatment and recovery services, opportunities for pain management, and research and data, are all keys to winning this battle for all Nevadans.*

*Again, thank you for your work and unwavering commitment to this fight. I hope you find the presentations throughout this Summit valuable, and I encourage you to take what you learn back to your communities as we come together to create a healthier Nevada.*



## Opioid Response Summit 2019

### State of the State – Where are we now, where are we headed?

#### **Objective**

This session reoriented Summit participants to the scope of the opioid issues in Nevada. The comprehensive panel discussion included an overview of opioid and other substance abuse related issues as they exist in Nevada today. Panelists reviewed data, discussed changes in prescribing rates and practices, fatal and non-fatal overdose data, changes, and progress made in the State's treatment infrastructure.

#### **Presenters**

##### **Keith Carter, Director**

Nevada High Intensity Drug Trafficking Area (HIDTA)  
Program

##### **Stephanie Woodard PsyD,**

Senior Advisor on Behavioral Health,  
Department of Health and Human Services  
Division of Public and Behavioral Health

##### **Yenh Long, PharmD, BCACP**

Program Administrator  
Nevada State Board of Pharmacy

#### **Summary**

Keith Carter, Director of High Intensity Drug Trafficking Area (HIDTA) Program began the panel.

- Drug use is a national issue. In the U.S., one in ten Americans use illicit drugs. The national drug strategy is working to “build a stronger, healthier, drug free society today and in the years to come by drastically reducing the number of Americans losing their lives to drug addiction in today’s crisis.”
- He shared information about the role, scope, and direction of HIDTA. The focus includes:
  - Preventing the start of drug use
  - Providing treatment services leading to long-term recovery for those suffering from addiction
  - Aggressively reducing the availability of illicit drugs in America’s communities.

Carter spoke to recent trends in Nevada, from 2016-19:

- Nevada has fewer pharmaceutical drugs on the streets than before, but more counterfeit pharmaceutical drugs.
- Trafficking, sales and use of methamphetamine remains high, and methamphetamine is sometimes blended with opioid drugs.
- Trafficking, sales, and use of heroin remains stable.
- Black-market marijuana is robust, and sometimes counterfeit marijuana products are blended with opioids.
- Cocaine trafficking and use has dramatically increased.

Next, Dr. Woodard highlighted important recognitions that Nevada received.

- Nevada has moved the needle in all five areas of the U.S. Health and Human Services (HHS) 5-point strategy: 1) addiction, prevention, treatment, and recovery services; 2) data; 3) pain management; 4) targeting of overdose reversing drugs; and 5) research.
- Nevada was one of two states recognized in 2018 by the National Safety Council for addressing six key indicators:
  - Mandating prescriber education
  - Implementing opioid prescribing guidelines
  - Integrating Prescription Monitoring Program (PMP) into clinical settings
  - Improving data collection/sharing





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- Treating opioid overdose
- Increasing availability of opioid use disorder treatment

Dr. Woodard also provided an overview of Nevada's key responses to the opioid crisis.

- **Expanding Access to Medication Assisted Treatment.** Nevada has made progress in expanding the availability of medication assisted treatment (MAT) but there are remaining challenges to helping more people have access. A survey of buprenorphine providers showed that while there are nearly 200 buprenorphine-waivered physicians in Nevada, not all prescribe and not all prescribe to their limits. Provider reimbursement was an important factor in providers not prescribing to the limit allowed. Nevada is working to continue access to MAT in rural and urban areas.
- **Implementation of Integrated Opioid Treatment and Recovery Centers (IOTRCs).** IOTRCs have been envisioned and implemented. They provide American Society of Addiction Medicine (ASAM) patient placement, mobile recovery outreach teams, peer recovery support, and IOTRCs are able to screen, assess, stabilize and hand-off to other services and programs.
- **Overdose Education and Naloxone.** Policy changes and new practices have helped to make naloxone more available within communities to prevent overdose. To date, nearly 5000 (4,925) naloxone kits have been distributed, and 277 reported reversals (note that reversals are not required to be reported). Warm handoff to a treatment provider has been identified as an important component of improving survival rates from overdose.
- **Monitoring of Opioid-Related Overdose Deaths.** Since 2010, opioid-related deaths have decreased. Law Enforcement and Public Health are working together to watch trends closely to respond to fentanyl hotspots. Polysubstance use is a critical factor related to overdose death seen through Nevada's surveillance.

Yenh Long presented on the state of policies related to prescribing with a focus on AB 239.

- Controlled substances for the treatment of pain can be highly effective and medically necessary. However, the current opioid epidemic and overdose rates associated with prescription drug underscores that such medications are not without inherent risks.
- Nevada's legislation does not tell prescribers when or how they can prescribe. The bill establishes a standard of care for prescribers so that, if prescribing such medications is clinically indicated, the prescriber and patient have the needed information to move forward with that prescription with some degree of confidence that the benefits outweigh the risks.
- Nevada opioid prescriptions decreased from 2017 to 2018. The change is unprecedented among states.
  - Opioid prescriptions with less than a 30-day supply decreased by 53%.
  - Opioid prescriptions with greater than or equal to a 30-day supply and less than a 90-day supply decreased by 24%.
  - Opioid prescriptions with greater than or equal to a 90-day supply decreased by 50%.
- All Nevada counties observed a decrease in both the number of and rate of opioid prescriptions by month, with the decrease in rates ranging from 25% (Lincoln) to 56% (Humboldt).
- Despite decreases, the Nevada PMP shows that prescribing rates are higher than the national average and even higher than CDC estimates for the state. This points to the need for continued efforts.

**The presentation for this session can be found in the resources section.**



# Opioid Response Summit 2019

## Luncheon Keynote Address

**The Honorable Aaron Ford, PhD, MA, JD**

Attorney General, State of Nevada

Attorney General Ford was introduced by Terry Kerns, Nevada's first Substance Abuse and Law Enforcement Coordinator. The following are remarks from Attorney General Ford's keynote address:

*Nationwide and in Nevada, opioids – prescription and illicit – are the main driver of drug overdose deaths. Nobody is safe, as this affects individuals, families and communities, and costs the US hundreds of billions of dollars each year in crime, lost work productivity, and health care. According to the CDC, from 1999-2017 almost 400,000 people died from an overdose involving any opioid, including prescription and illicit opioids. In 2017, the number of opioid deaths was 6 times higher than in 1999. On average, 130 Americans die every day from an opioid overdose. In Nevada, from 2010 to 2018 emergency department encounters increased by 97% and inpatient admissions increased by 97%, and opioid-related hospitalization visits with stays of 15 or more days increased by 119%.*

*Given the magnitude of the epidemic facing Nevada, I've made it a priority for my office to combat the crisis, and we have collaborated with other state agencies in order to examine this issue and work to protect our communities. Manufactures of opioids have promoted the idea that pain should be treated by taking long-acting opioids continuously and supplementing them by also taking short acting opioids. But patients develop tolerance to opioids relatively quickly and as tolerance increases a patient typically requires progressively higher doses, but higher doses often arrest respiration altogether. Manufacturers designed and implemented a sophisticated and deceptive marketing strategy to create a series of misperceptions in the medical community and ultimately reverse the long-settled understanding of the risks of opioids. The manufactures promoted and profited in the billions from their misrepresentations about the risks and benefits of opioids even though they knew the marketing was false and misleading. Distributors compounded the systematic and deceptive marketing schemes by facilitating the supply of far more opioids than could have been justified to serve the market, including into Nevada. For all of these reasons, in June of this year, my office filed an expanded complaint to bring justice to multiple conspirators responsible for the opioid crisis that killed thousands of Nevadans, and devastated our health care and public safety systems. The Complaint lists over 40 defendants. Manufacturer defendants include Teva Pharmaceuticals, Actavis Pharma, Purdue Pharma, members of the Sackler family which controlled Purdue Pharma, SpecGX LLC, Mallinckrodt LLC, as well as top executives of Insys Therapeutics, and various entities created by manufacturers and their executives to hide assets and evade liability. Distributor defendants include McKesson Corporation, Cardinal Health LLCs, AmerisourceBergen Drug Corporation, Walgreen Co., Walmart Inc. and CVS Pharmacy.*

*The defendants created an unprecedented public health crisis for their own profit and the deaths of thousands of Nevadans is on their hands. Their conspiracy to dupe doctors into prescribing more and more deadly and addictive pills has left countless Nevada families and the state suffering in the wake of their greed. Their blatant disregard for human life shocks the conscience. My office will not rest until they pay for the devastation they have caused to our state. Legal causes of action include violations of Nevada's Deceptive Trade Practices Act,*



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*False Claims Act, Racketeering Act, negligence, and public nuisance. Purdue Pharma defendants also face allegations of violating a 2007 Consent Decree with the state.*

*At the AG's Office, I believe our job is justice, and that doesn't always mean locking people up and throwing away the key. Justice sometimes means we refuse to give up on people who suffer from addiction and a variety of mental health conditions. Drug courts help participants recover from use disorder with the ultimate goal of reducing future criminal activity. Initiating drug abuse treatment in prison and continuing treatment upon release is critical to both individual recovery and to public health and safety. Drug courts are used as an alternative to incarceration, and reduce the burden and costs of repeatedly processing low - level, non - violent offenders through the nation's courts, jails, and prisons while providing offenders an opportunity to receive treatment and education. Drug court participants are required to abstain from substance use, to be accountable for their behavior and to fulfil the legal responsibilities of the offenses they have committed.*

*As a part of my office's commitment to addressing Nevada's opioid epidemic, we have developed and executed a four-pronged plan to combat this growing problem using non-taxpayer dollars (funding derived from \$5.3M Volkswagen settlement). We hired Terry Kerns as Nevada's first Substance Abuse Law Enforcement Coordinator. In addition to being an FBI Special Agent, she is a registered nurse who brings a wealth of experience and knowledge with degrees in the medical profession and emergency management. Fundamentally, she is ensuring a coordinated response to the opioid crisis in NV and will endeavor to bridge the gap between local law enforcement and state victims service providers. She has also been critical to our community outreach and educational campaigns:*

- ✓ She's presented to the legal, law enforcement and medical communities.*
- ✓ She's presented to all health classes at Carson City High School for the past 2 years.*
- ✓ She provides continuing education to the Nevada Advanced Practice Registered Nurses, the Nevada Nurses and the Nevada Paramedics groups.*
- ✓ She plans and executes training opportunities to administer anti-overdose drugs to those in need.*

*We purchased incinerators to safely dispose of drugs that have been delivered to safe locations across our State in Boulder City, Elko County, Mineral County, Nye County and Storey County (they are all within Sheriff's Offices). All incinerators are in place and fully operational. The goal is to reduce the supply of unused prescription drugs in the home should reduce the risk of diversion and harm. Experts recommend incineration of these drugs as the most safe and proper method of disposal in order to minimize the impact on the environment. Encouraging community participation in prescription drug take-back programs is only as effective as the State's ability to destroy these dangerous drugs.*

*We've provided with the Department of Health and Human Services with \$250,000 to purchase anti-overdose (naloxone) drugs to help save more lives.*

- ✓ 56 Law enforcement and first responder agencies across the state have been supplied with 2,927 2-dose units of naloxone.*
- ✓ 13 Distribution across Nevada sites have distributed over 3,516 units of naloxone (including the Integrated Opioid Treatment and Recovery Centers).*



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- ✓ *With the assistance of County Coalitions, Overdose Education and Naloxone Distribution trainings have distributed 1,506 2-dose naloxone kits to members of the community statewide.*
- ✓ *With the assistance of County Coalitions, Overdose Education and Naloxone Distribution trainings have distributed 1,506 2-dose naloxone kits to members of the community statewide.*

*And, we've provided \$500,000 to after-school prevention and education programs to encourage students like you to live healthy lives free of opioid abuse, and provided \$675,000 to the Department of Health and Human Services to strengthen efforts of statewide partners working on prevention and education efforts.*

*Boys and Girls Club of Truckee Meadows was granted \$500,000 to fund after-school programs for youth throughout the state in support of opioid, prescription drug and illicit drug prevention efforts. Adopting the Positive Action Program tackles drug prevention through a holistic approach that reaches children on a physical, intellectual, social, and emotional level. Replaces the (outdated) SMART program. The Boys and Girls Club of the Truckee Meadows identified six other programs around the state to implement this program.*

*Our Substance Abuse Law Enforcement Coordinator, Terry Kerns has been working diligently to implement Overdose Detection Mapping Application, also known as ODMAP. ODMAP was created by the Washington/Baltimore High Intensity Drug Trafficking Area to detect, track and log overdoses to facilitate real time drug overdose information sharing between law enforcement agencies fire departments, and emergency medical services.*

*This real-time drug overdose reporting will allow law enforcement and medical professionals to identify spikes in overdoses, even allowing geolocation of such spikes. Drug overdose events can be investigated regarding their cause, origin and the geographic spread of such overdoses. With this information, public health agencies can work to prevent additional overdoses through the implementation of appropriate response plans. Furthermore, law enforcement can use a variety of investigative methods available to trace the overdoses back to drug dealers, larger scale distributors, and ultimately, to the drugs' primary sources, including organized criminal syndicates. There is at least one agency from every county (17) signed up to use ODMAP. My office has submitted an application for a Bureau of Justice Affairs grant for ODMAP statewide implementation and response. This grant is \$700,000 over 2 years, and we should be hearing the results of this grant later this month. Terry is also working with all counties on their overdose spike response plans. The state targeted response (STR) grant provided some initial funding for each county to write their plans. We are also planning tabletop exercises (TTXs) that address the OD spike response plans.*

*I am proud of the impact my office has been able to make. We will continue to work with regional behavioral health coordinators to holistically address substance use disorder and mental/behavioral health issues throughout the State. This crisis has brought attention to the fact the addiction does not discriminate. We need to address the drivers of addiction in general if want safer and healthier communities. From a law enforcement perspective, this means reducing access and deflecting to treatment.*



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## Building Partnerships for Community Collaboration

### Objective

Panelists discussed local efforts by coalitions and groups that formed to respond to opioid addiction and overdose and their work to coordinate and collaborate on solutions to address substance use disorder (SUD). They highlighted innovative practices occurring at a local level to reduce morbidity and mortality from an opioid overdose. Program discussion included overdose education and naloxone distribution, Leave Behind Naloxone Program, Harm Reduction Coalition, Take Back Days, and Community Preparedness Overdose Response Plans.

### Panelists

**Darin Balaam**

Sheriff

Washoe County

**Jessica Flood, MSW**

Northern Regional Behavioral Health

Coordinator

Nevada Rural Hospital Partners

**Jessica Johnson, MPH**

Health Educator

Southern Nevada Health District

**Jamie Ross**

Executive Director

PACT Coalition for Safe and Drug-free

Communities

### Summary

- Local efforts that promoted coordination and collaboration in addressing SUD were noted by region as follows:
  - Washoe County: Law enforcement has used their position as leaders to bring people to the table. Law enforcement used to focus on community policing, but the culture is changing to service-based community policing. Naloxone kit distribution was conducted to identified inmates at risk of overdose. The Sheriff's Department has currently handed out 114 naloxone kits to inmates leaving the jail. Additionally, a detention services unit was created to collaborate and link inmates to services before and after leaving incarceration.
  - South: Southern Nevada Opioid Advisory Council (SNOAC) was formed at the summit three years ago to bring together various partners who were working to address the crisis into one coordinated effort. SNOAC evolved to incorporate medication-assisted treatment (MAT) which allowed for comprehensive conversations that brought in even more partners.
  - Rural Nevada: The Resilient 8 is an example of eight counties in Rural Nevada who have combined efforts and formed an effective collaboration to address the opioid crisis in the rural counties.
  - In discussing the importance of cross-sector representation for local planning efforts, panelists noted that inclusion of several sectors allows for representatives to establish a process of communication across fields, a shared language, and a shared vision.
- Challenges and strategies to overcome them included:
  - The perception of scarcity of resources can be overcome by having multiple counties at the table.
  - Resistance to MAT and needle exchange can be overcome if one of the counties is interested and can serve as a model for others.
  - There is an assumption by some partners and community members of enabling with MAT and needle exchange programs. It was only until deputies saw the positive outcomes of these options that buy-in occurred.
  - Communication within Clark County has proven to be difficult, but SNOAC now serves as the repository of program information. Additionally, relationships are key to the success of moving things forward, but relationship building takes time.
- Innovations highlighted by panelists included:



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- Storey County adapted Mobile Outreach Support Team (MOST) for rural counties and just received the Health Resources and Services Administration (HRSA) implementation grant.
- Washoe County is bringing service providers into the jail, and has seen collaboration, energy, and excitement surrounding this.
- In general, partners are bringing in conversation around harm reduction and working to educate service providers on how to frame a conversation using the correct terminology across sectors.

