Substance Use Disorder & Opioid Use Disorder in Nevada: Policy Analysis and Infrastructure Assessment Report

Nevada Department of Health Care and Financing Policy

December 2020

Updated Version 3

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This document is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $1,684,013 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Executive Summary

Under section 1003 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act), which became law on October 24, 2018, the Centers for Medicare & Medicaid Services (CMS), in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), is conducting a 54-month demonstration project aimed at increasing the capacity of Medicaid providers to deliver substance use disorder (SUD) and opioid use disorder (OUD) treatment and recovery services. The project includes 18-month planning grants awarded to 15 states, and 36-month demonstrations with up to five states that received the demonstration grants.

On September 23, 2019, the Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), announced that the state was one of the 15 selected, and was awarded $1.68 million for the planning phase of the demonstration project.

DHCFP partnered with the Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) to develop a plan to increase the number of providers offering SUD, including OUD, treatment and recovery services by 20 percent statewide. The goal of the planning grant is to develop an integrated care system for the treatment of SUD and OUD that is available statewide to all Nevada residents, regardless of urban or rural locale, and also targets pregnant and postpartum women and their infants to address neonatal abstinence syndrome (NAS). The activities in the planning grant focus on:

- Identification, recruitment, and training of providers eligible to deliver treatment and recovery services to expand access and provider capacity, especially in rural areas, including ongoing assessment, engagement, and collaboration with the provider community and key stakeholders.
- Development of policies, protocols, and strategies to enhance access to services and improve coordination of services, including a Medicaid screening, brief intervention, and referral to treatment (SBIRT) policy, a comprehensive medication-assisted treatment (MAT) policy, alternative payment methodology (APM) for MAT services, reimbursement optimization, and increased utilization of telehealth and related technologies.

DHHS engaged Myers and Stauffer LC (Myers and Stauffer) to provide technical assistance (TA) and project management services for the planning grant and development of the demonstration application. The Myers and Stauffer team includes individuals with industry-level expertise in health care delivery system and payment transformation, rate setting, program integrity, and health information technology (health IT) for government-sponsored health care programs.

This **Policy Analysis and Infrastructure Assessment Report** serves as a critical component in the research and development process of a successful demonstration application. The purpose of the assessment report is to present the current policy and infrastructure landscape regarding SUD service system in Nevada, including provider capacity, benefit design and coverage, prior authorization management,

integrated care delivery, and reimbursement. The report also illustrates areas of opportunity, and includes emerging and best practices, as well as recommendations to enhance and expand SUD treatment and recovery services statewide.

The assessment report covers the following main areas:

- Current Opioid Use and Provider and Treatment and Recovery Services Capacity in Nevada.
- Nevada Substance Abuse Healthcare System Landscape, Challenges, and Opportunities.
- Benefits Utilization Management Landscape and Opportunities.
- Technology-Enabled Approaches to Expand Capacity and Services.
- Application and Expansion of the Hub-and-Spoke Model.
- Fiscal Projections.

The report was developed between March 2020 and June 2020, and utilized information from various sources, including specific DHHS stakeholder discussions and communications, as well as statewide and county-level assessments, epidemiology and surveillance briefs, provider surveys, data reports, document review, and other research.

Key Recommendations

Though Nevada has made significant progress in addressing the state's opioid epidemic, there still exists an ongoing need to expand and enhance access to SUD treatment and recovery services, especially in rural communities. The following is a brief summary of the key recommendations included in the assessment report, and can be used as a starting point to develop a comprehensive and robust demonstration application.

- ***Improve Workforce Development and Retention Strategies.*** Specific opportunities include creation of an integrated care training program, primary care toolkit, SUD treatment website, and prescriber training; financial incentives for SUD providers, such as loan repayment programs in exchange for service delivery in rural or high-need areas such as Las Vegas; development of a statewide network of partnerships or pathway programs dedicated to increasing the number of mental health practitioners; and facilitating reciprocity of licensure for SUD providers licensed in other states wishing to practice in Nevada.
- ***Increase Availability of and Access to Medication-Assisted Treatment Services.*** Specific opportunities include advocacy; introducing reimbursement for care coordination and a team-based care model for MAT delivery that includes primary care, counselors, or other non-physicians; allowing MAT induction services in the emergency department (ED) setting; increasing outreach to state associations for other provider types that may be eligible to offer MAT services; and providing incentives, mentoring or support programs, driving awareness of MAT services

already offered by particular federally qualified health centers (FQHCs), as well as conducting actionable activities to further expand MAT services into FQHCs and rural clinics that do not currently offer such services.

- ***Reduce or Eliminate Provider Barriers to Offering MAT.*** Specific opportunities include incentives for becoming certified or waivered; providing waterfall reimbursement methodology and utilizing braiding or blended funding; addressing administrative barriers through scope of practice and Medicaid policy changes or clarifications, such as expansion of scope of practice and practice settings for physician assistants (PAs), advanced practice registered nurses (APRNs), psychologists, and nurse midwives; allowing physical health providers to bill for appropriate behavioral health services; and reviewing the provider enrollment process.
- ***Use Data to Support Expansion of SUD and OUD Services.*** Specific opportunities include implementing integrated care readiness and assessment tools, and enabling a statewide system of continuous evaluation of the level of health care integration and data governance oversight.
- ***Address Social Determinants of Health (SDOH) through Community Partnerships.*** Specific opportunities include continuing investment in community programs; optimizing current partnerships; and working within the Medicaid Enterprise to increase the capacity to report on member inquiries and ways in which to use reporting to best identify and intervene on specific SDOH measures.
- ***Streamline Benefits and Utilization Management.*** Specific opportunities include addressing the amount, duration, and scope of Nevada's SUD services, such as alignment with American Society of Addiction Medicine (ASAM) requirements; updating the Medicaid Service Manual (MSM) chapters, billing guides, and other provider resource materials; evaluating prior authorization requirements for outpatient behavioral health services; streamlining utilization management activities within managed care; adjusting PA requirements for outpatient behavioral health services; and streamlining utilization management activities within managed care organizations (MCOs).
- ***Leverage Available Technologies and Infrastructure to Support Expansion.*** Specific opportunities include enhancing education and training on how to leverage telehealth in recovery and treatment services within federal limits; developing a closed-loop referral management system integrated with the statewide health information exchange (HIE) to support movement of patient data between providers as a component of an integrated care network; expanding availability and promotion of the Expanding Capacity for Health Outcomes (ECHO®) project to recruit and train MAT providers, and exploring opportunities for reimbursement for SUD case management and review via Project ECHO® (Extension for Community Healthcare Outcomes) clinics.
- ***Expand Nevada's Hub-and-Spoke Model.*** Specific opportunities include establishing a Medicaid state plan or waiver benefit that supports the hub-and-spoke model; supporting regional implementations of hub-and-spoke; leveraging telehealth treatment options; and creating an oversight body to manage development, expansion, and evaluation. See Section 5.3.

- ***Employ the Collective Impact Collaboration Model.*** Consider using a collaboration model such as Collective Impact to move the needle in expanding provider capacity and Medicaid beneficiary access to SUD and OUD treatment and recovery services.
- ***Seek Federal Match Funding.*** As Nevada continues to identify opportunities to improve health outcomes by expanding access to OUD and SUD health care services across the care continuum, available sources of funding which are either budget neutral or have an enhanced federal match should be considered.
- ***Consider Using State Plan Authority to Develop Medicaid Health Homes for SUD.*** Medicaid health homes serve Medicaid recipients with complex heath care needs, including SUD, by providing integrated physical and behavioral health (both mental health and substance abuse) and long-term services and supports. Nevada can apply for a Medicaid Health Home program using a state plan amendment (SPA) where the state will receive (if approved) an enhanced federal funding match of 90/10 for health home services for the first 10 fiscal quarters from the effective SPA date. After this time period, the state would receive their customary match rate. Nevada can implement this program for both fee-for-service (FFS) and MCO Medicaid recipients, ensuring proper oversight and streamlining of policies and procedures across FFS and MCO environments.
- ***Use Funding Opportunities to Address Institutions for Mental Diseases (IMD) Exclusion.*** Allowing Medicaid coverage of medically-needed inpatient services provided in an IMD expands the continuum of care and promotes a smooth transition to outpatient treatment including access to MAT. There are different funding mechanisms to consider in seeking payment for IMD services.

Note: The purpose of this document is to gather information and confirm the current state of Nevada's policy and infrastructure regarding provider capacity and patient access to SUD and OUD treatment and recovery services. This report is intended to be a "living" document associated with the SUPPORT Act planning grant activities and will be updated as new information becomes available over the course of the project.

During the review sessions conducted by Myers and Stauffer, the Nevada SUPPORT Act Planning Grant Core Team will confirm findings, provide additional information where necessary, address outstanding questions, and participate in a dialogue that will update an inventory of recommendations presented in this document. Outcomes of these sessions and the confirmed recommendations will be used to develop the Nevada SUPPORT Act Strategic Plan, as well as provide data, strategies, and tactics to support Nevada's application for the CMS SUPPORT Act Demonstration Grant.

1. Introduction and Background

Nevada has made strides over the recent years in addressing the opioid crisis; improving in all five areas of the U.S. Department of Health and Human Services (HHS) five-point strategy: 1) addiction, prevention, treatment, and recovery services; 2) data; 3) pain management; 4) targeting of overdose reversing drugs; and 5) research. In April 2018, Nevada was recognized in *Prescription Nation 2018: Fighting America's Opioid Epidemic* as one of two states recognized in 2018 by the National Safety Council for addressing six key indicators to address the crisis: 1) mandating prescriber education; 2) implementing opioid prescribing guidelines; 3) integrating prescription monitoring program into clinical setting; 4) improving data collection/sharing; 5) treating opioid overdose; and 6) increasing availability of OUD treatment.[1]

Despite this progress, there continues to be a need for access to community-based treatment, behavioral health services, and MAT for those with SUD or OUD. The epidemic has also increased demand for effective withdrawal management, residential, and inpatient care. Despite this need, opioid treatment programs (OTPs) exist only in Clark County, Washoe County, and Carson City. Office-based opioid treatment (OBOT) providers, who offer outpatient treatment services outside of licensed OTPs,[2] are available to prescribe to patients only in 10 counties throughout the state. Based on research gathered, it was found that none of these providers are prescribing at the capacity allowed under the DATA 2000 waiver. DHHS has identified several opportunities to support expansion of these services to Medicaid beneficiaries by:

1. Increasing the number of providers eligible to offer some level of treatment and management services.
2. Improving outreach, training, and education available to providers of SUD and OUD services.
3. Developing a comprehensive MAT deployment and expansion strategy.
4. Implementing an APM specifically for MAT services.

In an effort to achieve these objectives, DHCFP applied for and was awarded the SUPPORT Act Planning Grant. Using funds from this grant, DHCFP is able to assess the state's current infrastructure and policy to identify challenges and opportunities to increase efforts in targeting the OUD health crisis. A detailed assessment was conducted to understand the state's current provider capacity, related impacts, and the degree to which primary and behavioral health care are being integrated. The assessment process

[1] Opioid Response Summit. Final Report of Nevada's Summit Proceedings. August 2019.
[2] American Society of Addiction Medicine, Policy Statement on the Regulation of Office-Based Opioid Treatment.

resulted in the collection of data which guided the findings and recommendations contained within this report.

1.1. Nevada SUPPORT Act Grant Goals and Objectives

Through the SUPPORT Act Planning Grant, DHHS aims to increase the capacity of Medicaid providers to provide SUD treatment and recovery services through ongoing needs assessments, recruitment of and training for SUD Medicaid providers, improved reimbursement for SUD treatment and recovery services, and dissemination of perinatal care practice standards. Specific goals and objectives include:[3]

1. Increase access to SUD and OUD treatment and recovery services by increasing the number of providers eligible to provide some level of SUD services.
2. Conduct community engagement activities across the state and gather information which will be used to improve the education materials and training activities available to Medicaid SUD providers.
3. Create a comprehensive MAT strategy and develop a corresponding chapter in the Nevada State MSM.
4. Eliminate the confusion regarding which providers are eligible to provide MAT and other challenges faced by providers that may hinder their willingness and ability to provide treatment and recovery services.
5. Focus on expansion of OUD treatment for the sub-population of pregnant and postpartum women and their infants to address NAS.

To assess need and target initiatives, the SUPPORT Act Grant funding will be used to evaluate prior community engagement activities conducted across the state, as well as perform additional stakeholder engagement as needed. Information gathered will be used to improve educational materials and training activities available to Medicaid SUD providers. Additionally, this information will be used to analyze gaps and to develop the strategic priorities for each county and the state overall. Training and strategic initiatives, including recruitment, will increase the number of providers eligible to provide some level of SUD services.

DHCFP will also create a comprehensive MAT strategy and develop a corresponding chapter in the Nevada MSM. Providers report a need for training in how to start prescribing MAT and how to offer MAT in

[3] Nevada SUPPORT Act Planning Grant Project Narrative.

primary care settings.[4] The lack of information may hinder their willingness and ability to provide MAT. Through the planning grant, DHCFP seeks to develop clear guidance.

To further increase clarity, DHCFP will consider implementing an APM specifically for MAT services. The traditional Medicaid payment models have been found to be insufficient in motivating providers to appropriately prescribe at capacity. The Patient-Centered Opioid Addiction Treatment (P-COAT) payment is an APM designed to improve health outcomes and reduce spending for OUD treatment by eliminating the barriers present in the current system which is payment under a fee schedule. The P-COAT model affords states the ability to customize the model to best address the OUD and SUD challenges in each state.

Due to a rate of 7.7 newborns diagnosed with NAS per 1,000 newborn hospitalizations in Nevada[5], DHCFP is targeting the subpopulation of pregnant and postpartum women with OUD, as well as their infants. Currently, DHCFP is working toward improving care for these subpopulations with its OUD, Maternal Outcomes, and NAS Initiative (OMNI). Under the SUPPORT Act Planning Grant, DHCFP is continuing to target this subpopulation by developing and disseminating comprehensive perinatal care practice standards, including universal screening protocols and discharge criteria, plans of safe care, and a provider training toolkit.

1.2. Overview of Substance Use and Service Delivery in Nevada

This analysis of the current status of the extent of the use of opioids and substances in Nevada uses national, state, and county data, as well as the trends leading to today's epidemic. Initial findings for opioid and substance use among subpopulations is also included.

1.2.1. Opioid Use and Trends in Nevada

Between 1999 and 2017 in the United States, the amount of prescription opioids dispensed and the number of overdose deaths involving opioids had both quadrupled.[6] However, from 2017 to 2018, relative decreases occurred in death rates involving all drug overdoses (-4.1 percent), all opioids (-2.0 percent), prescription opioids (-13.5 percent), and heroin (-4.1 percent). Conversely, a relative increase occurred in the rate of overdose deaths involving synthetic opioids (10 percent), likely driven by illicitly-manufactured

[4] STR Providers Training Survey Report.
[5] https://www.drugabuse.gov/opioid-summaries-by-state/nevada-opioid-involved-deaths-related-harms.
[6] CDC, 2017, available at: https://www.cdc.gov/nchs/hus.htm.

fentanyl and fentanyl analogs.[7] During this same period, the overall national opioid prescribing rate declined from 2012 to 2018, from 81.3 prescriptions per 100 residents down to 51.4 per 100 residents in 2018.[8]

Between 2016 and 2018 in Nevada, opioid painkiller prescribing rates declined by 31.8% and death rates declined by 14.2%. However, deaths related to synthetic opioids have increased by 127% since 2015.

Nevada has followed these national trends, and has seen a steady decline in opioid painkiller prescribing rates and opioid-related deaths in recent years. In 2016, Nevada ranked 12th out of 50 states in opioid painkiller prescribing rates, at 80.7 per 100 residents, compared to a national average of 66.5.[9] By 2018, Nevada ranked 22nd in nationwide opioid prescribing, at 55.5 per 100 residents annually, marking a decrease of 31.8 percent from 2016 to 2018.[10]

Neonatal exposure to substances has more than doubled since 2010 in Nevada.

Self reported use of heroin and other opioids among pregnant women has quadrupled between 2004 and 2014.

In 2016, Nevada ranked 22nd nationally on drug overdose deaths, two-thirds of which includes those related to prescription opioids, synthetic opioids, methadone, and heroin, with a rate of 21.7 per 100,000 population, compared to 19.8 in the United States.[11] The number of drug overdose deaths in the state has declined only slightly,[12] and Nevada now ranks 27th for drug overdose deaths as of 2018 at a rate of 21.2 per 100,000.[13] This may be attributed to the rise in use of synthetic opioids, such as fentanyl. Deaths related to synthetic opioids increased 127 percent from 2015 to 2018.[14]

Nevada has high rates of opioid use among special populations and NAS when compared nationally. Nevada ranks 4th highest in the nation for the percentage of people aged 12 or older who used prescription pain relievers non-medically in the past year from 2012 to 2014 (5.20 percent), down from second highest from 2010 to 2012 (5.92 percent).[15] While the rate of NAS has declined in Nevada from 8.6 per 1,000 births in 2016 to 7.6 in 2017, the national rate in

[7] Nana Wilson, PhD; Mbabazi Kariisa, PhD; Puja Seth, PhD; Herschel Smith IV, MPH; Nicole L. Davis, PhD. Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018. Morbidity and Mortality Weekly Report. Centers for Disease Control. March 20, 2020 / 69(11);290–297.
[8] CDC U.S. State Prescribing Rates, 2018, available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.
[9] Division of Public and Behavioral Health, 2018.
[10] CDC U.S. State Prescribing Rates, 2018, available at: https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html.
[11] CDC, 2017, available at: https://www.cdc.gov/nchs/hus.htm.
[12] CDC Opioid Drug Overdose Death Rates, 2018, https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2018.html.
[13] Nevada Opioid Surveillance, January 2020.
[14] Nevada Opioid Surveillance Dashboard. Available at: https://opioid.snhd.org/.
[15] National Survey on Drug Use and Health (NSDUH) available at: https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health.

2016 was 7.0 per 1000 births.[16] Nationally, as well as in Nevada, the rate of reported opioid use among new mothers at the time of hospitalization has quadrupled between 2004 and 2014. In 2014, the rate of reported use in Nevada was 4.5 per 1000 deliveries; however, that is lower than the national rate of 6.5.[17]

The following statistics illustrate the current state of the opioid crisis in Nevada:[18, 19, 20, 21, 22]

- In 2017, 401 individuals died of an opioid overdose in Nevada. The number of overdose deaths from heroin have increased from 19 in 2010 to 92 in 2017.
- In 2018, for every 100,000 people in Nevada there were:
    - 11 Opioid-involved deaths.
    - 12.5 ED visits.
    - 11.1 Hospitalizations.
- Seizures due to heroin use more than doubled from 2014 to 2015.
- Opioid-related hospitalization visits with stays of 15 or more days increased by 119 percent between 2010 and 2018.
- Death trends differed by type of opioid. Heroin deaths increased from 2010 to 2015, then remained stable from 2015 to 2016. Synthetic opioid deaths (for example, fentanyl) increased from 2015 to 2016. Methadone overdose deaths decreased from 2010 to 2016.
- Opioid-related deaths for American Indians and Alaska Natives (AIAN) closely follow the high rates for Whites. In Nevada in 2015 the opioid-related death rates were 22.0 per 100,000 Nevada population for Whites and 18.5 for AIAN (preliminary figures).
- Among Nevada's high school youth, 14.8 percent had taken prescription pain medicine without a prescription or not as prescribed, and 2.6 percent reported having used heroin.
- It is also important to note the state of mental health in Nevada. According to the *Mental Health in America's 2020 State of Mental Health in America* report, Nevada currently ranks 51st in the national overall for mental health, a ranking that indicates high prevalence of mental illness and

[16] Healthcare Cost and Utilization Project. Neonatal Abstinence Syndrome among Newborn Hospitalizations.

[17] Sarah C. Haight, MPH; Jean Y. Ko, PhD[1,3]; Van T. Tong, MPH; Michele K. Bohm, MPH; William M. Callaghan, MD. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. CDC Morbidity and Mortality Weekly. August 10, 2018 / 67(31); 845–849.

[18] Nevada Opioid Crisis Needs Assessment, 2018.

[19] Nevada Opioid Surveillance, January 2020.

[20] Nevada Opioid Dashboard available at: https://opioid.snhd.org/.

[21] Nevada State Office of Public Informatics and Epidemiology.

[22] http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OPHIE/dta/Publications/Nevada%20Opioid%20Surveillance%20%282010-2015%29.pdf.

low levels of access to care.[23] Everyday there are an average of 102 individuals waiting in emergency rooms across Nevada for behavioral health services.[24] These statistics underscore the need to continue to increase availability of targeted services and enhance the mental health care system, and ensure processes and systems are in place to link patients to the right treatment and setting.

1.2.1.1. Opioid-Related Deaths

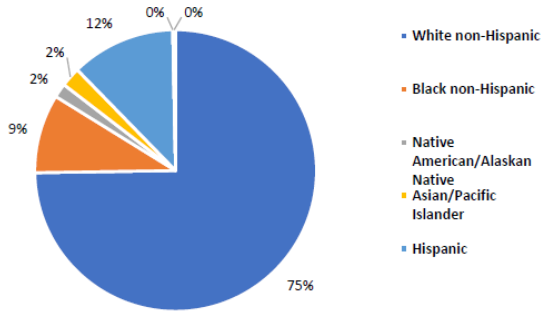
Opioid-related deaths in Nevada have declined 27 percent since 2010. Death rates are highest among White, Non-Hispanic (75 percent), and are lowest among Asian/Pacific Islander (two percent) and AIAN (two percent). However, the crude rates by population subset among Native American/Alaskan Native (14.1 percent) is nearly that of White, Non-Hispanic individuals (14.9 percent) (Figure 1). Deaths were more prevalent among males and individuals between the ages of 45 to 54, followed by those aged 55 to 64 years.

Figure 1.Opioid-Related Deaths by Race/Ethnicity in Nevada (2019*)

Opioid-Related Deaths by Race/Ethnicity, Nevada Residents, 2019*

Race/Ethnicity	%	Crude Rates
White non-Hispanic	75%	14.9
Black non-Hispanic	9%	10.3
Native American/Alaskan Native	2%	14.1
Asian/Pacific Islander	2%	2.3
Hispanic	12%	4.0
Other	0%	
Unknown	0%	

Rates are per 100,000 State of Nevada Population.



**Data from 2019 are preliminary.*
Source: Nevada Opioid Surveillance, January 2020.

Benzodiazepine-related overdose deaths have declined steadily since 2010. Roughly 85 percent of all benzodiazepine-related overdose deaths also involve opioids, and approximately 30 percent of all opioid-related overdose deaths involve benzodiazepines (Figure 2).

[23] DHHS. DPBH. Towards a Comprehensive Crisis Response System in Nevada.
[24] Ibid.

Figure 2. Opioid Related Overdose Death Trends (2010-2019)*[2]

Opioid-Related Overdose Deaths

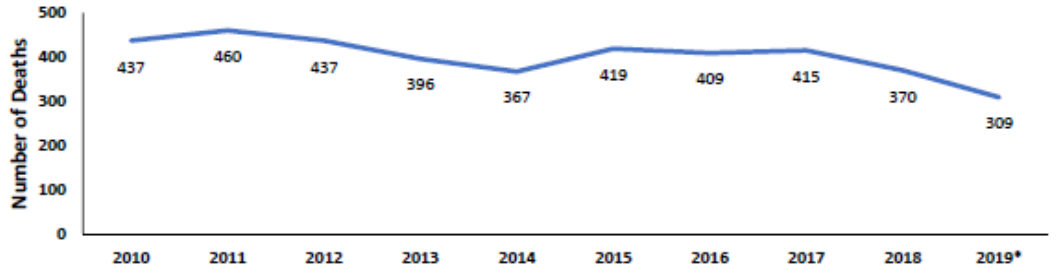
Year	Opioid-Related Overdose Deaths	Crude Rates	Percent Change	Benzodiazepine Related Overdose Deaths	Opioid and Benzodiazepine Related Overdose Deaths
2010	437	16.2		161	139
2011	460	16.9	5%	166	143
2012	437	15.9	-6%	162	140
2013	396	14.1	-11%	126	106
2014	367	12.9	-9%	126	110
2015	419	14.5	12%	133	119
2016	409	13.8	-4%	161	132
2017	415	13.9	0%	127	110
2018	370	12.2	-12%	142	115
2019*	309	10.1	-18%	103	83
Percent Change 2010-2018			-24%		

Rates are per 100,000 State of Nevada Population.

Each year:

- Roughly 85% of all benzodiazepine-related overdose deaths also involve opioids.
- Roughly 30% of all opioid-related overdose deaths also involve benzodiazepines.

Opioid-Related Overdose Deaths, Nevada Residents, 2010-2018



** Includes 2019 preliminary data.*

Source: Nevada Opioid Surveillance, January 2020.

Death trends differ by the type of opioid. The Nevada High Intensity Drug Trafficking Areas (HIDTA) has classified heroin, fentanyl, and methamphetamines among the top threats in 2018. Heroin deaths increased from 2010 to 2017, but have remained relatively stable the two years following. Synthetic opioid deaths (for example, fentanyl) increased from 2015 to 2019. Fentanyl is 50 to 100 times more potent than heroin and can easily be mixed into the drug supply. However, for all opioid-related overdose deaths in 2018, heroin accounted for 24 percent, natural and semi-synthetic 48 percent, methadone seven percent, synthetic opioids 19 percent, and unspecified narcotics two percent.[25] Methadone overdose deaths

[25] Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile.

decreased from 2010 to 2019. Overdose deaths containing both natural and semi-synthetic (for example, hydrocodone) opioids have been declining since 2017 (Table 1).

Table 1. Opioid-Related Overdose Deaths by Drug Category (2010-2019)*[3]

Opioid-Related Overdose Deaths by Drug Category, State of Nevada Residents, 2010-2019*					
Year	**Heroin**	**Natural and Semi-Synthetic**	**Methadone**	**Synthetic Opioids**	**Unspecified Narcotic**
2010	19	298	98	39	45
2011	40	300	97	45	46
2012	42	301	69	25	40
2013	48	241	70	25	39
2014	61	216	63	31	37
2015	79	254	57	31	37
2016	82	228	52	49	28
2017	92	234	45	64	18
2018*	102	207	33	76	10
2019*	32	40	7	26	1

A person can be included in more than one drug group, and therefore the counts above are not mutually exclusive.

**Data for 2018 and 2019 are preliminary. Data for 2019 includes Quarter 1 only.*

Source: Nevada's Evolving Opioid Crisis: Successes and Challenges Presentation.

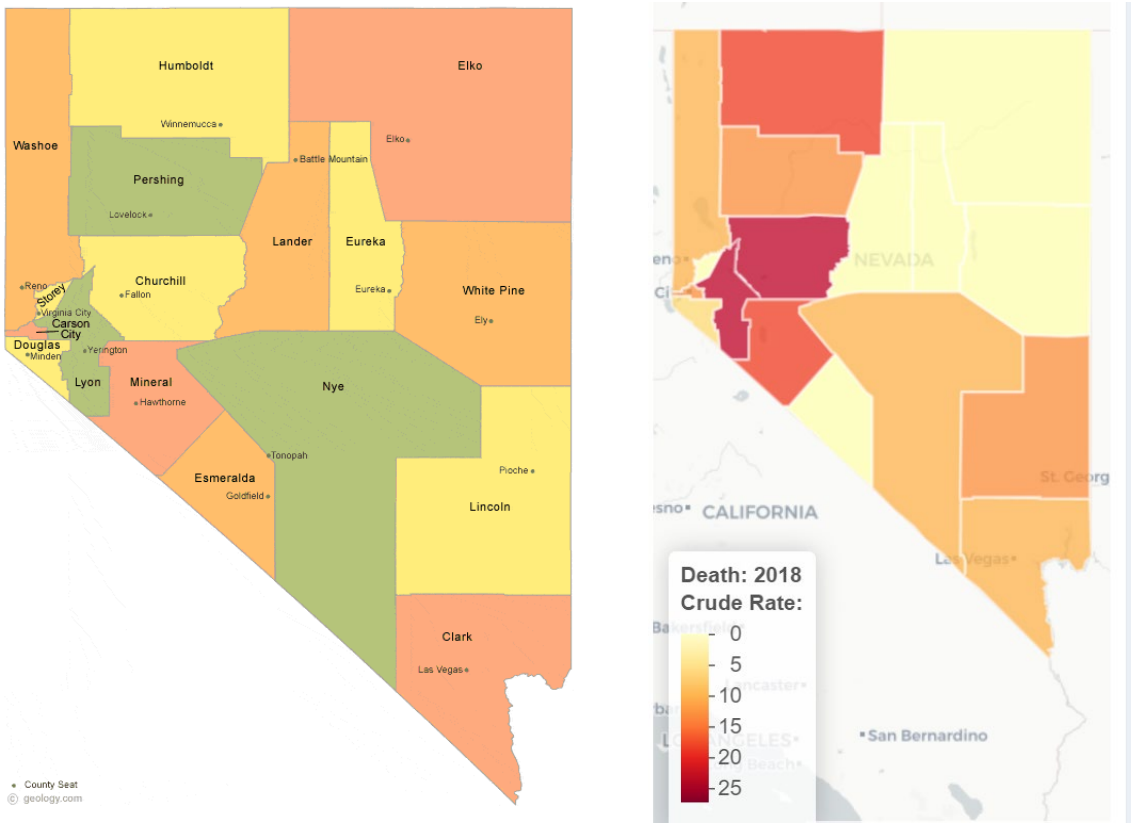
1.2.1.2. Opioids and Other Substances in Nevada Counties

There are 16 counties and one independent city in Nevada. There are three urbanized areas: Las Vegas-Henderson, Reno, and Carson City, which account for 90 percent of the state's population. Clark County, the largest urban area in Nevada, is the 11th most populous county in the nation[26] and accounts for 72 percent of the state's population with 2.2 million citizens. Washoe County is the next most populous county in Nevada, with approximately 472,000 residents. The remaining 400,000 residents live in the 14 rural and frontier counties.

Figure 3 illustrates the crude death rate per 100,000 residents by county from all opioids, including both prescription opioid pain relievers such as hydrocodone, oxycodone, and morphine, as well as heroin and synthetic opioids such as fentanyl that may be prescription or illicitly manufactured. Deaths related to chronic use of drugs are excluded from this indicator.[27]

[26] United States Census. County Population Totals 2010-2019.
[27] Nevada Opioid Dashboard. Division of Public and Behavioral Health, Electronic Death Registry System.

Figure 3. Crude Death Rates by Nevada County

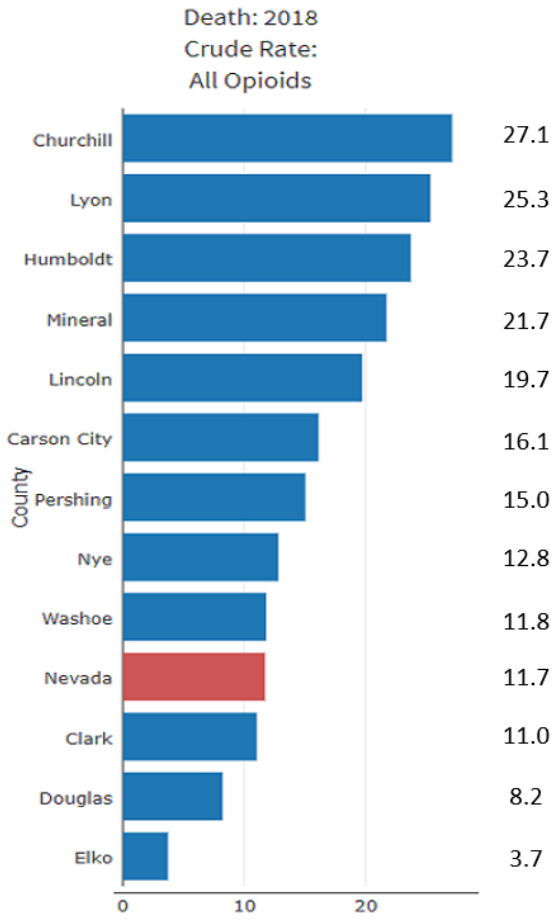


Sources: Geology.com, Nevada Opioid Dashboard.

As of 2018, overall opioid use was significantly higher in the Washoe County area, and Lyon, Mineral, and Storey County regions had significantly higher rates for opioid and heroin use.[28] Between 2015 and 2018, overdose deaths for concurrent heroin and methamphetamine use increased 29 percent in Clark County and 89 percent in Washoe County.[29] Heroin overdose deaths were highest among individuals 30 to 49 years old in Clark County (42 percent of deaths). In Washoe County, heroin overdose deaths were highest among individuals 18 to 29 years old (41 percent) and 50 to 69 years old (38 percent).[30] In 2018, Churchill, Lyon, and Humboldt Counties had the highest death rates for all opioids (excluding heroin) across the population (Figure 4).[31]

[28] Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile.
[29] Washoe County Regional Examiner's Office, 2018; Southern Nevada Health District, 2018.
[30] Southern Nevada Health District Office of Epidemiology and Disease Surveillance: Washoe County Regional Medical Examiner's Office).
[31] Nevada Opioid Data Dashboard, available at https://opioid.snhd.org/.

Figure 4. 2018 Nevada Death Rate (Crude) All Opioids (excluding Heroin) by County



Source: Nevada Opioid Data Dashboard, available at https://opioid.snhd.org/.

1.2.2. Stimulant Use Disorder

Stimulant use disorders include a range of problems associated with the use of methamphetamine, cocaine, and other amphetamines. Stimulant use disorders are associated with adverse health effects, increased hospital costs, and a range of social problems and criminal offenses. Stimulant overdose deaths were roughly 40 percent of all overdose deaths in the U.S. in 2018. The problem is not going away; rather, stimulant use is increasing to become a crisis similar to the opioid epidemic. Illicit stimulants, such as cocaine and amphetamines, are more accessible and are becoming cheaper and more potent. Additionally, treating addiction to stimulants is particularly challenging. Unlike opioid treatment, the U.S.

Food and Drug Administration (FDA) has not approved a pharmacological treatment for stimulant use disorders. [32]

Data is available that indicate stimulant usage is an issue for the country, as well as Nevada. In 2018, an estimated 561,000 people aged 12 or older had a stimulant use disorder in the past year. This corresponds to 0.2 percent of the population. Nationally, about 2.0 percent of the population 12 or older used cocaine in 2018, while 5.8 percent of young adults (aged 18 to 25) used cocaine in the last year. In Nevada, the comparable figures are 2.27 and 5.84 percent. In 2018, 0.7 percent of U.S. population used methamphetamines in the past year, with young adults using at the highest rate of 0.8 percent. In Nevada, the rates were higher, with 1.29 overall and 2.36 percent for young adults. In 2018, 1.9 percent of the population misused prescription stimulants in the past year, including approximately 6.5 of young adults. [33, 34]

This drug disorder is also reflected in mortality data. Nationally, from 2012 to 2018, the rate of drug overdose deaths involving cocaine more than tripled (from 1.4 to 4.5 per 100,000) and the rate for deaths involving psychostimulants with abuse potential (drugs such as methamphetamine) increased nearly five times (from 0.8 to 3.9 per 100,000).[35] In Nevada from 2016 to 2017, drug overdose deaths involving cocaine increased from 1.2 to 1.6 per 100,000 and psychostimulants with abuse potential from 7.5 to 8.3 per 100,000. Findings further support that increases in stimulant-involved deaths are part of a growing polysubstance landscape.[36] In 2016, Nevada's amphetamine death rate was highest in the nation and could pass the state's prescription opioid death rate, according to a new report from the Centers for Disease Control and Prevention (CDC). The death rate in Nevada of drug overdose deaths due to psychostimulants increased to 7.5 per 100,000 in 2016, up nearly 32 percent from 2015. [37]

[32] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.
[33] Substance Abuse and Mental Health Services Administration. (2019). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.
[34] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017 and 2018. https://www.samhsa.gov/data/sites/default/files/reports/rpt23235/2k18SAEExcelTabs/NSDUHsaePercents2018.pdf.
[35] https://www.cdc.gov/nchs/products/databriefs/db356.htm.
[36] https://www.cdc.gov/mmwr/volumes/68/wr/mm6817a3.htm.
[37] https://www.reviewjournal.com/life/health/nevadas-death-rate-from-meth-other-stimulants-highest-in-nation/ and https://www.cdc.gov/mmwr/volumes/67/wr/mm6712a1.htm?s_cid=mm6712a1_w#T3_down.

1.2.3. Substance Misuse by Population in Nevada

1.2.3.1. Adolescent Substance Misuse

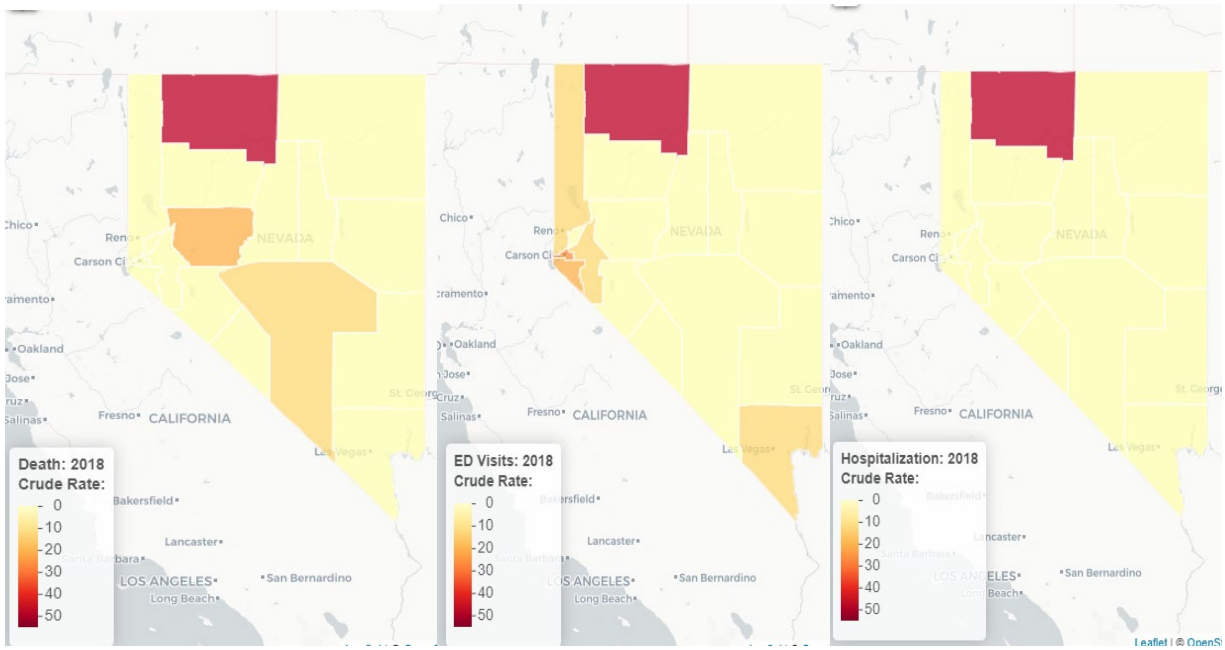
According to self-reported survey data, the proportion of high school students who reported ever using a prescription drug without a doctor's prescription decreased from 20.2 percent to 16.9 percent from 2011 to 2015.[38] By 2017, the lifetime prevalence had decreased to 14.8 percent and use in the past 30 days was 7.0 percent. These figures did not vary significantly by county. In 2017, self-reported lifetime heroin use in this age group was 2.6 percent statewide.[39]

Weighted lifetime prescription drug use was significantly lower among Asian students (5.2 percent) and highest among AIAN (28.0 percent). The same low usage for Asian students existed for past 30-day prescription drug use, with 2.3 percent of Asian students reporting current use, compared to 7.0 percent of the state sample.

In 2018, deaths, ED visits, and hospitalizations from all opioids (excluding heroin) among those aged 15 to 24 were highest in Humboldt County (Figure 5). These rates have been steadily rising in Humboldt County since 2011, even as rates across Nevada have declined for this age group. However, rates for prescription drug usage in this age group have declined in Humboldt and across the state. [40]

[38] Prescription drugs were defined as any prescription drugs including, but not limited to: Oxycontin, Percocet, Vicodin, Codeine, Adderall, Ritalin, or Xanax. Due to this broad definition, the question was more of a proxy for prescription opioid use rather than a direct measurement. In 2017, the question was updated to more accurately assess prescription painkiller use. The question now asks if the student has ever used a prescription pain medicine without a doctor's prescription or differently than prescribed.
[39] Nevada Opioid Crisis Needs Assessment, 2018.
[40] Nevada Opioid Dashboard, https://opioid.snhd.org/

Figure 5. 2018 Opioid-Related Deaths, ED Visits, and Hospitalizations (Ages 15-24)



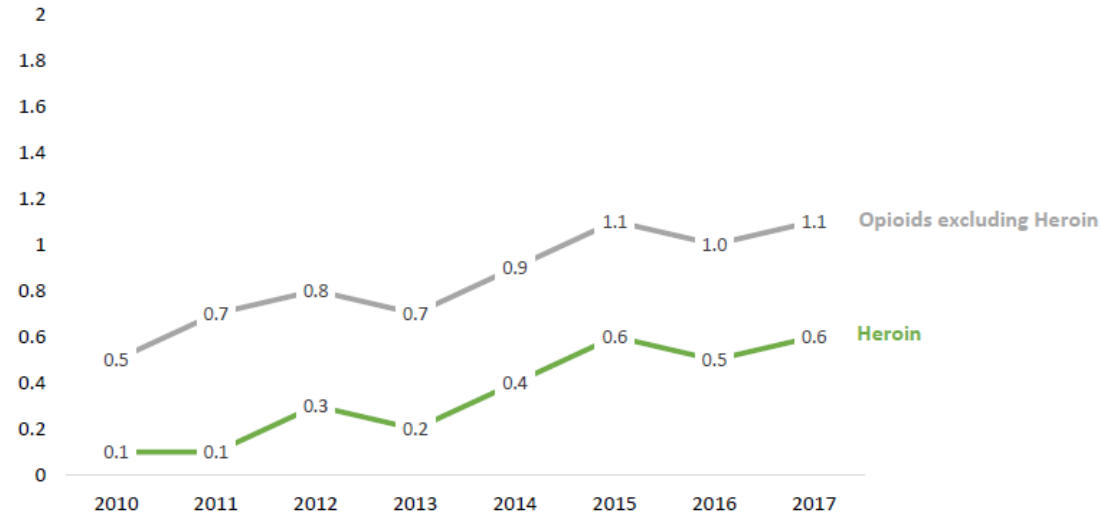
Source: Nevada Opioid Data Dashboard, available at https://opioid.snhd.org/.

1.2.3.2. Mothers' Prenatal Substance Misuse

Self-reported use of heroin and other opioids while pregnant and corresponding NAS has been on an upward trend since 2011 (Figure 6). At the county level, the average rate for self-reported heroin use while pregnant between 2012 and 2016 was highest in Esmeralda, Lincoln, and Nye counties, with a rate of 5.2 mothers per 1,000 live births (Table 2).[41] These rates are likely low due to underreporting.

[41] Nevada Opioid Crisis Needs Assessment, 2019.

Figure 6. Self-Reported Prenatal Opioid Misuse Rates (2010-2017)



(Source: Nevada Electronic Birth Registry System)
*Rates per 1,000 live births

Table 2. Self-Reported Opiate Use While Pregnant (2012-2016)

County	Heroin	Opiates
Carson City/Douglas	2.0	0.7
Churchill/Humboldt/Lander/Pershing	0.3	0.8
Clark	0.7	1.7
Elko/Eureka/White Pine	0.3	2.4
Esmeralda/Lincoln/Nye	5.2	2.1
Lyon/Mineral/Storey	1.9	1.3
Washoe	1.0	1.1
Statewide	0.8	1.6

*Rates are per 1,000 live births

Source: Nevada Opioid Crisis Needs Assessment, 2019.

Nevada has a Plan of Safe Care in place, which is in response to the federal Comprehensive Addiction and Recovery Act (CARA) legislation. Under the CARA Act, providers caring for infants up to one year of age affected by substance abuse in utero must: 1) report to Child Protective Services (CPS),[42] which is a requirement in order to receive federal child abuse prevention funds; and 2) complete the CARA Plan of

[42] CARA. A Fact Sheet for Providers.

Care (POC).[43] The purpose of the CARA POC, which is voluntary, is to identify the needs and services for the infant and family once the child is born.

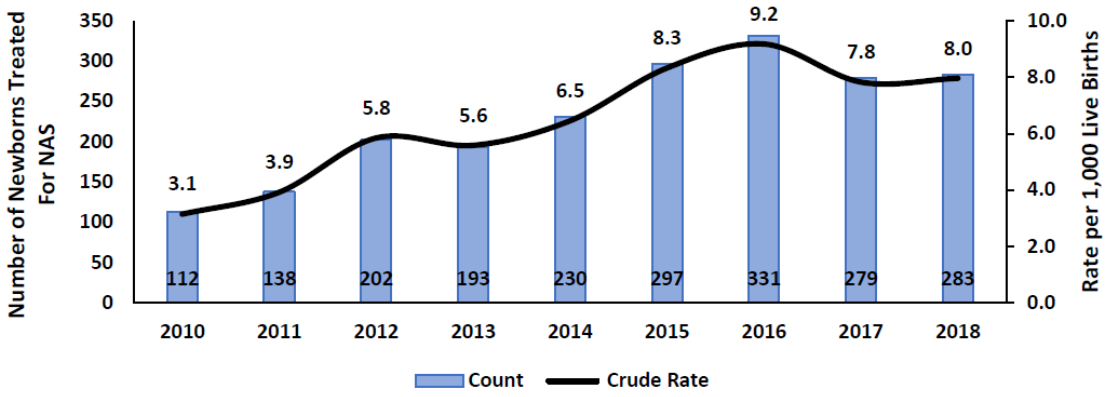
Nevada supports universal screening of SUD in pregnant women to get them engaged in treatment.[44] Prenatal substance exposure in the absence of other risk factors does not constitute maltreatment, and there is currently no need to notify CPS before the child is born.[45] Additionally, providers are not required to report positive toxicology screens of pregnant women in Nevada.[46] For additional information on maternal SUD policy and protocol, refer to *1.4 Nevada SUPPORT Act Key Focus Population* and *Table 10. Policies and Best Practices for Perinatal Care.*

1.2.3.3. Infants with Neonatal Abstinence Syndrome

From 1999 to 2013, the incidence of NAS in the United States increased 300 percent, from 1.5 to 6.0 per 1,000 hospital births.[47] State Medicaid programs paid 82 percent of treatment costs for babies with NAS between 1999 and 2014.[48] The number of infants treated in Nevada from 2010 through 2018 shows a decrease after the peak in 2016 (Figure 7).[49] Inpatient admissions (IPs) for NAS more than doubled over this period, from 112 newborns admitted in 2010 to 283 newborns admitted in 2018. White, Non-Hispanic individuals have a significantly higher NAS rate compared to all other ethnicities. The average length of stay for newborns with NAS in 2018 was 19 days.[50]

[43] State Policies on Substance Abuse during Pregnancy. Guttmacher Institute. Available at: https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy.
[44] Fact Sheet: Nevada's Oversight of Opioid Prescribing and Monitoring of Opioid Use. February 2019.
[45] CARA. A Fact Sheet for Providers.
[46] Substance Use and Pregnancy Provider Reference Guide. Dignity Health EMPOWERED Program.
[47] https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm.
[48] https://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome.
[49] SAPTA 2019 Epidemiologic Profile.
[50] SAPTA 2019 Epidemiologic Profile.

Figure 7. Incidence of NAS (2010-2018)



Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-10 codes replaced ICD-9 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

1.2.3.4. Justice-Involved Individuals

A subpopulation in the criminal justice population is a high number of individuals diagnosed with co-occurring mental health and SUDs, who are disproportionately represented in Nevada's criminal justice system. It is estimated that approximately 75 percent of these mentally ill offenders have a co-occurring SUD. Data compiled by Washoe County Mental Health Court from 2007 to 2011 report an average rate of 86 percent of participants with a co-occurring SUD. Besides enhanced clinical services, the most important treatment components needed to effectively treat the COD forensic population at the point of release is transitional or reentry services, particularly supportive housing. Due to a system failure within the treatment community and a lack of quality reentry services, there currently is an extreme lack of transitional and clinical services in Nevada that are needed to treat this underserved population. Where programs do exist, waiting lists, poor coordination, and lack of enhanced programming present barriers. Offenders exiting prisons and jails are challenged by the demands of reinstating Medicaid. Mentally ill offenders are often unable to follow through with agency procedures due to homelessness or disability.

In 2016, Nevada listed criminal justice interventions as a priority area for addressing opioid misuse. Within this priority area, a number of goals were established under the State Targeted Response (STR) and continued through State Opioid Response (SOR) funding including prevention of opioid overdose deaths, development of real-time opioid overdose reporting, and provision of support for justice-involved populations. From February 2018 through September 2019, close to 3,300 naloxone kits were distributed to more than 70 law enforcement and first responder agencies. During that same time span, four out of 72 agencies have needed to place reorders for additional naloxone kits.

Funds from the Opioid STR/SOR were used to educate and provide naloxone to first responders outside of Clark County. The project partnered with criminal justice programs to provide naloxone and overdose education to those being released. Currently two counties, Washoe and Mineral, jail facilities have initiated programs to distribute naloxone to individuals being released from jail. Washoe County has

additionally initiated a naloxone leave-behind program with their parole officers, who have been provided training and support through STR and SOR funding.

MAT re-entry court, provides housing, residential or outpatient treatment, case coordination, and job development. 68 new individuals have enrolled in the program and 13 individuals have successfully "graduated" from the program.

Judicial courts in Las Vegas are providing case managers to partner with the Las Vegas Metro Police Department, in effort to support law enforcement mobile case management teams and assist in coordinating care for individuals who are recommended for substance abuse treatment rather than incarceration. The case manager for this program was hired in January 2020. Since implementation, 76 individuals have been diverted from potential incarceration and referred to the team. Referrals to behavioral health services include: transitional living (44), vocational assistance (3), housing assistance (13), and Women, Infants, and Children (WIC)/Temporary Assistance for Needy Families (TANF)/Medicaid (13).

A Nevada treatment agency is currently conducting screenings in two prisons, connecting individuals to treatment upon release. Within the latest reporting period for SOR funding, 110 inmates were screened, resulting in five individuals released from incarceration to be admitted into a treatment program. The same agency conducted 144 assessments at parole and probation offices, providing referrals for treatment and recovery support programs (vocational, WIC/TANF/Medicaid, legal, food, etc.). The Washoe County Sheriff's office is implementing a MAT program within the county jail. This program will assess inmates for SUD, induct the appropriate individuals onto MAT, and assist in the ongoing coordination of treatment upon release. During the previous reporting period, 41 inmates have been screened for OUD risk, naloxone was distributed when necessary, 41 individuals received individual counseling, and six individuals have received MAT services.

1.2.3.5. Opioid-Related Hospital Use in the Medicaid Population

The number of opioid-related ED encounters for Medicaid beneficiaries in Nevada has increased from 400 in 2010 to 3,463 in 2017. Medicaid patients account for 48 percent of all opioid-related ED encounters.[51] Similarly, the number of opioid-related inpatient encounters among Medicaid beneficiaries in Nevada increased from 681 in 2010 to 3,416 in 2017, accounting for 39 percent of the opioid-related inpatient encounters in 2017.[52] The number of Medicaid ED visits and admissions based on opioid poisonings show a decreasing trend for substances other than heroin (Table 3).

[51] Nevada Opioid Surveillance January 2020.
[52] Nevada SUPPORT Act Planning Grant Project Narrative.

Table 3. Medicaid ED and Inpatient Admissions

Opioid Poisoning: Hospital Emergency Department (ED) and Inpatient Admissions (IP)

Drug	Heroin		Methadone		Opium		Other Opioids and Narcotics	
Year	ED	IP	ED	IP	ED	IP	ED	IP
2010	136	61	54	85	76	92	593	459
2011	158	59	53	67	95	117	585	532
2012	154	50	36	62	89	116	582	496
2013	172	79	29	59	102	136	532	528
2014	233	59	32	47	115	156	488	478
2015	272	78	36	58	93	109	456	453
2016	297	81	20	43	3	4	474	458
2017	317	84	30	41	2	0	484	412
2018*	341	103	20	28	2	3	371	352
Percent Change (2010 - 2018*)	*151%*	*69%*	*-63%*	*-67%*	*-97%*	*-97%*	*-37%*	*-23%*

Source: Nevada SUPPORT Act Planning Grant Narrative.

1.2.3.6. Hospital Use for Opioid-Related Services for All Patients[53]

According to opioid surveillance data published by the Office of Analytics in January 2020, comparable data from 2015 to 2018 for opioid-related services demonstrates a 15 percent increase for ED encounters and a 37 percent increase for admissions (Table 4). [54]

[53] IDC-10 codes utilized in analysis for opioid poisonings included 965.0 and T40.0-6, and for opioid deaths included X40-44, X60-64, X85, Y10-Y14, T40.0-6.
[54] Opioid Surveillance Data. Office of Analytics. Nevada Department of Health and Human Services. 2010-2019 (preliminary).

Table 4. Opioid-Related Hospital Utilization Data

Opioid-Related Hospital Data, State of Nevada Residents, 2010-2019*						
In October 2015, ICD-10-CM codes were implemented. Previous to October 2015, ICD-9-CM codes were used for medical billing. Therefore, 2015 data consists of two distinct coding schemes, ICD-9-CM and ICD-10-CM respectively. Due to this change in coding schemes, hospital billing data from October 2015 forward may not be directly comparable to previous data.						
Year	**Emergency Room Encounters (ED)**	**Emergency Room Crude Rates**	**Percent Change**	**Inpatient Admissions (IP)**	**Inpatient Crude Rates**	**Percent Change**
2010	2,963	109.5		4,362	161.2	
2011	3,188	117.1	7%	4,755	174.7	8%
2012	3,473	126.3	8%	5,042	183.3	5%
2013	4,122	147.2	17%	5,067	180.9	-1%
2014	4,543	159.8	9%	5,517	194.0	7%
2015	5,695	196.5	23%	7,032	242.7	25%
2016	7,495	253.8	29%	8,675	293.7	21%
2017	7,165	239.9	-5%	8,744	292.8	0%
2018	6,530	215.4	-10%	9,616	317.2	8%
2019*	1,515			2,433		
Percent Change 2010-2018			97%			97%
Rates are per 100,000 State of Nevada Population.						

Source: Nevada's Evolving Opioid Crisis: Successes and Challenges Presentation.

From 2010 to 2018, opioid poisonings in the ED decreased by 16 percent, and admissions decreased by 28 percent. The rate per 100,000 Nevada population with opioid poisoning with ED services decreased from 28.8 to 24.2 and with hospital admissions decreased from 22.1 to 16.0. In terms of demographics, in 2018, 73 percent of the opioid-related ED encounters were with White, Non-Hispanic individuals. In the hospital, 73 percent of admissions were White, Non-Hispanic individuals and were most prevalent among Nevada residents 25 to 34 years old (28 percent).[55]

[55] Opioid Surveillance Data. Office of Analytics. Nevada Department of Health and Human Services. 2010-2019 (preliminary).

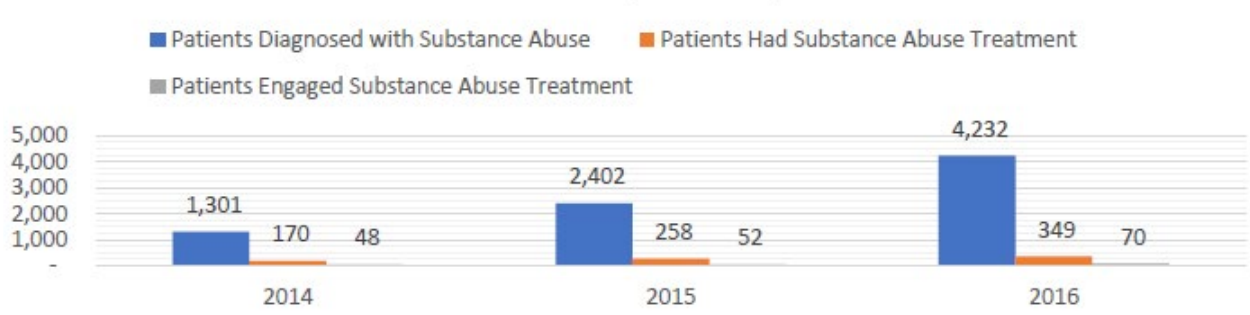
1.2.3.7. Pregnant Women and SUD Treatment Access

From April 2017 to March 2018, 871 pregnant women receiving Nevada Medicaid benefits were diagnosed with an OUD. Of these women, only 112 were on MAT and 19 submitted substance use treatment claims, which means that only 15 percent of pregnant women with an OUD received treatment from 2017 to 2018.[56]

Only 15% of pregnant women on Medicaid with an OUD received treatment from 2017 to 2018

In Nevada for substance abuse generally, the number of pregnant women who received treatment from 2014 to 2016 is a fraction of those diagnosed with substance abuse (Figure 9). The number of pregnant women diagnosed with substance abuse and the number who received treatment have increased linearly from 2014 to 2016. Of those diagnosed with substance abuse, approximately 10 percent received substance abuse treatment, and 22 percent were engaged with substance abuse treatment (had at least two or more treatments within 30 days of being diagnosed with substance abuse for the first time). Of those women who received substance abuse treatment, 44 percent had more than 10 treatments per year, 23 percent had four to nine treatments per year, six percent had three treatments, five percent had two treatments, and 21 percent had only one treatment per year.[57]

Figure 8. Pregnant Women Diagnosed, Treated, and Engaged with Substance Abuse Treatment (2014-2016)



Source: Nevada SUPPORT Act Planning Grant Project Narrative.

[56] DHHS, 2018.
[57] Nevada SUPPORT Act Planning Grant Project Narrative.

1.2.4. Prescription Monitoring Program Utilization, Legislation, and Impact

The Nevada Prescription Monitoring Program (NV PMP) is a database of information regarding controlled substances that were prescribed and dispensed in Nevada. NV PMP is an online tool that allows prescribers and dispensers access to a patient's controlled substance prescription medication history. The NV PMP is a tool to help prescribers determine if a controlled substance is medically necessary and appropriate. NV PMP is managed and operated by the Nevada State Board of Pharmacy. NV PMP is available through a web portal, or providers may elect to integrate NV PMP data into an electronic health record (EHR) or pharmacy management system via the Appriss Health PMP Gateway Platform.[58]

The Nevada Controlled Substances Abuse Prevention Act (Assembly Bill [AB] 474 or AB474), which went into effect on January 1, 2018, requires doctors and hospitals to report any drug overdoses to the State. AB474 also requires that licensing boards review data from the PMP to investigate inappropriate prescribing, dispensing, or use of a controlled substance prior to prescribing in order to impose appropriate disciplinary action. The aims of the legislation are to:

- Prioritize patient safety and responsibility.
- Preserve clinical decision making.
- Promote the patient-prescriber relationship.
- Reduce the amount of inappropriate prescribing.
- Prevent addiction to prescription drugs through monitoring and mitigating risk.
- Enhance the quality of care for patients with acute and chronic pain.
- Avoid the legislation of the practice of medicine by establishing a standard of care.[59]

In 2019, the Legislature passed AB239, which further refined the law. Under the law, prescribers must review a patient's PMP report and perform a risk assessment before prescribing a controlled substance. The law includes guidelines for the treatment of acute pain, and exemptions are made for hospice, palliative, cancer, and sickle cell prescriptions. This and other requirements are expected to reduce the number of people who develop SUD and OUD, while maintaining access to appropriate pain management medications and enhancing alternative pain management strategies.

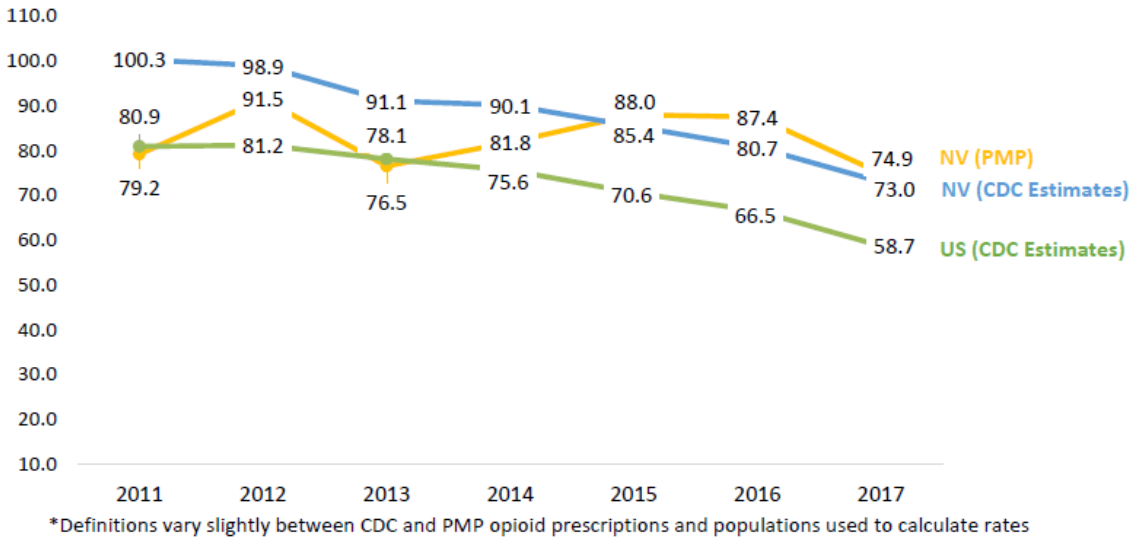
Comprehensive knowledge of pain management strategies and training about pain management competencies that cross disciplines are known barriers to implementation of the law. Other challenges

[58] Prescription Monitoring Program. Nevada State Board of Pharmacy. Available at: https://bop.nv.gov/links/PMP/
[59] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.

include communication between pharmacists and prescribers, confusion over interpretation of new provisions, misinformation to patients and prescribers, and knowledge of resources for SUD treatment.[60]

However, despite these challenges, there has been an overall reduction in opioid prescriptions for pain, according to data from the Nevada PMP and the CDC (Figure 10)[61]. According to Nevada PMP data, the opioid prescribing rate decreased from 87.4 in 2016 to 74.9 in 2017, and preliminary data show that the rate decreased further to 52.0 in 2018.[62] This yields a decrease in opioid prescribing by 40.5 percent statewide from 2016 to 2018. Opioid prescriptions with a less than 30-day supply and prescriptions with a supply greater than or equal to 90 days both decreased by 54 percent.[63]

Figure 9. Opioid Painkiller Prescriptions per 100 Population (2011-2017)



*Definitions vary slightly between CDC and PMP opioid prescriptions and populations used to calculate rates

At the county level, opioid prescribing rates in 2018 were highest in Nye County (98.6), Storey County (90.0), Mineral County (85.5), and Lyon County (80.9). All counties decreased from 2016 to 2018, except for Lincoln County, which increased 21.7 percent. The largest decreases in opioid prescribing rates were in Mineral County (46.0 percent) and Esmerelda County (49.0 percent) (Table 5).