## Overdose Education and Naloxone Training

### ***Objective***

This training provided an evidence-based protocol for identifying signs and symptoms of an opioid overdose and the administration of naloxone and emergency medical support.

This session included a brief explanation of what naloxone is and how it works. The Surgeon General's advisory related to opioid overdose was shared as well as information about SB 459, which is Nevada's "Good Samaritan" law related to calling emergency services in the event of an overdose. Trainers also shared information on overdose prevention. The information included training on how to identify an overdose, how to respond to an overdose, how to use naloxone in an overdose situation, and a summary of frequently asked questions about naloxone. Following training on how to use naloxone and the contents of their naloxone kit, participants had an opportunity to ask questions and complete a survey about the training. Each participant was provided with a naloxone kit for use in an emergency.

**The presentation for this session can be found in the resources section**

### ***Panelists***

#### **Morgan Green**

Program Coordinator  
Center for the Application of Substance Abuse Technologies  
(CASAT)  
University of Nevada, Reno

#### **Brandon Delise, MPH**

Epidemiologist  
Southern Nevada Health District



## Opioid Response Summit 2019

### Special Presentation: Prescription for Hope – Emmy Award Winning Nevada Documentary

#### **Objective**

In 2017, the Department of Health and Human Services partnered with the Nevada Broadcasters Association to produce an opioid abuse awareness documentary. "Prescription for Hope: Overcoming Nevada's Opioid Addiction," features stories of people statewide who have struggled with opioid abuse or have seen loved one's battle or die from addiction. In June 2019, the film was awarded a regional Emmy® for the Pacific Southwest Chapter. This session included a special screening of the 30-minute documentary and a facilitated panel discussion with the producers and individuals who shared their stories in the documentary. Panelists were presented special recognition certificates from the office of Congresswoman Dina Titus at the conclusion of the session.

#### **Panelists**

##### **Eric Bonnici**

Vice President-Executive Director  
Nevada Broadcasters Association

##### **Ryan Mills**

Health Resource Analyst  
Nevada Department of Health and Human Services

##### **Al Polito**

Filmmaker  
Prescription for Hope

##### **Cyndi and Ed Yenick**

BubHugs and Overdose Lifeline



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### Review of Treatment System- Integrated Opioid Treatment and Recovery Centers (IOTRC) Overview

#### Objective

In 2017, Nevada was awarded the State Targeted Response (STR) Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). These grant funds have been used in large part to build out a Hub and Spoke treatment model. Panelists presented on how they have worked to translate the Hub and Spoke treatment model to criminal justice settings, the importance of peer support in the model, and how they have been able to bring the flexibility of mobile recovery outreach teams to different environments. Programs highlighted included Foundation for Recovery and the Center for Behavioral Health IOTRC. The Life Change Center was also discussed.

#### Panelists

**Krista Hales, PhD, MS**

Director

Integrated Opioid Treatment and Recovery Center  
Center for Behavioral Health

**Lisa Lee, MA, CPRSS**

Program Director

Foundation for Recovery

**Quintella Winbush**

Peer Recovery Specialist

Center for Behavioral Health

#### Summary

- Panelists shared how integrated opioid treatment and recovery centers (IOTRC) differ from traditional opioid treatment, noting IOTRC's build services around people, expanding the breadth and depth of services to tackle social determinants of health, including pre- and post-treatment engagement and more comprehensive services. IOTRC programming includes specific staff to client ratios, colocation of services, use of peer support services, innovative practices, including syringe vending machines, and MAT. IOTRCs offer MAT in every form so that all options available to patients.
- Syringe vending machines were identified as a mechanism to allow for conversations with individuals who might not have come into a treatment center before and encourages conversations around harm-reduction. Innovative strategies like this can help people overcome the fear of treatment as 22 people engaged in treatment because of the syringe vending machines.
- Panelists described the additional services required to be an IOTRC, including that it is person-centered, allows for mobility throughout systems, and relies on community partners, and thus expands the circle of care and support. IOTRC serves as the subject-matter experts or central intake; then through collaborative care units, they link people to services needed. This includes relying on Office-Based Opioid Treatment (OBOT) providers to practice to the top of their licenses and move people into choice in medication management, focusing on mobility and options.
- Peers were identified as an essential part of the workforce as peers help build relationships, offer sympathy and understanding, mitigate shame, offer hope, and demonstrate that recovery is possible, and re-engagement with families and employment can be accomplished. Peers encourage self-efficacy, autonomy, and self-determination. The question peers ask is: "How can we be the people we needed in our early recovery?" Peers were described as "hope dealers," asking "what gives you hope, what gives your life purpose?"
- Panelists shared best practices for developing and implementing a person-centered treatment and recovery plan emphasizing the use of a participatory rather than paternalistic model of care that is trauma-informed, patient-centered, holistic (financial, intellectual, social, spiritual), and provides access to autonomy and self-





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determination by asking clients what they need and addressing basic needs such as hunger, housing, and safety.

- It was emphasized that the peer role is about diminishing power differentials, listening to your patients, and letting them drive what their treatment will look like.
- Mobile recovery outreach teams support individuals who have survived opioid overdose through the structure of a team composed of a counselor and peer specialist. The team determines who should conduct the assessment. The assessment is non-clinical and focuses on basic needs. Discussion of treatment is the very last question. The process allows for a decision tree leading to either treatment or safety (naloxone, syringes, etc.) and further support. To provide support, cooperative agreements are important for ensuring immediate help. It is also important to support peers doing mobile recovery outreach because they are also in recovery and can be triggered by some circumstances. Law Enforcement Assisted Diversion (LEAD) and Las Vegas Metropolitan Police were highlighted as key players in mobile outreach.
- To address marginalized populations, programs recruit peer specialists who can provide culturally competent services and are looking to continue to expand these services to meet the diverse needs of the communities served. Additionally, street outreach services are conducted that seek to reach people facing high barriers.

**The handout for this session can be found in the resources section.**

### Luncheon Keynote Address

#### **Special Introduction by The Honorable Susie Lee**

United States House of Representatives  
Nevada, District 3

Representative Lee expressed her commitment to addressing the opioid crisis, shared her work to craft bipartisan solutions and her support for the work of those in attendance at the Summit. She then introduced Director Heidig.

#### *Presenter*

##### **Edward Heidig, JD**

Director, Region IX  
U.S. Department of Health and Human Services

Director Heidig, JD, serves as the Director of Region IX for the U.S. Department of Health and Human Services (HHS). He shared HHS' five goals, which are part of the national strategy to address the opioid crisis. These include: 1) improving access to prevention, treatment, and recovery services, 2) targeting the distribution and availability of overdose-reversing drugs, 3) advancing the practice of pain management, 4) strengthening timely public health data and reporting, and 5) supporting cutting-edge research. Director Heidig noted the movement at the federal level from policy to practices and that the 2018 SAMHSA Omnibus bill has supported many of the funding streams that Nevada has utilized in the state's opioid response. He included data on the scope of the opioid epidemic and how Region IX, of which Nevada is a part, is collaborating across states in the region. He also shared that he had conducted a listening session with stakeholders from Nevada the previous evening to learn more about what is working and what is needed. Director Heidig also shared statistics about HIV and noted that Clark County, Nevada has reported increased rates of HIV. The importance of testing and the role that health centers can play in reversing this trend was noted as well.

**The presentation for this session can be found in the resources section.**



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## Next Steps

Dr. Stephanie Woodard, Senior Advisor on Behavioral Health to the Department of Health and Human Services, closed the Summit by acknowledging the work of many colleagues and the panelists who made the Summit a success. She then shared that Nevada has been fortunate enough to receive a number of grants that include goals for the future. The plan moving forward is to build on the momentum gained thus far and continue to focus on the following efforts:

- Continue to evaluate programs that Nevada has funded and to provide meaningful contributions to the evidence base of programs.
- Promote prescriber education through Project ECHO, including promoting Medication Assisted Treatment (MAT), non-pharmacological treatments for pain, safe prescribing protocols, and best practices regarding the treatment of opioid use disorder.
- Support general medical practices in efforts to integrate care behavioral health care.
- Continue to identify and pursue alternatives to opioid medications across healthcare settings and evaluate the financing of non-opioid treatment options for pain management.
- Mainstream addiction treatment and behavioral healthcare, removing silos and expanding to medical care settings, Federally Qualified Health Centers, and primary care settings, including the promotion of MAT and reimbursement strategies.
- Promote universal screening, intervention, and referral to treatment (SBIRT), starting with OB/GYNs and moving into all general healthcare settings.
- Reduce Neonatal Abstinence Syndrome (NAS) through awareness, education, prevention programming, recovery and supportive services, and evidence-based treatment for pregnant women with opioid use disorder.
- Incorporate Zero Suicide into healthcare systems to reduce suicide deaths from opioid overdose.
- Bring Caring Communities to scale and engage community members, faith-based communities, and natural supports in partnership with Prevention Coalitions and the Office of Suicide Prevention.
- Pursue the Institution of Mental Disease exclusion through CMS to leverage Medicaid funding to reimburse for inpatient withdrawal management and residential substance use disorder treatment services.
- Work with law enforcement and continue to promote data and information sharing between public health and law enforcement.
- Develop recovery housing options with supportive services.
- Further develop Peer Recovery Support Services (PRSS) across communities to engage individuals in recovery and treatment.
- Continue community preparedness planning in the event of increases in overdoses to ensure community systems are prepared to respond.
- Implement the Crisis Now initiative, utilizing OpenBeds for high-quality referrals to treatment and social services systems.
- Continue HIV prevention services, education, and training for substance use treatment providers working with individuals with opioid use disorder.
- Support specialty courts for best practice implementation to address individuals with addiction.
- Expand the role of pharmacists as collaborative partners in the care of individuals prescribed opioid medications to identify and reduce risks for misuse, diversion, and overdose.
- Continue to build partnerships across sectors, with an emphasis on coordination of activities, data collection, analysis, and surveillance, dissemination of evidence-based practices, and ensuring our communities are healthier and safer.



# Breakout Sessions

## Opioid and Criminal Justice Re-Entry

### **Objective**

During this session, panelists discussed strategies for re-entry and reintegration into the community. Discussion included a wide range of topics including treatment, recovery support services, discharge planning, and re-entry into the workforce.

### **Panelists**

**Dona Dmitrovic, MA**

Executive Director  
Foundation for Recovery

**Denise L. Everett, MA, MFT, LCADC-S**

Executive Director  
Ridge House

**Robyn Feese, MA, LCADC, CPC, NCC**

Substance Abuse Administrator  
Nevada Department of Corrections

**John Ponder**

Executive Director  
Hope for Prisoners

**Patrick Quackenboss**

Officer of Parole and Probation  
Nevada Department of Public Safety

### **Summary**

- Panelists described the status of substance use disorder (SUD) treatment and medication assisted treatment (MAT) available in corrections settings. The Nevada Department of Corrections received a "High Adherence" rating from the Correctional Program Checklist. The assessment tool measures adherence to known principles for reducing criminal recidivism. Nevada's rating has significantly increased from the first evaluation finding of "No Adherence" in 2017.
- The complexities of re-entry, coupled with insufficient supports, continues to lead to relapse and overdose (e.g., moving from constriction to freedom, structure to no structure, and the overwhelming procedures to re-enter society). The focus has shifted to targeting the primary needs of individuals and addressing the criminogenic conditions of the individual and their unique circumstances.
- Treatment providers described the need for a warm handoff by providers to help individuals have the experience of accessing services pre-release. This includes working closely with the correctional facilities and case managers to ensure individuals are moving to a safe, structured environment when released. Making connections with individuals before their release is pivotal. Relationships with parole and probation are key to supporting the individual and mitigate any manipulation fully.
- Recovery capital is a key principle of empowering the successful recovery of individuals. Building recovery capital includes looking at existing supports and skills and developing a re-entry plan that will enable them to stay engaged in the recovery supports process.
- The recovery-oriented system of care model built up by wrap-around services helps address individual treatment needs to support a successful re-entry. A comprehensive and targeted approach to include addressing issues like housing helps ensure individuals continue to be in a safe, stable environment. It is important to note that services that do exist may have criteria that would prevent individuals from accessing services, including housing. Services have to reach beyond the explicit needs of the individual and support individuals in addressing barriers to their re-entry.



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- Peer-recovery support services help connect individuals to the community and provide navigation assistance and support. Connecting with someone with a lived experience gives people the hope that they can achieve sobriety and successful re-entry. Peer support services establish trusting relationships that can build the foundation of long-lasting supports and provide warm handoffs to traditionally "cold" resources.
- MAT pilot programs continue to expand and garner buy-in from providers and communities.
- The use of the word rehabilitation in many cases should be "habilitation" with regards to re-entry since many individuals have never learned these life skills. Skill programming does happen during incarceration but has to be evidence-based (e.g., effective coping skills, effective communication skills). Parole and Probation and the Department of Corrections (DOC) are beginning to work together to provide support before release to increase knowledge about barriers for re-entry.
- The DOC is seeing increased interest from businesses in employing ex-offenders. However, workforce development is an area that needs growth and can be supported by all community partners.

### Investigating the Data, Emerging Trends in Overdose Death

#### **Objective**

Panelists discussed emerging trends related to stimulants and opioid overdose. Participants gained an understanding of factors related to methamphetamine use as a risk factor for opioid overdose, and potential prevention, harm reduction, and treatment implications for unidentified opioid exposure.

#### **Panelists**

**Kathryn Barker, MPH**

Senior Epidemiologist  
Southern Nevada Health District

**Keith Carter**

Director  
Nevada, High Intensity Drug Trafficking Area  
Program

**Chelsi Cheatom**

Program Manager  
TracB Exchange

**Brandon Delise, MPH**

Epidemiologist  
Southern Nevada Health District

#### **Summary**

This session included an in-depth review of overdose trends in Nevada, highlighting geographic and substance use characteristics.

- Four presentations were provided to participants. The first presentation outlined the High Intensity Drug Trafficking Area (HIDTA) Program. HIDTA's National Overdose Reduction Strategy (ORS) was reviewed. HIDTA brings together diverse organizations to break down information silos. The ORS is partnered with the CDC and embraces enforcement, prevention, and treatment. The Overdose Detection Mapping Application Program (ODMAP) was developed by HIDTA to aid the ORS. Discussion about ODMAP answered questions about its application and accuracy.
- Southern Nevada Health District (SNHD) reported how they use data to inform and track the drug overdose epidemic in Clark County. Data is reported from a variety of sources – deaths, hospital visits, poison control, ODMAP, the National Emergency Medical Services Information System (NEMSIS) for suspected overdoses, naloxone administration and distribution, and the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE).
- SNHD tracks all deaths where a drug overdose is among the causes of death on the death certificate. This is useful to measure severity, impacted age groups, the types of drugs attributing to overdose deaths, and the location of residents who died from overdose. SNHD shared data on hospitalization and emergency room



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visits due to heroin and showed a heat map that showed emergency department (ED) visits due to heroin overdose by zip code. This illustrated the increase of heroin overdose in the county.