Table 5. Changes in Opioid Painkiller Prescribing Rates by County (2016 and 2018)

County	Rate (2016)	Rate (2018)	% Change
Nevada	**87.4**	**52.0**	**40.5%**

[60] Ibid.
[61] Nevada Opioid Crisis Needs Assessment, 2019.
[62] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.
[63] DHHS Office of Analytics Data Source: Prescription Drug Monitoring Program (PDMP; 2018).

County	Rate (2016)	Rate (2018)	% Change
Carson City	105.4	65.5	37.9%
Churchill	106.8	67.2	37.1%
Clark	84.3	49.8	40.9%
Douglas	102.0	70.7	30.7%
Elko	71.7	39.9	44.4%
Esmeralda	72.5	37.0	49.0%
Eureka	92.7	56.0	39.6%
Humboldt	75.5	41.7	44.8%
Lander	85.2	49.6	41.8%
Lincoln	60.7	73.9	-21.7%
Lyon	130.0	80.9	37.8%
Mineral	158.2	85.5	46.0%
Nye	155.6	98.6	36.6%
Pershing	69.5	45.0	35.3%
Storey	146.9	90.0	38.7%
Washoe	87.5	51.1	41.6%
White Pine	99.9	60.6	39.3%

Source: DHHS Office of Analytics Data Source: Prescription Drug Monitoring Program (PDMP; 2018).

Doctor shopping is defined as seeing multiple treatment providers to procure prescription medications illicitly. Data from 2013 to 2018 shows that, as more providers in Nevada check PMP data as a part of standard prescribing procedures, the rates of potential "doctor shoppers" has declined. The total number of patients identified in the 24 quarters was 3,325. From the high of 302 patients in the second quarter of 2013 to the low of 12 patients in the fourth quarter of 2014, the volume of potential doctor shoppers dropped by 96 percent. From the beginning of 2014 to the end of 2018, the number of PMP queries increased by fivefold (Figure 11, Figure 12). [64]

[64] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.

Figure 10. PMP Data Queries per Quarter (2014-2018)

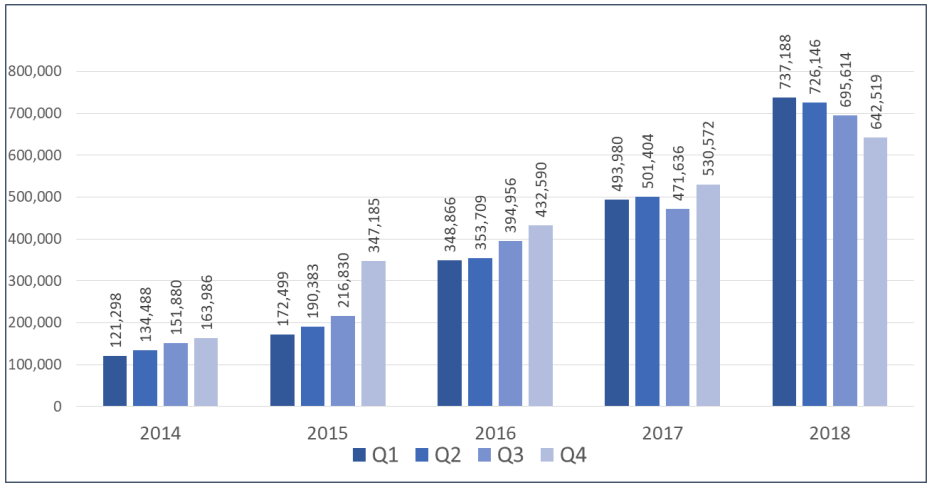
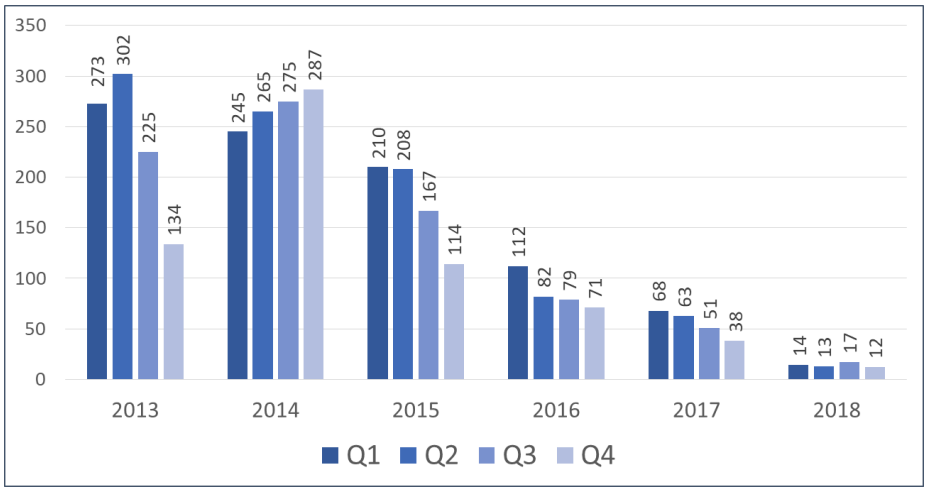


Figure 11. Potential "Doctor Shoppers" Per Quarter (2013-2018)



Source: Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.

1.3. SUD and OUD Treatment and Recovery Service Capacity

Opioid-related services are only reaching a fraction of the total number of Nevada Medicaid patients who have been diagnosed with SUD or OUD. For example, in 2018, the number of Medicaid beneficiaries diagnosed with OUD is many times larger than the number getting opioid-related services on managed care and FFS Medicaid. In total, 31.5 percent of those diagnosed with SUD or OUD received related services statewide. There is a range between the counties, with some counties providing no opioid-related services, and Carson City providing services to nearly half of those diagnosed (Table 6).

Table 6. 2018 Opioid-related Diagnosis and Services by County

	Opioid-Related Diagnosis			Opioid-Related Services		
County	FFS	MCO	Total	FFS	MCO	Total
CARSON CITY	293	56	**349**	114	52	**166**
CENTRAL OFF	2	-	**2**	1	-	**1**
CHURCHILL	106	-	**106**	9	-	**9**
CLARK	1,363	7,706	**9,069**	192	2,964	**3,156**
DOUGLAS	96	-	**96**	29	-	**29**
ELKO	69	22	**91**	-	-	**0**
ESMERALDA		-	**0**	-	-	**0**
EUREKA	3	-	**3**	-	-	**0**
HUMBOLDT	37	-	**37**	1	-	**1**
LANDER	8	-	**8**	-	-	**0**
LINCOLN	8	-	**8**	-	-	**0**
LYON	199	1	**200**	55	-	**55**
MINERAL	28	-	**28**	1	-	**1**
NYE	208	50	**258**	12	-	**12**
PERSHING	14	-	**14**	4	-	**4**
STOREY	8	-	**8**	6	-	**6**
WASHOE	542	1,505	**2,047**	145	308	**453**
WHITE PINE	18	-	**18**	1	-	**1**
Total	**3,002**	**9,340**	**12,342**	**570**	**3,324**	**3,894**

Source: Nevada SUPPORT Act Planning Grant Project Narrative.

A range of provider types offer SUD or OUD-related services to Medicaid beneficiaries. Special clinics serve the majority of patients (42 percent) and more than one in four patients sees a provider of unknown type (Table 7). Sub-specialty clinics represented under Special Clinics include: family planning, genetics, licensed birth centers, methadone, public health clinics, school-based health centers, rural health clinics, FQHC, Indian Health Service (IHS) non-tribal, comprehensive outpatient rehabilitation facilities, Certified Community Behavioral Health Clinic (CCBHC), community health clinics, state health division, special children's clinics, tuberculosis clinics, human immunodeficiency virus (HIV), and Substance Abuse Agency Model (SAAM). [65]

Table 7. SUD and MAT Provider Types and Patient Count, State of Nevada, FY 2018

Provider Type	FFS	MCO	Total
Hospital, Surgery	15	-	**15**
Hospital, Outpatient	126	-	**126**
Behavioral Health Outpatient	-	278	**278**
Special Clinics	2,230	4,490	**6,720**
Physician, M.D., Osteopath, D.O.	-	1,844	**1,844**
Laboratory, Pathology Clinical	-	2,036	**2,036**

[65] https://www.medicaid.nv.gov/providers/checklist_pt17.aspx.

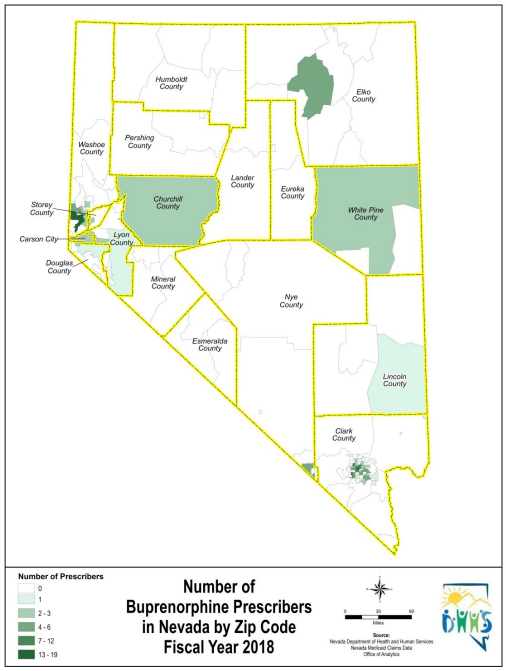
Provider Type	FFS	MCO	Total
IHS And Tribal Clinics	-	1	**1**
MH Rehabilitative Treatment	-	473	**473**
Unknown	-	4,490	**4,490**
Total	**2,371**	**13,612**	**15,983**

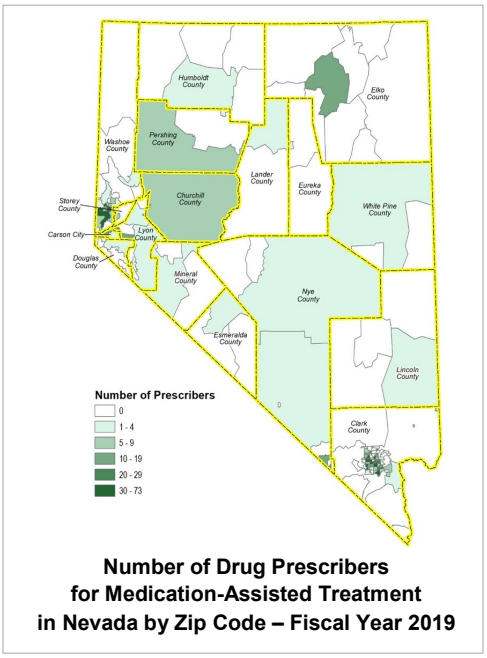
Source: Nevada SUPPORT Act Planning Grant Project Narrative.

1.3.1. Provider Capacity and Factors for Provision of MAT

As established by the data above, the need for SUD and OUD services is strong. There are currently 648 providers that are waivered to provide MAT through the use of buprenorphine, a significant rise from the previous year; however, not all providers prescribe. Of those who do prescribe, few prescribe to their upper limit.[66] There are 15 OTPs within Clark, Washoe, and Carson City. Capacity is available overall; however, connection to high-quality, integrated services remain a challenge in the state, especially in rural and frontier communities (Figure 13, Figure 14, and Figure 15). [67]

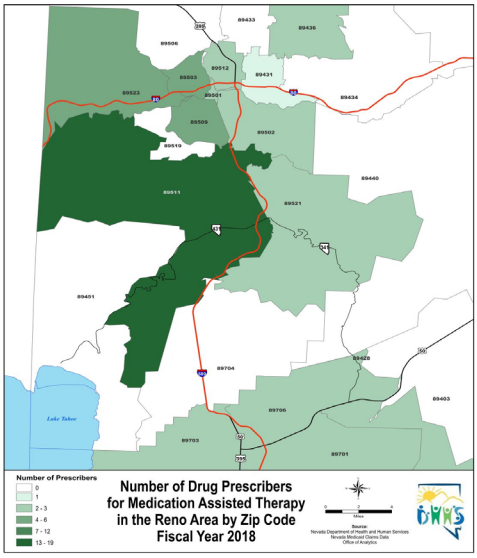
Figure 12. Increase in Buprenorphine Prescribers in Nevada, Washoe County, Clark County (2018-2019)





[66] QPR QE 12/31/2020.
[67] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.

Figure 13. Washoe County Drug Prescribers for MAT 2018- 2019



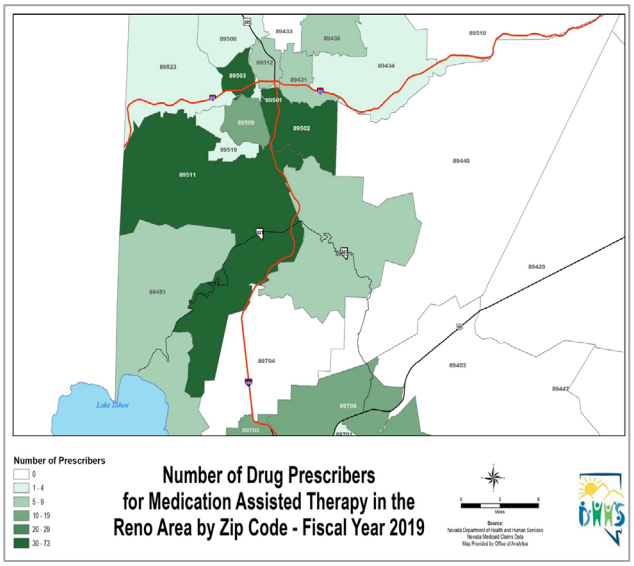
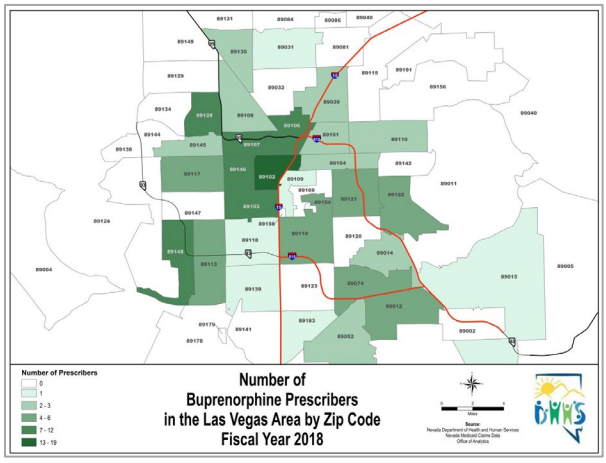
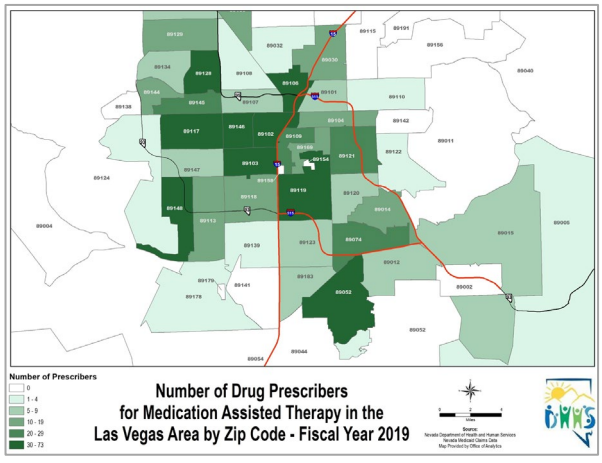


Figure 14. Clark County Drug Prescribers for MAT 2018- 2019





Source: Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.

To identify the barriers and limitations in the delivery of these services, DHHS has conducted numerous stakeholder engagement efforts to gather feedback from providers. DHHS collected additional data though the CCBHC demonstration grant, which included a provider assessment. Surveys were distributed to providers to assess willingness, qualifications, and capacity to provide substance abuse treatments. As a result, DHHS identified a significant gap: there was no comprehensive MAT policy or procedure. Also, there was no crosswalk for simplifying Medicaid billing for non-behavioral health providers, such as

primary care physicians, for SUD and OUD services. Some providers responded that they would be willing to provide services if there were changes in the billing structure.[68]

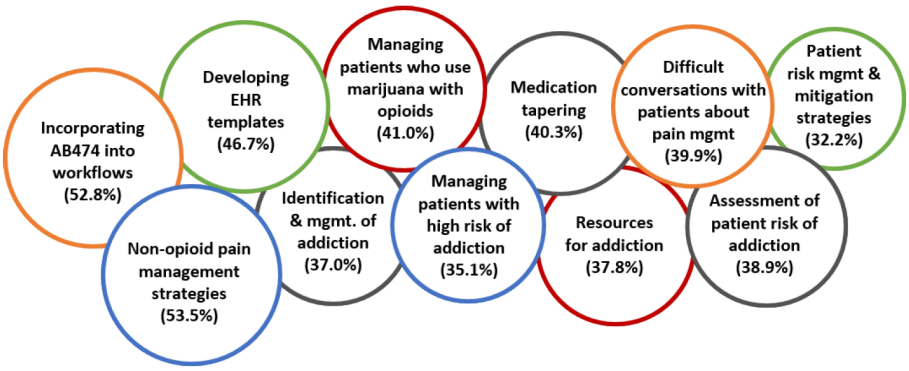
In February 2018, 1,074 health care providers responded to a providers' needs assessment survey designed to guide the development of opioid-related trainings and to facilitate the successful implementation of Nevada's STR to opioids grant project. The following boards represented the licensing of the majority of survey respondents:

- Nevada State Board of Medical Examiners (Physician 59 percent; PA nine percent).
- Board of Nursing (Advanced Practice Nurses 22 percent).
- Board of Pharmacy (16 percent).
- Osteopathic Medicine Board (DO six percent; PA two percent).

Roughly 74 percent of assessment respondents said they would likely attend or consider attending a training related to AB474. "Non-opioid pain management" and "incorporating AB474 into workflows" were the most frequently identified topics for potential training. Providers also rated other topics of high interest. As represented in Figure 16,[69] these included:

- "Developing electronic health record templates."
- "Managing patients who use marijuana with opioids."
- "Tapering medication."
- "Difficult conversations with patients about pain management."

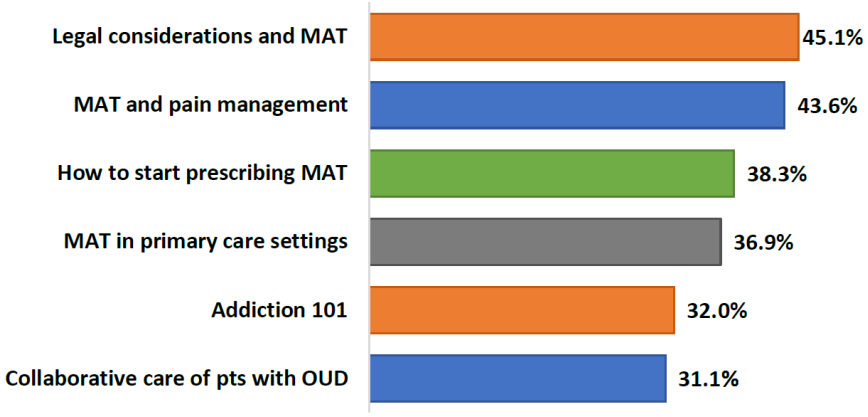
Figure 15. Provider Assessment of Training Attendance for AB474 Topics



[68] Nevada SUPPORT Act Planning Grant Project Narrative.
[69] Nevada Opioid State Targeted Response Training Needs Assessment – Providers Training Survey Report, February 2018.

Providers were asked to rate topics on their importance and rated "legal considerations and MAT" and "MAT and pain management" as the most important to address, followed by "how to start prescribing MAT," and "MAT in primary care settings" (Figure 17). Additional comments written in by respondents suggest that some providers are not interested in MAT trainings due to 1) not understanding what MAT is; 2) not agreeing with its use; or 3) not knowing what is meant by the federal "DATA 2000 Waivered" provision (Drug Addiction Treatment Act of 2000).[70] This suggests the need to perform additional educational outreach on these topics.

Figure 16. Provider Assessment of Topic Importance



Nevada's vast geography and health care provider shortage contribute to the challenge of SUD and OUD service capacity. Ninety percent (90 percent) of Nevada's population is concentrated Clark County, Washoe County, and Carson City. The number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 42.1 per 100,000 since 2008.[71] On the other hand, the number of health care providers who are DATA-waived to prescribe buprenorphine has increased from 98 in 2013 to 584 at the end of 2019 and 648 at the conclusion of 2020, which means Nevada has gained 550 waivered providers over the past seven years, and increased 64 waivered providers from 2019 to 2020.[72] [73]

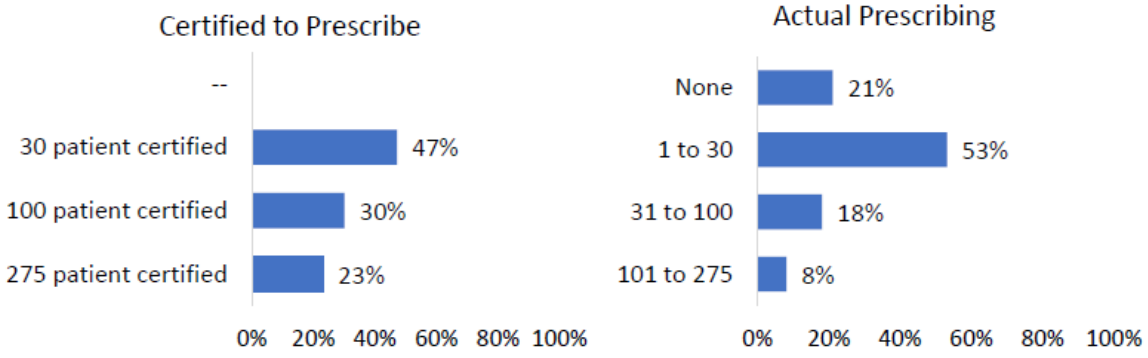
In August 2017, all 192 Nevada DATA 2000-waived providers were emailed a brief online survey; 182 received the survey. The survey included questions about their buprenorphine prescribing limit, current caseload of MAT patients, reasons for not prescribing at capacity, resources that could increase their MAT prescribing, counties in which they are prescribing, use of opioid and naloxone co-prescribing, psychosocial interventions offered, and interventions provided through contract arrangements. The

[70] Ibid.
[71] Griswold et al., 2017.
[72] QPR QE 12/31/2019 – 12/31/2020
[73] Levi, et al., 2013; SAMHSA, 2018.

distribution resulted in 71 responses for analysis. Survey results presented below should be interpreted with caution, based on the 39 percent return.

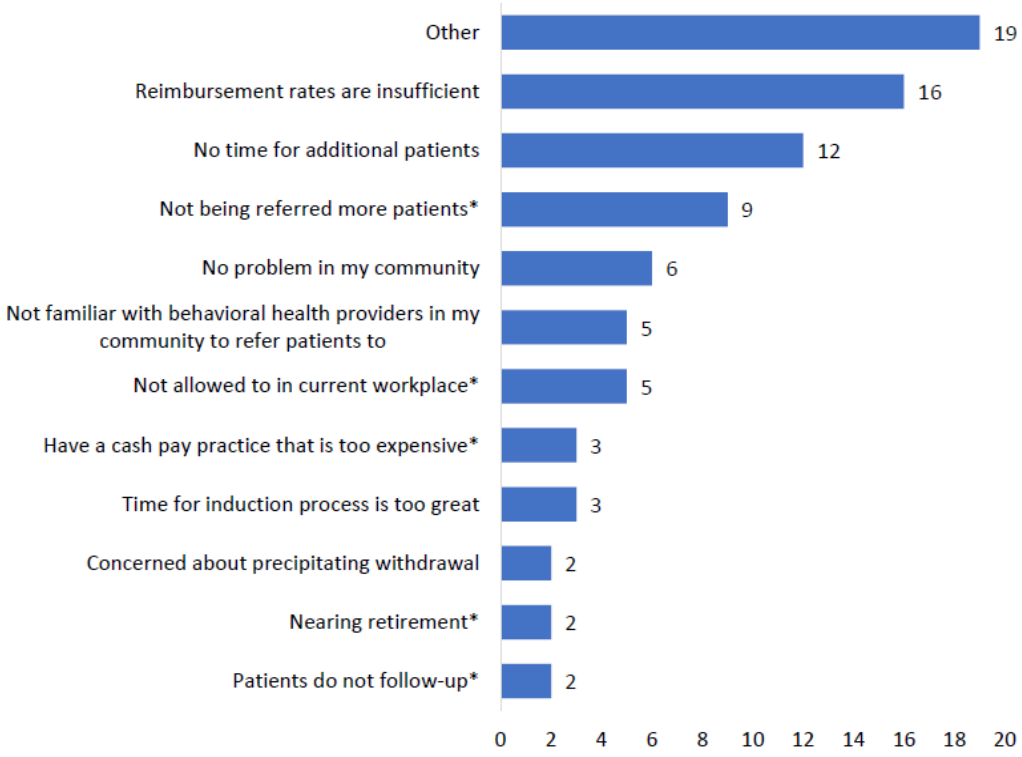
The DATA-waived providers offer OBOT. OBOT providers were prescribing in 10 counties: Carson City (5), Churchill (2), Clark (147), Elko (3), Humboldt (1), Lincoln (1), Lyon (1), Nye (1), Pershing (2), and Washoe (30). Of the OBOT providers who responded to the survey, none were prescribing at their capacity, although one had just increased their limit, so they were prescribing to their prior capacity. Three quarters of respondents were working in private practice. Nearly all (97 percent) of respondents said their practice or agency was accepting new clients. There was a range in the number of patients for whom the providers were certified to prescribe: 47 percent were certified for 30 patients, 30 percent for 100 patients, and 23 percent for 275 patients. While less than half of providers were certified to prescribe for only 30 patients, 74 percent of respondents were prescribing in this range. Almost one third were allowed to prescribe buprenorphine for up to 100 patients, but only 18 percent of respondents actually were. While nearly one quarter had increased their prescribing limit to 275 patients, only 8 percent were utilizing this ability (Figure 18).

Figure 17. Comparison of Provider Capacity and Actual Prescribing



Respondents were asked to select all of the reasons they were not prescribing at their buprenorphine capacity and were given the opportunity to write in additional reasons. The most often-cited reasons for not prescribing at capacity were insufficient reimbursement rates, lack of time for additional patients, and lack of referrals for more patients (Figure 19).

Figure 18. Reasons for Not Prescribing at Capacity

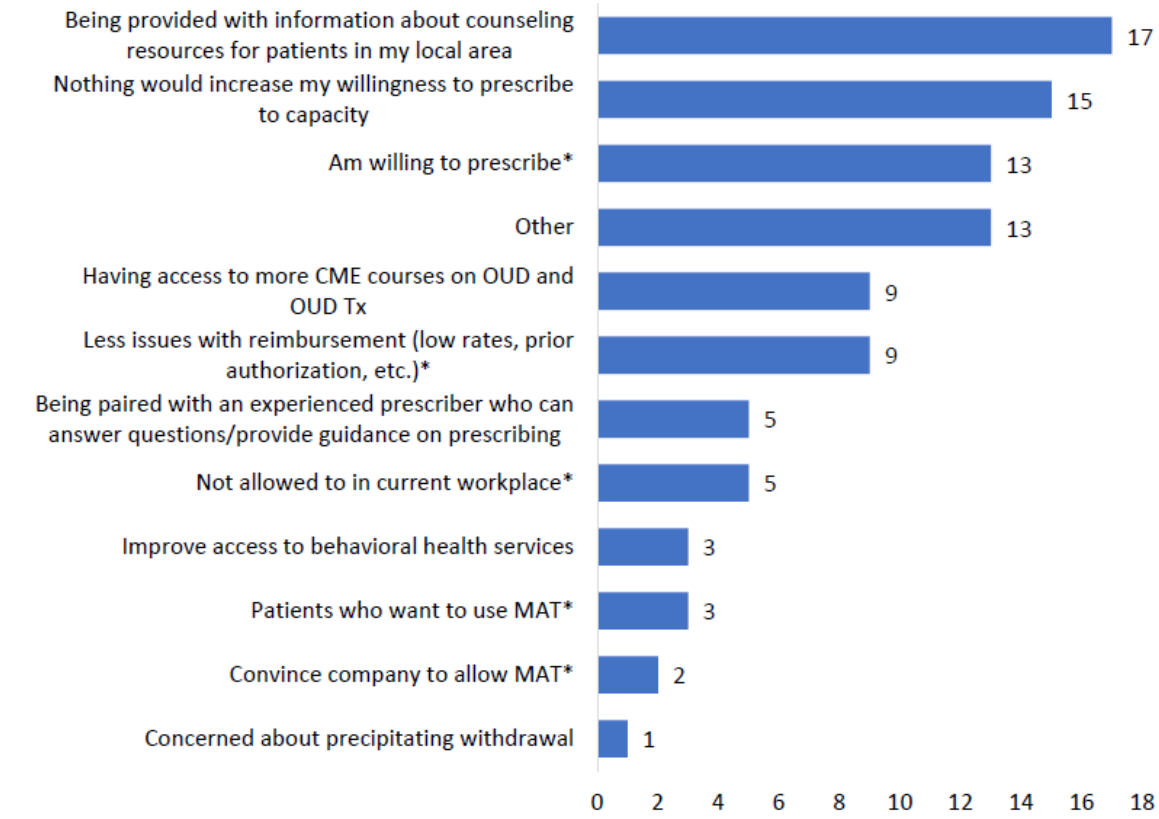


*represents aggregated responses written into Other
**Question was a select all that apply so the number of answers is more than the number of respondents

In a follow-up question, participants were asked what resources would increase their willingness to prescribe to capacity. The most common responses were that the prescriber would like "being provided with information about counseling resources for patients in my local area" and "nothing would increase my willingness to prescribe to capacity" (Figure 20). The MAT model includes the use of FDA-approved medications, in combination with counseling and behavioral therapies,[74] so community resources for therapy are important.

[74] https://www.Samhsa.gov/medication-assisted-treatment.

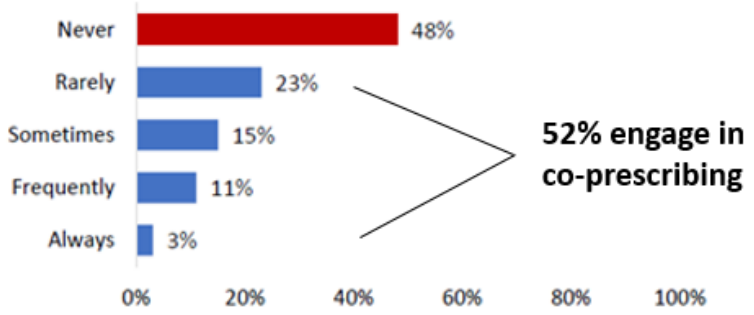
Figure 19. Resources that Would Increase Providers' Willingness to Prescribe at Capacity



*represents aggregated responses written into "Other"
**Question was a select all that apply so the number of answers is more than the number of respondents.

Over half of survey respondents (52 percent) indicated that they co-prescribed naloxone with opioid painkillers for high-risk patients, with 11 percent of those citing doing so "frequently" and 3 percent "always" (Figure 20).

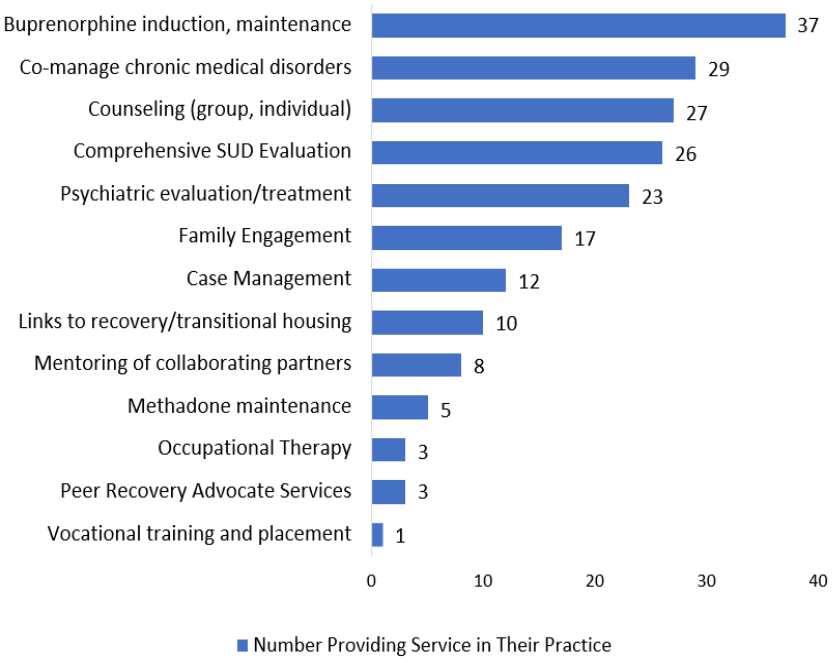
Figure 20. Frequency of Opioid Painkiller and Naloxone Co-prescribing



There is a growing body of evidence that supports inclusion of psychosocial supports in the delivery of MAT services. The World Health Organization emphasizes the importance of psychosocial services,

including assessment psychosocial needs, counseling, connections to family supports, and referrals to community services, as a complement to pharmacotherapy.[75] The majority of survey respondents (69 percent) were employed in a practice that offered psychosocial services or interventions and nearly half (48 percent) provided psychosocial interventions through contract arrangements with qualified behavioral health providers. The most common service offered was buprenorphine induction and maintenance. Counseling was reported as being offered by about one in four providers (Figure 21).

Figure 21. Types of Psychosocial Services/Interventions Offered by Provider Practices



1.3.2. Availability of Medication-Assisted Treatment

There are 15 OTPs in Nevada across Clark County, Washoe County, and Carson City that provide MAT. The 14 rural counties have no OTPs. Only one OTP cited being at capacity at the time of the assessment (Life Care Center in Sparks, Washoe County). Six centers committed to adding more staff as client needs increased (Mission Treatment Centers and Centers for Behavioral Health). All the OTPs except one provide maintenance therapy; the exception is using MAT only for detox, followed by referral to another provider.

[75] World Health Organization. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Geneva, Switzerland: World Health Organization; 2009.

Capacity to provide MAT services among the 12 OTPs responding to the DHHS assessment is 4,693 clients. The three other OTPs did not respond. [76]

Three OTPs, located in Clark County, Washoe County, and Carson City, receive funding from a federal block grant through SAPTA. At those facilities, the majority of clientele seeking MAT are publicly funded. Thirteen OTPs did not respond to requests for the number of publicly and privately funded clients served (Table 8 includes information from OTPs that did respond). For those that did not respond, it is expected that most clients are privately funded at those facilities. A detailed listing of OTPs and services includes the number served and the psychosocial interventions offered by county (Table 9).

Table 8. Public and Private Funding for OTPs (Among Respondents)

Program	County	Number Served Medicaid Funded	Number Served Publically Funded	Number Served Privately Funded
Adelson Clinic	Clark	69	75	21
Life Change Center	Various	435	107	241

Table 9. Nevada OTP Location, Capacity, and Services

Program	County	Program Capacity	Current Number Served	Psychosocial Interventions Offered
Adelson Clinic	Clark	300	183	Counseling and referral/coordination of care for other services needed by clients.
Center for Behavioral Health – Cheyenne	Clark	200	200	Counseling (variety of groups, including gender specific), family counseling, case management, coordinate care when mental health services are needed, physician available every day.
Center for Behavioral Health – Desert Inn	Clark	450	450	Counseling (variety of groups, including gender specific), family counseling, case management, coordinate care when mental health services are needed, physician available every day.
Center for Behavioral Health – McDaniel	Clark	400	400	Counseling (variety of groups, including gender specific), family counseling, case management, coordinate care when mental health services are needed, physician available every day.
Center for Behavioral Health – Reno	Washoe	300	300	Counseling (variety of groups, including gender specific), family counseling, case management, coordinate care when mental health services are needed, physician available two days per week.

[76] Nevada Opioid Crisis Needs Assessment, 2018.

Program	County	Program Capacity	Current Number Served	Psychosocial Interventions Offered
Desert Treatment Clinic	Clark	--	--	--
Eastern Treatment Clinic	Clark	--	--	--
Mission Treatment Centers Henderson	Clark	258	258	Counseling, coordinate care with other agencies for the client's needs (medical, mental health).
Mission Treatment Centers Las Vegas	Clark	260	260	Counseling, coordinate care with other agencies for the client's needs (medical, mental health).
Nevada Treatment Center (Nevada Integrated Behavioral Services Inc.)	Clark	300	125	Counseling (L1, 2.1 and 2.5), case management, co-occurring disorders (COD) services, coordination of care for client's needs.
New Beginnings Counseling Center Eastern	Clark	800	490	Counseling, domestic violence, driving under the influence (DUI) class, and the victim impact panel.
New Beginnings Counseling Center Lake Mead	Clark	500	180	Counseling, domestic violence, DUI class, and the victim impact panel.
Life Change Center – Carson City	Carson	275	275	Counseling; case management by dedicated case management staff; family programming; for women: parenting and prevention program, co-occurring capable program so can screen and then assist with referral and coordination of care; medication management; assessment for initial clients for proper placement; gardening program; social recreation program.
Life Change Center – Sparks	Washoe	450	450	Counseling; case management by dedicated CM staff; family programming; for women: parenting and prevention program, co-occurring capable program so can screen and then assist with referral and coordination of care; medication management; assessment for initial clients for proper placement; gardening program; social recreation program.
Seven Hills Hospital, Inc.	Clark	--	--	None.

1.4. Nevada SUPPORT Act: Key Focus Populations

In accordance with the SUPPORT Act grant specifications, the Nevada planning grant assessment and activities focused on specific Medicaid subpopulations including pregnant women, postpartum women,

and infants (including those with NAS), as well as adolescents and young adults between the ages of 12 and 21 years.

1.4.1 Association of State and Territorial Health Officials (ASTHO) (Opioid Use Disorder, Maternal Outcome, Neonatal Abstinence Syndrome Initiative) OMNI Maternal and Infant Population

To address the needs of maternal and infant populations and execute the necessary planning tactics to increase access to care and expand provider capacity, DHCFP will leverage the OMNI project started by the ASTHO in partnership with the CDC.

The goal of the ASTHO-OMNI initiative is to develop and disseminate comprehensive perinatal care practice standards, including universal screening and plans of safe care for pregnant women using substances, and infants with NAS.

ASTHO-OMNI is working with 16 states to provide opportunities to develop policies and establish collaborative environments where states/communities can learn from one another and share best practices for pregnant and postpartum women exposed to OUD in order to improve health outcomes.[77]

The Nevada ASTHO-OMNI Perinatal Health Initiative started in November 2018. Areas of focus include: provider awareness and training, access to and coordination of quality services. There are three main objectives outlined in the Nevada ASTHO-OMNI Action Plan:

- **Objective One:** Identify and support best practices for physical and behavioral health for the population of focus (pregnant women and non-pregnant women of child-bearing age) through development of training, tools, resources, and collateral.
- **Objective Two:** Determine optimal reimbursement policies and mechanisms, based on data, to ensure coverage for and access to the best practice array of clinical services and recovery supports needed for the population of focus.
- **Objective Three:** Design and disseminate CARA Plan of Safe Care implementation protocols and related training and education resources for providers, parents, caregivers and family members, and community members.[78]

Nationally, more than 40 percent of pregnant women enrolled in Medicaid receive a prescription for opioids. In addition, rates of NAS have increased more than 300 percent in the past decade at an average cost of over $200,000 per case. In Nevada, IPs for NAS have doubled since 2011 and, as of 2018, the

[77] ASTHO OMNI Action Plan, May 2020.
[78] Ibid.

average length of stay for a newborn with NAS was 19 days. MAT is the standard of care for OUD in pregnancy. It reduces risk of mortality almost six-fold, comparable to the baseline for regular population. While in treatment, relapse rates are similar to that of diabetes and better than those for hypertension and asthma. Symptoms of NAS vary depending on the type of substance use and include but are not limited to tremors, excessive and high-pitched crying, tight muscle tone, rapid breathing, and poor feeding. Researchers have found that with proper care and support, infants suffering from NAS typically recover and generally do not show significant mental impacts from the withdrawal process. However, Infants with NAS are at greater risk for low birthweight, jaundice, seizures, and sudden infant death syndrome all of which can potentially cause long-term health issues and developmental impacts. Without proper treatment, infants with NAS may experience long-term impacts like developmental delays, motor problems, behavioral problems and learning disabilities, speech delays, vision problems, and recurrent ear infections. With drug use during pregnancy and NAS on the rise, providers and patients need access to widely-adopted standards and protocols and appropriate plans of care. [79, 80, 81, 82]

Standards and protocols will be disseminated via toolkits and intended for inpatient providers, outpatient Obstetrician-Gynecologists (OBGYNs), and parents and caregivers. The following educational materials have been developed, or are currently in development, through a collaborative effort from the ASTHO OMNI workgroups:

- **Provider Toolkits.** The Provider Toolkit encompasses two toolkits: Inpatient and Outpatient. These were developed to address the assessment, care, and monitoring of pregnant women with SUD and their infants.
    - The OBGYN Outpatient Toolkit, formally named the Provider Reference Guide for Reproductive Health Complicated by Substance Use, is designed for OBGYN practice settings. The content includes: an introduction to SBIRT, how to use SBIRT, management after SBIRT, instruction for follow-up care, intrapartum pain control and clinical protocol, and postpartum clinical pathways. The toolkit also incorporates additional resources in the appendix. While the toolkit has been finalized by ASTHO OMNI, it is currently in phase 1 of distribution. Implementation phase 1 is limited to select large practices in Clark County. The Center for the Application of Substance Abuse Technology's (CASAT) Training and TA Approach to implementation focused on three identified priorities: a tailored training plan for large volume practices serving high need populations; potential adoption sites receive an email including a PDF of the reference guide toolkit, a link to an

[79] https://www.marchofdimes.org/complications/neonatal-abstinence-syndrome-(nas).aspx.
[80] https://www.seattlechildrens.org/globalassets/documents/health care-professionals/neonatal-briefs/neonatal-abstinence-syndrome-outcomes.pdf.
[81] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[82] Draft: ASTHO OMNI Family Toolkit.

instructional video, and a link to the readiness assessment; and a future planned ECHO series that corresponds with SBIRT in the OBGYN setting.

- The Inpatient Toolkit is currently in progress and will be designed for labor and delivery and postpartum inpatient settings. The toolkit was initially planned to cover neonatal intensive care unit (NICU) and pediatric protocols; however, it was decided that those would be better addressed in a future NICU Toolkit. Eight areas of focus are identified for this toolkit: current policy/protocol for screening pregnant women for OUD, NICU admission criteria for NAS, breastfeeding policy/protocol for opioid-positive women and women engaged in MAT, non-pharmacological options utilized for NAS infants on the postpartum floor, discharge criteria for opioid-positive babies on the postpartum floor, long-acting reversible contraception (LARC), pain management protocols, and MAT. The research for this toolkit concluded that there's a need for broad training and education for hospital staff on the full pharmaceutical range of LARC options to prevent future unplanned substance exposed pregnancies.

- **CARA Packet.** CARA was signed into law on July 22, 2016 to establish a comprehensive, coordinated, balanced strategy through enhanced grant programs that would expand prevention and education efforts while also promoting treatment and recovery.[83] The CARA Packet, formerly referred to as the Family Toolkit, is a collaborative effort between the Nevada Division of Public and Behavioral Health (DPBH) and the Division of Child and Family Services (DCFS) to develop and maintain an up-to-date guide for parents and caregivers. Educational materials for both the provider and the family are included in the packet and will be distributed to hospitals throughout the state. The packet includes the CARA POC Form, CARA Fact Sheet, NAS Handout, and Family Education Brochure.

  - The POC Form is a form to be completed by a hospital representative with the family for all infants known or believed to be born with fetal alcohol spectrum disorder (FASD), affected by substance use, or experiencing symptoms of withdrawal. The form will also be integrated into OpenBeds, a behavioral health referral tool, which will generate data collected from hospitals to be used in reporting. For additional information on OpenBeds, refer to the *5.3.3 Nevada OpenBeds and 2-1-1 Integration* section of this report.
  - A fact sheet for health care providers will be incorporated into the packet and will outline the goals of CARA: how Nevada defines a substance-affected infant, who decides if an infant is affected, what the CPS-reporting requirements are, refusal of the CARA POC, submission of the CARA POC, and CPS' involvement in the process after discharge.
  - The NAS Handout is intended for families and caregivers but is also a helpful resource for hospital staff. The handout explains symptoms of NAS, treatment of NAS, and long-term expectations of an infant impacted by NAS.

[83] https://cadca.org/comprehensive-addiction-and-recovery-act-cara.

- The Family Education Brochure is the guide for parents and caregivers and should be provided with the completion of the POC. The brochure includes: explanation of the CARA POC, the role of the care team, basic information on Nevada CPS-reporting laws, services available for mother and baby, impacts of SUD on infants, and information on marijuana and breastfeeding.

Distribution of the CARA Packet is expected statewide. ASTHO OMNI is working with CASAT on implementation and it is expected that individual TA will be provided to hospitals on an as-needed basis. Whether the materials are printed and distributed or distributed via a PDF link is largely dependent on budget.

Below are the standards and protocols developed within the ASTHO-OMNI project, which specifically address the assessment, care, and monitoring of pregnant women with SUD and their infants. (Table 10)

Table 10. Policies and Best Practices for Perinatal Care

Policy	Best Practices	Nevada Policy
Prenatal Screening	• American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) regard screening for substance use to be a part of comprehensive obstetric care. Screening is the provider's duty as a standard of care.[84] • SBIRT is the standard of practice for substance use in every pregnant woman and non-pregnant woman of reproductive age.[85] • Screen using a standardized questionnaire (5Ps or NIDA Quick Screen).[86] • Universal screening that is not based on targeted demographics, suspicion, or appearance.[87]	• Identify and help those that want assistance with added screening and referral to treatment known as SBIRT.[89] • Provider asks questions about alcohol, tobacco, and substance use, both legal and illegal.[90] • Conduct SBIRT when a pregnant woman or non-pregnant woman of reproductive age is being seen for the first time, or when pregnancy is first recognized.[91] • Screening on an annual basis if providing continuous care for a woman of reproductive age.[92]

[84] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[85] SAMSHA: Screening, Brief Intervention, and Referral to Treatment (SBIRT).
[86] ACOG: The American College of Obstetricians and Gynecologists.
[87] ACOG: The American College of Obstetricians and Gynecologists.
[89] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[90] Ibid.
[91] Ibid.
[92] Ibid.

Policy	Best Practices	Nevada Policy
	• Provide referral to treatment. For those accepting of follow-up care, refer to MAT provider, Behavioral Health or Addiction Medicine, Case Management and/or Social Worker.[88]	
Prenatal and Infant Assessment, Care, and Monitoring	• The CDC's guidance for treating pregnant and postpartum women with OUD includes: universal screenings for substance use during pregnancy, provision of MAT and behavioral counseling during pregnancy; and the postpartum period; anticipation and management of NAS for infants prenatally exposed to substances; and multidisciplinary, long term follow-up care for mothers and infants to improve outcomes.[93] • Nationwide, the standard of care for OUD in pregnancy is MAT.[94]	• Prenatal Care Providers must conduct assessment on first prenatal visit and then again during the 3rd trimester. [95] • Provider should refer to additional services if the patient is willing, including but not limited to behavioral/mental health, MAT treatment, and case management.[96] • Through a SAMHSA grant, Dignity Health has implemented the EMPOWERED Pathway in 2018 to screen, treat, and refer pregnant mothers.[97]
Hospital Protocol for Screening and Treatment of NAS	• An accurate report of the mother's drug usage should be obtained in order to properly treat the infant.[98] • A Neonatal Abstinence Scoring System is the industry best practice to help diagnose and grade the severity of the withdrawal. Using the scoring system, points are assigned for certain signs and symptoms and the severity of each. Scoring may also be used in treatment planning.[99] • Children's Hospital of Philadelphia (CHOP) protocol for NAS Scoring: start at two hours of life, assess infants at	• A neonatal abstinence scoring system is not required but is recommended to help diagnose and grade severity of withdrawal.[103] • Medications may be administered to treat withdrawal symptoms, but once signs of withdrawal are controlled, dosage must be gradually decreased to help wean baby off treatment drugs.[104] • If scoring system was used, the results should be used in conjunction with an assessment of other factors (infant's gestational age, overall health,

[88] SAMSHA: Screening, Brief Intervention, and Referral to Treatment (SBIRT).
[93] http://www.cdc.gov.
[94] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[95] Ibid.
[96] Ibid.
[97] Peterson, A Pharm D; Nagar, D, MD. Substance Use Disorder in Pregnancy and Neonatal Abstinence Syndrome. Presentation to the Nevada Legislative Committee on Health. November 2019.
[98] National Center on Substance Abuse and Child Welfare.
[99] Boston Children's Hospital Neonatal Abstinence Syndrome (NAS).
[103] Nevada Practice Guidelines for CARA POC.
[104] Nevada Practice Guidelines for CARA POC.

Policy	Best Practices	Nevada Policy
	least every four hours, score 30 to 60 minutes after feeding.[100] • Many states, including Florida, determine a diagnosis of NAS if the infant meets all three of the following criteria:[101] ○ Presence of a constellation of clinical signs consistent with NAS not explained by another etiology. ○ Documented history of maternal use during pregnancy of prescription or illicit drugs associated with NAS or laboratory confirmation. ○ Severity of illness that resulted in prolonged neonatal hospitalization. • As of 2018, 44 states will prosecute women for prenatal illicit drug use, 24 states and the District of Columbia consider prenatal drug use child abuse or neglect, and four states recognize substance use as ground for civil commitment.[102]	medical history, exposure, and tolerance/response to medications). to determine ongoing course of treatment.[105] • Nevada state law requires health care professionals to notify CPS when it is determined an infant is affected by FASD or prenatal substance abuse or has withdrawal symptoms resulting from prenatal substance exposure. [106]
Hospital Protocol for Discharge Planning	• CARA was signed into federal law in July 2016. It included amendments to the Child Abuse Prevention and Treatment Act (CAPTA). If a woman uses prescription medications or substances while pregnant, the hospital staff caring for the baby will provide her with a CARA POC, a referral to services to address the	• DPBH partnered with DCFS to create a process for CARA Plans of Care to be implemented statewide and requiring providers to complete a CARA POC. [108] • Chapter 449 of NAC was amended to meet the requirements of CARA. The regulation requires a health care provider, who provides services to an infant born with withdrawal

[100] CHOP Clinical Pathway for NAS.
[101] CDC Infant and Maternal Characteristics in Neonatal Abstinence Syndrome, Selected Hospitals in Florida.
[102] https://www.healthaffairs.org/do/10.1377/hblog20180426.63403/full/.
[105] Ibid.
[106] Draft: ASTHO OMNI Family Toolkit.
[108] Nevada Practice Guidelines for CARA POC.

Policy	Best Practices	Nevada Policy
	health of the baby and the mother's SUD treatment needs.[107]	symptoms, to establish a CARA POC.[109] • A copy of the plan must be provided to the legal guardian and family. DPBH monitors the implementation of the plan.[110] • Provider should determine if necessary to discuss contraception including LARC.[111]
Marijuana and Breastfeeding	• According to the CDC, when advising mothers on the medicinal use of marijuana while breastfeeding, consideration should be given to the potential risks of marijuana exposure and benefits of breastfeeding to the infant and mother.[112] • The CDC recommends that if a mother continues to use marijuana or cannabidiol (CBD) while breastfeeding, she should be encouraged to significantly reduce her intake.[113]	• Guidance varies across the state depending on the provider and institution. The state of Nevada has not adopted a standard policy or protocol for breastfeeding and marijuana.[114]

In Nevada, policies and protocols addressing pregnant and postpartum women and their infants are evolving. The table above illustrates where Nevada stands in relation to national best practices. In many areas, Nevada meets industry standards and has recognized where policy can improve. ASTHO-OMNI is an integral component to Nevada's policies and protocols to improve treatment of women with SUD.

1.4.2 Nevada Tribal Population

Federally-recognized tribes are eligible for funding and services from the Bureau of Indian Affairs. Nationally, there are currently 574 federally recognized tribes, 27 of which reside in Nevada.[115] In Nevada, there are 27 separate reservations, bands, colonies, and community councils. According to Nevada's Indian Commission, 97 percent of Nevada's tribal nations are rural, their population numbering

[107] SAMSHA Summary Doc: https://ncsacw.samhsa.gov/files/CAPTA_SEI_Statutory_Summary.pdf.
[109] Ibid.
[110] Ibid.
[111] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[112] http://www.cdc.gov.
[113] http://www.cdc.gov.
[114] ASTHO OMNI, NV Perinatal Health Core Team Meeting Notes (May 22, 2020).
[115] State-recognized Indian Tribes are not federally recognized; however, federally recognized tribes may also be state recognized.

approximately 32,426 or 1.1 percent of the state's population. As of July 2019, 1.7 percent of Nevada's population identified their race/ethnicity to be American Indian, including residents both on and off reservations.[116, 117, 118, 119]

The IHS, an agency within the HHS, is responsible for providing federal health services to AIAN. The IHS provides a comprehensive health service delivery system for approximately 2.6 million AIAN who belong to federally recognized tribes in 37 states.[120]

The IHS is divided into 12 physical areas of the United States and each area serves a unique group of tribes on a day-to-day basis. The Phoenix Area Indian Health Service (PAIHS) office in Phoenix, Arizona oversees the delivery of health care to Native Americans in Nevada and parts of Arizona and Utah, serving approximately 140,000 AIAN in the tri-state territory. The system of care includes IHS, tribally operated healthcare facilities, and urban Indian health programs. These services range from primary care (both inpatient and outpatient) to tertiary care and specialty services. Additional services include dental, behavioral health, public health nursing, health education, and environmental health services. There are two Youth Regional Treatment Centers in Nevada.[121, 122]

PAIHS Service Units in Nevada:

- **Colorado River Service Unit:** While headquartered in Parker, Arizona, the Colorado River Service Unit serves Nevada through the Irene Benn Health Clinic in Moapa, Nevada, which offers behavioral health services and substance abuse counseling. This clinic serves approximately 490 patients.[123]
- **Elko Service Unit:** The Elko Service Unit provides rural, community-oriented, and family-focused primary care. This unit is considered one of the leaders in quality care, as many of their quality indicators rank high nationally. According to IHS, there are 7,139 patients registered at Elko including representation from three reservations and four colonies.[124] Reservations include Duckwater, Ely, and Goshute, with tribal health facilities. Colonies include Battle Mountain, Elko, South Fork, and Wells. The Unit is made up of community health services (outreach for isolated communities), Southern Bands Health Center (ambulatory clinic and family practice accredited by the Accreditation Association for Ambulatory Health Care), and other facilities.[125]

[116] https://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx#nv
[117] https://www.leg.state.nv.us/App/NELIS/REL/80th2019/ExhibitDocument/OpenExhibitDocument?exhibitId=36430&fileDownloadName=Nevadas%20Great%20Basin%20Tribes_Nevada%20Indian%20Commission.pdf
[118] SUPPORT Act Grant Narrative
[119] Census.gov
[120] https://www.ihs.gov/aboutihs/
[121] https://www.ihs.gov/locations/
[122] https://www.ihs.gov/locations/#
[123] https://www.ihs.gov/phoenix/healthcarefacilities/coloradoriver/
[124] A colony is a reservation within an established city.
[125] https://www.ihs.gov/phoenix/healthcarefacilities/elko/

- **Owyhee Community Health Facility (OCHF):** Located in Owyhee, Nevada, near the border with Idaho, OCHF provides health care to the Shoshone-Paiute Tribes of the Duck Valley Reservation, AIAN enrolled or descendant of a federally recognized tribe, and to individuals living on or near the reservation. OCHF offers ambulatory care services, managed care community health, emergency medical services, and translation. The Duck Valley Shoshone Paiute Alcohol Center is also a branch of the OCHF.[126]
- **Schurz Service Unit (SSU):** Located in Reno, the SSU provides information technology, purchased and referred care and administrative services to the following tribes: Pyramid Lake Paiute, Fallon Paiute-Shoshone, Lovelock Paiute, Winnemucca Indian Colony of Nevada, and Yomba Shoshone. All direct healthcare operations for these tribes are administered by SSU.[127]

The Nevada Skies Youth Wellness Center is located on the Pyramid Lake Paiute Reservation in Wadsworth. The center is a 16-bed facility and is a satellite facility of Desert Visions but owned and operated by the IHS. Admission criteria include that clients are male, 12 to 18 years old, eligible for direct services from the IHS, diagnosed primarily of addictive disease to substances, and deemed medically stable.[128]

Ely Health Station is a public rehab located in Ely, Nevada. The center specializes in the treatment of alcoholism, OUD, and SUD. Those enrolled for OUD receive physical, mental, and emotional support. Treatment includes MAT in addition to counseling. Ely Health Station accepts little to no fee for various programs. Located on the Ely Shoshone Reservation, Ely Health Station is affiliated with Newe Medical Clinic and is a part of the Elko Service Unit.[129]

The PAIHS program about alcohol and substance abuse promotes education for the prevention of substance abuse. Intervention in the form of treatment at the appropriate level is a primary focus of PAIHS integrated behavioral health. Aftercare in another key element to the treatment of substance abuse, and the continuum of care includes successful recovery. The PAIHS has a number of behavioral health initiatives: ASAM training, Methamphetamine and Suicide Prevention Initiative, Phoenix Area Integrated Behavioral Health Initiative, Integration of Behavioral Health into the Primary Care Setting, Tele-Behavioral Health, and social services consulting.

Nevada 2-1-1 has partnered with four tribal clinics outside of IHS including Nevada Urban Indians (NUI), Fallon Tribal Health Clinic, Walker River Paiute Tribe Health Clinic, and Las Vegas Paiute Tribe Health and Human Service Outpatient Services.[130]

[126] https://shopaitribes.org/spochf/
[127] https://www.ihs.gov/phoenix/healthcarefacilities/schurz/
[128] https://www.ihs.gov/phoenix/adolescenttreatmentcenters/nevadaskies/
[129] https://www.aaoshawa.org/drug-addiction-rehab-in-NV-Ely-Ely_Health_Station.htm
[130] https://www.nevada211.org/indian-health-service-clinics/

- **Nevada Urban Indians:** In 1975, NUI opened a limited clinic providing medical services to the urban Indian population of Washoe County. The Substance Abuse Program includes assessments, behavioral and mental health services, counseling, case management, and referrals.[131]
- **Fallon Tribal Health Center:** The Fallon Tribal Health Center is a tribally owned and operated clinic on the Fallon Paiute Shoshone Indian Colony. Behavioral health, community health, and substance abuse care are among the services offered.[132]
- **Walker River Paiute Tribe Health Clinic:** The Walker River Paiute Tribe Health Clinic provides ambulatory and community health care along with referrals to specialty care to Indian residents on or around the Walker River Indian Reservation. Services offered include primary care, behavioral health, substance abuse counseling, and pharmacy.[133]
- **Las Vegas Paiute Tribe Health and Human Services:** Operated by the Las Vegas Paiute Tribe, the Las Vegas Paiute Tribe Health and Human Services is a collaboration with the IHS. Services provided include outpatient medical and behavioral health care. Indians in need of assistance for a behavioral or mental illness can receive family counseling, substance abuse counseling, and psychiatry.[134]

DHHS actively participates in the annual Intertribal Council of Nevada (ITCN) conference. ITCN is a tribal organization serving the member reservations and colonies in Nevada. The governing body of ITCN consists of an executive board, composed of tribal chairman from each of the Nevada and Great Basin tribes. The main intent of ITCN is to serve as a large political body to represent the small Nevada tribes. The tribal liaison works directly with State and tribal leaders to address tribal healthcare needs.

[131] https://www.nevadaurbanindians.org/
[132] http://www.fpst.org/departments/fpst-clinic/
[133] https://www.wrpt.org/agai-dicutta-numu/health-clinic/
[134] https://www.lvpaiutetribe.com/hhs

2. Scope and Methodology

2.1. Scope of Assessment

In September 2019, DHHS was awarded an 18-month planning grant. Through the SUPPORT Act planning grant, DHHS aims to increase the capacity of Medicaid providers to provide SUD treatment and recovery services. DHHS' objectives include:

- Increasing the education and delivery program for pregnant women with OUD and NAS.
- Increasing access through expanding eligible providers.
- Connecting with current providers to add SUD or OUD services.
- Developing a comprehensive MAT policy.
- Providing an APM for MAT services.
- Providing services and staff training through Project ECHO® Nevada, a distance learning and peer consultation program for medical professionals through the University of Nevada, Reno (UNR), School of Medicine.