- Overdose deaths in Clark County due to heroin, synthetic opioids such as fentanyl and use of methamphetamines have increased by between 100 and almost 300% between 2012 and 2018. Psychostimulants are playing a significant role in changing overdose trends.
- SNHD can also track the distribution of naloxone. SNHD uses local overdose data to inform action, seek funding, identify hotspots, mobilize local resources, and support policy changes.
- One challenge is that deaths or overdoses from prescription drugs versus illicit drugs can skew data as that information is often not known.
- Trac-B Exchange operates the first storefront syringe service and harm reduction program in southern Nevada. The ability to operate this program was made possible by Nevada Senate Bill 410, which became effective in July of 2013. The bill allows Trac-B to provide sterile hypodermic devices to clients to reduce the transmission of disease. Trac-B data indicates that substances used by clients in the past 30 days included heroin (71%) followed by methamphetamines (59%).
- Trac-B clients reported that 40% have overdosed in the past. This is collected from naloxone kit refill forms, which are a source of data self-reported by kit recipients. 89 people self-reported using naloxone with 72 indicating the person did not die from overdose, 2 deaths from overdose and 15 instances where emergency services were called and either successfully intervened, or the outcome was unknown.
- Trac-B is also operating a fentanyl test strip program. Post-test results indicated that clients reported they would change their behavior as a result of the test strip findings. The study indicated that safe use techniques are important, as is the mode of use.
- The State Unintentional Drug Overdose Reporting System (SUDORS) was described as starting in Nevada in 2017 and is in place statewide with the Washoe County Office of the Medical Examiner, Clark County Office of the Coroner/Medical Examiners, Southern Nevada Health District, and State Department of Health and Human Services all using the system. The system provides demographics on deaths due to overdose as well as top drugs in causes of death presented in the initial findings.
- Panelists described how route of administration impacts changing trends and risk for communicable disease with increases in injection as a route of administration raising public health concerns related to communicable disease. They also noted an increase in polysubstance use, including use contributing to the cause of death. Circumstances preceding death included a history of mental illness treatment or mental health problem, followed by a physical health problem and substance abuse. Data is preliminary and included deaths that occurred between January 2017 and June 2018.
- Limitations for data include a lag from the time data is collected to when policy or practice can adapt, missing data, and the potential for recall bias with witness reports.
- Discussion included how to use the data and limitations of the data and data collection systems.

**The presentation for this session can be found in the resources section.**

## OpenBeds Demonstration

### *Objective*

In 2018 the Division of Public and Behavioral Health received grant funding from the Centers for Disease Control and Prevention (CDC) which is being used to implement the OpenBeds Network in Nevada. OpenBeds is an electronic treatment bed registry that will create a behavioral health referral network in the State of Nevada. The system allows for electronic referral from a hospital or office-based setting to a treatment provider. This session included a demonstration of the OpenBeds system and discussion for the State's implementation plans and priorities.



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## Panelists

### Steve Carroll

Vice President for Business Development

OpenBeds, Inc

### Elyse Monroy

Contracted Program Coordinator

Division of Public and Behavioral Health

CDC Opioid Crisis

### Rachelle Pellissier, MPA

Executive Director

Crisis Support Services in Nevada

Crisis Call Center – Sexual Assault Support Services

### Stephanie Woodard, PsyD

Senior Advisor on Behavioral Health

Department of Health and Human Services Division  
of Public and Behavioral Health

## Summary

- Panelists provided background as to why the State is incorporating OpenBeds into its data platforms and described the linkage with the implementation of the Crisis Now model. People in Nevada are placed on a legal 2000 (L2K) hold and this results in waits for emergency room beds for admission to an inpatient facility. The goal is to place individuals who need inpatient care in an appropriate setting and move away from the idea that a bed is the only solution. There is recognition that lower-level care is also an option. Currently, crisis responses focus in on de-escalation or a law enforcement referral; this system allows people to get the appropriate services needed. All levels of care are represented in the system.
- Nevada's current registry—HavBed—provides triage for medical services in the case of a catastrophic event. Prescribers have expressed concerns regarding connecting patients to care when a patient presents risk regarding addiction. With CDC funding, there is an opportunity to integrate Nevada's PMP with medical records; NarxCare, a robust analytics tool and care management platform that helps prescribers and dispensers analyze real-time controlled substance data from Prescription Drug Monitoring Programs (PDMPs) and manage substance use disorder, will run a risk score for dependency.
- OpenBeds is an end-to-end, closed-loop, behavioral health platform, and Software as Service (SAS) to make the referral process more efficient and effective for facilities, and as a result, will provide systems-level improvements tailored to a state's needs. It provides de-identified, aggregate data regarding capacity and gaps in care. Referring entities hold an account at no-cost. The system also allows for the development of a public-facing portal that will provide public access to the network via the Internet.
- The American Society for Addiction Medicine (ASAM) Global Assessment Tool is included as part of the OpenBeds system to allow for referral to an appropriate level of care. Nevada 2-1-1 may serve as a social services support piece and will connect patients to other social services required.
- Nevada is committed to use of the system and how it pairs with the Crisis Now Model, including:
  - 24/7 air traffic control for mobile teams across the state (from legislation, IRTOCs, and Certified Community Behavioral Health Clinics (CCBHCs)). Crisis Support Services of Nevada will be air traffic control to assist people in finding appropriate services.
  - OpenBeds will serve as a tool for discharge planning regarding L2K patients.
  - Panelists emphasized OpenBeds's capability to provide statewide, aggregate data around referrals to appropriate levels of care, bed capacity, and usage if providers commit to implementing it. This data will be of great benefit to the system as a whole, as well as individual providers.
- Regional Behavioral Health Coordinators and their Boards have been engaged. A regional rollout will begin in Washoe County by the end of the year and then move to northern and central rural systems and then to Clark County.
- This initiative is funded through a three-year grant from the CDC, and a plan to sustain the system with state funding is being developed.



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- Benefits of using the system include real-time referral capabilities, processes that are more efficient and allow more time with clients, quality discharge plans that result in better risk management, and increased engagement.

**The presentation and brochure for this session can be found in the resources section.**

### Strategies for Integration

#### *Objective*

Panelists discussed strategies and best practices for treatment of substance use disorders (SUD) in primary care and other settings.

#### *Panelists*

**Lesley Dickson, MD, FAPM**

Medical Director  
Center for Behavioral Health

**George Kaiser, MD**

Veterans Administration Hospital

**Farzad Kamyar, MD, MBA**

Director of Collaborative Care  
High Risk Pregnancy Center, Las Vegas

**Danica Pierce, LCSW, CFLE**

Program Coordinator  
Medication Assisted Treatment  
Northern Nevada HOPES

**Amanda Tinkleman, MD**

Medical Director  
Community Counseling Services of West Nassau  
Psychiatrist  
Perinatal Program, Zucker Hillside Hospital Assistant  
Professor of Psychiatry  
Zucker School of Medicine at Hofstra, Northwell

#### *Summary*

- Panelists described best practices for opioid use disorder treatment in primary care, and other settings, acknowledging there are gaps in primary care education on how to manage patients before and after addiction is identified as a concern.
- Explicit outreach between primary care and treatment is necessary to let ‘front-end’ providers, such as primary care physicians, know that referral locations exist. This strategy may increase screenings as physicians will have a place to which to refer patients with positive screens.
- Universal screening is the single most important thing that can be done for all patients, particularly for pregnant women. As screening becomes more common, SUD will become less stigmatized.
- Strategies discussed included scheduled reminders for screens and treatment, the importance of asking screening questions the right way (not “you aren’t using drugs, are you?”), urine tests to help determine other substances patients may be using, and using screening tools. Screening, Brief Intervention, and Referral to Treatment (SBIRT), the 5Ps<sup>1</sup>, or the National Institute of Drug Abuse (NIDA) quick screens are all helpful tools. The ACES questionnaire looks at traumatic instances that occur in childhood, with a score of 6 or higher indicating a 12 times greater chance of IV drug use. Screening could be done during each

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<sup>1</sup> The 5Ps\* is an effective tool of engagement for use with pregnant women who may use alcohol or drugs. See <http://www.ilpqc.org/docs/toolkits/MNO-OB/5Ps-Screening-Tool-and-Follow-Up-Questions.pdf> retrieved on August 31, 2019



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appointment. Colocation of medical providers with behavioral health providers allows for behavioral health staff to join an appointment following a positive screen.

- Risk mitigation strategies useful in office-based opioid treatment (OBOT) settings include offering co-occurring disorder treatment, naloxone distribution, assessing for PTSD, mood disorder, depression, and treating individuals holistically. There is also a movement to prescribe medication assisted treatment (MAT) during incarceration to reduce recidivism and relapse.
- Panelists reviewed medications available for MAT, as follows:
  - Methadone (pros/cons are: good for heavy users, but has daily requirement at beginning, is federally regulated, and has side effects), Buprenorphine (pros/cons are: 'sticky' on receptor, but must be in mild withdrawal already, less stigma), Vivitrol (pros/cons are: blocks receptor, better for mild SUD), and naloxone (to reverse overdose is not a treatment).
  - Cost factors were noted, including that insurance doesn't always pay for services, generic filmstrips can be a great cost saver, and the importance of discussing payment options and issues with patients.
- Decision-making processes when selecting medication and treatment for patients emphasized the need for shared decision making between the patient and the physician. In addition, the impact of different medications on a developing fetus is also important to consider, as most pregnancies to women with SUD are unplanned. Buprenorphine is a recommended option for women of reproductive age because of the reduced risks to the fetus related to withdrawal, low birth weight, and reduced head circumference.
- Obstacles, challenges, or barriers to implementing best practices include the impact of social determinants of health, little to no assistance in rural communities, lack of transportation, childcare, insurance, and insurance changes. Stigma was noted as a major barrier, including some instances of providers 'firing' patients, as well as some unpredictable non-patient barriers such as a pharmacy being out of medication.
- Because of the legalization of marijuana, use is ubiquitous and therefore, mostly disregarded, except within the pregnant population where engagement is critical. However, with fentanyl being added to marijuana, patients need to be aware and careful. Panelists recommended purchasing marijuana products from a dispensary rather than the street.





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## Syringe Service in the Continuum of Care

### Objective

Injection drug use is a risk factor for exposure to certain blood-borne infections, including HIV and Hepatitis C (HCV). In 2016 the Centers for Disease Control and Prevention (CDC) released a county-level risk assessment that found two Nevada counties at risk for spikes in HIV and HCV transmission in people who inject drugs. Panelists discussed the integration of HIV and HCV prevention and opioid use disorder screening and treatment.

### Panelists

#### Chelsi Cheatom

Program Manager  
Trac-B Exchange  
Harm Reduction Center Las Vegas

#### Jennifer Gratzke, MPH

Disease Investigator and Intervention Specialist

#### Danica Pierce, LCSW, CFLE

Program Coordinator  
Medication Assisted Treatment  
Northern Nevada HOPES

### Summary

- Panelists discussed the bidirectional integration of syringe service and treatment/recovery supports. At Northern Nevada HOPES, an FQHC in Northern Nevada, most clients using syringe services aren't clients of HOPES, so making connections with local clinics is very helpful and important for service delivery. Staff have been able to set up syringe exchange services monthly in parking lots of local clinics. In Southern Nevada, Trac-B, a program of the Harm Reduction Center in Las Vegas, has installed public health vending machines in MAT locations. Organizational receptiveness and readiness to help patients is crucial—they have to welcome the integration of syringe services into their treatment plans.
- In discussing strategies for integrating responses at the intersection of opioid use disorder and infectious disease epidemics, panelists referred to an article regarding integration of infectious disease into programming for people who are in abstinence. One example is currently occurring at the Clark County Detention Center. Panelists noted that holistically addressing people is important. For example, all clients at the Harm Reduction Center are being tested for HIV and HCV regardless of what they come in for.
- Panelists described the goals of harm reduction and guiding principles for implementation, noting that community provider capacity building is a major goal. They also noted the importance of using motivational interviewing and not 'telling them what to do.' At the same time, the intersection requires a pragmatic and realistic approach to take advantage of the expertise of the treatment providers.
- The importance of engagement in reducing risk of exposure for communicable diseases and overdose was identified as very important. Examples of engagement included:
  - Providing vaccinations for Hep-A (ex: of collocated services), education about what happens to syringes when they are returned
  - Engagement during incarceration was discussed as individuals in forced states of abstinence while incarcerated are at risk for overdose upon release, so it is important to do overdose prevention during this time
  - It was recommended that every patient be given naloxone and asked if they still have it during subsequent visits
  - Homeless camp outreach and naloxone distribution was another strategy discussed
- Panelists described differences related to urban/rural harm reduction strategies such as vending machines; opportunities for expansion such as working with law enforcement and using innovative programs like shipping syringes to rural areas. Visiting rural communities to ask what they need/want was discussed as the first step. Syringe service is now being offered remotely in all counties, and increased naloxone distribution



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is being offered via this method as well. The readiness of the county to accept change is key, as is bringing in education on harm reduction.

- Medical vending machines are a promising practice. They must be connected to power and Wi-Fi and are able to collect information on vending machine users. Each user receives one kit per week and can also access safe sex kits, hygiene kits, pregnancy kits, etc. Other items can also be placed into the vending machines including HIV rapid test kits and other STI kits, or anything available over the counter. If a client loses their card, they can enter their code, or have it looked up for them to access kits.
- Misconceptions with syringe services include a belief that it is a free-for-all: get whatever you want, with no structure, and no linkage to care. In reality, syringe service is all-encompassing and an opportunity to connect with other types of care and treatment. There is less stigma or barriers if clients try to access care via syringe service or vending machines. The vending machines are gateways to treatment, especially with their placement in MAT or other relevant treatment locations.

**The handout for this session can be found in the resources section.**

### Community Based Responses: Best Practices for Peer Support Services

#### ***Objective***

Panelists discussed the scope of work for peers in various settings. Participants gained an understanding of the roles and opportunities created through peer support services.

#### ***Panelists***

##### **Will Allphin**

Director of Programs  
Foundation for Recovery

##### **Dona Dmitrovic, MA**

Executive Director  
Foundation for Recovery

##### **Krista Hales, PhD, MS**

Director  
Integrated Opioid Treatment and Recovery Center  
Center for Behavioral Health

#### ***Summary***

- The session began with a discussion of the various roles peers can play in the treatment and recovery continuum from pre-engagement to long-term recovery. Low-barrier engagement outside of treatment settings is best for the pre-contemplation phase (barriers can include insurance, compliance, etc.)
- Core competencies and scope of practice for peer recovery support specialists are developed through comprehensive training and lived experience to ensure peers are trained to work within the scope of practice and ethics. Moving non-clinical people into a clinical setting can be a steep learning curve. Motivational Interviewing is a key skill. As people in recovery, peers have principles that they live by, including recovery values such as to take care of the self first, be open to all pathways to recovery—including MAT—and providing support for individuals to make their own choices. Peers must recognize that they have a separate personal program of recovery from the clients with whom they are working.
- Agencies can best integrate peers into their programming by establishing a specific goal for peers. These can include increasing connectivity for patients through a peer accompanying them throughout and providing



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regular check-ins, establishing their role in a mobile outreach team, using peers in a peer advisory setting and inpatient town hall, and acting as a liaison to clinical staff. Essentially, peers help patients bridge the gap between themselves and clinicians. One suggestion was to maximize adolescent peers.

- Panelists discussed the role of recovery communities and their expertise in supporting agencies to integrate peers. This included supporting the notion that all recovery meetings are valid with an acknowledgment that MAT can be a barrier to support. Peers help eliminate fear and reduce stigma.
- Barriers to using peers included stigma from the healthcare industry and low billing rates. Agency policies can also be a barrier. Another barrier specific to acute hospitals is that they cannot hire someone with a felony charge. However, it was noted that it shouldn't be assumed that peers would have felony convictions just because they are in recovery.

## Pain Management in General Medical Settings: Best Practice Strategies

### ***Objective***

Panelists discussed pain management in a general medical setting, and participants gained a better understanding of best practices.

### ***Panelists***

#### **Daniel Burkhead, MD**

Innovative Pain Care Center  
President

Clark County Medical Society

#### **Michael Lewandowski, PhD**

Clinical Associate Professor  
School of Medicine, Department of Psychiatry University of Nevada, Reno

#### **Denis Patterson, DO**

Nevada Advanced Pain Specialists

### ***Summary***

Panelists shared best practices in providing multi-disciplinary pain management in primary care settings. They walked through scenarios of potential patient situations and to shared best practices in their treatment and care.

### **Practices for Pain Management**

- In a general medical setting, the common medical conditions that are often accompanied by chronic pain are typically back and neck pain. These common medical conditions are best treated based on acuity.
- It is recommended to determine if pain is acute or chronic. For chronic pain, patient needs may best be addressed through a team approach, applying a variety of options to treat the whole person.
- Early steps for physicians include assessing what drugs the client is using and what alternative therapies have worked or not worked. Panelists noted that often people have never been referred to physical therapy or other potential solutions for pain.
- Factors that should be considered when managing chronic pain in a general medical setting include patient characteristics, risk profiles, or disorder severity for a referral to specialty pain management.
- Risk assessments for depression and anxiety are also important. There are many assessments. Some assessments the patient fills out, and others are completed by the provider. Both are useful.