The strategies the State is implementing include ongoing needs assessments; recruitment and training for SUD Medicaid providers; development of a program for pregnant women with OUD; creation of state policies for broader provider coverage and standardization of MAT; and improved reimbursement and payment methodology for SUD treatment and recovery services.

DHCFP, in partnership with Myers and Stauffer, developed this assessment report to present the policy and infrastructure findings regarding provider capacity, benefit design and coverage, prior authorization and utilization management, integrated care delivery, reimbursement opportunities, and fiscal projection. This report is a structured analysis of information, including population health trends and current status of the SUD service system in Nevada, emerging and best practices for SUD treatment and recovery services from other states and national organizations, and opportunities for Nevada to improve health care delivery and health outcomes.

2.2. Assessment Methodology and Approach

Through the analysis of available health data, specifically related to opioid and SUDs, Myers and Stauffer developed a methodology to conduct an assessment of Nevada's strengths and weaknesses in addressing OUD in the state. The findings from this assessment were used to develop a series of recommendations, which are discussed throughout this report.

This assessment utilizes information from various sources, including Nevada stakeholder discussions and communications, as well as data reports, documents, and research. The information from these sources was used to create recommendations within policy and infrastructure areas related to SUD treatment and

recovery services. As a recipient of a SUPPORT Act planning grant, DHCFP is eligible for a 36-month demonstration grant; the report outlines specific recommendations for the State's continuing efforts to develop a SUD services system.

During the creation of this report, Myers and Stauffer conducted a Training Gap Analysis examining existing resources and training evaluations created by partners in the state. The analysis, located in *Appendix D* includes findings from the 2018 Training Needs Assessment, national and state best practices, existing relevant state initiatives, evaluation of available training and education programs, and opportunities. This report contains a findings table with complete information on 2019 CASAT Training schedule and participant evaluations.

2.2.1. Stakeholder Engagement

The institutional knowledge gained from stakeholder experience and expertise was an invaluable resource for this assessment. Nevada DPBH recently completed many SUD-related projects and the results from these engagements allowed for a more streamlined stakeholder process.

To address specific questions for the SUPPORT Act requirements and to fill in gaps of information, both DHCFP and DPBH stakeholders were engaged continuously for the assessment. Stakeholders were engaged through:

- Regular scheduled leadership strategy meetings between DHCFP, DPBH stakeholders, and Myers and Stauffer.
- Ad-hoc meetings with key organizations that support SUD services in Nevada, including Social Entrepreneurs, Inc. (SEI), CASAT, DHCFP, and DPBH.
- Formal group interviews of select stakeholders which included SEI, CASAT, DHCFP, and DPBH. In total, five group interviews were held, each with a focus on a particular topic area, including the following:
    - Provider certifications, administrative barriers, SUD services scope, and provider capacity. Occurred on April 14, 2020 with 13 attendees.
    - Development of prior authorization requirements, administrative barriers, SUD services scope, and provider capacity. Occurred on April 14, 2020 with eight attendees.
    - Provider billing for behavioral health services, SUD, and OUD treatment billing for medical and behavioral health providers. Occurred on April 15, 2020 with 12 attendees.
    - FQHC policy modification to expand integration of behavioral health services into primary care. Occurred April 15, 2020 with seven attendees.
    - Telehealth, delivery of services in rural and frontier Nevada, and Project ECHO®. Occurred April 20, 2020 with three attendees.
    - Hub-and-Spoke. Occurred April 30, 2020 with four attendees.

- Recipient challenges and barriers. Occurred May 4, 2020 with four attendees.

During the creation of this report, Myers and Stauffer conducted a Stakeholder Engagement Gap Analysis examining relevant stakeholder engagement activities from 2015 to current. The analysis, located in *Appendix E* includes a summary of findings table, conclusions, best practices, and opportunities. At the completion of the assessment, DHCFP will continue to engage stakeholders regarding their observations, asking what works or does not work; identified risks; cost drivers; barriers that lead to inefficiency in health care delivery; and which factors lead to poor quality outcomes and higher costs. DHCFP will collaborate with health care providers and systems, the state hospital association, medical associations, SAPTA providers, tribal communities, and community advocacy organizations.

Limitations. An overarching stakeholder engagement limitation was the inability to verify the accuracy of the responses with supporting documentation or data. Based on directives from DHCFP and the general work environment due to the COVID-19 pandemic, stakeholder engagement activities were held virtually rather than in person. The pandemic generated a number of competing projects and extraordinary demands on stakeholders. COVID-19 concerns also limited in-person interactions other than the kick-off meeting for the project. These two factors reduced the planned volume and format of stakeholder engagement. Despite the concerns about COVID-19, adequate information was gathered through intensive virtual communications, including remote interviews, emails, and other sources.

2.2.2. Data Collection and Analysis

Various data collection methods and reports were used to inform this document. Whenever possible, existing data reports from previous projects were utilized; however, there were instances where additional or more recent data was needed. A formal data request process was implemented, in which new data requests were vetted for relevance and need, including whether existing reports provided the information. Myers and Stauffer used this process to request various standard and ad-hoc reports. The information received from these requests was critical in creating an informed assessment. All information collected was indexed and stored within the Nevada Support Act Planning Grant Project Repository and accessible from DHCFP Microsoft Teams' intranet.

Limitations. An overarching limitation of the project was the reduced availability of key stakeholders, because it was necessary for COVID-19 demands to receive priority. This reduced the availability of both the DHCFP and DPBH data teams to complete data requests. This caused the SUPPORT Act project team to be more selective when requesting data and reports. The data teams were successful completing the data requests that were necessary to conduct the assessment.

2.2.3. Document Review

A document review process was established to ensure a complete understanding of the current status of SUD services within the state, the key project activities completed or planned, and the relevant state

regulations and policy. The document review also identified gap areas. Many strategic plans, policy documents, reports, and need assessments were reviewed for this assessment.

Examples of key documents that were reviewed include Nevada Opioid Crisis Needs Assessment (2018); SAPTA Situational Analysis (2017); opioid surveillance data (2010-2018; completed March 2019); Substance Abuse Treatment for Pregnant Women (2017); Clark County Community Health Needs Assessment (May 2019); Substance Use, Mental Health, and Suicide in Nevada 2018 Needs Assessment; Regional Capacity Assessments (2019); and Nevada's Perinatal Health Action Plan for 2019-2020.

In total, more than 600 documents related to Nevada and national SUD treatment and recovery services were reviewed as part of the assessment. Many of these documents had been used to create the planning grant application and have relevance to many aspects of the ongoing project including the assessment. The documents gathered covered many areas such as community preparedness, capacity, statistics, billing, reimbursement, case management, training, action plans, toolkits, barriers, and strategic plans.

2.2.4. Research and CMS Cohorts

Myers and Stauffer began the research process with the SUPPORT Act documents provided with the planning grant. Documents collected from the State, CASAT, and SEI were cataloged into a document repository of more than 600 documents. After receiving initial documents from the state of Nevada, CASAT, and SEI, the Myers and Stauffer team was able to identify topics for which additional information was needed. Subsequently, two formal document requests for additional information from the State were made, and five stakeholder interviews were scheduled and conducted to address the gaps identified.

At the time of the writing of this report, members of the Nevada SUPPORT Act planning grant team attended six calls hosted by CMS for the cohort of SUPPORT Act grantees. The topics discussed on these calls helped with the identification of best practices from a national context and formulation recommendations specifically suited for the state of Nevada. The CMS calls included the following topics:

- Coordinating Benefits with Medicare-Enrolled OTPs (January 31, 2020).
- Addressing Provider Capacity for Delivering SUD Treatment Services in Rural Communities (February 20, 2020).
- Using Data to Increase SUD Medicaid Provider Capacity (February 27, 2020).
- Increasing Medicaid Provider Availability and Use of MAT (March 18, 2020).
- Providers Serving Special Populations: Perinatal Populations and Substance-Exposed Infants (March 26, 2020).
- Addressing Value-Based Payment Elements of Quality Measures and Patient Attribution to Increase Medicaid Provider Capacity in SUD Treatment (April 29, 2020).

CMS cohort meetings will continue throughout the planning grant.

2.2.5. Process for Determining Recommendations

Myers and Stauffer conducted extensive research of other states' approaches and national best practices for SUD and OUD treatment and recovery services, care coordination, reimbursement, provider scopes of practice, and provider willingness. In looking at successful models, Myers and Stauffer was able to identify best practices which informed the recommendations in this document.

In the process of formulating best practices and recommendations, Myers and Stauffer considered the geographic uniqueness of Nevada, with its urban, rural, and frontier settings. Additionally, the statewide inventory of SUD and OUD providers and services was considered in parallel with the need, including subpopulations like pregnant and postpartum women and their infants.

2.2.6. Strategic Planning

After the creation of the Infrastructure Assessment Report, Myers and Stauffer will construct a strategic planning process in preparation for the demonstration grant application. There are three phases of strategic planning:

- **Step 1: Strategic Analysis.**
    a. Define Leadership and Membership.
    b. Examine Opportunities.
    c. Determine Current State.
    d. Assess Stakeholder Needs.
    e. Identify Aspirations and Envision To-Be State.
    f. Agree to Recommendations Process.
    g. Conduct Gap Analysis.
    h. Confirm Planning Process.
- **Step 2: Strategic Development.**
    a. Create the Vision.
    b. Select the Mission.
    c. Develop Values Statement.
    d. Confirm Priorities.
    e. Establish Goals.
    f. Develop Measurable Objectives.

g. Define Actions and Tactics.

h. Agree to Responsible Parties.

i. Create Map to Reasonable Timeline.

j. Generate Logic Model.

- **Step 3: Strategic Plan.**

a. Define Strategy Development Outputs.

b. Generate Plan Implementation Roadmap.

c. Develop Core Indicator Measurements and Monitoring Framework.

Key deliverables from strategic planning will be the gap analysis, mission and vision statement, core values statement, and logic model. Workgroups of diverse stakeholders will be established to confirm and prioritize recommendations. These workgroups will help ensure appropriate timelines are established and requirements are met for the demonstration grant application process.

3. Current Nevada Landscape

3.1. Substance Abuse Care System Capacity

In the past decade, several federal policies have enhanced buprenorphine treatment coverage and addressed provider concerns about reimbursement, care coordination, and peer support at the individual and institutional level. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) required that mental health and SUD care be covered on a par with medical-surgical care. The Affordable Care Act (ACA) extended parity benefit protections to at least 62 million additional people covered by individual, small group, and Medicaid plans. Buprenorphine coverage is now required in all states under Medicaid, Medicare, and the vast majority of private insurers.[135] More recently, two laws — CARA and the 21st Century Cures Act — increased funds for OUD treatment desperately needed in certain states. While many of these funding mechanisms address provider barriers to buprenorphine prescribing, additional funding for MAT is critical. This section evaluates options for policies that improve provider capacity.

While provider capacity is an issue nationwide, Nevada is below the median for SUD and OUD capacity. In many areas, SUD is still considered a separate professional field with limited coursework requirements in medical schools, and schools of psychology or social work. This is in spite of the fact that these professions are often the first point of contact for people with addiction disorders. Even waivered physicians have low prescription rates. Low utilization rates among waivered providers are often attributed to limited bandwidth and infrastructure.[136]

Nationally, surveyed primary care physicians continue to report they are not comfortable with the general idea of prescribing MAT. The need to identify clinicians willing to provide SUD services is a critical step in addressing provider capacity, but those willing to prescribe must also have a solid foundation to continue treatment services. Not only is a mental shift needed, but a structural shift is also needed to support not only addiction specialties and treatment facilities but also primary care physicians, OBGYNs, and mental and behavioral health practitioners. The shift has to particularly include those who work in a private practice setting.

The Calculating for an Adequate System Tool (CAST) was created at SAMHSA and designed to provide risk assessment of county-level social and community determinants of substance abuse that lead to adverse outcomes like hospitalization, as well as an assessment of local service need across the continuum of care. The tool was intended to define demand, need, and current service capacity of a community substance abuse care system. From January to June of 2019, SAPTA, in collaboration with SEI and Nevada's Regional

[135] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[136] Source: M50 Mathematica Policy Research: Examining Substance Use Disorder Treatment Demand and Provider Capacity In a Changing Health Care System; Ellen Bouchery (May 2018).

Behavioral Health Coordinators (RBHCs), conducted a system-wide assessment using the CAST tool. The state of Nevada is divided in five geographical regions: Southern Region, Northern Region, Rural Region, Southern Rural Region, and Washoe Region. All but one of Nevada's regions, with the exception of the Northern Region, are equal to or above the national median for being at risk for substance misuse-related hospitalizations. Accounting for polysubstance misuse, the number of individuals within the state that need, but do not receive, treatment for substance abuse disorders is estimated to be approximately 400,000. It was determined that Nevada's most pressing need is to increase the number of treatment services available to residents across the state.[137] The CAST tool utilizes SDOH, population and demographic data, and community resources available to estimate hospital risk score, regional usage rates of commonly-misused substances, and a community capacity. Hospital risk scores indicate the likelihood that the regions hospitalization rate for SUDs will be above the national median hospitalization rate for SUDs. Regional usage rates of commonly-misused substances are the numbers of individuals within the region that will misuse substances within a given year. Community capacity calculator ranks the region's capacity to address and combat substance misuse via Promotion, Referral, Treatment, and Recovery activities and resources.[138]

The provided results included providers that offer daily OTPs, and are broken down into five categories: promotion, prevention, referral, treatment, and recovery.[139] There are significant unmet needs as outlined below:

- Promotion: 40 percent unmet need, insufficient capacity across all five regions.
- Prevention: 84 percent unmet need, insufficient capacity across all five regions.
- Referral: 33 percent unmet need, insufficient capacity across all five regions.
- Treatment: 70 percent unmet need, insufficient capacity across all five regions.
- Recovery: 63 percent unmet need, insufficient capacity across all five regions.

The five CAST assessment categories encompass 29 components of a behavioral health care system. A description of each assessment category is outlined below:[140]

- Behavioral health **promotion** efforts are intended to raise awareness about specific substance use concerns, provide universal outreach to the community, and facilitate the intentional coordination of population health promotion efforts by community coalitions.

[137] SAPTA Regional Capacity Assessment, K. Marschall and C. Duarte, SEI.
[138] Nevada Substance Abuse Prevention and Treatment Agency, Capacity Assessment Report Nevada, July 2019.
[139] Capacity Assessment Report: Nevada Executive Summary 7/15/2019.
[140] Nevada Substance Abuse Prevention and Treatment Agency, Capacity Assessment Report Nevada, July 2019.

- **Prevention** programs are early intervention strategies intended to reduce the impact of SUDs. Prevention programs are organized around the three population-defining strategies of universal, selective, and indicated programs.
- The **referral** system as defined in CAST is one that links individuals to treatment, be it voluntary or involuntary.
- **Treatment** service types vary widely, and CAST does not offer tools for assessing the quality of care provided within a community. The use of CAST is intended to provide insight about the amount of treatment access and type of treatment access that members of the community are being offered.
- Knowing the nature of a community's **recovery** support network can help to understand how and if resources may need to be allocated to support those in recovery, thereby reducing risk of relapse.

The results of the community capacity calculator, as shown in Figure 22, uses algorithms to estimate need for core components of the SUD prevention and treatment continuum in a region. The resulting numbers from the calculator indicate Estimated Need, which is the difference between the observed and adjusted community need. Estimated Need was a result of a formula considering maximum community need (combines community characteristics, the frequency for which this resource is needed, and the number of individuals that can be serviced by provider), a program usage rate (the estimated percentage of individuals expected to utilize the resource), adjusted community need (estimated need based on max community need and program usage rate), and observed community totals (number of resources of this type available within the given region). [141]

Components outlined in this section using results from the CAST tool (Figure 22) inform recommendations throughout this report. Negative numbers, demonstrated within a red box, denotes that the region does not have sufficient capacity for that component. Positive numbers, demonstrated within a green box, denotes that the region has sufficient capacity for that component. Values of "0" in green communicate a value between .001 and .990, therefore indicating that the region exceeds the need for that component only marginally. Values of "0" in red communicate a value between -.001 and -.990, therefore indicating that the region fails to meet the need for that component but only marginally.[142]

[141] Capacity Assessment Report: Nevada Executive Summary 7/15/2019.
[142] Nevada Substance Abuse Prevention and Treatment Agency, Capacity Assessment Report Nevada, July 2019.

Figure 22. Nevada CAST Results (2019)

Numbers provided in this chart represent units of service for each component. Note that service units vary for each component. For more information, see the *Capacity Assessment Report: Nevada*.

		Clark County Southern Region	Northern Region	Rural Region	Southern Rural Region	Washoe Region
Promotion	Marketing Ads	-380	-946	+159	+311	+1,856
	Media Advocacy Events	-43	-21	-2	+30	+23
	Community Coalitions	-1	+4	+4	+2	+2
Prevention	School-Based Prevention Programs	-364	-26	-13	+10	-60
	Community-Based Prevention Programs	-460	-43	-16	-4	-95
	Housing Vouchers for Low-Income Residents	-4,710	-487	-256	-142	-1,015
	Needle Exchange	-2	-22	-1	-5	-1
	Prescription Drug Disposal Locations	-20	+1	+7	+6	-4
Referral	Adult Specialty Courts	+11	+20	+3	+2	+10
	Youth Specialty Courts	-2	+2	+4	0	+1
	Social Workers	+114	-94	-70	-13	+69
Inpatient Treatment	Detoxification	+2	+2	+1	0	0
	24-hour/Intensive Day Treatment	+7	+2	0	+3	+9
	Short-Term (30 days or fewer)	-13	-4	-2	-1	-21
	Long-Term (more than 30 days)	-7	-3	-1	-1	-19
Outpatient Treatment	Detoxification	+4	0	0	0	+1
	Counselors	+60	-22	-10	+25	+107
	Psychiatrists	-180	-34	-18	-8	-39
	Psychologists	-26	-3	-3	-1	-3
	Opioid Treatment Program (OTP)	-10	-3	-2	-1	-3
	Office Based Opiate Substitution (OBOT)	-98	-37	-18	-12	-23
Recovery	Religious or Spiritual Advisors	-669	-59	-31	-12	-140
	12-Step Groups	+245	+16	0	+13	+243
	Transportation for Those Receiving Treatment	-125	+4,732	-2,795	+527	+6,327
	Employment Support for Those Receiving Treatment	-58	-10	-4	-1	+4
	Educational Support	-34	-4	0	+1	+2
	Parenting Education	-58	-10	+49	-12	+40
	Housing Assistance	-19	-16	0	-4	+7
	Insurance Assistance	-223	-15	-14	0	-9

Source: Nevada Capacity Assessment Executive Summary, July 15, 2019.

The state's demographics include urban, rural, frontier, and tribal communities. Clark County, the largest urban area in Nevada and the 15th most populous county in the country, accounts for 72 percent of the state's population with just over two million citizens. Washoe County is the next most populous county in Nevada, with approximately 434,000 residents. The remaining 400,000 residents live in the 14 rural and frontier counties.[143]

- Southern Region consists of Clark County. This is the state's most populous region as it encompasses Las Vegas.[144]
- Northern Region includes Storey, Carson City, Douglas, Lyon, Mineral, and Churchill counties. It is sparsely populated and includes the capital city of Carson City.[145]

[143] Nevada Health IT Roadmap, 2020-2024.
[144] SAPTA Regional Capacity Assessment Report: Clark County Southern, 2019.
[145] SAPTA Regional Capacity Assessment Report: Northern Region, 2019.

- Rural Region encompasses Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pines counties. This includes rural and frontier lands with several reservations.[146]
- Southern Rural Region includes Esmeralda and Nye counties. This includes rural and frontier lands.[147]
- Washoe Region consists of Washoe County. This is the state's second most populous county, as it encompasses Reno.[148]

Out of the 16 counties in Nevada, 11 are designated as health professional shortage areas (HPSAs), defined as having a population density of less than six persons per square mile with a travel time of more than 30 minutes to access a health professional. According to recent data from the Health Resources and Services Administration (HRSA), in a report from the University of Nevada, more than 960,000 Nevadans live in a primary care HPSA at 34 percent including 816,000 urban residents which accounts for 32 percent of the population and 613,000 residing in Clark County.[149] Since 2017, the number of primary care physicians per 100,000 people has decreased three percent (percent change over time, controlling for population change) from 107.9 to 107.6, which continues a steady downward trend from recent years.[150] This is a much greater issue in rural areas. Almost half, or 143,000 residents, live in primary care HPSA, and nine rural and frontier counties are designated as a primary care HPSA.[151] These trends in HPSAs are an even greater issue among mental health professionals. Currently 1.5 million Nevadans live in a mental health professional shortage area, which is 53.3 percent of the population.[152] That includes 100 percent of rural residents with little to no access to mental health care services, and 48 percent of urban residents. However, since 2017, the number of mental health providers increased 6 percent, from 190.7 to 202.9 per 100,000 residents.[153]

Despite significant decreases in Nevada's uninsured population in recent years, approximately 400,000 people have no health insurance. Nevada has the sixth highest uninsured rate in the nation and the second highest uninsured rate among Medicaid expansion states. Clark County residents represent 77.2 percent of the uninsured population, translating to 307,434 people or 14.7 percent of the County's population. Nevada's uninsured populations may be categorized as follows: 225,000 people are eligible but

[146] SAPTA Regional Capacity Assessment Report: Rural Region, 2019.
[147] SAPTA Regional Capacity Assessment Report: Southern Region, 2019.
[148] SAPTA Regional Capacity Assessment Report: Washoe County, 2019.
[149] John Packham, Ph.D. "Health Workforce in Nevada. Supply and Demand Update," UNR School of Medicine. July 25, 2016.
[150] Ibid.
[151] Ibid.
[152] Ibid.
[153] Nevada Health IT Roadmap, 2020-2024.

unenrolled, 109,000 people are ineligible due to immigration status, and 69,000 state citizens are uninsured due to affordability challenges in the marketplace.[154]

Myers and Stauffer received MCO data from the Network Adequacy Quarterly Report in October 2019. Currently, Medicaid managed care is operating only in urban Clark and Washoe counties, and includes Anthem Blue Cross Blue Shield Nevada, Health Plan of Nevada (HPN), and SilverSummit HealthPlan. The report detailed Primary Care Practitioner (PCP)-to-recipient ratios which were determined by the following rules: vendor must have at least one full-time equivalent (FTE) for primary care provider, considering all lines of business for that provider, for every 1,500 recipients per service area. However, if the PCP practices in conjunction with a health care professional, the ratio is increased to one FTE PCP for every 1,800 recipients per service area. It is important to note that the data below does not show the entire picture, just the MCO landscape (Table 11, Table 12, and Table 13).[155]

Table 11. HPN MCO Provider-to-Participant Ratios

County	No. of PCPs	No. of Enrollees	PCPs per 1,500 Enrollees
Clark	247	210,323	1.76
Washoe	95	28,567	4.99
Statewide	342	238,890	2.15

Source: HPN Network Adequacy Report 2nd Quarter 2020.

Table 12. Anthem Blue Cross Blue Shield Nevada MCO Provider-to-Participant Ratios

County	No. of PCPs	No. of Enrollees	PCPs per 1,500 Enrollees
Clark	632	180,947	5.24
Washoe	241	25,702	14.07
Statewide	873	206,649	6.34

Source: ANT Network Adequacy Report February 14, 2020.

Table 13. SilverSummit HealthPlan Nevada MCO Provider-to-Participant Ratios

County	No. of PCPs	No. of Enrollees	PCPs per 1,500 Enrollees
Clark	736	45,797	24.11
Washoe	191	6,382	44.89
Statewide	927	52,179	26.65

Source: SSH Network Adequacy Report February 14, 2020.

[154] *Nevada's Uninsured Population*, The Guinn Center, 2019.
[155] HPN_402_Network Adequacy_2nd Quarter_2020.

Both the shortage of health care professionals statewide, and in rural and frontier areas, have made access to primary care, specialists, and behavioral health significantly more difficult. Rural communities across the country have higher rates of alcohol use among youth, higher rates of opioid prescribing, and higher rates of prescription opioid-related overdose deaths. Compared with urban areas, rates of substance use during pregnancy, including prescription opioid use, are frequently higher in rural areas. Populations of Native Americans aged 12 years and older have disproportionately high rates of alcohol use disorders and illicit drug use, and those 18 years and older have a disproportionately high incidence of serious mental illness. In rural communities nationally, there is a longstanding shortage of mental and behavioral health providers, as well as SUD treatment providers, and severely limited specialty services for detoxification.[156]

CAST Tool Conclusions About System Adequacy. Following a facilitated review and discussion of each region's CAST results, including an analysis of the region's social characteristics, risk score, and unmet need analysis in the context of planning efforts already underway, up to five priorities were identified for each region by their respective RBHCs in consultation with the region's Behavioral Health Policy Board and stakeholders. The most frequently identified needs and priorities for action across all regions fall into the treatment category.[157] Treatment needs and other needs identified as opportunities are included in the following:

- **Expansion of Treatments**
  - Increase availability of short and long-term residential inpatient treatment. Priority for Southern Region, Northern Region, and Washoe Region.
  - Increase number of psychiatrists and psychologists listed as specializing in substance abuse and addiction issues. Priority for Southern Region, Northern Region, and Washoe Region.
  - Increase outpatient treatment by leveraging technology and offering more options for treating COD. Priority for Rural Region.
  - Increase availability of crisis stabilization and outpatient detoxification services. Priority for Washoe Region.
- **Expansion of Prevention Services**
  - Increase the number of beds and affordable housing units available via housing vouchers. Priority for Southern Region, Northern Region, and Washoe Region.
  - Expand prescription drug disposal locations and initiate events in communities that do not have them. Priority for Southern Rural Region.
  - Increase prevention programming in schools. Priority for Washoe Region.

[156] SUPPORT Act Section 1003 Planning Grant: Addressing Provider Capacity for Delivering Substance Use Disorder Treatment.
[157] Documents 020, 024, 025, 031, 036 – Nevada Capacity Assessments.

- **Promotion of Advocacy**
  - Increase advocacy events to promote substance misuse education. Priority for Southern Rural Region.
  - Increase marketing advertisements placed across all media. Priority for Rural Region.
- **Recovery Assistance**
  - Increase the availability of transportation vouchers and services for people seeking treatment. Priority for Rural Region and Southern Rural Region.
  - Increase the number of housing assistance supports available. Priority for Rural Region.
- **Referral Programs**
  - Increase the number of case managers available to assist with care coordination. Priority for Washoe Region.
- **Training and Awareness Campaigns**
  - Increase mental health training for law enforcement, in conjunction with administering naloxone. Priority for Southern Rural Region.

Provider Capacity Survey Results. In 2019, DHCFP held two listening sessions focused on engaging providers on MAT Policy. Providers and prescribers represented both large health systems and small clinics, behavioral health institutions, women's health centers, SUD treatment facilities, and pharmacies. When SUD service providers in Nevada were surveyed by the state, the most commonly cited barrier for waivered providers was reimbursement. Maintaining 30 active patients at one time per licensed provider is cited as an impossibility among rural and frontier doctors. Providers stated that they wish to see FQHCs involved in MAT, as well as family counseling and social work interns, and emergency medicine visits.[158, 159]

3.2. Eligible Provider Baseline Data

Nearly one in every eight adults enrolled in Medicaid has a SUD, and a significant barrier to treatment is a shortage of SUD professionals in every state.[160] As of February 2020, Nevada had 34,554 Medicaid-enrolled providers in more than 50 specialty fields. Table 14 below, portrays the number of Medicaid-enrolled providers per relevant specialty; general care, maternal health, addiction, APRNs, PAs, licensed clinical social workers (LCSWs), and community health. Table 14 below, displays providers who have

[158] NV Division of Health Care Financing and Policy, Medicaid MAT Policy and Financing Listening Session Meeting Summary 9/17/2019.
[159] NV Division of Health Care Financing and Policy, Medicaid MAT Policy and Financing Listening Session Meeting Summary 10/15/2019.
[160] National Academy for State Health Policy; 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce (Nov. 2019) https://nashp.org/50-state-scan-how-medicaid-agencies-leverage-their-non-licensed-substance-use-disorder-workforce/#toggle-id-6.

enrolled and are billing for Medicaid, but does not include providers who have enrolled and are not currently billing. It is important to note this table is not limited to MAT waivered providers, but encompasses a full picture of provider population that depicts a broader provider willingness.[161]

Table 14. February 2020 Nevada's Medicaid-Enrolled Providers (Select Specialties)

Provider Type	No. of Medicaid Enrolled Providers as of 2/2020
General Care Providers (Includes Family Practitioners, General Practice, and Internal Medicine)	3,141
Women's Health (Includes OBGYN, Gynecology, and Maternal and Fetal Medicine)	566
Emergency Medicine	1,150
Methadone	6
Qualified Mental Health Professional (QMHP)	1,299
Psychologist	78
Rural Health Clinics	17
FQHCs	48
Community Health Clinics	25
SAAM	68
APRNs	414
Nurse Midwife	61
PA	1,507
CCBHCs	8
Licensed Clinical Social Worker	347

Source: February 2020 Provider Enrollment Dashboard Intranet.

[161] Table Source: February 2020 Provider Enrollment Dashboard Intranet.

3.3. MAT Services in Nevada

Nationally, the current number of MAT-waivered physicians is not sufficient to ensure access to buprenorphine treatment for all individuals with OUD, even if every waivered physician were prescribing at the maximum of their waivers. Many providers claim that they face difficulties if they are the only MAT-waivered clinician in the practice and they are left to figure out how to manage drug testing, relationships with pharmacies, and prior authorizations.[162] This concern poses a potential problem and obstacles to many physicians that might be interested in attaining waivers. A fundamental issue was the lack of a state policy for MAT services for individuals on Medicaid.