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- The earlier a referral to a pain management specialist, the better to mitigate and address needs before they become chronic. Inappropriate referrals include simple acute injuries. If it becomes an extensive and lengthy healing process, then refer to a physician.
- Panelists noted the importance of checking the Prescription Monitoring Program (PMP) every three months (the legal requirement), but better yet, to check the PMP with every visit. Advancements to the integration of the PMP with electronic health records (EHR) will make this process easier.
- Alternative treatments supported by research include:
  - Physical therapy, chiropractic, massage therapy, behavioral health, acupuncture
  - Cognitive Behavioral Therapy (CBT)
  - Meditation, mindfulness
  - Sleep hygiene
  - Psychologist (but referred to as a Behavioral Medicine Specialist, so the client doesn't get the message that we believe the problem is "in their heads")
- These practices often require trial and error, and so we suggest a handful of sessions. If the intervention is working, continue, and if not, try another.
- One issue with the alternatives is insurance acceptance and limits.

### Practices for Identifying Potential Prescribing Problems

- The PDMP nationally is shared across many states, but not California, which can make it challenging to identify if the patient may be obtaining medications across state lines. However, it is still possible to get information from other systems.
- Urine drug screens are helpful to see what other substances might be being used by the patient, as well as determining if the opioid medications are being used as prescribed (and if not, a potential red flag that medication is possibly being diverted). When information from a urine screen does not match what the patient has disclosed, it may be a red flag, an opportunity for a more in-depth conversation, or both.

### Reducing Opioid Use through Time

- Quality of life and activities of daily living/function are important questions for patients that can help to identify whether opioids are helping or hurting the patient.
- Tapering can be effective; when done slowly and properly. Timing and individual needs should be considered in the tapering regime. It can take a long time to taper, and additional needs arise during the treatment that can be helped through a medical team.
- It is important to work with clients to help them develop the motivation to reduce the need for substances. This includes asking the client, "what does it do to you versus for you?"

### Resources

- Project ECHO is a great resource for physicians in Nevada, wanting to learn more about these topics.
- Published guidelines exist for tapering; there is also an app called Reducer.



## Opioid Response Summit 2019

### Public Health, Law Enforcement, and their Data Intersections

#### Objective

Panelists discussed the impact of lethal drugs on the public health system, data sharing to drive public health, public safety decision making, and tools, like the Overdose Detection Mapping Application Program (ODMAP), and resources within Nevada's two fusion centers.

#### Panelists

**Cordelia Alexander-Leeder, MPH**

Health Resource Analyst  
Nevada Division of Public and Behavioral Health

**Ryan Clark**

Public Health Preparedness Analyst  
Southern Nevada Health District

**Keith Carter**

Director  
Nevada High Intensity Drug Trafficking Area

**Brandon Delise, MPH**

Epidemiologist  
Southern Nevada Health District

**Terry Kerns, PhD, RN, MSN**

Substance Abuse / Law Enforcement Coordinator  
NV Office of the Attorney General

**Selby Marks**

Director  
Nevada Threat Analysis Center

#### Summary

- Panelists discussed that the drug overdose epidemic is exacerbated by the potency of opioids and the increase of additional drug use. Poly-drug use adds additional complications, where the likelihood of overdose increases substantially. Concurrently, there has been an increase in HIV and Hepatitis C rates. Nevada has higher rates of HIV than the U.S. as a whole. New compounds go undetected through toxicology screens and forensic analysis, and it can be challenging to detect the emerging trends in drugs.
- Public Health and Law Enforcement data sharing can drive public health efforts. There are common goals shared between each entity, including the safety of the public, a mechanism to identify threats, and the protection of employees during responses to those threats.
- Data that drives policy and practice decisions can come from both sectors. Memorandums of understanding (MOUs) are in place or are the process of development to solidify data sharing between the two agencies. Existing data sets can be leveraged from each agency to help create a complete view of the public health issues.
- On the national stage, creating this model is more complicated and limited than here in Nevada. Law enforcement and public health agencies have operated separately for so long. A long list of barriers has emerged over the years including laws, policies and procedures, and HIPAA regulations that must be balanced with Intelligence Sharing Laws. Developing data sharing procedures and systems starts at a local level through networking and basic relationship building. Currently, fusion centers serve as a mechanism to merge and analyze law enforcement and public health data. In the future, other agencies may be able to develop informal and formal data sharing agreements and procedures as well.
- Overall there is agreement that data sharing needs to be a priority, because data is used to create effective programs, make informed decisions about funding and concerted efforts, and provide the public updates about the state of the crisis at hand. One example of an effective data sharing platform is The Nevada Opioid Dashboard.
- Fusion centers have expanded their areas of focus to include analyzing data specific to the opioid crisis. There is a trend to move to proactive data analytics (away from reactive analytics), especially in law enforcement and public health partnerships through resources like the ODMAP. However, there are risks of unregulated (validated or checked for quality) data sharing between agencies which could lead to



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misinterpreting data. Ultimately, this can compromise the trust communities have in the data and the partner agencies.

- ODMAP was created under the principle that law enforcement often looks at heat maps and real-time information to place resources appropriately. ODMAP is a tool that everyone can use to assess overdoses that are occurring in each area, help with analysis of the communities impacted, and level resources where needed.
- A challenge of the tool is inserting timely data and garnering buy-in for using the tool consistently. The benefit of ODMAP is that once a certain threshold of data is met, the system has predictive capabilities that can alert public health and law enforcement of spikes indicating an emerging trend within a region, allowing them to respond appropriately within 24 to 72 hours.
- Nevada's fusion centers are in the process of obtaining a public health analyst to focus on overdose data analysis. This supports public health and law enforcement, expands cross-systems work (law enforcement, coroners and medical examiners, emergency medical services, and public health). The analyst function is to collect, analyze and communicate information related to opioids, crimes, morbidity, and mortality across the state.
- Tools like ODMAP will also allow for each discipline to assess trends without sensitive information, avoiding the complexities of release of information restrictions. Nationally, there is a goal that all 50 states have drug intelligence officers to create a network and provide a one-stop shop for general information and intelligence for all stakeholders that are integrated with public health.
- Las Vegas Metropolitan Police Department (Metro PD) has worked to promote collaboration and data sharing with public health. Public Health is currently developing an MOU which will formalize complete and timely data sharing. An additional MOU with Metro PD will allow them to share their data with the state overdosing drug reporting system, which will allow for a more comprehensive understanding to inform interventions.
- The Nevada Threat Analysis Center (NTAC) does not have a dedicated analyst in place yet. The data analyst will need to have an understanding of the various types of databases and sensitivities related to the analysis of the data. That position will need to be filled by someone who is well versed in public health.
- Hospitals began reporting overdose-related death data in 2018 as a result of AB 474, providing a more complete picture of opioid overdose impact statewide.
- Opportunities still exist to promote data sharing through regular updates on trends to keep up with the ever-changing supply. More collaboration with laboratories from public health and law enforcement to ensure new drugs are being identified as soon as possible is another opportunity. There is collaboration among chemists in Washoe and Clark counties, who meet quarterly to share information about new drug discoveries, etc. Post-toxicology data mining is used to analyze drug trends for newly discovered substances that were not part of the current testing protocol.
- Full buy-in for AB 474 is still needed from health care providers. Currently, representatives from Public Health are meeting with facilities to bring awareness about reporting and overcome reporting barriers. In order for data sharing to become a regular part of operations trust must be built across and within organizations. Relationships must be built person-to-person which will also impact the organizational relationships. Along with formal and personal relationships, an understanding of the work of the other agency is important, including the difference in terminology between agencies. Sustaining those relationships through collaboration requires processes and personnel.



# Opioid Response Summit 2019

## Criminal Justice Interventions

### **Objective**

Panelists described the courts' responses to the opioid crisis in rural and urban communities. Participants gained an understanding of the role courts play in substance use disorder prevention, treatment, and recovery.

### **Panelists**

#### **The Honorable Linda Bell**

Judge  
Eighth Judicial District Court

#### **Marian Mosser, PhD**

Director  
Criminal Justice Pilot Project

#### **The Honorable Dorothy Nash Holmes, JD**

Judge  
Reno Municipal Court  
Department 3  
City of Reno

#### **DeNeese (Dede) Parker**

Specialty Court Administrator  
Clark County

#### **James Popovich**

Specialty Courts Program Manager  
Washoe County Second Judicial Court

### **Summary**

- The session began with each panelist describing court programming developed to address the opioid epidemic. In the eighth judicial district, Medication Assisted Treatment (MAT) is utilized across all courts with opioid programming and is now considered the standard of care. Courts are now offered within the Youth Offender and Re-entry programs. A model, referred to as "building a triangle", was emphasized. It relies on probation, parole, and the courts to form a working partnership to ensure the provision of assessment, screenings, treatment, supervision and monitoring, case management, and recovery support services.
- Panelists referenced the Drug Court Standards and 10 Essential Elements of Opioid Intervention Courts handouts as the standard by which drug courts operate. They emphasized the importance of rapid assessment, screening, and treatment as well as frequent supervision and monitoring, and intensive case management.
- Trauma-informed care is now provided which includes bringing in behavioral health, housing, and other support service providers to pre-court meetings in order to provide judges with an overview of the patient. This allows them to help in the best way possible rather than taking a more punitive approach. Judges on the panel emphasized how important it is for judges to be sensitive to past experiences, trauma, and participants, and to be aware of triggers. This includes changing the physical configuration of the courtroom, including where the participants stand, and to be sensitive to persons suffering from Post-Traumatic Stress Disorder (PTSD). They also noted the importance of pre-sentence screening, trauma screening, and having a clinical psychiatrist available for evaluation. Multidisciplinary teams meet daily to discuss which failures to comply are compliance issues and which are trauma issues. Courts have now incorporated Cognitive Behavioral Therapy (CBT) from masters-level clinicians, ensuring that treatment providers for high-risk participants have curriculum on criminal thinking and treatment matching, and that treatment is individualized and patient-driven.
- Many successes were noted, including that Nevada courts are taking people out of prison early and bringing them into the Re-entry court in lieu of keeping them incarcerated. For the Washoe County Second Judicial Court, 92% of graduates of state recidivism program remained arrest-free. The collaborative nature of drug



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courts was noted as what makes them work well. In Southern Nevada, there has not been one person from the MAT re-entry court that has relapsed on opiates thus far. In Washoe County, there has been an increase in specialty courts, from 45 to 75, including the introduction of MAT courts. It was noted that the humanity of the programs has substantially grown as well. One court received a grant to distribute naloxone kits and has implemented that practice.

- Challenges for the court system include guarding against burn out for staff and the teams working with clients, securing housing upon release, and lack of insurance. It is critical that community partners reach out to let specialty courts know what support is available to serve their clients.

**The handouts for this session can be found in the resources section.**

## Overdose Prevention for Difficult to Engage Populations

### ***Objective***

Panelists discussed prevention, treatment, and harm reduction strategies targeted toward difficult to engage populations including individuals who are experiencing homelessness.

Participants learned strategies and practices to serve hard to reach populations

### ***Panelists***

#### **Angela Quinn**

President and Chief Executive Officer  
FirstMed Health and Wellness Centers (FMHWC)

#### **Robert Harding**

Coordinator  
Evaluation & Research School of Community Health  
Sciences  
University of Nevada, Reno

#### **Chelsi Cheatom**

Program Manager  
Trac-B Exchange  
Harm Reduction Center Las Vegas

### ***Summary***

- Panelists described strategies to provide outreach to individuals who are considered high risk (i.e., individuals who inject drugs, who are HIV positive, who are homeless, who are being trafficked for sex). These strategies include placing vending machines in a stigma-free location. For people who are HIV positive, transportation and harm-reduction education are critical. For people who are homeless, outreach needs to take place where they are located. It is important to distinguish between sex-workers and those who are trafficked and conduct outreach where they are while respecting that difference. Other strategies include offering services at satellite exchanges and storefronts with a focus on harm-reduction to meet people where they are and have them tell you what they need. The goal is to create a seamless system of care and collocate services.
- The most effective engagement strategies for hard-to-reach populations include offering an opportunity to talk with someone with lived experience and offering Fentanyl test strips, which connected people to naloxone education. Other engagement strategies include incentivizing engagement, using motivational interviewing, and providing trauma-informed care. It is also helpful to invite people to join the group initiating the outreach.
- Unique challenges or barriers to care that need to be assessed and managed when working with difficult to engage populations include housing, transportation, co-occurring disorders, and physical conditions. The





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goal is to create a system of care and to address stigma, especially for people who are pregnant or have had adverse experiences with “services.” Outreach workers should also pay attention to attire when reaching out to new populations.

- Connecting individuals to care for hard to reach populations is unique as organizations need to consider flexibility in policies, such as requiring people to call for appointments, and policies around tardiness and missed appointments, etc. It is helpful to provide transportation to services, to adjust hours of services, and to focus on housing first. Accepting people with animals (one organization provides a pet pantry) is important as well.

**The presentation and handouts for this session can be found in the resources section.**

### **Prescription for Collaboration: Prescribers and Pharmacists in Collaborative Care Practice**

#### ***Objective***

Panelists discussed the pharmacists’ role in prescription misuse prevention. Participants gained an understanding of how collaboration between pharmacists and providers can support improved patient outcomes. The discussion also included utilization of medication therapy management programs to manage high risk patients.

#### ***Panelists***

##### **Andy Pasternak, MD, MS**

Physician and Owner

Silver Sage Center for Family Medicine and Silver Sage Sports Performance

Treasurer

Nevada State Medical Association

##### **Beth Slamowitz**

Senior Policy Advisor on Pharmacy

Nevada Department of Health and Human Services

Division of Health Care Financing and Policy

#### ***Summary***

Panelists shared situations and success stories where collaboration between physicians and pharmacists had led to improved outcomes for the patients. They also provided examples where communication between physicians, pharmacists, and patients had broken down and offered factors that may be in play. Panelists emphasized the importance of communication and the promise of improved patient outcomes through collaboration between physicians and pharmacists.

- The pharmacists’ role in prescription misuse prevention and risk reduction begins with collaboration with physicians. It is helpful to have Collaborative Practice Agreements (CPAs), so both have the same information and can share information where everyone’s primary interest is in the care of the patient. Pharmacists may see or overhear conversations where the patient is not using the prescription as prescribed and can inform the physician or talk with the patient.
- Pharmacists can be very helpful as part of a care team. This may not be feasible in all settings, but when possible, the perspectives can be complimentary. Talking and listening were key practices to help physicians and pharmacists work together. It is also important to learn about what each profession offers to help improve patient outcomes.



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- In discussing medication therapy management (MTM), there can be differences or a need for additional communication with both providers. Anxiety and depression medications can lead to complications and issues with safety. Effective communication will provide both physician and pharmacist with more current, accurate, and up to date information about the patient. This collaboration can allow physicians with patients with cancer to be more focused on patient care versus focusing on addiction concerns. Collaboration between pharmacists and providers supports improved patient outcomes.
- Situations where pharmacists weren't willing to fill prescriptions was an important topic to audience members. Panelists provided information about some of the factors that are on the pharmacist "side" of this situation. Each situation is different, but some of the key factors may be:
  - availability of medication from wholesalers,
  - corporate policies that require a more detailed ID-9 code,
  - a concern about the safety or perceived risk of the prescription, which includes liability for overdose,
  - a red flag that appears on the side of the pharmacist that may not have been visible to the physician, noted in records, consumer behavior, or other sources.
- Recognizing that time is always a factor for both physicians and retail pharmacists; it is still important and useful to communicate by phone.

### *Future or ongoing challenges and questions from both audience members and panelists included:*

- Corporate policies that may not be visible to the physicians
- Liability concerns for both prescribers and pharmacists
- Policies or practices for more detailed ID-9 codes (which may be available or may be out of reach)
- Deceptive practices of people seeking medication to sell, with continued "doctor shopping" and also "pharmacy shopping"
- Agreements with insurance to use specific pharmacies (and, what to do when the collaborative relationships are not in place, but the insurance requires a specific pharmacy be used)
- Different formularies and concerns from clients about differences between them
- Time constraints that limit full communication between physician and pharmacist
- Privacy questions about what information should be shared and how

### *Practices to overcome challenges included:*

- Inquiry and working to understand what factors are in play
- Respect and trust for the respective professions
- Open-mindedness to work together as a team and take into account the medical professionalism of all parties on the team
- Collaborative practice agreements
- Communication and problem-solving (together)

**The handouts for this session can be found in the resources section.**



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### Building Capacity for Investigations of Drug-Related Deaths

#### **Objective**

Panelists discussed existing strategies and practices for overdose death investigations in rural and urban communities in Nevada. Discussion included a review of drug related death investigation data, and training and federal resources for drug related death investigations.

#### **Panelists**

**John Fudenberg, D-ABMDI**

Coroner  
Clark County Office of the Coroner/Medical Examiner

**Laura Knight, MD**

Washoe County Chief Medical Examiner and Coroner

**Kerry Lee**

Sheriff  
Lincoln County

**Kevin Malone**

Sheriff  
Humboldt County

**Sarah Mullinax**

Masters of Public Health Intern

#### **Summary**

- Panelists noted that Clark County and Washoe County Medical Examiner/Coroners offices operate similarly, and Sheriffs serve as the ex-officio coroners in the other 15 counties in Nevada. This presents challenges as the role and training of a corner/medical examiner is different from that of Sheriff. Furthermore, the medical-legal profession (coroners and medical examiners) charge is different from law enforcement, but this proves difficult when the Sheriff is the coroner. The state is trying to increase scene investigation training to support Sheriffs in this position.
- Additional measures should be taken to demonstrate independence, like leveraging other counties for death investigations where a conflict of interest exists for a Sheriff, such as in an officer involved death. The bifurcated system can lead to differences in processes, practices, and standards, which can lead to differences in the data collected. New legislation (SB 463) provides structure to post-mortem investigation in overdose-related deaths, bringing Nevada in alignment with national standards, as well as providing more accurate documentation of cause of death on death records. However, following the national standards for autopsy and post-mortem investigations can prove significantly more expensive to implement for the smaller counties.
- Guidelines for autopsy requirements in overdose deaths are being drafted that take into account these implications on smaller counties. Importantly, the guidelines should help with training on the complexities of death investigations. Most of the counties throughout the state are doing full autopsies for overdose deaths through either the Washoe or Clark County Coroner/Medical Examiner offices. The new guidelines and legislation will work to educate and assist rural coroners in supporting the Sheriff and staff to appropriately assess these investigations. Additionally, SB 463 may serve as a tool for requesting additional funding to support these efforts.
- In reviewing drug-related death investigation data, some differences were noted between Washoe, Clark and rural counties. Washoe County sees an increase in drug overdoses, with a major increase in methamphetamine, mostly unintentional. Additionally, Washoe County sees an increase in the use of a combination of drugs in overdose cases. Craton is increasing in popularity. Clark County is seeing a significant increase in fentanyl deaths over the past five to ten years, but this could be due to lack of testing of fentanyl early on. Rural counties have also seen an increase in overdose deaths. Law enforcement notes that they are also more aware of what to look for at death scenes due to the efforts to mitigate this public



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crisis, and that could influence the numbers as well. There is a slight increase in unintentional overdose deaths, and usage rates are significantly increasing.

- Testimony in criminal cases includes the physicians that prescribed the opioids. The investigations are more sensitive and rigorous, especially in smaller, rural communities. Investigations begin with assessing the prescribing history of the provider. Counties noted an increase in provider collaboration with law enforcement (where allowable) regarding over-prescribing, false billings, and overuse. General reporting has increased, and the medication disposal sights are constantly full.
- The Overdose Detection Mapping Application Program (ODMAP) is evolving and will eventually be a robust data set that can assist both law enforcement and coroners/medical examiners. Currently, vital statistics provide a consistent and reliable data source for coroners and law enforcement on the actual cause of death.
- In terms of training for drug-related death investigations, with scarce resources rural communities have to leverage partnerships with organizations and agencies that do have the resources. When the Nevada Division of Investigation (NDI) or where the Federal Bureau of Investigations (FBI) is involved in an investigation, those partnerships become critical and rural counties rely heavily on these resources. Additionally, the NDI and FBI serve as training resources for rural communities, as does the Clark County and Washoe County Coroner/Medical Examiner offices. NDI and the FBI are working towards implementing online training that can make this information timelier and more accessible.
- Legislative changes resulting from SB 463 increased the cost of death certificates (paid to the coroners office) from one dollar to four dollars. These funds can be used for training and Clark County uses this revenue stream for that purpose and opens trainings statewide. Clark County has also used the revenue to create two mental health programs, providing services for coroners and first responders to mass casualties.
- The annual death investigation conference has continued to focus on opioid-related deaths. The conference brings together experts from around the nation to help educate coroners and medical examiners on how to assess opioid-related deaths, and on investigation procedures.
- The complexities of death investigations don't change based on the county; what is different is the complexity of training and resources. The partnerships between agencies, county officials and providers has led to the successful adaptation of practices to address this issue. The challenge is always to identify the drugs that people are using and test for those drugs. Trend data is incredibly important to ensure accurate death investigations. The average time frame to get a toxicology report back to update data (e.g., into ODMAP) is nine days, which is significantly faster than the national average. When results are positive for opioids, it can take between 14-21 days. Standard turnaround for autopsy reports is 90 days, which is the national standard. A pilot project with the Drug Enforcement Administration (DEA) is underway to indicate in real time the preliminary cause of death then affirm/modify those results once the autopsy has been completed.
- The more data collection is automated, and information pushed out and shared with appropriate partners, the more data sharing can make a difference in the investigation of drug-related deaths.
- The coroners/medical examiners have looked for chronic medical conditions and chronic pain and have seen cases where the lack of access to medication (opioids) has led to suicide.



## Pain and Addiction Treatment

### **Objective**

This presentation explored the intersection of pain and addiction treatment. Participants gained a better understanding of best practices in treatment for co-occurring pain and addiction.

### **Presenter**

**Pamela Rinato**

Clinical Director

Las Vegas Recovery Center

### **Summary**

- This presentation began with an overview of the emergence of the opioid epidemic from 1999 through 2009 by which time the rate of primary non-heroin opiates, synthetic hospitalization rates were at 45 per 100,00 for more than half of the country. The surge in opioid deaths peaked in 2016. In 2017 the CDC reported that more than 72,000 Americans died of overdoses and that painkillers and other illicit drugs contributed to nearly 68% of the total overdose deaths. In Nevada alone, it's estimated that there were over 700 overdose-related deaths.
- A description of what pain is was provided. Long-term opioid use often begins with the treatment of acute pain. Clinicians should prescribe the lowest effective dose of immediate-release opioids. Generally, three days or less is sufficient and more than seven days is rarely necessary. Acute pain is usually sudden and caused by something specific. It typically does not last longer than six months and subsides when there's no longer an underlying cause. Some common causes of acute pain are surgery, broken bones, dental work, burns or cuts, and labor and childbirth.
- According to the American Society of Addiction Medicine (ASAM), addiction is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. The longer one uses opioids, the greater the risk and the risk seems to rise quickly. Long-term opioid use often begins with the treatment of acute pain. Chronic pain is greater than six months in duration.
- Best practices were described and discussed including that clinicians should prescribe the lowest effective dose and consider alternate pain management strategies like Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), Attention/Distraction, Control/Placebo Effect, and Fear Reduction. Exercise and physical therapy, chiropractic treatment, therapeutic massage, Reiki, acupuncture, nutrition, yoga and Chi Gong were also noted as additional alternative pain management strategies. Kabat-Zinn's work on mindfulness-based stress reduction was referenced as another resource for alternative pain management also noted. Medication Assisted Treatment (MAT) including use of methadone, buprenorphine, naltrexone, and naloxone was discussed as an approach to support persons in chronic pain with SUDs.
- Hypnosis was discussed and participants viewed a YouTube clip of surgery being conducted on a patient while under hypnosis.
- Treatment approaches include cognitive behavioral therapy over ten sessions, as well as other patient-specific identified modalities. Challenging red-flag thoughts, or thoughts that make you more likely to become depressed, were explained as follows: These thoughts often cause negative emotions such as depression, anger, or frustration. Negative emotions are the number one predictor of relapse. Other tactics include using the five-panel CBT journal sheet, correcting mistakes in thinking, and Eye Movement Desensitization and Reprocessing Therapy (EMDR) to move trauma from the emotional to the cognitive side of the brain, utilizing props like paddles and light bars, or bilateral stimulation. Hypnosis is used throughout



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Europe, and Stanford is doing research and tests on the efficacy of hypnosis. Hypnosis is regulated through the American Society of Clinical Hypnosis, which requires training and coursework.

- The presenter noted that rather than thinking some types of pain are worse than others, it's the thought processes that matters, not the type or level of pain. A pain signal travels from the site of the injury, up the spinal cord, to the center in the brain, and no other factors influence this model. It is one dimensional, as pain is exclusively a biological and sensory experience. You must change the thought process in order to treat the patient. When a patient presents for treatment, they are motivated, which is the first step toward recovery.
- The presenter noted that all pain is real, and emotions drive the experience of chronic pain. Opioids often make the pain worse, so it is recommended to use treatments that improve and maintain function. The Gate Control Theory offers a comprehensive explanation of pain:
  1. Pain intensity is impacted by the opening and closing of the "gate."
  2. The types of information being sent from the emotion and thought centers of the brain determine the extent to which the gate is opened (which increases pain) or closed (decreases pain).
  3. This is multi-dimensional as it considers thoughts, emotions, and biological factors in the pain experience.
- The concept of grounding and ways of promoting mental and physical grounding were provided.
- Non-narcotic options for chronic pain were presented including those previously documented as well as topical pain relievers, oral non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, injections of local anesthetics and corticosteroids, anticonvulsants, antidepressants, and spinal cord stimulation and radiofrequency ablation.

**The presentation for this session can be found in the resources section.**

## Patient and Provider Perspectives on Post-Overdose Outreach Interventions Models

### ***Objective***

This presentation discussed innovations, feasibility, and the acceptability of mobile outreach response teams. Findings from research highlighted the need to engage populations in the design and implementation of programs to increase the use of naloxone, emergency services, and post-overdose intervention.

### ***Panelists***

**Krysti Smith, MPM**

Project Manager  
University of Nevada, Reno

**Karla Wagner, PhD, MA**

Associate Professor  
School of Community Health  
University of Nevada, Reno

### ***Summary***

Panelists discussed post-overdose intervention based on research with patients and prescribers. The work highlighted the importance of including multiple perspectives, including those of patients, in the design and improvement of treatment systems.



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- People are still afraid to report an overdose for fear of losing housing and their children, and that the police will begin harassing them. There is also a conception that they will be treated differently in the emergency room once it's revealed they are a drug user.
- While the Good Samaritan overdose provided many protections, there is still considerable risk for people who may have been involved in the overdose, and this may impact the steps that people take when an overdose takes place.
- The assumption that overdoses will come to emergency rooms may need further inquiry and testing, in part due to the first issues noted. For many, calling an ambulance may be considered by people who use drugs to be the same as calling law enforcement.
- To bring patient-centered care to more people in Nevada, panelists identified the need to continue federal funding and to provide the benefits of Mobile Recovery Outreach Teams (MROT) for hospitals as a way to improve outcomes resulting in decreases in overdoses.
- Patient advocates were identified as a way to help persons who have overdosed have a voice on their side, someone to listen, and give people hope and a possible pathway to recover. Friends and family can also benefit as MROT provide resources for them as well, offering benefits to everyone.
- Providers are often overwhelmed, and one more thing seems unmanageable. However, if framed in the context of long-term sustainability of recovery, they may be more open to MROT.
- Timing was discussed as a consideration. For providers, the suggestion was to pay attention to when to offer advice or not. For the patient, the optimal timing is as soon as possible, when the time is right.
- naloxone distribution was noted as important and can open doors for treatment and collaboration.
- Suggestions to optimize interventions include that eligibility definitions should be straight forward, the MROT must arrive as soon as possible to the emergency department. Staff must be sensitive and aware of the unique lived experience of the persons with whom they are working. Peer support staff are critical and need to be compensated with a living wage to continue to be successful. People who are being outreached to must be voluntary participants and direct their treatment moving forward. It is essential to talk first about what's going on with them and build rapport.
- MROT can bridge gaps and facilitate treatment while reducing the burden on emergency department staff.

**The handouts for this session can be found in the resources section.**



## Opioid Response Summit 2019

### Standard of Care: Pain Management and Medically Necessary Opioid Prescribing

#### **Objective**

Panelists discussed medically necessary prescribing and reduced opioid use in the acute care environment.

#### **Panelists**

**Brett Frey, MD**  
Emergency Medicine Physician  
Renown Medical Center

**JD McCourt, MD, FACEP, FAAEM**  
Medical Director  
Adult Emergency Center  
University Medical Center  
**Dean Polce, DO**  
US Anesthesia Partners Nevada

#### **Summary**

- Panelists began by sharing the impact of AB 474 since it was passed in 2018. When pain was recognized as the fifth vital sign, aggressive pain management became practice, which contributed to the current situation. However, there has been a 39% reduction in prescriptions for opioids after AB 474 was implemented and a 56% reduction in co-administration. AB 474 encouraged a more consistent approach statewide. It required mandatory checking of the Prescription Monitoring Program (PMP) which wasn't the case before AB 474. One panelist noted that his hospital had a pain policy in 2011, but AB 474 has benefits because it codified what was already being done.
- At the same time, it was noted that there have been some downstream, unintended consequences. For example, it has fostered fear in some patients and prescribers and can be problematic in the emergency room setting. One persistent challenge is that patient expectations have changed regarding pain. Many people expect to feel no pain at all, which is unrealistic. Pain as a fifth vital is challenging because it is not objective.
- Changes have occurred in how acute care settings are assessing pain, including a greater ability to identify opioid misuse behavior. Additionally, the use of PMP allows for objective data to say to a patient, "This report is concerning to me."
- Changes that occurred in how acute care settings manage pain include a reduction of prescription length, increased efficacy to relieve pain, and the use of anesthesiology to manage acute pain. However, training is needed to ensure pain management and opioid stewardship. Education of the public is needed regarding the promise of being "pain-free."
- Key opioid and non-opioid treatment algorithms are used to guide treatment practices. Algorithms exist for all surgeries, and where they are implemented, they are dominant. They require buy-in from pre- to post-operative and buy-in from patients, surgeons, insurance, hospitals, and payors. They also require minimal use of a substantial number of drugs, as there are more options beyond opioids. Hospitals need to dictate the use of algorithms because production pressure is high; when they do, there will be a greater success rate. A multimodal approach has been in use in the emergency room (ER) for a long time, including the use of Ketamine and Lidocaine. The Medicaid Formulary is anemic in regard to this; improvements in the Formulary would help to encourage further multimodal approaches.
- Some successes and challenges in implementing alternatives to opioid prescribing in acute care settings were discussed. Intravenous Tylenol is really successful but still emerging as a practice. Nerve management can provide great relief. In one emergency room, they have developed an entire program using a specific set





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of alternatives to opioid use. Ultrasound Guided Nerve Blocks is a process that involves identifying peripheral nerves and injecting a local anesthetic which can provide 8-12 hours of relief or more. It helps prepare patients for surgery and is extremely safe. Patients have also been refusing narcotics, which may be a positive indicator. One panelist had also noticed a decrease in the type of patient requesting pain management.

- Chiropractic, acupuncture, and mindfulness and meditation are very useful but can be challenging to implement in some settings, such as the ER. Other challenges include time, money, drug shortages, and misuse. Anesthesiology can help in lieu of opioid use, especially for the elderly because it helps to avoid the cascade of events that can lead to morbidity.
- Examples were provided about how the dosage indicated on a single bottle of a medication can lead to waste, which is very difficult to understand in the face of drug shortages.
- It was noted that marijuana smoking causes an increase in anesthetic requirements, but that the cultural changes around the use of marijuana have allowed people to be more honest about their use.
- The panelists discussed critical factors to consider for ethical decision making. Suggestions included to start slowly with lowest dose and frequency, identify opioid misuse behavior before prescribing, and that the path of least resistance is the wrong path. It was also suggested that ethical legislation would consider the financial investment required to fund recovery, including MAT prescribing in the Emergency Department. Finally, the panelists noted that patient questionnaires should not include pain questions.
- Panelists discussed the benefits of the new direction established by AB 474. Pain management practices, including new practices around nerve blocking, were described as fantastic (e.g., hip replacements). Treatment of those who misuse substances has also changed to include recovery programs. Additionally, the importance of access to multimodal wraparound services after an acute hospitalization or an acute pain event, including the expansion of telemedicine, was noted.
- Other topics discussed with participants included that acute pain with a short course of medication does not lead to opioid abuse. It was emphasized that patient-centered and patient-driven care are important as is public education around patient empowerment and asking for information from doctors about what will happen after a procedure so that they can expect the pain and manage it properly. Buprenorphine was also discussed, as it is currently dealt with through partnerships with MAT centers; a next step is to start a Buprenorphine program with recovery teams in emergency settings.