This gap identified in the Nevada OUD treatment system was remedied in June 2020, when the DHCFP proposed a new MSM chapter addressing MAT for individuals that have been diagnosed with an OUD. The MAT policy will include the process of treatment to outline expectations, the use of the buprenorphine medication, and qualifications of providers. According to state policy outlined in the MSM, MAT is the use of medications, in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of SUDs. Buprenorphine is an opioid partial agonist/antagonist that is FDA approved for the treatment of opioid dependence by physicians in an office-based setting. Medication of choice is buprenorphine/naloxone for non-pregnant recipients and buprenorphine single ingredient for pregnant recipients.[163]

Nevada providers were polled by DHHS in September 2019 to further identify barriers and obstacles to the provision of MAT services. The respondents reported that they felt providers were not readily accessible to patients or that they did not know the proper behavioral health resources needed to perform multi-disciplinary treatment planning and care. Provider feedback included how MAT services were approached, which typically included designating one day for MAT services and on these days the provider would interact with as many patients as possible. If a patient meets criteria for OUD, they are first offered information on MAT. If they choose to follow up, they will begin a treatment plan that includes MAT and referred out for additional treatment needs. If the patient follows up with a provider that does not offer MAT, they are then referred to a MAT-waivered individual.[164]

In Nevada, MAT is offered to patients who have a current diagnosis of OUD as defined by either the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the current edition of the International Classification of Diseases, and who meet predetermined criteria. Providers' choice of

[162] Article: Why Do So Few Doctors Have Buprenorphine Waivers? MedPage Today, Judy George; February 2018. https://www.medpagetoday.com/psychiatry/addictions/71169.
[163] MSM Chapter 1200 and 3800
[164] NV Division of Health Care Financing and Policy, Medicaid MAT Policy and Financing Listening Session, Meeting Summary 09/17/2019.

medication is buprenorphine and naloxone combined for non-pregnant patients, and buprenorphine single ingredient for pregnant patients.

State guidelines suggest MAT be managed as an elective treatment and include signed, informed consent. The purpose of MAT policy is to establish minimum requirements for authorized OBOT providers to prescribe and, in limited circumstances, dispense buprenorphine to individuals requiring and seeking treatment for opioid addiction.[165] According to current draft MAT policy in Nevada, requirements for eligible providers to prescribe buprenorphine as treatment for opioid dependence include the following:

- Buprenorphine prescribers must have a DATA 2000 waiver from SAMHSA.
- Current qualifying practitioners include physicians, nurse practitioners (NPs), PAs, clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs).
- Providers also have patient limits, including the following:
    - During the first year prescribing buprenorphine, an eligible provider may maintain a patient load of 30 or fewer individuals receiving MAT at any point in time.
    - After one year of prescribing to 30 or fewer patients, an eligible provider may apply for a waiver from SAMHSA to treat a maximum of 100 patients.
    - After one year of prescribing under a waiver to treat a maximum of 100 patients, a provider may apply for an additional SAMHSA waiver to treat up to 275 patients. The provider must reapply every three years.

Currently, the MAT policy in Nevada is in draft form. During the public hearing scheduled for June 23, 2020, revisions to MSM Chapter 3800 will be proposed to outline MAT for individuals that have been diagnosed with OUD. This policy encompasses the qualifications of eligible providers, use of the buprenorphine medication, the process of treatment to outline expectations, and the phases of care throughout the MAT process.

[165] MAT Policy Criteria DHHS.

4. Nevada Substance Abuse Health Care System

4.1. SUD and OUD Service Delivery Challenges and Limitations

A review of Nevada needs assessments conducted by local and state-level organizations, identified the following gaps and challenges.

4.1.1. Workforce Development and Retention Barriers

A consistent barrier to realizing a fully-integrated health care system is a shortage of both primary care providers and mental health providers. In the 2019 Nevada State Health Needs Assessment, every county reported a limit of services or providers as a leading barrier to improving the health of its residents. All counties were designated by HRSA as having at least one HPSAs. (Table 15)

Table 15. 2019 Population Residing in Health Professional Shortage Areas

County/Region	Primary Care HPSAs		Mental Health HPSAs	
	Number	Percent of Population	Number	Percent of Population
Rural and Frontier				
Churchill County	25,844	100.0%	25,844	100.0%
Douglas County	32,012	65.4%	48,973	100.0%
Elko County	21,874	39.9%	54,890	100.0%
Esmerelda County	957	100.0%	957	100.0%
Eureka County	1,873	100.0%	1,873	100.0%
Humboldt County	13,415	79.3%	16,906	100.0%
Lander County	6,194	100.0%	6,194	100.0%
Lincoln County	4,935	100.0%	4,935	100.0%
Lyon County	55,124	100.0%	55,124	100.0%
Mineral County	4,466	100.0%	4,466	100.0%
Nye County	46,337	100.0%	46,337	100.0%
Pershing County	6,639	100.0%	6,639	100.0%
Storey County	4,206	100.0%	4,206	100.0%
White Pine County	10,200	100.0%	10,200	100.0%
Region Subtotal	**234,076**	**100.0%**	**234,076**	**100.0%**
Urban				
Carson City	52,063	93.2%	55,885	100.0%
Clark County	1,408,516	63.7%	2,210,674	100.0%
Washoe County	331,526	72.3%	287,547	62.9%
Region Subtotal	**1,792,830**	**65.8%**	**2,554,896**	**93.7%**
Nevada Total	**2,026,181**	**67.3%**	**2,842,440**	**94.3%**

Source: 2019 Nevada State Health Needs Assessment.

Health care workforce shortages are being felt across the nation and are typically felt the hardest in rural areas and in specific fields, such as behavioral health, oral health, and primary care.[166] Maintaining and developing the health care workforce is necessary in order to provide comprehensive and quality care to all Nevada residents. Targeting workforce development barriers must be a priority in order to improve both the quality of and access to health care services.[167]

4.1.1.1. Workforce Training

In addition to being sufficiently sized, the workforce must also be properly trained to effectively deliver integrated care. The educational curriculum of the current health care workforce largely did not include the skills unique to integrated care delivery. This presents a significant barrier as providers must understand the new paradigms for interaction with their patients and with clinical teams.[168] Orientation and training programs help providers understand their specific roles, as well as the roles of their teammates.[169] SAMHSA and HRSA developed nine core competencies to establish a foundation for the development of an integrated care workforce:

1. **Interpersonal Communication.** The ability to establish rapport quickly and to communicate effectively with consumers of health care, their family members, and other providers.
2. **Collaboration and Teamwork.** The ability to function effectively as a member of an inter-professional team that includes behavioral health and primary care providers, consumers, and family members.
3. **Screening and Assessment.** The ability to conduct brief, evidence-based and developmentally-appropriate screening, and to conduct or arrange for more detailed assessments when indicated.
4. **Care Planning and Care Coordination.** The ability to create and implement integrated care plans, ensure access to an array of linked services, and the exchange of information among consumers, family members, and providers.
5. **Intervention.** The ability to provide a range of brief, focused prevention, treatment, and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.
6. **Cultural Competence and Adaptation.** The ability to provide services that are relevant to the culture of the consumer and their family.

[166] https://nashp.org/states-agencies-partner-to-address-health care-workforce-shortages/.
[167] https://bhw.hrsa.gov/shortage-designation/application-review-process.
[168] Advancing Integrated Care through Psychiatric Workforce Development: A Systematic Review of Educational Interventions to Train Psychiatrists in Integrated Care, 2018.
[169] http://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA2P3_Team-based-Care-Case-Studies_Full-Report.pdf.

7. **Systems-Oriented Practice.** The ability to function effectively within the organizational and financial structures of the local system of health care.
8. **Practice-Based Learning and Quality Improvement.** The ability to assess and continually improve the services delivered as an individual provider and as an inter-professional team.
9. **Informatics.** The ability to use information technology to support and improve integrated health care.[170]

UNR has supported the development and facilitation of workshops tailored to the implementation of integrated care. In 2014, the UNR School of Social Work applied and received an HRSA grant, Behavioral Health Workforce Education and Training for Professionals and Paraprofessionals. The purpose of this grant was to educate and train professionals to address the behavioral health needs of children, adolescents, and transition-age youth and their families. The grant provided a $10,000 stipend to all participants that completed a field placement and attended 10 three-hour workshops hosted by the UNR. The workshop series was designed to reflect the multidimensional aspects of engagement, assessment, intervention, and evaluation. The key elements incorporated into the workshops included neuroscience, socioeconomics, drug and alcohol abuse, bullying, trauma and grief, and evidence-based practice models. The series demonstrated to trainees how to engage in the delivery of integrated care. Program exit surveys revealed that a majority of participants were committed to working in the behavioral health field with the target population.[171] However, in order to effectively implement integrated care, provider training will need to address strategies and tactics to integrate care. In addition, such training is only available to new and incoming workforce rather than being available to all applicable practitioners.

In 2019, Sara Hunt PhD, Assistant Dean of Behavioral Health Sciences at the University of Nevada, Las Vegas School of Medicine, submitted a proposal to the Health Sciences System Committee. The proposal called for Nevada to create a Mental Health Workforce Education and Development Network and was based on the Behavioral Health Education Center of Nebraska (BHECN) model. She proposed creating a statewide network of partners dedicated to increasing the number of health professionals. Broadly defined, the network would be constructed with various entry points into the Nevada System of Higher Education (NSHE). These entry points would be accessible to Nevada residents who are interested in mental health careers and need corresponding education. Pathways to education and employment in Nevada would be created to guide students and trainees through the needed steps based on their entry point. Regularly-scheduled regional and statewide workshops and conferences would provide training and promote collaboration between trainees and established professionals, who would serve as mentors.[172]

[170] https://www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf.
[171] Integrated care workforce development: university-community collaboration, 2020.
[172] https://nshe.nevada.edu/wp-content/uploads/file/BoardOfRegents/Agendas/2019/12-dec-mtgs/hss-refs/HSS-6b.pdf.

Most states offer pipeline programs through Area Health Education Centers (AHECs) or similar organizations. Nevada has three AHECs: Desert Meadows AHEC serving Las Vegas and Southern Nevada, High Sierra AHEC serving Reno and Northern Nevada, and Frontier AHEC serving rural Nevada. The centers provide continuing education classes, TA, student programs, and distance linkages to enhance practice opportunities for health practitioners.[173] The Nevada AHEC Scholars Program is also available for undergraduate and graduate-level health profession students interested in rural or underserved urban health care. The scholars participate in clinical and non-clinical, didactic, and community-based projects with a focus on leadership development.[174] Additionally, every other year, the Nevada Health Workforce Research Center at the UNR School of Medicine and the Nevada AHECs team up to publish a manual containing detailed information on the health occupations available in Nevada. This manual is targeted to middle and high school students interested in exploring a career in health care.[175]

At the state level, the Nevada State Office of Rural Health at the UNR School of Medicine operates the NHSC. Established in 1989 by the Nevada State Legislature, it was created to designate areas of underservice within the state and match practitioners to those areas of need. Rural communities in Nevada are particularly lacking in health resources and support. Awardees are eligible to receive up to $25,000 each year for two years in tax-free loan repayment funding.[176]

Additionally, Nevada currently has the infrastructure in place to support the development and administration of large-scale training, such as Project ECHO®, (Extension for Community Healthcare Outcomes) a learning and mentoring system of medical education and care management.[177] The UNR is home to Project ECHO® Nevada, supported by the School of Medicine, as well as CASAT, supported by the School of Community Health Services. Project ECHO® Nevada is a telementoring program focused on expanding the capacity of health professionals to effectively treat chronic and complex health conditions in rural and underserved populations throughout Nevada. Project ECHO® hosts a variety of clinics covering such topics as complex pediatrics and MAT.[178] CASAT's primary focus is improvement of prevention and treatment for individuals with addictive behaviors through helping states, organizations, students, and the existing workforce to apply research-based practices. CASAT hosts in-person workshops, online videos, webinars, and self-paced trainings. CASAT also assists in designing and implementing programs and evaluations.[179] Either or both of these programs may have the capacity to undertake statewide training that could support integrated health care.

[173] https://med.unr.edu/statewide/ahec.
[174] https://comagine.org/program/ahec.
[175] UNR. (2020). 2020-2021 Health Care Careers Manual.
[176] https://med.unr.edu/rural-health/health-service.
[177] https://echo.unm.edu/about-echo/ Accessed May 19, 2020.
[178] https://med.unr.edu/echo.
[179] https://casat.org/about-us/.

4.1.2. Existing Challenges with MAT Services

Less than 40 percent of those with OUD receive evidence-based treatment. Buprenorphine, used as part of MAT, has potential to address this gap in care because of its approval for use in non-specialty outpatient settings, effectiveness at promoting abstinence, and cost effectiveness. However, less than four percent of licensed physicians nationally are approved to prescribe buprenorphine for OUD, and approximately 47 percent of counties do not have a buprenorphine-waivered physician. It is important to understand the national context of SUD and provider capacity as many states are experiencing the same dilemma as Nevada. Across the country, providers are reticent to prescribe buprenorphine because of regulatory hurdles to obtain the waiver needed to prescribe buprenorphine in non-addiction specialty treatment settings.[180, 181]

Of the 16 counties in Nevada, only 13 have a registered DATA 2000 Waivered provider. Of those 13, only three have more than 10 providers: Carson City, Clark, and Washoe counties. These counties are also the only counties categorized as "urban" in the Nevada Rural and Frontier Health Data Book — Ninth Edition.[182] Additionally, when dividing the state into the five Regional Behavioral Health Policy Boards, Clark and Washoe Counties were designated with their own boards.[183] This demonstrates the significant variances that exist in terms of population and capacity within the state. (Table 16 below).

[180]Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[181] *Draft* Introduction to MAT Policy.
[182] Nevada Rural and Frontier Health Data Book — Ninth Edition, 2019. UNR.
[183] http://dpbh.nv.gov/Boards/RBHPB/Board_Meetings/Meetings/.

Figure 23. DATA 2000 Waivered Providers by County

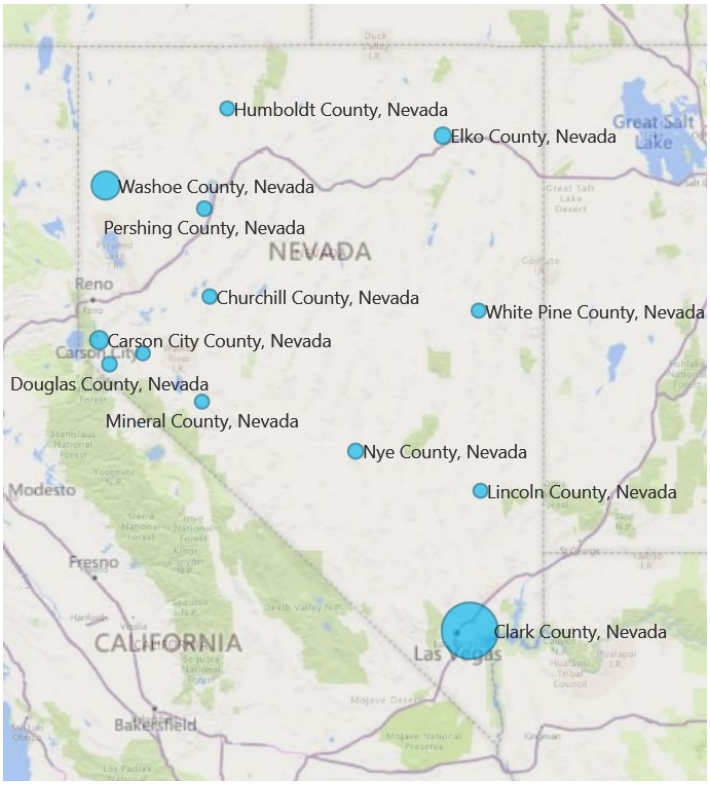


Table 16. DATA 2000 Waivered Providers by County

County, State	Count
Carson City County, Nevada	14
Churchill County, Nevada	2
Clark County, Nevada	281
Douglas County, Nevada	3
Elko County, Nevada	8
Humboldt County, Nevada	1
Lincoln County, Nevada	1
Lyon County, Nevada	1
Mineral County, Nevada	1
Nye County, Nevada	4
Pershing County, Nevada	3
Washoe County, Nevada	57
White Pine County, Nevada	1

The substance abuse treatment field faces many human resource management challenges due to the fact that clinicians have high caseloads, low pay, and often face both resistance to treatment and relapse among their clients. Due to these factors, turnover rate among clinicians is high, nationally estimated between 16 percent and 50 percent annually. The substance abuse treatment workforce is also unique, since an estimated 37 percent to 57 percent of clinicians nationally are in recovery from substance abuse themselves. It is important to note that, as a profession, doctors and nurses suffer the highest rates of addiction. Addressing the issues existing SUD providers face, including stigma, and improving education and training are great starting points for increasing provider willingness.[184, 185]

4.1.3. Nevada Provider Administrative Requirements

Nevada has a number of administrative challenges related to expanding services for individuals with SUD; specifically, certification issues, scopes of practice limitations among health care providers, and enrollment administrative burden and complexity.

4.1.3.1. Provider Certification

Currently, providers must apply for a federal Drug Enforcement Administration (DEA) waiver submitted through SAMHSA in order to dispense narcotics for detoxification or treatment. A minimum of eight hours of training is required. After receiving the waiver, providers are restricted to concurrently treating up to 30 patients with OUD. Many providers consider the legislative requirements to be a burden and have difficulty maintaining the record-keeping requirements.[186] When polled nationally, providers complain that regulatory agencies impede, rather than facilitate, prescribing.[187] Issues may be addressed by reducing the length of training, eliminating waiver fees, funding mentoring programs, partnering with hospitals and medical societies, and reviewing federal regulations stipulating provider limits on the number of patients who are eligible to receive buprenorphine.[188, 189]

As noted earlier, buprenorphine prescribers must have a Drug Addiction Treatment Act of 2000 waiver from SAMHSA. The waiver applies only to qualifying practitioners and requires initial training. This federal requirement is unlikely to change in the near future.

[184] Manuscript: Recovery at Work: The Relationship Between Social Identity and Commitment Among Substance Abuse Counselors. Sara L. Curtis MS, M.MFT. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2937091/.
[185] AddictionCenter: Addiction In Medical Professionals https://www.addictioncenter.com/addiction/medical-professionals/.
[186] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[187] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[188] Meeting Report; Closing the Gaps in Opioid Use Disorder Research, Policy, and Practice: Conference Proceedings (Addiction Science & Clinical Practice 2018); Matthew A Miclette, Jared A Leff.
[189] https://aspe.hhs.gov/basic-report/state-and-local-policy-levers-increasing-treatment-and-recovery-capacity-address-opioid-epidemic-final-report.

In addition, if a DATA 2000-waivered provider wants to receive funds for community-based treatment services through federal block grant funding administered by the state, there is a separate certification requirement. SAPTA certification is guided by Nevada Revised Statutes (NRS) 458.025, which requires that any alcohol and drug abuse program which receives state or federal funds through SAPTA must be certified by SAPTA.[190] SAPTA certifies community programs crucial to building a continuum of care, based on the types of services they provide, and whether they are for adolescents or adults. The SAPTA certification regulations and grant applications are complex. Direct services covered under the SAPTA grant funding include treatment, recovery, and support for people without insurance coverage, underinsured individuals, and low-income individuals who are in a target population for Nevada (pregnant women or women with children, youth, and adults with co-occurring disorder, intravenous drug users, and individuals in the criminal justice system.)[191]

4.1.3.2. Scope of Practice

The NRS set out laws defining the scope of practice, licensing requirements, specific education and demonstrated competency, and governing licensing bodies for a range of health professionals. The Nevada Administrative Code (NAC) further defines regulations for scope of practice, describing the procedures and services health care practitioners are authorized to provide.

The scopes of practice for physical health providers do not explicitly call out behavioral health services. Broadening the scope of practice policies will allow the state to update edits in the Medicaid Management Information System (MMIS) to permit billing for behavioral health services. The scopes of practice for two physical health providers described below confirms the absence of behavioral health services for reimbursement.

Advanced Practice Registered Nurses. The demands of the shortage of primary care physicians and the aging population make NPs (also called APRNs) especially important. The supply of primary care NPs is projected to increase by 30 percent, from 55,400 in 2010 to 72,100 in 2020. Approximately half of NPs practice in primary care. Assuming that NPs and PAs provide the same proportion of services in 2020 that they did in 2010, the combined demand for NPs and PAs would increase by only 17 percent; however, if NPs and PAs are used to provide more primary care services, their projected demand will be higher.

Advanced Practice Registered Nurses Scope of Practice. APRNs are critical to caring for our vulnerable populations, with the majority of NPs accepting Medicaid and uninsured patients. They are also more

[191] http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/dta/Grants/SAPTA%20NOFO%202020-2021%20-%20Release%2005142020%20ADA%20Compliant.pdf.

likely than other providers of primary care to practice in rural communities. This highlights the importance of the scope of practice.

An HHS report found that APRNs' scopes of practice vary widely "for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work." Federal agencies made recommendations that states should consider changes to their scope-of-practice statutes to allow all health care providers to practice to the top of their license, utilizing their full skill set. Also, they recommended that states consider legislation and regulations to allow non-physician providers to be paid directly for their services. [192]

Joyce M. Knestrick, PhD, APRN, C-FNP, FAANP, president of The American Association of Nurse Practitioners agreed:

"We wholeheartedly agree that outdated [SOP](scope of practice) laws need to be removed and all health care providers should practice to the top of their license, utilizing their full skill set…We are encouraged and agree with the administration's recommendation that patients suffer when faced with barriers to access resulting from outdated [SOP] laws."[193]

The APRN scope of practice can be viewed from three perspectives: practice authority, prescriptive authority, and as primary care providers. Practice authority can be defined as NPs' ability to practice with or without physician oversight. Scope of practice and license requirements for APRNs are detailed in NRS 632.237[194] and NAC §632.255.[195] These laws and regulations specifically address the scope of practice by detailing what the APRNs can provide through their services; for example, the policies authorize them to prescribe certain substances, order home health care, and engage in diagnosis and treatment decisions. The law sets the framework for APRN practice; however, the development of specifics is led by a professional board, in this case, the Nevada State Board of Nursing (NSBN). The NSBN developed a scope of nursing practice decision tree to summarize the Nurse or APRN scope of practice[196], which is set forth in the NAC.

The scopes of practice referenced do not specifically include or exclude SUD; this leads to confusion about the ability of APRNs to provide these services. In addition to the scope of practice, NAC §632.2597[197] recognizes additional roles for APRNs with the following populations:

[192] Reforming America's Healthcare System Through Choice and Competition. https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.
[193] https://www.aanp.org/news-feed/nurse-practitioners-commend-trump-administrations-recommendations-on-scope-of-practice-laws.
[194] https://www.leg.state.nv.us/NRS/NRS-632.html#NRS632Sec161.
[195] https://www.leg.state.nv.us/NAC/NAC-632.html#NAC632Sec255.
[196] https://nevadanursingboard.org/wp-content/uploads/2019/12/SOP-Tree.pdf.
[197] https://www.leg.state.nv.us/NAC/NAC-632.html#NAC632Sec259.

a. Women's health or gender-specific health.
b. Family health and caring for a patient across the life span of the patient.
c. Mental health.
d. Adult health.
e. Gerontology.
f. Pediatrics.
g. Neonatal.
h. Any other population of focus approved by the Board.

The NSBN requires additional documentation and training for these roles. APRNs may provide services for people with SUDs by citing the regulation above.

Physician Assistants. In 2018 in the U.S., there were approximately 131,000 certified PAs practicing in all areas of medicine.[198] From 2010 to 2020, the supply of primary care PAs is projected to increase by 58 percent, from 27,700 to 43,900.[199] Nationally, about a quarter of PAs practice primary care (family medicine/general practice, general internal medicine, and general pediatrics); in Nevada, it is close to one third. However, the number of PAs is lower than most other states: Nevada has approximately 30 PAs for 100,000 of population, ranking 42nd.

According to one expert,[200] Nevada law is vague in defining the PA scope of practice. The overriding restriction imposed by both the statutes and regulations is that the PA may perform those services delegated to him by the supervising physician.[201] The PA is further restricted to performing those services approved by the Board of Medical Examiners that are within the scope of their education, training, and experience.[202]

The American Academy of Physician Assistants (AAPA) recommends that PA scope of practice be as broad and flexible as possible to address a wide range of situations and specialties.[203] Under Nevada law, NRS §630.271[204], a PA may perform such medical services as the PA is authorized to perform by his or her supervising physician.

[198] http://scopeofpracticepolicy.org/practitioners/physician-assistants/ Website maintained by the National Conference of State Legislatures and the Association of State and Territorial Health Officials.
[199] HRSA Health Workforce, Projecting the Supply and Demand for Primary Care Practitioners Through 2020. https://bhw.hrsa.gov/health-workforce-analysis/primary-care-2020.
[200] Havins, Weldon E. NV Physicians Legal Handbook. https://wehavins.com/nev-physicians-legal-handbook/chapter-28-physician-assistance-and-the-supervising-physician/.
[201] https://www.leg.state.nv.us/nrs/NRS-630.html#NRS630Sec271 and https://www.leg.state.nv.us/NAC/NAC-630.html#NAC630Sec360.
[202] https://www.leg.state.nv.us/NAC/NAC-630.html#NAC630Sec360.
[203] PA Scope of Practice. https://www.aapa.org/download/61319/.
[204] https://www.leg.state.nv.us/NRS/NRS-630.html#NRS630Sec271.

The scope of practice policy website summarizes scopes by state on an interactive map. The following practices are followed in Nevada:

1. **Supervision Requirements.** According to NAC §630.370, adequate supervision is defined in state regulations. The physician must develop and carry out a program to ensure the quality of care provided by a PA. The physician must spend part of a day with a PA to act as a consultant and monitor the quality of care once a month.
2. **Prescriptive Authority for Physician Assistants.** According to NAC §639.1373, a PA may prescribe drugs and Schedules II to V controlled substances in accordance with written guidelines mutually developed and agreed upon by the PA and the supervising physician.
3. **Scope of Practice Determination.** According to NAC §630.360, medical services provided by a PA must be within the scope of practice of the supervising physician and commensurate with the education, training, experience, and level of competence of the PA.[205]

There is not explicit language regarding SUD services in APRN scope of practice. Concerning SUD and OUD services, in Nevada fewer than 170 NPs and PAs have obtained a DATA 2000 waiver to prescribe buprenorphine-containing products as of March 2020.

4.1.3.3. Medicaid Provider Enrollment

Enrolling as a Nevada Medicaid provider is a complex process with numerous details for providers to understand and keep up to date on. The *Provider Enrollment Information Booklet* [206] (Enrollment Booklet) is divided into approximately 60 provider types with 230 or more corresponding specialty codes.

Providers complete enrollment materials for all provider types they plan to bill. If a provider wants to treat patients under multiple provider types, per the enrollment requirements, the provider must submit multiple enrollment packets.

In the enrollment process, providers must select a specialty code, which further defines the type of practice. The MMIS uses specialty codes, and provider types, to determine which services are available to the practitioner for billing and reimbursement. As an example, one physician may enroll under provider type 20 (physician services) and choose a specialty code 920 (physician), while another provider type 20 practitioner may register as a psychiatrist, specialty code number 146. The 920 specialty code opens up CPT codes specific to a general practitioner, while the 146 specialty code opens up CPT codes specific to the psychiatrist. If the codes are not active, the provider will not be able to get reimbursed for their

[205] http://scopeofpracticepolicy.org/states/nv/#.
[206] https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf.

services. The MMIS maintains and applies software coding to link specialty codes and reimbursement codes, and through a series of edits, allows specific providers to claim reimbursement for their specific codes.

The current enrollment process may cause undue administrative hardships on providers having to register in multiple provider types and specialties, as well as linking individual practitioners. Even though the enrollment process is web-based, it is difficult for practice administrators to manage. An example is an FQHC, which would have to enroll under multiple provider types and specialty codes, including provider type 17 – special clinic, specialty code 18 – FQHC, and then another provider type 54 – targeted case management, specialty code 954 – targeted case management.[207] The current enrollment process may discourage providers from participating in Nevada Medicaid.

4.1.4. Potential Policy Limitations

Recognition of SUD and OUD as Acute Disorders. SUD and OUD are chronic disorders that usually require more than just medication or mental health services independently. Chronic disorders are generally more difficult to treat, as their treatment plans are more complex and can require input from multiple providers.

DHCFP recognizes that addiction is not an acute condition, and that the mechanisms underlying SUD and OUD require long-term, individualized treatment to support a patient's recovery. DHCFP also recognizes that policy and legislation play an important role in addressing the barriers in moving from an acute to chronic care approach to SUD and OUD treatment.

Punitive Policies Regarding Substance and Opioid use in Pregnancy. Research shows that such punitive laws actually lead to reduced substance abuse treatment admissions among pregnant women, and that a smaller share of pregnant women are referred to treatment by health care providers in states with such policies.[208] A separate research study found that infants born in states with punitive policies, such as considering drug use as a form of child abuse, were more likely to be born with a withdrawal syndrome, such as NAS.[209]

As reported previously, while the State may be moving towards a more harm reduction-based approach to policy development for SUD and OUD in pregnancy, publicly-available information describes the existence of more punitive policies.

[207] Nevada Medicaid Provider Enrollment Information.
Booklet https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf.
[208] Danielle N. Atkins et al, State Policies That Treat Prenatal Substance Use As Child Abuse Or Neglect Fail To Achieve Their Intended Goals, *Health Affairs* (2020).
[209] Faherty LJ, Kranz AM, Russell-Fritch J, Patrick SW, Cantor J, Stein BD. Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome. *JAMA Netw Open.* 2019;2(11).

4.1.5. Data Access and Reporting Limitations

Nevada's multi-disciplinary teams like CCBHCs and FQHCs collaborate with medical and behavioral health providers to integrate care. These teams bring together community behavioral health agencies and primary care providers. Medical practitioners and behavioral health providers can refer between practices, but integration and continued communication between medical and behavioral providers is limited. Nevada is seeking to create relationships between behavioral health and primary care providers specific to substance use through comprehensive payment models like patient-centered opioid addiction treatment methods.

In addition, the Primary Care-Mental Health Integration team provides mental and behavioral health care services to enrolled veterans in collaboration with primary care providers. These services are joined to the primary care setting and Clinical Program for Assertive Community Treatment (PACT) teams. It supports PACT-based treatment of both mental health conditions and behavioral aspects of chronic medical conditions.[210]

However, state-level data related to the current utilization of integrated care[211] in Nevada could not be readily identified, and therefore, the level of integrated care within the state could not be determined at this time.

High-level data regarding utilization of SUD services revealed that the majority of Medicaid beneficiaries were receiving SUD treatment services, including MAT, from the authorized special clinics provider types. These include but are not limited to FQHCs, CCBHCs, methadone clinics, non-tribal Indian health programs, and SAAM clinics. (Table 17)

[210] https://www.lasvegas.va.gov/Behavioral_Health/Primary_Care_Mental_Health_Integration_PCMHI.asp.
[211] https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc.

Table 17. Medicaid Beneficiaries Receiving SUD Treatment, Captured May 26, 2020

Service Category	No. of Enrollees With SUD Receiving Care in This Category Fee for Service	No. of Enrollees With SUD Receiving Care in This Category Managed Care
Physicians' services (PT 20)	540	3,139
Services provided by other licensed practitioners (PT 15, 21, 22, 24, 25, 26, 34, 36, 41, 76, 77, 81, 85)	19	1,315
Diagnostic and rehabilitative services (PT 27, 56, 63, 82, 43)	749	825
Inpatient services (PT 11, 13, 44, 51, 56, 75, 78)	0	87
Outpatient hospital services (including ED services) (PT 10, 12, 14, 52, 79)	353	2,262
Prescription drugs (PT 28)	0	1
NP services (24)	3	75
Clinic services (PT 17)	2,778	5,666
CCBHC services (PT 17 SPEC 188)	177	0
Total	**4,619**	**13,370**

Source: DHCFP data warehouse.