**The handouts for this session can be found in the resources section.**



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## Criminal Justice Interventions-II

### **Objective**

Panelists discussed criminal justice deflection and diversion programs currently being implemented in various communities statewide. They discussed the Law Enforcement Assisted Diversion (LEAD) and Mobile Outreach Street Teams (MOST) programs. Participants learned best practices and strategies for these programs.

### **Panelists**

#### **Terry Kerns, RN, MSN**

Substance Abuse / Law Enforcement Coordinator  
Nevada Office of the Attorney General

#### **Jessica Flood, MSW**

Northern Regional Behavioral Health Coordinator

#### **Taylor Allison**

Executive Director  
Partnership Douglas County

#### **Ken Furlong**

Sheriff  
Carson City

#### **Marquis Hines**

Officer  
Law Enforcement Assisted Diversion Program  
(LEAD)  
Las Vegas Metro Police Department

#### **Lissette Ruiz**

Officer  
Law Enforcement Assisted Diversion Program  
(LEAD)  
Las Vegas Metro Police Department

### **Summary**

- This session began with a discussion on views on law enforcement diversion/deflection and how to balance an individual's need for treatment with public safety. Panelists detailed that law enforcement, in general, is undergoing a paradigm shift where officers are striking a balance between public safety and helping the individual. This shift in mindset is difficult to embrace and is most effective when officers see the benefits of crisis intervention and addressing the root causes of crime for individuals with mental illness and substance use disorders. LEAD officers encounter the same people they encountered before LEAD but are now addressing the underlying causes (mental health and substance use disorder) instead of arresting them and isolating them in jail – which can exacerbate the problem.
- When an individual in Carson City opened fire in an IHOP restaurant several years ago, taking several lives, it was later discovered that he had been seeking help for his undiagnosed mental illness. His family was aware of his suicidal and homicidal thoughts but did not know where to turn. This is a key example of the disconnect between communities and law enforcement, and the need for communities to see law enforcement as being there to help, not just criminalize.
- In summary, LEAD officers are not handling new issues on the streets, they are handling the same interactions with more tools and connections at their disposal to respond to situations in an effective, compassionate manner.
- Panelists discussed best/emerging effective practices for diversion programs. Some counties across the state are embracing law enforcement and crisis intervention and collaborating with agencies in the county to create a tailored system to address the unique needs of the community, but each is rooted in the same underlying training and principles of crisis intervention. Diversion is a new concept nationwide and is still garnering support from officials that drive policy. Crisis Intervention Training (CIT) gives first responders the tools that are paramount to successful diversion. CIT is expanding across the state, and trainings hosted in counties that currently do CIT are open to anyone. CIT gives law enforcement and other first responders insight into what the individual is going through, breaks down stigmas associated with individuals in crisis, and provides tools to help assess and address the situation in an effective manner.



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- Strategies that have worked well in implementing programs in the community included CIT, MOST, LEAD, CRT, and diversional, which need to be adapted to the individual community needs and resources available. These models are all rooted in the same underlying concept, but cannot be placed into communities without adaptation. Nevada has done this successfully and will continue to expand these efforts to work with the urban, rural, and frontier counties.
- Collaboration was also noted as another ingredient to diversion that is necessary for counties to implement the model successfully. An example is having clinicians do a ride-along with officers to break down the silos and address crisis situations in real-time as a team. Collaboration between agencies is seen as key to the success for all of these models, as when agencies are better connected, understand each other's purpose, and leverage each other's strengths, communities are better served.
- Lessons learned that can help guide other communities in Nevada with implementing diversion/deflection included an acknowledgment that policing is shifting from a "brute force" model to crisis intervention. There is extreme distrust in law enforcement from communities that lead to immediate escalation when law enforcement intervenes. The next step for law enforcement is to build trust with the communities they serve by educating the community on this new wave of law enforcement. Taking care of law enforcement and other first responders must be a priority that works in tandem with these efforts. It is important to prioritize the health and well-being of law enforcement as well because it allows them to do their jobs to the best of their ability.
- These programs and models are resulting in the reduction of stigma by both law enforcement and the community. Communities are empowered through these services and are open to this shift in law enforcement and public safety that destigmatizes issues facing communities.

## Inside Nevada's PMP: Opioid Use Among the General Public, and Heroin Users

### *Objective*

In 2015, the Reno Police Department (RPD) was awarded the Harold Rogers Prescription Drug Monitoring Program (PDMP) Practitioner and Research Partnerships grant. The RPD's work with the University of Nevada, Reno to conduct large scale analysis of PDMP data recently concluded. This session provided an overview of the findings.

### *Presenter*

**Stacy Ward**

Substance Abuse Prevention Specialist and PDMP Grant Coordinator  
Reno Police Department

### *Summary*

- This presentation, related to the Prescription Drug Monitoring Program, highlighted research findings from the recent study. Nevada's Prescription Monitoring Program, referred to as the PMP, captured existing data, risk indicators, and patterns of prescription, with the intention to specifically identify a link between heroin use and prescriptions. It only reflects controlled substances. Highlighted research findings include: the prevalence of different risk indicators in the patient population, patterns of prescribed drug use among heroin arrestees, and how they compare to that of the general public and local case studies.
- A review of overall Nevada PMP prescriptions indicated that more than 14 million or 53% were for opioids. The next highest category was slightly over seven million or 26% for barbiturates/benzodiazepine.
- The following indicators were used to determine the frequency of patients at high risk of prescription misuse, addiction, and overdose:



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- **“Doctor shopping”**: defined as obtaining prescriptions from five different doctors within a three-month period (Coplan et al., 2016)
- **“Pharmacy shopping”**: defined as visits to five or more different pharmacies within a three-month period (Chenaf et al., 2016)
- **High MME dosage**: defined by whether or not a patient received prescriptions that exceeded 90 daily MMEs (Chang et al., 2018)
- **“Holy Trinity” prescriptions**: defined as a prescription comprising of an opioid, benzodiazepine, and a muscle relaxer within a one-month period (Horsfall & Sprague, 2017)
- **Combination prescriptions**: defined as a prescription comprising of a combination of an opioid and benzodiazepine within a one-month period (Maxwell & McCance-Katz, 2010)
- **Payment type**: defined by whether or not a patient paid for the prescription in cash (Hartung et al., 2017)
- **Dual payment type**: defined by whether the patient used both cash and insurance to pay for the same type of opioid medication within the same year
- **Prescription incidence**: defined by whether or not a patient receives prescriptions for more than seven consecutive months within a year (Ciesielski et al., 2016)
- Prevalence of Risk Indicators included High MME Dosage, Cash Payment, Dual Payment Type, and Prescription Incidences within 7 Months. For individuals with no heroin use but opioid misuse, cash payment, high MME, and prescription incidences were the top three risk indicators. For individuals with heroin use and opioid prescriptions, doctor shopping was 146 times higher, and pharmacy shopping was 600 times higher than their non-heroin user counterparts.
- Notable difference included; 2 times higher prevalence of any problem/risk indications present in the heroin arrestee population than among the general public (70% vs 34%), opioid and benzodiazepine combination (both drugs within 1 month): 4.5 times higher rate among heroin users, doctor shopping (5 or more doctors in 3 months): 146 times higher rate among heroin users, pharmacy shopping (5 or more pharmacies in 3 months): 600 times higher rate among heroin users. Data showed that a substantial number of opioids were prescribed even after the individual was arrested for heroin.
- Through the analysis, the biggest finding was that it is not a linear progression from prescription opioid use to heroin use. The concurrent use of prescribed opioids is relatively common among heroin users and concurrent use of benzodiazepines is relatively common among heroin users where 33% obtained *prescribed* benzodiazepines and opioids within the same month (not accounting for illicit opioid use).
- In response to participant questions, it was noted that methadone is reflected in the PMP if it is prescribed for pain management. It is not reflected if methadone is being provided through a treatment center. The PMP data is statewide; however, the analysis took Washoe County arrest data for heroin use and juxtaposed it to the general population of prescribers. Of that population in Washoe County, 59% of heroin users had an opioid prescription. Heroin users were determined by arrests made in Washoe County and were not adjusted to include suspected users who have not been arrested. The analysis did break data down by physician type, and the highest rates for prescription were made by mid-level physicians’ assistants. One notation is that prescriptions are not logged in the PMP until the prescription has been filled. This leaves a gap of time where individuals take advantage of the missing data and doctor shop before filling multiple prescriptions.

**The handouts for this session can be found in the resources section.**



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### Suicide Awareness and Prevention in Pain Management Settings

#### **Objective**

Panelists presented data related to suicide risk in pain management settings and suicide prevention strategies for populations in these treatment settings.

Participants learned about the relationship between pain management and suicide and learn evidence-based practices to help prevent suicide. Panelists described shared risk factors and discussed standards of care and Zero Suicide.

#### **Panelists**

##### **Stephanie Woodard, PsyD**

Senior Advisor on Behavioral Health  
Division of Public and Behavioral Health  
Department of Health and Human Services

##### **Misty Vaughan Allen, MA**

Suicide Prevention Coordinator  
Nevada Department of Health and Human Services  
Division of Public and Behavioral Health  
Office of Suicide Prevention

#### **Summary**

- The presenters provided prevalence data regarding chronic pain, including adolescents, adults, and veterans. Prevalence of chronic pain is a common phenomenon impacting more than 116 million Americans with one-sixth to one-quarter of adults reporting significant persistent pain and one-quarter of adolescents also reporting chronic pain. Persistent pain is prevalent among Veterans, with 75% reporting some form of persistent pain.
- Chronic pain is considered an invisible disability. It includes a significant psychological burden with a fear cycle and a narrowing of life and lifestyle where pain becomes the focus and can lead to suicidality. Individuals with chronic pain are twice as likely to die by suicide, and this increases to thirteen times as likely for people with opioid use disorder. Other risk factors for suicide include stressful events, prolonged stress, exposure to another person's suicide, and access to lethal methods of suicide. Other factors that increase the risk of suicide for persons experiencing chronic pain include pain severity, pain diagnoses, pain catastrophizing, and perceived burdensomeness. Insomnia, a desire to escape from pain, passive coping strategies, and prescription opioid use are additional factors that increase suicide risk among chronic pain patients. Detailed descriptions of subpopulations and their risk were also described. Approximately 10% of new patients prescribed opioids developed new-onset depressions after 30 days of opioid treatment.
- Many people with chronic pain experience stigma, self-blame, and judgment. Seventy percent of people who commit suicide have reached out in the thirty days prior to committing suicide. This can be combatted by building caring communities and reducing social isolation. A holistic, public health approach includes integrated, person-centered care, pain management, suicide prevention, psychiatric and addiction care, and medical care. In addition to caring communities and reduced isolation, other protective factors include: receiving effective mental healthcare, having skills and abilities to solve problems, connectedness, and reduced access to lethal means.
- When screening for suicide risk, consider prevention strategies that address risk factors among the general population and people with chronic pain and engage partners within the health system in prevention efforts to promote screening. When concerned about a person, ask with compassion. For providers, this includes making sure they are comfortable with asking the question and know what their plan is to treat or connect someone to the right resource if the answer is yes.
- One in six physicians recognize when suicidality exists, but providers need to be equipped to assess for suicide risk and are encouraged to add this assessment into their practice. Some missed opportunities are through pharmacies, families, and health care for preventing suicide. There is an opportunity to merge post-



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suicide attempts and post-overdose responses. If risk is identified, providers should proceed with an active referral for hospital or outpatient care as judged appropriate.

- The Zero Suicide model has seven essential elements:
  - Lead: system-wide culture change committed to reducing suicides. It is a top-down, outside-in movement.
  - Train: develop a competent, confident, and caring workforce that has received suicide prevention education.
  - Identify: focus on screening to identify persons at risk via comprehensive screening and assessment using a tool such as the ASQ, Columbia Suicide Severity Rating Scale (C-SSRS), or other tools.
  - Engage: can include the family and includes crisis support planning, safety planning, and spirituality to develop a suicide care management plan.
  - Treat: targeted treatment for suicide using evidence-based treatments such as Cognitive Behavioral Therapy (CBT).
  - Transition: keeps people connected to resources through warm handoffs and supportive contacts.
  - Improve: addressed policies and procedures for continuous quality improvement through data collection, monitoring, plan adjustments, continuous research, and surveys.
- Ways to integrate Zero Suicide into practice include providing information related to the contact numbers for help, listening and paying attention, especially to people with chronic pain who are showing other risk factors (e.g., a stressful life event), early intervention and identification, and addressing people when they have to accept that they need to find a way to live with chronic pain, when a “solution” is not available.
- Zero Suicide information was provided to help participants detailing resources and numbers to call for providers use to navigate when a patient expresses suicidal ideation. The Office of Suicide Prevention was also provided as a statewide resource along with many others found in the presentation materials for this session.

**The handouts for this session can be found in the resources section.**



## Neonatal Abstinence Syndrome (NAS) Prevention

### Objective

Panelists discussed screening, prevention, and interventions for neonatal abstinence syndrome (NAS). Discussion included topics such as the universal screening standard of care and information about the Empowering Mothers for Positive Outcomes with Education, Recovery, and Early Development (EMPOWERED) and Maternal Opioid Treatment Health Education and Recovery (MOTHER) Programs.

### Panelists

**Brian Iriye, MD**

Managing Partner  
High Risk Pregnancy Center Current  
President

Society for Maternal Fetal Medicine

**Farzad Kamyar, MD, MBA**

Director of Collaborative Care  
High Risk Pregnancy Center, Las Vegas

**Deepa Nagar, MD**

Neonatal-Perinatal Medicine, Pediatrics, Dignity  
Health

**Andria Peterson, PharmD**

Clinical Pharmacy Specialist in  
Pediatrics/Neonatology  
Assistant Professor of Pharmacy Practice

### Summary

- Panelists presented information on NAS and neonatal opioid withdrawal syndrome (NOWS). The opioid crisis is a significant part of the increase in maternal mortality rates and a major cost burden. Buprenorphine appears to be superior for neonatal and childhood outcomes in comparison to methadone. Opioids have lasting effects on fetal brain development.
- Past fears of opioid detoxification treatment on fetuses appear to be overestimated. Weaning or detoxification of certain motivated patients combined with behavioral therapy and social support may be considered a reasonable option.
- There are cost benefits from screening, prevention, and intervention. In 2012, the cost of NAS in the United States (US) was \$1.5 billion, with 81% of costs to Medicaid. The U.S. has the highest maternal mortality rates of any of the developed nations. Nevada also has a high percentage of pregnancy-associated deaths linked to drug usage. Pregnancy only coverage for Medicaid ends 60 days after delivery plus whatever time remains in the month. There are also increased stressors after delivery of a new baby, and corresponding increased housing and financial needs. Overdose-related deaths peak 7 to 12 months after delivery.
- Evidence was presented on the use of buprenorphine compared to methadone in pregnancy. Three different prospective studies have shown lower NAS rates for infants delivered to mothers receiving buprenorphine with shorter lengths of hospitalization, significantly shorter duration of NAS treatment, and requiring significantly less morphine.
- Buprenorphine crosses the placenta less than methadone; hence, fetal exposure to opioids is lower when using buprenorphine. One study highlighted that there were 13 extra cases of NAS for every 100 women treated with methadone versus buprenorphine. The study also demonstrated a stronger association in term pregnancies with 17 extra cases of NAS per 100 with methadone vs. buprenorphine. A meta-analysis of studies indicated a lower risk of pre-term birth, greater birth weight, and larger head circumference with buprenorphine treatment of maternal opioid use disorder (OUD) during pregnancy in comparison to methadone treatment, and no greater harm. Additionally, an average of \$23,000 per patient in savings was realized for patients treated with buprenorphine for seven months of treatment.
- There are concerns about the potential negative impact of withdrawal treatment on the fetus and increased rates of maternal relapse during withdrawal; the rate of relapse with medically supervised withdrawal with



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mental health and social services support averages 35%, while during pregnancy rates of relapse appear lower with detoxification at 22.5%. However, in a study of medication assisted treatment (MAT) program in pregnancy (MOTHER Study of 175 patients), 24% discontinued care, 34% did not complete the study, and 12% had a positive drug screen other than medication prescribed at delivery. In another study of MAT in pregnancy, 23% discontinued care and 45% were found to have opioid usage despite MAT. The presenter questioned whether, based on the data, medically supervised withdrawal was much worse than MAT in pregnancy. It was noted that with medically supervised withdrawal, some patients will become drug-free and if they cannot complete detoxification, patients can always be stabilized at a lower dose or returned to their prior dose.

- A 2016 study and review of the current literature seems to indicate that fears of detoxing while pregnant are overstated as there are more than 700 cases of reported opiate detoxification during pregnancy without a fetal demise related to the process.
- Panelists suggested that based on this data, a course of treatment is to offer patients continued treatment versus weaning versus detox as options without coercion. It is suggested to place patients into MAT programs to stabilize and then wean down or enter an inpatient detox program if desired and appropriate. This is indicated only in motivated patients without co-existing problematic polysubstance abuse who have access to behavioral health and adequate follow-up.
- Evidence that the fetal brain is affected should be discussed as part of a shared decision-making process on eventual treatment in pregnancy. Medically assisted withdrawal/detox and weaning risks and benefits should also be discussed and only attempted with behavioral health and social services support. The goal should be stability with an understanding of the patient's specific desire for care after an educated process of shared decision-making.
- For non-pregnant women of childbearing age, buprenorphine should be strongly considered the treatment of first choice due to the effects on babies, the ability to wean, and the fact that more women on these medications have unplanned pregnancies. MAT providers for non-pregnant women should discuss reproductive risks of medications and prescribe or refer for long acting reversible contraceptives (LARC).
- The MOTHER and EMPOWERED programs were highlighted. The MOTHER program works with partners in the community to provide complete wrap-around services including individual and group counseling and therapy, additional behavioral health care as needed, MAT providers to continue care post-partum, social work and case management and education for WIC, CPS, lactation, and parenting classes. The EMPOWERED program was specifically created to help find and provide resources for all of the above.
- Presenters then highlighted NOWS as an increasing problem in Nevada. The MOTHER program at the High Risk Pregnancy Center provides MAT for pregnant patients, reduces mortality for mothers and neonates, and reduces NAS/NOWS. NOWS is a specific form of NAS with 50-80% of opioid exposed infants developing NOWS. Effects of withdrawal manifest in neurological, gastrointestinal, and autonomic symptoms similar to an adult in withdrawal. Rate of hospital births for NAS increased from 1.5 to 6 per 1,000 hospital births from 1999 to 2013 (300% increase). In the Dignity Health system nationwide, the rate of NICU admissions for NAS increased from 7 to 27 cases per 1,000 admissions from 2004 to 2013.
- In Nevada, the rate of NAS increased from 3.9% to 5.3%, which does not include infants who were not started on medications or not admitted to the NICU. The prevalence of NAS in Southern Nevada also increased between 2015 and 2016. More pregnant women appear to be seeking treatment, but compliance is poor. Polysubstance use is high with opioids and benzodiazepines are primary concerns, and marijuana use is increasing as well. Nevada NAS rates are nearly double national rates with three consecutive years of data. The average mean charge for a NAS baby is \$93,400 as compared to \$3,500 for a healthy newborn in 2012 dollars. This does not consider the long-term effects of NAS which includes limited long-term developmental outcomes, the lifelong impact from social, emotional, physical, and mental health challenges that last into adulthood, and ongoing costs for medical care, education, and social services.





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- In reviewing MOTHER project referrals, slightly over 100 referrals have been made in the Clark County area. To date, about 1 in 10 enroll in the program due to eligibility, presence of other medications or substance issues, or because of refused treatment. While the program is new, and numbers are small, the outcomes of delivered patients showed that none of the infants of participants needed medication for NAS/NOWS. The average hospital stay for infants was four days compared to an average stay with NAS of 21 days, and 80% did not go to NICU. The cost savings for MOTHER project patients compared to non-patients was significant.
- Voluntary universal screening is currently being promoted in Nevada. Mandated universal screening will hopefully bring attention to patients that are falling through the cracks. Panelists expressed hope that the promotion of and payment for Screening, Brief Intervention, and Referral to Treatment (SBIRT) will increase. Training is needed for OB/GYNs to promote the screening of all patients. Some are doing urine tests only and with training may become more comfortable about referral for a positive screen.
- In response to a question about withdrawing heroin users on methadone, it was suggested not to focus on current patients but on future patients. Consider buprenorphine for those that are of reproductive age or pregnant first, then methadone. Transferring a patient from methadone to buprenorphine can be done by tapering methadone to 10mg a week until they can be transferred over, but the risk is that they may disengage from treatment.
- The panels also responded to a question about how to transfer patients between medications, stating there are significant challenges with having to taper before a transition, but it has been done successfully. For some patients, they need to taper or wean completely, then have one to two days of withdrawal, then place a bridge device for five days, which brings the patient to seven days of being opioid-free before going to another treatment.

**The handouts for this session can be found in the resources section.**



# Indian Country (Urban and Rural) Responses to the Opioid Epidemic

### **Objective**

Panelists discussed the historical and current context for the opioid epidemic and its impact on Native people, including current challenges and barriers surrounding treatment. Panelists also shared programs, practices, and strategies that show promise for both prevention and treatment of substance use disorder.

### **Panelists**

#### **Danielle Lukins, MFT**

Therapist and Center Manager  
Healing Center, Washoe Tribe of Nevada and California

#### **Martin Stephens**

District Injury Prevention Specialist  
Indian Health Services (IHS)  
US Department of Health and Human Services

#### **Quinton Thomas, MD**

Medical Director  
Healing Center, Washoe Tribe of Nevada and California

### **Summary**

Panelists began the conversation of the opioid crisis within the larger context and setting of intergenerational traumas that continues its legacy today.

Panelists acknowledged that because of the sovereignty of tribes, even tribes within 50 miles of each other often have different laws. Differences between tribes mean that programs, policies, and practices may differ and as do assets and needs. There are more than 500 federally recognized tribes who also have a variety of governance, laws, and structures. Acknowledging that there are major differences in culture, language, and situation, panelists were asked to share both challenges and opportunities.

### **Critical Issues**

- **Structure and Capacity to Meet Grant Requirements.** Many tribes now receive block grants, but are not yet capable of meeting the grant requirements and there has not been a transition to help ready them. This is a considerable barrier. For example, a physician who is buprenorphine waived cannot treat on the reservation because the other aspects of structure are not in place. The barrier to meet the requirements is large, and the capacity is very limited. The tribes have liability, which adds additional risk and prevents advancements – such as use of medication assisted treatment – from moving forward.
- **Stigma of Seeking Treatment and Issues of Privacy.** The small community and dual relationships of some providers, including mandated reporting, relationships with tribal law enforcement, and, and shared spaces are barriers for people seeking treatment.
- **Qualified and Consistent Providers.** A revolving set of providers diminishes peoples' trust and willingness to connect and communicate with treatment staff. Competitive pay for competent professionals is difficult to achieve. Affordable housing for providers can also be an issue. Additionally, there are a limited number of tribal providers. Outside providers are not trusted at the outset and must earn trust through time and consistency.
- **Resistance to Change at Leadership Levels.** There is resistance to change, and it is sometimes difficult for those in Council leadership positions to see the issues and magnitude of the problem (e.g., unintentional, and intentional overdose among elders.)



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- **Fear of Legal Consequences.** Some are fearful of Tribal Police being called if they reach out for help. Tribal police are often their family and relatives.
- **Siloed Care.** Other challenges include breaking down silos among the community and various support options.
- **Funding.** There is also an ongoing struggle with funding. Funding comes from Indian Health Services. A purchase referred care means that only the most acute services are paid for, and when issues are not life-threatening, opioids have been prescribed (instead of root causes addressed).
- **Chronic Disease and other Contributing Factors.** Opioid and substance use is complex, with many contributing factors and these can be even more challenging for the native communities, due to increased individual risk factors. Alcohol and drug abuse rates are high, and suicide and homicide rates are high, including for children. There are also high levels of poverty and geographic isolation. Opioid use disorder is associated with other chronic diseases, for example, diabetes, kidney failure, liver disease, and even accidents due to disease.
- **Different Laws.** With recreational marijuana use, if you are found on the reservation with any amount of marijuana or drugs, you can go to jail.
- **Challenges with Data Sharing.** Ours is the second-highest population for overdoses, but that is likely very underreported because the tribe may not share data.
- **Housing Issues.** Stable housing is critical (and an unmet need) for both people in treatment and for providers.

### Practices and Opportunities

- **Addressing Stigma.** At the Washoe tribe, they have worked to address the stigma around behavioral health, as well as outside providers. In the recent past, they have been able to increase the use of drug and alcohol counseling at the healing center by addressing the stigma and working to build trust between community members and providers. Another strategy is for people to use providers in a different location. Sometimes “outside” providers can be helpful so that people can seek treatment with a greater sense of privacy.
- **Earning Trust.** With community outreach, trust has to be earned. Outreach is often performed by attending various tribal events. Panelists reinforced that building trust and demonstrating commitment is critical. It was suggested to give the tribes the power of the pen to form a board rather than a full Tribal Council. Slight shifts in viewpoint can possibly make differences. To address intergenerational trauma and be solution-focused, we can lift up communities by approaching the Tribal Council. It is important to ask permission from the top down, and it will take time. People need to keep showing up even if rejected.
- **Securing Funding.** Indian Health Services currently provides baseline services. Additional doctors are/will be coming on board over time. Identifying needs and writing grants is also an important opportunity to bring in needed resources. Tribes have the opportunity to investigate funding initiatives and identify them to build capacity.
- **Preventing Fatal Overdose.** There is work in Nevada to procure, train on, and provide naloxone. There is also an opportunity to bring in the drug neutralization kits to allow people to dispose of medications properly. Bulk medications safes are also a potential strategy. Some practices include effectively marketing naloxone and meeting with grant requirements. In addition, home health visits are occurring with Community Health Network, and the naloxone can be a way to build trust.
- **Safe Disposal of Medications.** Another practice is medication drop off sites and support to follow through with syringe disposal. The Bureau of Indian Affairs has some data on naloxone by EMS or police that may be useful.
- **Engaging Tribal Leadership.** In discussing opportunities, more involvement with tribal leadership for behavioral health needs is an opportunity. In addition, bringing colonies together even within a tribe is an opportunity to create more unity.



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- **Improving Infrastructure.** Expansion and improvement of clinics are important – there is not space to adequately serve the needs.
- **Improving Housing.** Set up housing first to secure stable housing for patients and employees of clinics.
- **Acknowledging and Recognizing Strengths.** Panelists recognized the importance of caregiver support and the opportunity to support families and the people caring with families both formally and informally.
- **Therapies Rooted in Tradition and Culture.** Strategies such as equine therapy also may be promising. Indigenous food programs provide an opportunity to work and contribute to a sense of community.
- **Upholding and Acknowledging the Unique Assets of Individual Communities.** A global approach is great, but even tribe to tribe is different. Each tribe must offer unique individual support via a healing forest. Hope and positivity can be a start for recovery.
- **Reimbursement for Services.** Tribal members are eligible for Medicare/Medicaid, which is a payment source for behavioral health.
- **Expanding Medication Assisted Treatment (MAT).** In terms of MAT, some tribes don't have the structure of counseling to support this. But MAT is planned for the Washoe Tribe this fall or winter. Judicially mandated MAT has a better chance of success. Another opportunity is bringing MAT to the clinic and the addition of the Carson satellite office.
- **Services and Supports for the Whole Person.** Medication is just a tool. Treatment should focus on spiritual, physical, and mental health.
- **Supporting Families and Peers.** Additional supports may be needed to support the intergenerational families, with recognition of caregiver support. Peer support with tribal populations may be promising but also has a variety of laws and rules, and people must pass an extensive and invasive process.
- **Helping and Not Hurting.** Providers have to be willing to be a productive extension of the community. Go in and listen and learn first. Leave your agenda at the door. Listen, do not tell. Include the individual with the treatment plan. Go in as a friend. Understand that it will take time.



# Participant Takeaways and Lessons Learned from Breakout Sessions

Throughout each breakout session, participants were provided notecards and asked to document key takeaways and lessons learned from each session they attended. Key takeaways were defined as something they learned during the breakout session that would impact how they proceed in their practice or with their programming. Lessons learned were defined as a piece of information they learned during the session that was particularly impactful. Notecards were collected after each breakout session and logged to identify key themes of importance. Many of the key takeaways and lessons learned overlapped. Key themes are provided for sessions where note cards were submitted upon the session's conclusion. The following are the key themes and lessons learned as identified by participants of the Summit. Verbatim statements from participants are noted in *italics*.

### **State of the State: Where are we now; where are we headed?**

Key topics covered by the presenters included the following:

- 1 in 10 Americans use illicit drugs.
- Nevada has moved the needle in all five areas of the HHS 5-point strategy: 1) addiction, prevention, treatment, and recovery services, 2) data, 3) pain management, 4) targeting of overdose-reversing drugs, and 5) research.
- Reimbursement issues resulted in many providers not prescribing to the limit allowed.
- Hub and spoke model developed with Integrated Opioid Treatment and Recovery Centers (IOTRCs) and community-based services to address capacity and connectivity in urban and rural areas.
- Warm handoff to treatment providers is an important component of improving survival rates from an overdose.
- Law Enforcement and Public Health work together to watch trends closely to respond to fentanyl hotspots.
- NV opioid prescriptions decrease, from 2017 to 2018, is unprecedented among states.
- The number of "doctor shoppers" has decreased substantially from 2013 to 2018, partly due to AB 474 (resulting in decreased exposure to opioids).

Yenh Long clarified during the question and answer period that the Nevada Prescription Monitoring Program (PMP) is able to query patient data through linkage with 23 other states. California is prohibited from sharing data with other states, but prescribers on the border with California can sign up for the Controlled Substance Utilization Review and Evaluation System (CURES). PMP data is also shared with the Veterans Administration.

### **Opioid and Criminal Justice Re-Entry**

Programming and coordination were the most cited key takeaways for this session. Planning for re-entry should include what happens at county jails prior to prison sentencing, providing programming within the prison facilities, and strengthening partnerships with in-custody service providers to support a warm handoff as people are released from prison. Better coordination and communication among all contacts within the criminal justice system, including jails, prisons, parole and probation and recovery services – including housing - help support re-entry. Removal of silos has really improved connectivity, but significant gaps remain. Resources are needed to provide holistic and comprehensive services. Government programs and policy initiatives can help change social perception and reduce recidivism.



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Lessons learned were consistent with key takeaways, with a bit more emphasis on challenges. Better coordination with health care is needed to improve outcomes where out of 14,000 inmates, only 3% receive treatment for substance use disorder (SUD).

Programs cited: Foundation for Recovery, Ridge House, WestCare.

### Investigating the Data, Emerging Trends in Overdose Death

Key takeaways focused on sharing data across systems, e.g., State Unintentional Drug Overdose Reporting System (SUDORS), Overdose Detection Mapping Application Program (ODMAP), and data sharing among Multidisciplinary Teams (MDTs), and stakeholders to raise awareness and develop prevention strategies. Specific overdose issues include higher risk after a period of abstinence, high correlation with depression, and the promotion of naloxone to prevent overdose.

Participants cited lessons learned on the relation of data collection to resources such as naloxone distribution, fentanyl test strip program, or *being on the lookout for meth, benzo, and synthetics*. Inaccuracies across different data systems, compared with ODMAP, were identified.

### Open Beds Demonstration

While most providers and stakeholders in this session were hopeful about the policy implications for 24/7 referral and better collaboration with Medicaid Managed Care Organizations, one participant noted the lack of provider input before the state contracted for the service.

### Strategies for Integration

Participants noted the benefits of multiple services in colocated settings to facilitate follow-up and collaboration; *referral follow-through is 90% when colocated with the referral source*. Many underscored the need for universal screening and rescreening, with the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Federally Qualified Health Centers and other providers for high-risk populations. Respondents also reflected the need to address the stigma around MAT, using a multidisciplinary approach, including American Society of Addiction Medicine (ASAM) criteria's six dimensions to educate patients/clients. Understanding how buprenorphine, Vivitrol, and methadone are used for different health issues was another takeaway.

A significant lesson learned is how *laws for screening for substance use can interfere with women getting into prenatal care*. Screening needs to link to referral for treatment services. Nurses and others need education on overdose and use of naloxone; educational PSAs encourage treatment. Different drugs such as buprenorphine, naloxone, Vivitrol, naltrexone, and subcutaneous injections are often used for psychiatric issues. One-third to one-half of those with substance use disorder have PTSD.