Nevada recognizes there is a need for increased efforts to improve access to care through health care workforce data collection. There is a limited foundation for estimating current and future health workforce supply and demand and incomplete data needed for evidence-based policymaking to improve access and contain costs. Nevada lacks a consistent and easily-accessible source of information about its health care and public health workforce, including detailed data on current and projected health workforce supply and demand.[212]

The state's health care workforce is crucial to assuring that high-quality health care is accessible by all Nevadans. Rapid population growth and insurance coverage expansions have increased demands on clinics, hospitals, and other providers. Accurate data on the state's health care workforce is needed to ensure an effective, efficient, and equitable health care system in Nevada. This is especially important in light of the current COVID-19 pandemic.[213]

There are opportunities to improve Nevada's health care workforce and leverage federal funding through improved data collection. Improving health care workforce data collection will provide the State with a greater understanding of where the workforce stands against national trends, as well as potentially identifying areas that require attention and opportunities for improvements. The results may benefit the

[212] Health Workforce Data Collection in Nevada through the Licensure Renewal Process, John Packham PhD University of Nevada Reno School of Medicine – White Paper June 2020.
[213] Improving Access to Care through Health Care Workforce Data Collection, John Packham PhD University of Nevada Reno School of Medicine. – Presentation Slides June 2020.

medical community focused on SUD treatment as provider capacity could drive future initiatives and increase the SUD workforce.[214]

4.1.6. Access to Social Determinants of Health Services

To provide whole-person, comprehensive care, it is critical to consider the environment in which a person resides. Health inequities are not biological but social problems. Reduced access to resources, or unequal distribution of resources, increase the likelihood for poor health outcomes.[215] The factors that influence individual and population health are known as SDOH. SDOH are defined as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[216] For Americans, other factors on health include the availability and access to: high-quality education, nutritious food, decent/safe housing, affordable/reliable transportation, culturally sensitive health care providers, health insurance, clean water, and non-polluted air.[217] It is increasingly recognized that to improve population health and increase health equity, environmental factors, and other SDOH, must be addressed and considered when developing innovative high-quality health interventions. Consequences of health disparities and SDOH include substance use, lower health outcomes, reduced quality of life, violence, and crime.[218, 219]

In 2019, DHHS surveyed 75 state and community level stakeholders, including representatives from community services, public health, Medicaid providers, and agency employees. Results from this survey informed the 2019 Nevada State Health Needs Assessment. Stakeholders prioritized populations of the highest risk for SUD: individuals with behavioral health issues, seniors, children, low-income families, minority populations, homeless populations, veterans, individuals with intellectual and developmental disabilities, individuals with chronic disease, young adults and transitional aged youth, and victims of domestic abuse/sex trafficking. 33 percent of surveyed stakeholders responded that above all outlined significant health issues, behavioral, mental health and substance abuse are the most critical.

In the 2019 Nevada State Health Needs Assessment, key informants in every county identified aspects of SDOH as barriers to improving the health of their residents. Insufficiency of transportation, quality education, and vocational opportunities were most often cited. Housing and absence of internet access were frequently cited as barriers. A strategy to address SDOH gaps is to provide outreach about existing services. Nevada 2-1-1 is part of a nationwide network of call centers that provides information and referral services to residents. Available information includes basic human services; physical and mental

[214] Ibid.
[215] Presentation: Addressing SDOH, Paul Devereux PhD MPH at the University of Nevada Reno.
[216] https://www.who.int/social_determinants/en/.
[217] Ibid.
[218] Taking action on the social determinants of health in clinical practice: a framework for health professionals, 2016.
[219] Addressing Social Determinants of Health: The Need for Provider-Community Collaboration, 2018.

health resources; employment support services; programs for children, youth, and families; support for seniors and persons with disabilities; volunteer opportunities; and support for community crisis and disaster recovery[220] (Figure 24).

Figure 24. 2-1-1 Services Requests by County, May 2020

	Carson City	Churchill County	Clark County	Douglas County	Elko County	Esmerelda County	Eureka County	Humboldt County	Lander County	Lincoln County	Lyon County	Mineral County	Nye County	Pershing County	Storey County	Washoe County	White Pine County	Nevada
Housing and Shelter	185	33	27,099	44	75	3	6	23	2	2	110	2	112	0	2	1,509	9	29,216
Food	43	9	10,617	13	22	2	4	10	0	1	48	5	71	7	0	627	6	11,485
Utilities	75	16	7,473	43	50	1	4	12	1	2	84	2	25	3	0	383	8	8,182
Health Care	121	35	10,248	48	40	4	8	21	1	7	112	9	85	4	2	1,227	8	11,980
Mental Health and Addictions	41	4	3,889	9	11	0	3	2	1	3	24	2	32	0	0	352	0	4,373
Employment and Income	20	3	4,156	10	9	0	0	4	0	3	10	1	14	1	1	206	2	4,440
Clothing and Household	16	2	2,476	1	2	2	0	1	0	1	10	1	4	1	1	129	0	2,647
Child Care and Parenting	1	3	817	0	2	0	1	0	0	0	2	4	2	0	0	39	0	871
Government and Legal	27	8	5,160	13	3	0	3	3	0	3	22	2	26	1	0	314	1	5,586
Transportation Assistance	35	8	2,976	14	24	0	0	10	2	1	18	7	35	0	0	244	9	3,383
Education	1	1	616	1	1	1	0	0	0	0	2	0	1	0	1	60	0	685
Disaster	1	2	75	1	0	0	0	0	0	0	1	0	1	0	0	10	0	91
Other	128	37	17,805	44	53	6	10	22	6	10	94	6	117	9	0	1,402	11	19,760
Total	694	161	93,407	241	292	19	39	108	13	33	537	41	525	26	7	6,502	54	102,699

The 2-1-1 referral resources are significant. At the end of fiscal year (FY) 2019, the 2-1-1 database had 3,799 programs, 2,179 sites, and 1,084 agencies as referral resources. In FY 2019, 2-1-1 worked to deepen relationships between stakeholders by:

- Partnering with DHHS agencies to assist in various marketing campaigns.
- Creating formal collaborations with several community agencies, including the Crisis Call Center, CARE Coalition, Nevada Health Centers (NVHCs), and the Clark County Office of Emergency Management, and Homeland Security.

[220] https://www.nevada211.org/wp-content/uploads/2019/12/2019-Q4-Abbreviated-Report.pdf.

- Participating in more than 230 community outreach events.
- Hosting quarterly meetings of the Nevada 2-1-1 Community Ambassador Alliance to gain feedback and gather ideas from community partners.[221]

Stakeholder interviews revealed another source of information: DHCFP customer service lines receive requests for social assistance. Although the primary function of these lines is to assist Medicaid recipients in locating health services, staff maintain a community referral list to assist Medicaid recipients seeking social support services.

Publicly available Nevada 2-1-1 data reflected a number of categories that are tracked, including request categories, such as food and housing, and client characteristics, such as military experience, race, ethnicity, language, age, and gender. The 2-1-1 resources are available to clients in multiple languages. The interactive geographic feature allowed choices such as zip code, school district, or region. The data also show percentage of requests that were met. However, in reports, as well as the interactive 2-1-1 counts site, it was not possible to review categories of client requests by population characteristics such as race or age.[222] This data would be extremely meaningful for identifying health disparities and establishing baseline data. For example, if the percentage for a specific ethnicity with housing and shelter requests were higher than for other groups that could lead to targeted policies and interventions.

The results from the CAST tool, as previously described in Section 3.1, utilized SDOH and community data to evaluate the capacity of the substance abuse care system within Nevada's five defined geographic areas. It was identified that the state is in critical need of community programs that address SDOH to address **prevention and recovery**. These programs include housing vouchers for at-risk populations, needle exchanges, transportation, and assistance obtaining housing, assistance obtaining employment, educational support for those in recovery, and parental supports and education.

The **prevention** category encompasses early intervention strategies intended to prevent the onset and mitigate the impact of SUDs on individuals and communities. Both housing vouchers for at-risk populations and needle exchange programs fall into the prevention category. [223]

Housing vouchers for those populations identified as high-risk are critical, as getting people "off the street" and in a safe and secure shelter can prevent the onset and mitigate the impact of addiction of these individuals and communities. Making housing more available to certain high-risk populations can be an early intervention method to prevent the impact of SUDs on an individual's community. The results

[221] http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/2019GMUAnnualReportADAcompliant.pdf.
[222] https://nv.211counts.org/ and https://www.nevada211.org/reports/.
[223] Nevada Capacity Assessment 2019.

of the CAST tool indicated that housing vouchers for low-income patients (and general population) are at a deficit and needed statewide. Across Nevada's five regions, there is an immediate need for housing vouchers for high-risk populations. The State should consider increasing the number of dedicated beds for the homeless, across all types of homeless continuum of care projects.

Needle exchanges can exponentially reduce rates of Hepatitis. (Hepatitis C and HIV contracted by using heroin). There already exist needle exchange locations in Nevada; however, according to the CAST results not enough to meet demand. Many exchanges also offer free naloxone. Trac-B Exchange was the first storefront syringe exchange in Clark County, Southern Nevada. Their goal is to provide potentially life-changing services and tools to addicts in the community. Trac-B Exchange offers HIV and Hepatitis C testing, naloxone, needles and syringes, vaccinations, meetings for sex workers, and other community services and products. Trac-B is a non-profit and partnered with Southern Nevada Health District and the Nevada AIDS Research and Education Society in 2017 to place syringe vending machines in three locations around town. The machine distributes up to 30 syringes per week per person. As of September 2019, there were five needle exchange vending machines in Southern Nevada.[224]

For **recovery support**, capacity may vary by region. It is important to note that relapse among those who have received treatment is a major concern for regional SUD care systems. Transportation, employment support, educational support, parenting support, and assistance obtaining housing for those receiving treatment are essential programs to support recovery. While there are clear areas of unmet need in recovery support, increasing awareness of existing resources and how to access them, ensuring sufficient housing, and increasing access to treatment were seen as highest priority. The CAST results prioritized transportation and housing, as it recognized that other entities, community partners, and government organizations are engaged in efforts and plans that address unmet needs in some of the identified areas (employment support, parenting support, and education).[225]

Increasing assess to supplemental recovery programs, like employment support, educational support, and parenting support, are categorized as "unmet needs" across all five regions; however, ensuring sufficient housing and increasing access to treatment through the availability of transportation services were seen as fundamental. Without housing and transportation, the additional recovery programs are unsustainable.

Transportation was identified as a high-risk category for Nevada's Southern Region (Clark County) and Rural Region. With an adequate referral system, it is critical to have sufficient resources to refer individuals to and transportation available to facilitate access to treatment. Transportation presents a major issue for

[224] http://www.harmreductioncenterlv.com/.
[225] Nevada Capacity Assessment 2019.

those in recovery in rural and frontier regions. These residents are geographically isolated from services. Lack of transportation creates barriers to recovery across almost all of the communities within the Rural Region. Technology, mainly telehealth, presents opportunities to meet the needs of rural residents without requiring them to travel long distances. Appointments for office-based opiate substitution can be short, but for patients in remote areas getting to a 15-minute appointment can take all day. It should also be mentioned that in evaluating provider capacity in Nevada, there are still some resources that can only be accessed in more populated areas If people cannot get to treatment, they are unlikely to benefit from other resources within the recovery component. It is stated that all unmet needs identified by CAST are compounded by the lack of transportation.[226]

Stable housing reduces the risk of relapse and could reduce the demand on the existing capacity for SUD. In the 2019 Nevada Capacity Assessment, it was reported that there is a severe shortage of affordable and safe housing options (including transitional housing). Increasingly, communities and funders working to address SDOH, have identified the important role that housing plays in stabilization and recovery, with the understanding that housing is a component of comprehensive health care. Beyond the provision of housing vouchers, Clark County Nevada has highlighted affordable housing development as a capacity building priority to strengthen the infrastructure of support across the continuum of SUD prevention and recovery. It is noted that assistance obtaining affordable housing was ranked an immediate priority in all regions with the exception of the Washoe Region.[227]

Harm Reduction

One of the Harm Reduction Coalition principles directly addresses health disparities and SDOH: The realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm. [228]

Harm Reduction Trainings: CASAT offers trainings about harm reduction, including the 45-minute online course, *Pain Medicine Update.* The course focuses on the cultural change in pain management, concerns for special populations, identification of those at risk for abuse of medications, and psychosocial and addiction issues. CASAT also offers a bi-weekly harm reduction continued education course that defines harm reduction and explains how professionals can utilize stages of change. [229]

Trac-B Exchange: Serving Clark, Nye, and White Pine County, Trac-B Exchange has a 24/7 mobile recovery team. Trac-B is already an established innovative needle exchange program serving high-risk populations

[226] Rural Region Capacity Assessment 2019.
[227] Clark County Southern Region Capacity Assessment 2019.
[228] Harm Reduction Coalition Guiding Principles.
[229] CASAT Virtual Site Visit.

in the Las Vegas area. Since July 2019, the program is working on credentialing with several hospitals in Las Vegas and Ely, and have conducted ten outreach events in the community and among the homeless.

Trac-B Exchange has a Licensed Alcohol and Drug Counselor (LADC) and Peer Supportive Recovery Specialist to provide recovery service to their communities. LADC supervise the peers and initiate treatment services. Peers provide resources and transportation assistance into treatment programs.

Foundations for Recovery (FFR): FFR is deploying a mobile recovery team in Northern Nevada to partner with local and rural hospitals and Washoe County Detention, and to provide community outreach to at-risk homeless populations. Since July 2019, they have expanded credentials to Renown and Carson Tahoe hospitals, conducted three outreach events, and hold weekly meetings within Washoe County Corrections targeting women interested in recovery.

Nevada Recovery Support Services: Through the SOR, 335 clients received recovery support services. In addition to traditional treatment agencies, there were two peer-led programs that received SOR subawards for peer support services. These agencies both initiated mobile recovery teams, peer recovery support services, and established peer-led warmlines designed to connect individuals who are not in acute crisis to needed services. Mobile recovery teams provide interested EDs with educational materials, contact information, and naloxone kits. Teams coordinate support linkages with other agencies to assist with housing, life skills, employment, and legal issues in support of sustained recovery, as well as links to social and recreational activities to encourage a sober, healthy lifestyle.

Additionally, Trac-B and FFR collaborated to develop and operate peer warmlines to serve both Southern and Northern Nevada. These warmlines were created to help connect individuals to care and support, and to provide information. Peers are available 24/7 to provide resources to those contemplating recovery or in need of someone supportive outside of a crisis.

4.1.7. Health Disparities in SUD

As described in the previous section about SDOH, groups of people with social, economic, and environmental disadvantages often have poor health, higher risk for disease, and limited access to health care. The context in which people live helps explain the reasons that the burden of illness, premature death, and disability disproportionately affect certain populations. SDOH, race and ethnicity, sex, sexual orientation, age, and disability influence health.[230] Many health disparities reflect systemic issues, such as discrimination. National Institutes for Health defines disparities as the differences in the incidence,

[230] MMWR, Introduction: CDC Health Disparities and Inequalities Report — United States, 2013. https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a2.htm?s_cid=su6203a2_w.

prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.[231] For example, infant mortality rates are two and a half times higher for African Americans than for the general population.[232] Although disparities in health and health care affect populations of people, they also limit overall gains in quality of care and health and result in unnecessary costs for the nation.[233]

In 2016, the HHS, Office of Minority Health surveyed states and territories about their efforts to reduce health disparities and found that:

- Twenty-three states or territories had a strategic plan addressing minority health or health equity.
- A common goal and activity is development of measures and data collection/analysis.
- Many states implemented Medicaid expansion, immunization programs, and chronic disease management efforts.
- Many states implemented interventions for specific populations, such as children, refugees, and/or individuals experiencing homelessness.
- Private funders, local communities, managed care plans, and providers also are engaged in disparities reduction efforts. [234]

Unfortunately, the report concluded that Nevada lacked an assessment plan that would measure progress toward reducing health disparities, and did not include any data about substance use.[235]

Health disparities affect people with SUD. For example, a literature review found disparities in treatment for SUDs for racial and ethnic minority youth. Compared to non-Latino Whites with SUD, Black adolescents with SUD reported receiving less specialty and informal care, while Latinos with SUD reported receiving fewer informal services. Potential mechanisms for racial and ethnic disparities were identified as federal and economic health care policies and regulations; the operation of the health care system and provider organization; provider level factors; the environmental context; the operation of the community system; and patient-level factors.[236] Another study of justice-involved youth 12 years after detention found SUDs in young adulthood differed considerably by sex, race or ethnicity, and the substance abused. Access to

[231] https://www.nhlbi.nih.gov/health/educational/healthdisp/index.htm.
[232] https://image.slideserve.com/211792/examples-of-health-disparities-between-white-population-and-ethnic-minority-populations-in-the-u-s-l.jpg.
[233] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
[234] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
[235] https://minorityhealth.hhs.gov/assets/PDF/OMH-Health-Disparities-Report-State-and-Territorial-Efforts-October-2018.pdf.
[236] J Am Acad Child Adolesc Psychiatry. 2011 January; 50(1): 22–31. doi:10.1016/j.jaac.2010.10.005.

quality services was an issue: about half of youths in detention do not receive treatment needed for drug abuse.[237]

Another study analyzed primary care service for veterans with SUD. One conclusion is that even in an integrated health care system, patients with SUD may have worse patient experiences than patients without SUD. Patients with SUD specifically reported worse experiences for measures including access, provider communication, and information received.[238] As important access to care is, it must be access to quality care. A literature review looked at approaches to improving general medical care for individuals with SUD and mental health issues. The approaches included on-site medical consultation, team-based approaches, and models involving facilitated referrals to primary care. Linkage to and quality of medical care demonstrated a substantial positive impact: health improvement and improved abstinence rates were evident.[239]

Focusing on Nevada, data and research about health disparities is limited, and about disparities related to substance use services or health outcomes for people with SUD almost absent. A number of demographic factors identify groups that often experience disparities: nearly nine percent under age 65 have disabilities, over 12 percent live in poverty, and over 30 percent speak a language other than English at home. The University of Nevada, Las Vegas, Center for Center for Health Disparities Research (CHDR) primarily focuses on children's issues and teen pregnancy; however, a recent report analyzed trends for federal Region IX (Nevada, Arizona, California, Hawaii, and some U.S. territories) and found data often associated with disparities:

- Nevada has the largest percentage of uninsured unauthorized immigrants in the region.
- Eleven percent of residents are uninsured.
- In Nevada, minorities represent 48 percent of residents.
- Thirty percent of AIAN in Nevada live in poverty.
- Nevada falls short of the national average of 32 SUD providers per 1,000 adults with addictions, with only 11 per 1,000.

[237] Health Disparities in Drug- and Alcohol-Use Disorders: A 12-Year Longitudinal Study of Youths After Detention (Am J Public Health. 2016;106:872–880. doi: 10.2105/AJPH.2015.303032).
[238] Health Equity. Volume 3.1, 2019 DOI: 10.1089/heq.2018.0069. Substance Use Disorder-Related Disparities in Patient Experiences of Primary Care.
[239] Improving general medical care for persons with mental and addictive disorders: systematic review. Gen Hosp Psychiatry Mar-Apr 2006;28(2):145-53. doi: 10.1016/j.genhosppsych.2005.10.006.

Unfortunately, although the data illustrates a number of public health challenges and achievements, the report did not examine health access or outcomes by population.[240, 241] A presentation to the Nevada legislature by CHDR is from 2005, but many factors are likely still valid:

- Baseline data about disparities is unavailable for Nevada.
- An important access challenge is cultural and linguistic competence.
- Nevada needs to improve surveillance and data collection, and support public health research.[242]

Notably, research in the Nevada Journal of Public Health, a publication of the Nevada Public Health Association, published "Mental Health Disparities among Sexual Minorities" this year; however, the article did not refer to SUD data.[243]

One lens for Nevada to consider disparities in access to health, is access for rural populations. The CMS Rural Health Council recently explored issues for this population and recommended the following:

1. Apply a rural lens to CMS programs and policies.
2. Improve access to care through provider engagement and support.
3. Advance telehealth and telemedicine.
4. Empower patients in rural communities to make decisions about their health care.
5. Leverage partnerships to achieve the goals of the CMS Rural Health Strategy.[244]

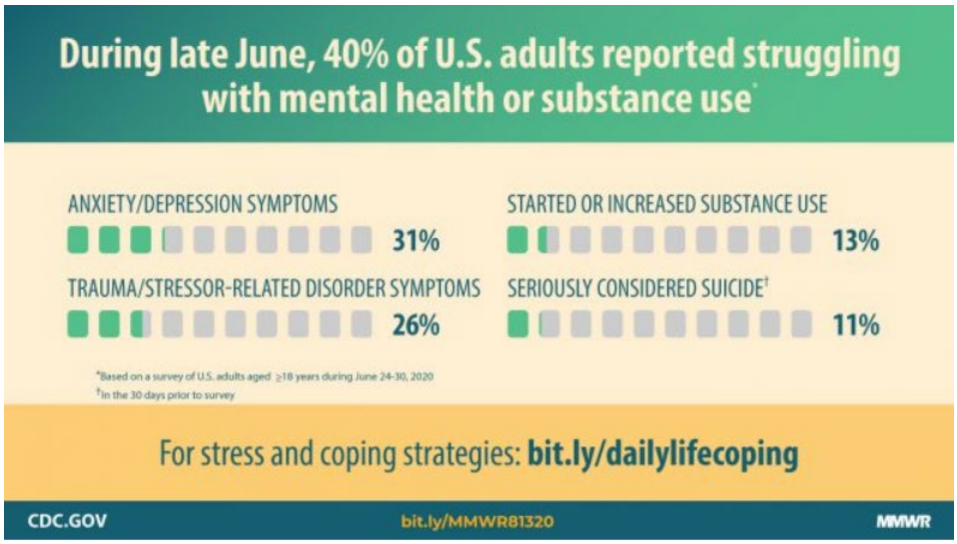
A notable achievement is the website and data reports created by the Southern Nevada Health District. The intent is to help the community understand the public health indicators that affect the quality of life. The data is kept up to date as information becomes available. The website has a disparities dashboard and includes some data demonstrating health disparities for substance use; for example, drug and opioid deaths are broken out by race/ethnicity, with the highest rates In Clark County for Whites. The site includes the Clark County Community Health Needs Assessment (2019) and notes that Clark County ranked in the bottom quarter of all counties in the United States for the rate of children with access to health insurance.[245]

[240] https://www.unlv.edu/units/center-health-disparities-research.
[241] https://www.unlv.edu/sites/default/files/page_files/27/PublicHealth-EnvironmentalScanOfRegionIX-AnAccessToHealthCareReport.pdf.
[242] University of Nevada Las Vegas, Center for Center for Health Disparities Research. Presentation to legislative committee on health care. December 2005 https://www.leg.state.nv.us/73rd/Interim/StatCom/HealthCare/exhibits/18775I.pdf.
[243] http://www.nphaonline.org/resources/Documents/NJPHDocs/NJPH%20Keeley%202020.pdf.
[244] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[245] http://www.healthysouthernnevada.org/.

Impact of COVID-19 on Mental Health Disparities

Additionally, impacts from the COVID-19 pandemic are evident in population health. Across the United States, the COVID-19 pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders. In June 2020, a survey of 9,896 Americans aged 18 and older, found that overall 40.9 percent of participants reported at least one adverse mental or behavioral health condition (including anxiety, depression, trauma and stress-related disorders, and increased substance use) related to or attributed to the impacts of COVID-19. 10.7 percent of participants reported considering suicide within the past 30 days, with much higher rates among young adults ages 18 to 24 (25.5 percent) and minority racial/ethnic groups (18.6 percent Hispanic, 15.1 percent Black).[246]

Figure 25. Impact of COVID-19 on U.S. Mental Health



Results from the survey were stratified by gender, age, race/ethnicity, employment status, essential worker status, unpaid adult caregiver status, rural-urban residence classification, whether respondents knew someone positive for COVID-19, and whether the respondent was receiving treatment for diagnosed anxiety, depression, or post-traumatic stress disorder (PTSD) at the time of the survey. At least one adverse mental or behavioral health symptom was reported by more than one half of respondents who were aged 18 to 24 years (74.9 percent) and 25 to 44 years (51.9 percent), were of Hispanic ethnicity (52.1 percent), or who held less than a high school diploma (66.2 percent), as well as those who were essential workers (54.0 percent), unpaid caregivers for adults (66.6 percent), and who reported treatment for

[246] NIH Article: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic (June 24-30, 2020). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7440121/.

diagnosed anxiety (72.7 percent), depression (68.8 percent), or PTSD (88.0 percent) at the time of the survey.

Black respondents reported increased substance use and past 30-day serious consideration of suicide at a higher rate than White and Asian respondents. Respondents who reported treatment for diagnosed anxiety, depression, or PTSD at the time of the survey reported higher prevalence of symptoms of adverse mental and behavioral health conditions compared with those who did not. Symptoms of a COVID-19-related trauma and stressor-related disorder, increased substance use, and suicidal ideation were more prevalent among employed than unemployed respondents, and among essential workers than non-essential workers. Adverse conditions also were more prevalent among unpaid caregivers for adults than among those who were not, with particularly large differences in increased substance use (32.9 percent versus 6.3 percent) and suicidal ideation (30.7 percent versus 3.6 percent) in this group.[247]

According to the Harvard T. H Chan School of Public Health, the United States should anticipate and prepare for long-term mental health issues as a result of COVID-19. People with a history of behavioral and mental health illness are at a greater risk for relapse and report high instances of isolation and decreased support systems.[248] Targeted community-level intervention and prevention measures, including telehealth and communication strategies, could help address mental health conditions associated with the public health crisis.[249]

4.2.7. Targeting Health Equity in Nevada

Building Nevada's capacity in data surveillance, collection, and reporting is a first step to identifying health disparities and addressing health equity. This work involves the SDOH, health data, and engagement of a broad stakeholder group at the state and community levels.

As Nevada's population becomes increasingly diverse, addressing health disparities is increasingly important. For example, as of 2018, U.S. figures show Hispanics are two and a half times more likely to be uninsured than Whites (19.0 percent versus 7.5 percent). Individuals with incomes below poverty are also more likely to be uninsured. Nationally, in spite of progress towards equality, these disparities have persisted after the ACA and Medicaid expansion.[250]

Without having specific data about disparities in Nevada, research from national studies promotes some ideas. Dealing with the systemic issues experienced by minority youth with SUD to reduce disparate

[247] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.
[248] https://www.hsph.harvard.edu/news/hsph-in-the-news/covid-19-pandemic-may-cause-long-term-mental-health-issues/.
[249] https://medicine.umich.edu/dept/psychiatry/michigan-psychiatry-resources-covid-19/specific-mental-health-conditions/addiction-substance-use-recovery-during-covid-19-pandemic.
[250] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

treatment could be achieved by adoption of certain state policies to increase eligibility in public insurance and allocate necessary funds to guarantee availability of substance abuse treatments, including linguistically appropriate services. Since treatments appear to work well independent of race/ethnicity, translational research to bring evidence-based care in diverse communities can bolster their effectiveness.[251]

Interestingly, one study called for monitoring health equity not just along traditional data related to identity, such as race/ethnicity, but also for groups who may face discrimination related to SUD conditions.[252]

National data about justice-involved individuals show a number of avenues to improve health equity; namely, to first address the disproportionate incarceration of African Americans. Systemic assessments for co-morbid conditions and evidence-based services to treat substance abuse—during incarceration and after release— would reach a sizeable portion of people in need and address health disparities in a highly vulnerable population.[253]

The role of culture in SUD and treatment is complex; however, culturally validated measures for assessing and tracking substance use outcomes are lacking, and may include variables related to discrimination, ethnic mistrust, ethnic orientation, and acculturation. Substance abuse treatment for minority youth needs to be evaluated for effectiveness, both with and without elements of cultural competence.[254]

Work recently funded by HHS to the Nevada Office of Minority Health and Equity will support the State's work in building health equity. The goals are to disseminate the standards for cultural and linguistic appropriateness and to increase health insurance for minorities. Both these efforts call for creation of baseline data that will leverage their work with targeted interventions.[255]

[251] J Am Acad Child Adolesc Psychiatry. 2011 January ; 50(1): 22–31. doi:10.1016/j.jaac.2010.10.005.
[252] Health Equity. Volume 3.1, 2019 DOI: 10.1089/heq.2018.0069. Substance Use Disorder-Related Disparities in Patient Experiences of Primary Care.
[253] Health Disparities in Drug- and Alcohol-Use Disorders: A 12-Year Longitudinal Study of Youths After Detention (Am J Public Health. 2016;106:872–880. doi: 10.2105/AJPH.2015.303032).
[254] J Am Acad Child Adolesc Psychiatry. 2011 January ; 50(1): 22–31. doi:10.1016/j.jaac.2010.10.005.
[255] https://minorityhealth.hhs.gov/omh/content.aspx?ID=10164&lvl=2&lvlid=51.

4.2. Opportunities and Recommendations

4.2.1. Workforce Development and Retention

4.2.1.1. Workforce Development

During the course of our research, Myers and Stauffer identified professional development opportunities underway in other states looking to increase their provider knowledge of OUD and SUD service delivery. A summary of our findings is listed below.

Massachusetts. Massachusetts, partnering with some medical schools, is taking steps to incorporate MAT training into medical education. Medical schools in the Commonwealth have incorporated training about buprenorphine prescribing into recently required additional training about opioids. The topic was also added to continuing medical education requirements.[256]

Nebraska. The BHECN recruits and educated students in behavioral health fields and trains and retains professionals already in the workforce. In 2017 it was documented that Nebraska was in a critical behavioral health professional shortage, not unlike Nevada, and 88 of their 93 counties were designated behavioral HPSAs by HRSA. In 2017, BHECN published a retention toolkit with resources to help organizations tailor a retention plan. Additionally, the BHECN "Ambassador Program" creates a pipeline of Nebraska students interested in behavioral health by mentoring students beginning as early as their high school years and following them through college, professional school, and onto careers in the field. The program also targets students from rural communities. The BHECN virtual mentor network connects students considering a career in behavioral health or psychiatry with mentors in the final stages of earing their professional or medical degrees. The BHECN psychiatry student interest group at University Nebraska Medical Center (UNMC) promotes medical student-run education, mentorship, and outreach. BHECN also recruits students and recent graduates to become community health workers or provisionally licensed drug and alcohol counselors that will commit to serving rural and underserved communities.[257] [258]

Georgia. The state of Georgia has a medical education program that is designed to increase the number of doctors serving rural communities. Augusta University offers a specialized accelerated program to medical students who commit to practice in rural Georgia for six years. Students in the program benefit by a three-year, shorter medical school, a three-year primary care residency in Georgia, and free medical school tuition. In 2019, Georgia state legislature included $500,000 in the budget for next fiscal year for the program's administration. It was estimated that if the program cost the state $20 million a year by

[256] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[257] https://www.unmc.edu/bhecn/index.html.
[258] https://www.unmc.edu/bhecn/_documents/2017-retention-toolkit.pdf.