### Syringe Service in the Continuum of Care

Participants noted the *safer using patterns and a compassionate stance of harm reduction that includes a holistic approach to address disorders while educating on risk and status of infectious disease* was a key takeaway. Many participants commented on the need to meet clients where they are. Stakeholders expressed gratitude for public health vending machines that reflect changing attitudes toward a variety of behaviors.

Lessons learned include integration of a range of responses from vending machine syringes, to needle exchange and law enforcement distribution. A solution-oriented approach through education, prevention, harm reduction, and respectful care is important.



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Program cited: Trac-B

### **Community Based Responses: Best Practices for Peer Support Services**

Key takeaways identified peer support services as an *essential component of a recovery-oriented system of care*. Multiple participants noted their intent to integrate peer support services into their practice, including *low-barrier connections*, and the need to *change prohibitive policies that prevent integration of peers*.

Participants learned about the effects of stigma related to the opioid crisis, as well as Medicaid barriers to integrating peer support into their practice. Some are interested in becoming *peer to peer specialists*, as non-clinical people working in clinical settings, while other peer recovery coaches are creating their own recovery community.

### **Pain Management in General Medical Settings: Best Practice Strategies**

Key takeaways supported non-narcotic approaches for pain, such as physical therapy, combined with slow tapering and radiology studies to assess whether opiates help. Chronic pain requires a team approach and consideration of patient-specific needs, combining self-report with physician assessments.

Lessons learned were similar regarding the psychological components of acute versus chronic pain and implementing a team approach with various specialists. *Finding out a patient's goal for where they want to be at the end of pain management is crucial to develop the best alternative method*. Challenges identified are referrals for non-reimbursed treatment and pharmacies, creating barriers out of fear.

### **Public Health, Law Enforcement, and their Data Intersections**

A key takeaway for many related to the conflict between *health-based and evidence-based data*, and the need for better data-sharing and collaboration. Programs in the works were referenced to improve information sharing between counties and bordering states. Some were impressed with the interactions and intersections between public health and law enforcement, noting the need to educate others to understand HIPAA to avoid overapplication. Several noted the high rates of HIV and Hepatitis C in Nevada and especially Clark County.

A lesson learned was the need to find a balance between collecting data and maintaining individuals' privacy. One participant asked, *how is it determined that a threat or piece of data "must" be released or shared?* People were also interested in *Fusion Center* activities and the *Threat Analysis Center*, citing the need for these staff to participate in the ODMAP program.

### **Criminal Justice Interventions**

Participants noted a culture change related to MAT that has affected all agencies; specialty courts, in particular, help reduce recidivism by supporting opiate withdrawal programs. One representative of a regulatory agency noted their *probation program hasn't changed in 10 years; it will change now*. Another asserted the need to *lean into harm reduction; especially if you want any grant funding*.

A significant lesson learned was the importance of affordable housing: *I didn't realize the immense impact to those subpopulations*. The success of the Washoe County program, based on data analysis, was cited as a strategy for other diversion programs. *Trauma-informed care* in the courtroom was cited by multiple people as an effective practice, demonstrating care and respect for corrections population.



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### Overdose Prevention for Difficult to Engage Populations

A key takeaway for this session was to *pass out extra needles as an outreach tool for peers to give others to utilize*. Great idea from Trac-B! In reference to emergency situations, one participant asked *Does HIPAA allow our contacting multiple physicians?*

Lessons learned include ideas for implementation in rural and frontier areas or in a tribal community, with enthusiastic support for fentanyl test kits. One participant who learned about needle exchange vending machines needs to *figure out how to make it work in rural WA*.

### Prescription for Collaboration: Prescribers and Pharmacists in Collaborative Care Practice

Key takeaways include the need for collaboration to support patient health care, but corporate policies may create barriers. *Explaining pressures to the other would be helpful . . . Respect and Trust*.

A lesson learned is the value of Collaborative Practice Agreements allowing pharmacists to prescribe. *It would be great if a neutral entity with some authority could encourage physicians and pharmacists to collaborate, work together in a collegial way to take care of the patient. Maybe the Board of Pharmacy?*

### Building Capacity for Investigations of Drug-Related Deaths

A key takeaway was that SB 463 will enhance data collection around suicide and overdose deaths. The quality and accuracy of data are important, including entering what the forensic pathologist states onto the death certificate. While one person was *excited to utilize this information in my interactions with rural sheriff coroners*, another stated *programs are not so simple for rural law enforcement to implement*.

Possibly the same writer from above learned the lesson: *Don't become a sheriff in a rural county – you get to be the coroner, too!* Another was interested to see *how standardization is received and applied in regard to the rural coroner system*. Other lessons learned include the increase of fentanyl overdose versus other opioids, and how *laws can be a tool to get more resources and funding*.

### Integrated Opioid Treatment and Recovery Centers (IOTRC) Overview

Many respondents noted the benefits of peer support services with a patient-centered approach to *meet people where they are at*. *The peer support model is changing recovery centers throughout Nevada*. Several referenced the need for housing and treating all the patient's needs, in addition to addiction treatment. A paramedic expressed excitement to transition from an emergency responder to *be present or there for someone before the 911 [call] or emergency incident, or to play a role post-incident in recovery*.

Lessons learned include IOTRC as a hub for further resources, while peer support services can be expanded to facilities like emergency departments, or environments like tribal communities. The lesson of listening to your patients and letting them make decisions was repeated throughout.

### Pain and Addiction Treatment

A key takeaway is that pain is real – both emotional and physical. Changing “red-flag” thoughts to more positive thoughts through cognitive behavioral therapy can be simple and successful. There are multiple non-narcotic approaches to pain control, including alpha stim, CBT, and physical therapy. Many notes reflected this one comment: *Information regarding hypnosis and surgery and recovery was amazing; thank you!* Another person noted a takeaway to *reduce dosing and/or move to pain management ASAP*.





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An important lesson learned is that *the goal of pain management is NOT to get rid of pain, necessarily, but to increase quality of life!* Other lessons include *change thinking pattern for chronic pain patients*, grounding techniques combined with CBT to reduce pain, and that hypnotherapy is being used in Europe with reduced recovery periods. Multiple participants expressed new learning and excitement at the opportunity to learn more and possibly implement these techniques in their practices.

### **Patient and Provider Perspectives on Post-Overdose Outreach Interventions Models**

Key takeaways included the *great idea* of EMS distribution of NARCAN and wound care kits and the need for collaboration between EMS and Emergency Rooms. *Nevada is so lucky to have Dr. Wagner and her team doing this important work!*

A challenge was identified in working among emergency medical services, hospitals, and tribal communities; some are apprehensive about going onto reservations because permission is needed from the tribe. There is also resistance from the tribal government to sign Memoranda of Understanding (MOUs) and work with non-tribal entities.

### **Standard of Care: Pain Management and Medically Necessary Opioid Prescribing**

Many respondents noted the problem with pain-scale questions in patient satisfaction surveys and the need for policy changes. Multiple pain medications were reviewed, but there needs to be reeducation about opioid management and pain management because *doctors now have a prescribing phobia*. *Production pressure* around the hospital's *bottom line* creates additional barriers to best practices. Some referenced alternative treatments, e.g., chiropractic mindfulness and meditation in the emergency department.

Non-opioid options for pain include Ketamine and Toradol. Multiple respondents referenced buprenorphine as the *AZT of OUD*, but emergency departments can't deliver it.

### **Criminal Justice Interventions**

Key Takeaways include the need to change mindsets and *making sure that programming is supportive of what law enforcement needs to appropriately address mental health and substance use disorder*. Flexibility within a functional system is needed rather than a streamlined system that won't work for everyone. Collaboration was cited multiple times as an essential element. Crisis Intervention Teams (CIT) and Law Enforcement Assisted Diversion (LEAD) training, as well as in-service training, are all good resources that need to be broadly distributed.

Many respondents learned the need for positive relationships with law enforcement and coordination with community businesses and services to spread awareness through CIT. One expressed the need for public health to understand the challenges of law enforcement and be more concerned with innocent victims who are exposed to, and possibly injured by, illicit activity. However, most were impressed with how Nevada is implementing deflection and diversion programs, including a funder of Forensic Assessment Services Triage Team (FASTT) and Mobile Outreach Support Teams (MOST) who expressed pride in the work being done and a commitment to continue funding these programs.

### **Inside Nevada's PMP: Opioid Use Among the General Public, and Heroin Users**

Key takeaways included the availability of PMP data to all providers, but others would like access to PMP as part of data abstraction, eventually for use in identifying risk factors and prevention, or opportunities for intervention. Breakdowns in communication still take place between entities.



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An important lesson learned is that detox from benzodiazepines is life-threatening. One participant asked why more physicians don't utilize PMP and why nurses don't have access. Another noted the limiting factor of not having physicians on-site at SUD and behavioral health centers.

### **Suicide Awareness and Prevention in Pain Management Settings**

A key takeaway is to *lock-up firearms to protect against suicide*. Participants noted strategies to implement in their practice, including *continued screening* and *adding resources to their directory*.

A lesson learned extended the importance of *screening all clients versus relying on clinical judgment*. An increased risk for suicide is chronic pain, which frequently co-occurs with insomnia.

### **Neonatal Abstinence Syndrome (NAS) Prevention**

Participants noted the national scope of NAS and the importance of universal screening. The data are showing that methadone use results in babies with smaller head circumference was a clear signal to most to switch to buprenorphine for women of childbearing age, while a minority felt the studies were not complete or that this practice stigmatizes methadone clinics. Others noted the need to work together through community outreach to improve Medicaid coverage.

Lessons learned also referenced the effects of methadone. They noted the high rates of NAS in Nevada (double the national rates), and the related costs to the state. Several participants identified the need and opportunity to do more to help mother, including long-acting reversible contraception (LARC)/family planning and more research. Several participants stated that withdrawing patients from methadone is not best practice, and they would not refer patients to these programs.

### **Indian Country (Urban and Rural) Responses to the Opioid Epidemic**

Key takeaways for this session include the importance of cultural competency, recognizing historical trauma for tribal populations, as well as awareness of tribal barriers to treatment. Multiple levels of laws are problematic; *there should be agreements between the entities prior to trying to provide services*.

Some participants were not aware of all the tribal hardships, and lessons were learned about structural oppression and generational trauma, as well as the lack of trust between service agencies and tribal councils. The need to establish MAT in tribal settings, recognizing the vast differences across different locations, was also recognized. One participant suggested calling the Center for Substance Abuse Treatment (CSAT) for funding.



# Recognition

In 2016, more than 450 participants met in Las Vegas to develop Nevada's Blueprint: Addressing the Prescription Opioid and Heroin Crisis. Since that time, individuals, community-based organizations, policymakers, health care providers, law enforcement, industry representatives, and other interested stakeholders have worked to implement the recommendations from the Summit. Their work has been tireless in support of Nevada's efforts to address the prescription drug abuse epidemic, while promoting provider education, strengthening data collection and sharing, expanding treatment options, promoting collaboration, and engaging law enforcement as partners. Nevada now has many new programs, systems, and policies as a result of these efforts. At the Summit, participants were invited to submit forms to recognize specific individuals and organizations from across the state for their work. Each has made a positive impact related to opioid abuse education, prevention, intervention, treatment, data collection, or policy, along with many others not listed below. Those recognized by participants at the 2019 Summit are listed alphabetically.

*Dr. Miriam Adelson*

*Keith Carter*

*Chelsi Cheatom*

*Trey Delap*

*Dona Dmitrovic*

*EMPOWER*

*Jessica Flood*

*Foundation for Recovery*

*Krista Hales*

*Dr. Brian Iriye*

*Kathryn Barker*

*Terry Kerns*

*Lisa Lee*

*Elyse Monroy*

*MOTHER Project*

*Dr. Deepa Nagar*

*Southern Nevada Health District*

*Specialty Courts*

*Trac-B*

*Washoe County Sheriff's Department*

*Dr. Stephanie Woodard*

*Cyndi Yenick*

*Ed Yenick*



# Presentations and Handouts

All presentation and handout materials can be found at the following Google Drive location:

<https://drive.google.com/open?id=1YI2nyUNy4Flu6OZjQ5TUvbLRTuDvSQ7v>

Individual presentations or handouts can be accessed by following the links below for each item listed:

**State of the State – Where are we Now, where are we Headed?**

***Nevada's Evolving Opioid Crisis: Successes and Challenges Presentation***

*Presented by: Stephanie Woodard, Keith Carter, and Yen Long*

**Investigating the Data, Emerging Trends in Overdose Death**

***Investigating the Data, Emerging Trends in Overdose Death Presentation***

*Presented by: Kathryn Barker, MPH, Keith Carter, and Chelsi Cheatom*

**OpenBeds Demonstration**

***OpenBeds Opioid Summit Briefing Presentation***

*Presented by: Steve Carroll, Rachelle Pellissier, MPA Stephanie Woodard, PsyD, and Elyse Monroy*

***OpenBeds Brochure Handout***

**Syringe Service in the Continuum of Care**

***Hepatitis C Treatment, Access, and Uptake Handout***

**Overdose Education and Naloxone Training**

***Reducing Accidental Overdose Fatalities with Naloxone Presentation***

*Presented by: Morgan Green, Jamee Millsap, MA, LADC, and Brandon Delise, MPH*

**Public Health, Law Enforcement, and their Data Intersections**

***The Nevada Opioid Dashboard***

**Criminal Justice Interventions**

***Adult Drug Court Best Practice Standards I Handout***

***Adult Drug Court Best Practice Standards II Handout***

***10 Essential Elements of Opioid Intervention Courts Handout***

**Overdose Prevention for Difficult to Engage Populations**

***Good Practice Guide to Integrated Sex Worker Programming Handout***

***Why Ashton Kutcher's Tears Are Everything That's Wrong with the Anti-trafficking Movement Handout***

***Concept of Trauma and Guidance for a Trauma-Informed Approach SAMSHA Handout***

***The meaningful guide to involving sex workers in healthcare services geared at them Handout***

***Technical Brief - Engaging target populations in the context of the HIV epidemic Handout***

***How to be an Ally to Sex Workers Handout***

***Stages of Change Overview Handout***

***Harm Reduction Coalition Handout***

***Harm Reduction Behaviors Surrounding Fentanyl Use Presentation***



# Opioid Response Summit 2019

Presented by: Chelsi Cheatom, M.Ed

**Prescription for Collaboration: Prescribers and Pharmacists in Collaborative Care Practice**  
**Collaborative Practice Agreements Handout**

**Review of Treatment System- Integrated Opioid Treatment and Recovery Centers (IOTRC) Overview**  
**Review of Treatment System -IOTRC Requirements Handout**

**Pain and Addiction Treatment**

**Chronic Pain Management Presentation**

Presented By: Pamela Rinato, PsyD, LCSW

**Patient and Provider Perspectives on Post-Overdose Outreach Interventions Models**

**Feasibility and acceptability of (MROT) for opioid overdose patients in the emergency room Handout**  
**Emergency department-based peer support for opioid use disorder: Emergent functions and forms Handout**

**Standard of Care: Pain Management and Medically Necessary Opioid Prescribing**

**American College of Emergency Physicians Research Forum 201.418 Handout**

**ALTO Program Handout**

**Controlled Substance Policy UMC of Southern Nevada Handout**

**Enhanced Recovery After Surgery: A Review Handout**

**Pain Medication Policy for Patient Safety Handout**

**Adult ED Analgesic Alternatives to Opioids Handout**

**Luncheon Keynote Address**

**Opioids: A Regional Perspective on a National Epidemic Presentation**

Presented By: Director Edward Heidig

**Inside Nevada's PMP: Opioid Use Among the General Public, and Heroin Users**

**Prescription Drug Misuse in Nevada Presentation**

Presented By: Stacy Ward

**Suicide Awareness and Prevention in Pain Management Settings**

**2019 NV Suicide Prevention Conference Save the Date Handout**

**Recommended Standard Care for People with Suicide Risk Handout**

**Crisis Now Summit Flyer Handout**

**What is Zero Suicide Handout**

**2019 Opioid Summit Suicide Awareness and Prevention in Pain Management Presentation**

Presented By: Misty Allen and Stephanie Woodard

**Neonatal Abstinence Syndrome (NAS) Prevention**

**Opioid Use Disorder- Pregnancy New Principles and Recently Displaced Myths Presentation**

Presented By: Brian Iriye, MD, Farzad Kamyar, MD, Deepa Nagar, MD, Andria Peterson, PharmD



## Opioid Response Summit 2019

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