2028, simply putting 48 doctors into rural underserved areas would yield an economic benefit to the state of more than $340 million.[259, 260]

Association of American Medical Colleges. In 2016, it was recognized that 63 percent of national overdose deaths involved opioids. The AAMC identified pain management and SUD as key topics for medical education to help future doctors battle the opioid epidemic. A survey of college faculty illustrated 97 percent of respondents challenges assessing students' knowledge of prescription drug misuse. As a result of this finding, enhancing faculty capacity to model evidence-based practices emerged as an opportunity. [261] [262]

Maine. Three years ago, 30 to 60 percent of hospital visits and 30 to 40 percent of primary care visits in Maine were related to alcohol, yet most healthcare providers are not trained about discussing the health consequences of substance abuse with patients. To create awareness and fill the gap, the Lunder-Dineen Health Education Alliance of Maine, in collaboration with Massachusetts General Hospital, partnered with stakeholders across Maine to create an innovative pilot program. The program, *Time to Ask*, included training for providers and expert consultation to assist primary care practices in making this transformation. The program targeted physicians, PAs, NPs, medical assistants, and social workers. Phase 1 findings revealed that the program had a positive impact on primary care health professionals' knowledge, skills, and attitudes, while promoting practice change. Although alcohol abuse is treated differently than OUD, states could benefit from implementing a similar campaign to address the importance of knowing how primary care can appropriately discuss OUD with patients.[263, 264]

Alabama. *Zero Addiction* is Alabama's addiction marketing campaign, which combats social stigma. On March's CMS cohort call, a representative for the state of Alabama described the state as having some of the strictest drug laws in the nation. They said further that *Zero Addiction* has promise to increase treatment seeking and thus reduce the number of addicts in their prison system. They expect a trickle-down impact from an increased number of addicts seeking therapy bringing about an influx of medical professionals willing to address addiction in their regular practices. The CDC reports that doctors in Alabama write more prescriptions like OxyContin, Vicodin, and Percocet than any other state.[265] In

[259] https://www.augustachronicle.com/news/20190504/medical-college-of-georgia-changes-aim-to-get-more-doctors-to-rural-ar.
[260] https://www.augusta.edu/mcg/fammed/residents/facilities/rural.php.
[261] https://www.aamc.org/news-insights/responding-opioid-epidemic-through-medical-education.
[262] https://journalofethics.ama-assn.org/article/how-should-medical-education-better-prepare-physicians-opioid-prescribing/2019-08.
[263] https://lunderdineen.org/alcohol-use-time-ask.
[264] https://giving.massgeneral.org/maine-alcohol-initiative/.
[265] CDC State Prescribing Rates, 2018 https://www.cdc.gov/drugoverdose/maps/rxstate2018.html.

addition to addressing stigma around addiction, the campaign sought to reduce the number of opioids being prescribed.[266, 267]

Connecticut. The Connecticut Department of Mental Health and Addiction Services maintains a consumer-facing webpage developed to help individuals obtain information on the availability of addiction services in the state. The website includes information on slots for detoxification, residential addiction treatment, and recovery homes. Within each category, facilities are listed by specific type of care offered. The department also maintains a publicly-accessible map of MAT providers participating in Medicaid, as well as providers offering other substance use treatments. The resource allows providers to map and identify contact information, with filters for specific medication offered, level of care needed, and ages served. [268]

California. The State developed a toolkit to expand the capability of primary care teams to confidently and willingly provide SUD services that are becoming fully integrated with primary care. The focus of the toolkit is in three areas: shifting attitudes of providers, increasing the awareness of SUD, and accelerating access to integrated SUD treatment. To implement these focus areas, the toolkit says to connect SUD services to the mission of the office, learn from other providers, give clear directions, provide support, raise awareness, build skills of the providers, clarify the process, and finally to measure the impact of the work.[269]

Recommendation: Provide Workforce Training

- ***Early Prescriber Training.*** Training would be more effective if mandated as a part of graduate school education, similar to training commonly incorporated for other medications with complicated dosing (e.g., warfarin). Medical school curriculum should include education around buprenorphine, naloxone, and methadone. This topic could be taught in addition to training of safe opioid prescribing, and pain management practices. Increasing the clinical exposure of students while enrolled in courses in which they learn about opioid prescribing would enhance their capacity to apply their learning (for example, by learning to identify patients who are at greater risk for misusing prescribed opioids).
- ***Integrated Care Training Program.*** Consider developing a training program solely focused on the principles and workflows of integrated care. DHHS could develop a program for physicians facing the opioid epidemic, recognizing Nevada's unique landscape (rural, frontier, and tribal communities). DHHS may consider adding to the types of trainings currently offered by CASAT to include technical

[266] CMS Cohort: Providers Serving Special Populations: Perinatal Populations and Substance-Exposed Infants, 3/26/2020.
[267] http://www.zeroaddiction.org/.
[268] https://www.maine.gov/dhhs/documents/Memo-Maine-Behavioral-Health-Capacity-Oct-11-2019.pdf.
[269] https://www.chcf.org/wp-content/uploads/2019/01/CIN-Toolkit-3-Strategies-to-Help-Primary-Care-Teams-Treat-Substance-Use-Disorders.pdf.

workflows and principles of integrated care. Based on attendee post-training evaluations, participants are open to more in-depth management trainings.[270]

- ***Creation of a Primary Care Toolkit.*** Nevada Medicaid may consider sponsoring a workgroup to design a primary care toolkit that outlines screening best practices, explains state and national protocols, and provides resources for community SDOH services. This toolkit is very similar to the ASTHO OMNI OBGYN provider toolkit but instead of focusing on pregnant and postpartum women and their infants, it would target primary care teams.
- ***Address Stigma to Change Provider Attitudes.*** National campaigns, like Shatterproof, have made it their mission to destigmatize addiction in the United States. While national campaigns are ideal to destigmatize addiction in the general population, a targeted approach is needed to address the stigma among physicians treating SUD. Enhanced educational and training practices with tactics to influence provider attitudes and reduce stigma are pertinent to increase provider willingness to offer SUD treatment and recovery services.[271, 272] Such tactics can include promotion of successful recovery stories, presentations of achievable outcomes proven to increase provider satisfaction, and the inclusion of provider champions.[273]
- ***SUD Treatment Website and Social Media.*** Nevada may create a public-facing website for providers looking for resources on substance use treatments. Similar to Connecticut's site,[274, 275] the website could include a map of MAT-waivered providers, outpatient facilities, behavioral and mental health providers specializing in SUD, MAT-waivered OBGYNs, and relevant contact information for community organizations addressing SDOH. This website can also reference resources such as 2-1-1, CASAT, and existing and future educational toolkits. The website could be an expansion of the existing website (https://behavioralhealthnv.org/).

  Nevada may feature a family and consumer social marketing campaign on the website. The campaign could feature health communications that increase public awareness of the risk associated with prescription opioids and reduce the public stigma associated with SUD and OUD.[276]
- ***Early Education to Promote Careers in Behavioral Health.*** Create a pipeline of Nevada students interested in behavioral health, beginning as early as high school and continuing through higher

[270] 2019 CASAT Training Evaluations.
[271] Manuscript: Training Physicians to Treat Substance Use Disorders; Soteri Polydorou MD. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741399/.
[272] Manuscript: Undergraduate Medical Education in Substance Abuse: A Review of Quality of the Literature; Devyani Kothari MD https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3148085/.
[273] https://www.careinnovations.org/wp-content/uploads/TAPC_v5.pdf.
[274] https://public.tableau.com/views/CTBHPMedicaidMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no
[275] https://www.ctaddictionservices.com/index.php.
[276] Meeting Report; Closing the Gaps in Opioid Use Disorder Research, Policy, and Practice: Conference Proceedings (Addiction Science & Clinical Practice 2018); Matthew A Miclette, Jared A Leff.

education and careers in the field. Engage students in rural communities with information and resources to explore the field of behavioral health and the importance of increasing capacity in remote regions. In support of this pipeline, Nevada should explore potentially implementing support initiatives like ambassador programs, virtual mentoring, student training, and internships. These efforts should not only support future medical providers and prescribers but also allied health and behavioral health professionals and addiction specialists.

- ***Special Medical School Program.*** Nevada should explore the creation of a special medical school program designed to increase provider capacity in rural communities and increase the number of doctors practicing in behavioral health and addiction medicine. Looking at Georgia as an example, Nevada could consider offering a shorter, three-year medical school, a three-year specialized residency, and free medical school tuition for students who contractually commit to certain practice requirements (serving rural communities, special populations, and/or behavioral health and addiction medicine) for a fixed number of years. While this program is a comprehensive and broad undertaking, Nevada might want to consider partnerships with public medical schools to create a program to build workforce capacity.
- ***Increase Partnership Opportunities.*** Nevada state departments may consider how it can further partner with medical schools, public and community entities, and other health institutions to further implement educational opportunities to train the future workforce. The state should explore and encourage opportunities and programs for students and professionals to gain experience addressing SUD, treating special populations at-risk or suffering from SUD, and those with limited or no access to care. Partnerships could include tribal communities, needle exchanges, and community resources (like facilities serving the homeless).
- ***Continue to Foster Existing Relationships.*** DHHS already has working relationships with numerous colleges and universities focusing on projects targeting health innovations and workforce capacity. Many of the above recommendations will rely on these existing relationships, in addition to new partnerships.

4.2.1.2. Workforce Recruitment and Retention

Across the country, many states have an insufficient workforce to address SUD and OUD. These gaps are reflected in national data. Recently, there were 83,336 physicians across the country—approximately eight percent of all active physicians in the United States—who have obtained a DATA 2000 waiver to prescribe buprenorphine.[277] The average state had 25 waivered physicians per 100,000 residents, compared with 279 non-waivered physicians per 100,000 residents, with significant variation in the

[277] https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data.

number of waivered physicians per capita across the states. In Nevada, the current number of waivered providers has increased from a total of 192 in 2017 to 648 as of December 2020.[278, 279, 280]

Though there is no single solution for addressing workforce shortages, there are a number of strategies that have been demonstrated to alleviate this burden, such as recruitment and retention programs.[281, 282]

Michigan. The Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan conducted interviews nationwide with 75 state experts and reported that scholarship and loan repayment programs were perceived as the most effective strategy for provider recruitment.[283] Pipeline or pathways programs were also identified in the BHWRC interviews as an effective strategy for recruitment and retention. Pipeline programs cultivate middle school, high school, or college student interest in health professions.[284] Pipeline programs have historically been used to recruit from underrepresented populations in the health care workforce to increase the diversity of providers.[285]

Oregon. Stakeholders recommended legislative action to incentivize SUD specialty treatment providers to provide SUD services, especially in rural and underserved areas. Incentives include a state loan repayment program; student loan repayments; stipends; financial incentives for treatment providers to offer services in underserved areas; relocation assistance for treatment professionals moving to rural, frontier, or other underserved areas; educational opportunities; and direct financial support for telemedicine equipment and training.[286]

National Health Service Corps. National Health Service Corps (NHSC) is a loan repayment program. This program repays loans in exchange for at least two years of service at a facility located in a HPSA or a medically underserved area (MUA)/population. Currently, Nevada NHSC has 75 clinicians and 11 vacancies through the federal NHSC.[287, 288, 289]

Nebraska. BHECN supports the behavioral health workforce and promotes retention through professional development, training opportunities, and resources to connect with colleagues. BHECN

[278] Nevada Opioid Crisis Needs Assessment, 2019.
[279] https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator/results/_none/_none/_none/NV.
[280] QPR QE 12/31/2020.
[281] https://www.ncsl.org/documents/health/WorkforceStrategies2017.pdf.
[282] The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy, 2020.
[283] Ibid.
[284] The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy, 2020.
[285] Measuring the Success of a Pipeline Program to Increase Nursing Workforce Diversity, 2016.
[286] https://www.oregon.gov/gov/policy/Documents/HB%204143%20Report%20FINAL.pdf.
[287] https://data.hrsa.gov/topics/health-workforce/nhsc.
[288] HRSA designates Medically Underserved Areas/Populations: areas or populations designated as having too few primary care providers, high infant mortality, high poverty or a high elderly population. See https://data.hrsa.gov/tools/shortage-area/mua-find.
[289] https://www.ncsl.org/documents/health/WorkforceStrategies2017.pdf.

acknowledges that recruitment, retention, and competency are among leading predictors of workforce success, and many hiring managers consider them a top priority. Organizations in Nebraska, like in many other states, face complex factors within its workforce to meet the challenges of hiring and retaining talent. To better assist employers looking to retain employees, in 2017 BHECN developed and distributed a retention toolkit with resources for Nebraska's behavioral health workforce. The retention toolkit provides a guide for employers to tailor a retention plan to fit the needs of their organization. In the creation of the toolkit, the state sought to answer "what are effective retention practices for behavioral health professionals?" and "do effective practices differ between urban, rural, and frontier areas?" The toolkit is now publicly available. Nebraska's success is based on a collaborative effort between academic and professional stakeholders. These partnerships are an essential factor in successfully implementing promising interventions, particularly for complex public health issues.[290, 291]

***Recommendation:* Develop Provider Recruitment and Retention Strategies**

- ***Continue to Invest in Recruitment and Retention Strategies.*** One strategy is the offering of financial incentives to providers. Should the State want to consider financial incentive opportunities, this strategy can be further explored by the Core team as the state moves forward with planning strategically for the completion of the SUPPORT Act application. In order to increase provider capacity, the state should consider incentivizing a provider once they meet certain goals or requirements of their waiver, instead of simple placing the incentive on receiving the waiver alone. Attaching goals or requirements to the incentive will ideally drive both an increase in waivered providers and an increase in prescribing. Funding strategies for financial incentives are outlined in *Section 4.2.2. Increase MAT Services* of this document. Financial incentives could be included in the upcoming MCO RFP or Nevada may consider funding through an 1115 waiver or additional grants.
- ***Continue Stakeholder Engagement Efforts.*** The state might want to consider ongoing engagement with both currently waivered providers and providers considering obtaining MAT waivers. This continued engagement would keep the state informed of the issues faced by these providers, potentially highlight opportunities for pilot programs, and give the State the opportunity to facilitate collaborations. Additionally, behavioral health and addiction professionals should be engaged as they often experience lower wages and higher rates of burnout. The Stakeholder Engagement Analysis in *Appendix E* provides detailed initiatives for continued outreach.

4.2.2. Increase MAT Services

DHCFP has taken steps to increase access to OUD services by creating a MAT policy that addresses the requirements for providers who are providing outpatient addiction treatment services for OUD in an

[290] Community-Academic Partnerships: Approaches to Engagement, 2019.
[291] https://www.unmc.edu/bhecn/_documents/2017-retention-toolkit.pdf.

office-based opioid treatment setting. However, there remain opportunities to further increase MAT services. The following summarizes approaches other states are using to increase OUD service access.

Massachusetts. The use of nurse care managers (NCMs) in Massachusetts addressed many of the barriers to prescribing more buprenorphine that providers often describe, including scarcity of time, limited clinical supports, and insufficient nursing support. The NCM collaborative care model was implemented in 2007 with initial funding provided by the State. This program was initially supported by the Massachusetts Department of Public Health Bureau of Substance Abuse Services (BSAS), the administrative state agency that oversees addiction prevention, treatment and recovery support services. The OBOT-B model was designed to provide treatment to marginalized individuals living in the communities of CHCs including the homeless, under-insured, ethnic and racial minorities, and those with co-occurring physical and/or mental disorders. Originally, funding was provided for three years for each site, renewable twice for two additional years, enabling seven years of potential funding. The funding supported one full-time NCM at each site with the expectation that each NCM would support an active panel of 100 patients. As the program expanded in 2011, its funder, BSAS, increased the caseload requirement to 125 patients per NCM the addition of a medical assistant for support. The program transitioned to a model in which practices billing Medicaid for services. During the transition, Massachusetts BSAS disseminated the OBOT-B Massachusetts Model from its development at Boston Medical Center to implementation at 14 community health centers. The financial sustainability of the OBOT-B program using NCMs allowed seven FQHCs involved in the program to expand beyond grant funding to better serve their communities. After implementation of the NCM model, access to OUD treatment increased substantially from 2007 to 2014, the number of patients accessing buprenorphine grew from 327 to 3,000. The number of physicians prescribing buprenorphine increased from 24 in 2007 to 114 in 2012.[292, 293] The workflow delineates roles for team members (Figure 26).

[292] Pew Charitable Trust Report 2018: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/11/innovative-approaches-can-help--improve-availability-of-opioid-use--disorder-treatment.
[293] American Hospital Association, "Boston Medical Center – STATE OBOT-B" https://www.aha.org/case-studies/2016-09-02-boston-medical-center-state-obot-b.

Figure 26. Massachusetts NCM Model: Patient Flow in the OBOT Collaborative Care Model [294]

Virginia. Virginia implemented the Preferred OBOT program, which establishes a "Gold Card" option for OBOT providers who meet enhanced standards, and in turn, receive additional and enhanced payments. Virginia's Preferred OBOT program outlines a set of mandatory criteria for clinical services and staffing, including a waivered physician or mid-level practitioner with a collaborative practice agreement or supervision by a physician; a collocated licensed behavioral health provider; counseling services; interdisciplinary care coordination; and risk management/patient monitoring.[295] Virginia's Medicaid program launched an enhanced SUD treatment benefit, Addiction and Recovery Treatment Services (ARTS). This benefit provides treatment for SUD statewide and expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, Family Access to Medical

[294] Colleen T. Labelle, "Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers" *Journal of Substance Abuse Treatment 60 (2016) 6-13.*
[295] Source: Review of State Strategies to Expand Medication-Assisted Treatment; A Report to the Laura and John Arnold Foundation; May 2019.

Insurance Security (FAMIS), FAMIS MOMS, and the Governor's Access Plan. This expanded continuum includes community-based addiction and recovery treatment services, coverage of inpatient withdrawal management, and residential SUD treatment.[296]

New York. Under a Section 1115 Medicaid demonstration waiver, one region, the Staten Island Performing Provider System, offers buprenorphine coaching and other support for waivered providers. This has resulted in high rates of active buprenorphine prescribing: 77 percent of waivered prescribers who received support prescribe buprenorphine.[297] Additionally, New York State's goal is to link 80 percent of Medicaid payments to value by the end of its delivery system reform incentive payment (DSRIP) program waiver period. To assist, Community Health Independent Practice Association, composed of FQHCs throughout New York, piloted an integrated primary care bundled payment that holds providers accountable for 14 physical and behavioral health conditions, including SUDs. Similarly, Maimonides Medical Center and Mount Sinai Health Partners are participating in a two-year pilot of the payment model, called "Total Care for Special Needs Populations."[298]

California. Partnership HealthPlan of California, a Medi-Cal MCO, offered incentive payments of $500 for primary care physicians to receive the waiver to prescribe buprenorphine in tandem with efforts to mitigate billing issues posing a barrier to MAT in primary care. Another MCO in California, Central California Alliance for Health, offered bonus payments of $1,000 to waivered physicians and eligible mid-level practitioners to help grow its MAT network. Additionally, Partnership HealthPlan rewards primary care providers who perform an average of at least one urine toxicology screen annually for patients prescribed opioids for 90 days or more. This allows providers to track whether or not patients are taking pain medications as prescribed and to see if they are using any illegal substances.[299, 300]

Connecticut. In Connecticut, there has been a push for Emergency Medicine Providers to address OUD, via MAT. The ED, and particularly the psychiatric emergency room (PER), is often the initial point of care for patients with OUD. MAT induction occurs in the ED, PER, and Veterans Administration (VA). Across the state, emergency physicians are made aware of the Providers Clinical Support System, which offers mentoring and support information to clinicians about clinical practices for prescribing medication for opioid addiction.[301] ED providers in Connecticut receive the Husky Health Emergency Department Practitioner Pain Management Toolkit. The Toolkit includes prescribing guidelines, information on how to

[296] Manual: Virginia Addiction and Recovery Treatment Services.
[297] Source: Review of State Strategies to Expand Medication-Assisted Treatment; A Report to the Laura and John Arnold Foundation; May 2019.
[298] Center for Health Care Strategies; Encouraging Substance Use Disorder Treatment in Primary Care through Value-Based Payment Strategies; https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/.
[299] Source: Review of State Strategies to Expand Medication-Assisted Treatment; A Report to the Laura and John Arnold Foundation; May 2019.
[300] Center for Health Care Strategies; Encouraging Substance Use Disorder Treatment in Primary Care through Value-Based Payment Strategies; https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/.
[301] https://pcssnow.org/event/medication-assisted-treatment-in-the-emergency-room-setting/.

address pain management in emergency settings, SBIRT, how to address OUD in the ED, and MAT prescribing. It also includes referral information for Behavioral Health Services. Having a toolkit for ED practitioners helps them adhere to national prescribing guidelines and makes them aware of resources available for patient referrals.[302]

Increased MAT Treatment Coverage and Expand Provider Types. Several federal and state policies have enhanced buprenorphine treatment coverage in the past decade and address provider concerns around reimbursement, care coordination, and peer support at the institutional and clinician level. One way states have increased access to SUD treatment is by expanding provider types allowed to practice in various SUD service settings. There are only physicians, APRNs, NPs, and a handful of PAs who are waivered in DATA 2000 in Nevada. The state is missing a large number of potential providers who can become waivered. CRNAs, CNMs, and CNSs can become waivered by SAMHSA to provide buprenorphine with 24 hours of training. While some of these provider types do not typically work in settings where MAT services can be provided, the state may establish a relationship with each of the groups' associations and provide information about becoming waivered. For example, CRNAs can work independently in the state so there can be a CRNA who might be in a position to provide MAT services in an office setting. Nevada has only 36 PAs who are certified to provide buprenorphine, while there are 1,507 PAs enrolled in Nevada Medicaid. This is a group of physician extenders who could expand the number of providers offering MAT services. Like the provider groups mentioned above, the State may consider establishing a relationship with the PA association in Nevada to provide information on becoming MAT-waivered and certified.

Recommendation: **Deploy Tactics to Increase MAT Services**

- ***Financial Incentives for Care Coordination.*** The state of Nevada may consider financial incentives for care coordination, across health care professional types including behavioral health counselors and other non-physicians in specialty and non-specialty settings.[303, 304] Allowing providers to receive reimbursement for a collaborative, team-based care model of MAT, provides a pathway for primary care offices to deliver sustainable, high-quality, evidence-based treatment.
- ***Promotion of a Team-Based MAT Care Model.*** Concisely delineated expectations for nursing, behavioral health, and care coordinator professionals' guarantees physicians the clinical support staff and administrative resources necessary to treat a complex patient population with chronic care needs. Team-based MAT care models are optimally cost-efficient, allowing prescribers to practice at the top of their license while nurses, behavioral health professionals, and care coordinators provide

[302] https://www.huskyhealthct.org/providers/provider_postings/pain_documents/ED_Practitioner_Pain_Management_Toolkit.pdf.
[303] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[304] Draft Nevada MSM Chapter 3800.

the care management, counseling, and coordination services vital to ensuring good outcomes that benefit Medicaid beneficiaries, as well as all patients seeking treatment for SUD.[305]

- ***MAT Induction Services to Occur in the ED Setting.*** Initiating buprenorphine induction in the ED prior to discharge or hospital admission serves as an opportunity to engage patients in treatment.[306] Through increased MAT treatment coverage and the expansion of provider types, allowing MAT services into Nevada's emergency rooms is possible. This treatment approach is ideal for patients with moderate to severe OUD who are experiencing withdrawal and those being treated for opioid overdoses. Such an approach may also help address OUD in pregnancy, as the use of buprenorphine is not contraindicated in pregnancy. While the treatment pathway might vary from hospital to hospital depending on their access to behavioral health services, this gives ED providers the opportunity to better identify appropriate candidates for MAT services. States that have done this successfully, including California and Connecticut, have seen the use of SBIRT and addiction treatment with buprenorphine more than double the percentage of individuals who received screening and referral only. [307] Follow-up care is recommended for patients who receive MAT in an emergency setting 24 to 48 hours after treatment and must be specific to the resources available in the community, such as behavioral therapy, continuing MAT, telemedicine, and community-based treatment. In previous years, buy-in for MAT induction in the ED has been low across the state of Nevada. Should the state of Nevada move forward with this recommendation, the next step should be a stakeholder engagement activity to assess willingness among ED providers and staff and then later the creation and distribution of an Emergency Medicine Toolkit.
- ***Billing Guidelines to Identify MAT Service Provider Claims.*** The implementation of billing guidelines will allow the State to identify a provider claim as a MAT service. This may be accomplished by requiring providers to add a specific code to the claim that denotes service provided is a MAT service. Billing guide was completed and posted online effective July 10, 2020. The state plans to have providers use a U5 modifier to indicate on the claim that a MAT service was provided.
- ***State Outreach to Provider Associations.*** Consider outreach to associations for CRNAs, CNMs, CNSs, and PAs to provide information about how providers can become MAT waivered.
- ***Enhance FQHC Provider Training to Support SUD and OUD Services.*** FQHCs currently provide integrated care and serve all patients regardless of payment status. DHHS can apply lessons learned from funded programs such as the Treating Addiction in Primary Care (TAPC) Safety Net program

[305] Article: Why Do So Few Doctors Have Buprenorphine Waivers? MedPage Today, Judy George; February 2018. https://www.medpagetoday.com/psychiatry/addictions/71169.
[306] Source: Meeting Report; Closing the Gaps in Opioid Use Disorder Research, Policy, and Practice: Conference Proceedings (Addiction Science & Clinical Practice 2018); Matthew A. Miclette, Jared A. Leff.
[307] Emergency Department Medication-Assisted Treatment of Opioid Addiction: https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf.

which successfully expanded MAT services into more than 20 health centers in California.[308] Such outcomes present strategies and tactics to increase SUD and OUD services and include: providing health care providers with training incentives, SBIRT, mentoring and support programs, increased reimbursement levels, and reduction of prescribing limits.

- ***Measure Outcomes through Performance Metrics.*** Whichever solutions the State chooses to implement, performance metrics should be considered. The implementation of both process and outcome measures related to waivered and certified providers would enable Nevada Medicaid to track how these policy changes have impacted provider capacity.

4.2.3. Address Stimulant Use Disorder

Recommendations are based on research concluding that implementing evidence-based practices requires a comprehensive, multi-pronged approach. This will lay the groundwork for implementing treatment practices.

- Develop a comprehensive approach including education and awareness, training providers, prevention, treatment, and recovery.
- Consider cultural and linguistic appropriateness; for example, the Rosebud Sioux tribe has a methamphetamine rehabilitation program adapting a Lakota model.[309]
- Plan for the geographic challenges that Nevada represents; for example, can any programs be implemented through telemedicine?
- Consider the evidence base for treatment. Four practices to treat stimulant use disorders have strong evidence of their effectiveness:
    - Motivational interviewing.
    - Contingency management.
    - Community reinforcement approach.
    - Cognitive behavioral therapy.[310]

[308] https://www.careinnovations.org/wp-content/uploads/TAPC_v5.pdf.
[309] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020. Page 33.
[310] Substance Abuse and Mental Health Services Administration (SAMHSA): Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

- Review existing programs for substance use prevention and treatment, and ensure stimulants are explicitly addressed, following years of focusing on opioids. For example, State requests for proposals can incentivize programs that address stimulants.
- Summarize hospital and death data related to stimulants. Consider collecting new data to inform population-based approaches.

Aside from the Rosebud Sioux tribe's methamphetamine rehabilitation program described above, there are other effective programs addressing stimulant use:

- The Homeless Person Health Project (HPHP) of the County Health Services Agency in Santa Cruz County, California provides contingency management as an optional component of MAT. The program results include reduced drug use and positive patient engagement.
- The Crystal Clear Project (Methamphetamine) of Mount Sinai West Hospital in New York City provides motivational interviewing and cognitive behavioral therapy for men who have sex with men and bisexual men who misuse methamphetamines. Anecdotal outcomes include reduction in the severity of methamphetamine use and reduction in risky sexual behaviors.[311]

4.2.4. Reduce Provider Administrative Barriers

The administrative challenges of health care providers identified by Myers and Stauffer lead to a set of recommendations that would expand the number of providers of OUD and SUD services, as well as provider capacity. The following sections make recommendations to address certification issues, scopes of practice limitations among health care providers, and enrollment administrative burden and complexity.

4.2.4.1. Addressing Provider SAPTA Certification Barriers

As DHHS continues to explore avenues for increasing access to OUD and SUD services, careful evaluation for the risks and benefits of the State's current administrative processes must be considered. Currently, providers who are seeking to provide certain ASAM levels of care must be SAPTA certified by the State which can present some challenges for providers. Recommendations for increasing the number of providers to become SAPTA certified are listed below.

Recommendation: **Decrease SAPTA Certification and Funding Barriers**

- ***Waterfall Reimbursement.*** The State may consider a reimbursement model that reduces the administrative burden of administering grant funds for organizations not accustomed to handling

[311] Ibid.

grant payments. For example, MMIS could parse the reimbursement payments through the edits built into the system and when the reimbursement was not a Medicaid expense it would filter down to the DPBH code and be paid from state or federal grant money. This would allow providers to bill Medicaid for all services rendered.

- ***Braided or Blended Funding.*** The State may consider using a braided or blended funding which merges multiple sources of funding to advance the State's SUPPORT Act goals. Braided funding combines state, federal (Medicaid funding, waivers, grants), and private funding streams for a united goal(s), ensuring to separately track and report on the use of the individual funding source. Blended funding is the same principle, with the exception that all blended funding sources are combined and not tracked and reported on individually.

- ***Incentivize Providers.*** As discussed in *Section 4.2.2. Increase MAT Services*, some states have gone the route of incentivizing providers to become DATA 2000-waivered and state certified, if applicable. The incentives can include additional funding such as bonuses for the providers once certified or when the provider completes the training. Low reimbursement rates are one of the primary reasons which providers do not offer MAT services. By providing a bonus for becoming certified, the providers are getting additional dollars, allowing MAT services to expand through an increase in the number of providers. Incentives can be targeted to address the areas of the state with the greatest identified needs. For example, an incentive could be created to increase the number of waivered providers to work with patients in rural areas.

4.2.4.2. Addressing Provider Scope of Practice Barriers

Nationally, the importance of scope of practice policies has grown as states struggle with health care workforce shortages, the growth of mental health issues, and the opioid crisis. The workforce shortages are in primary care,[312] as well as specialty practices. Measures such as the extent that non-physicians can provide services independently and which professionals can prescribe controlled substances can alleviate workforce shortages but must be weighed against provider education, training, and experience. As recommended by a report from University of Michigan School of Public Health, "One strategy to enhance workforce capacity is to ensure that behavioral health professionals can receive reimbursement for common procedures in behavioral health, especially when those services fall well within their expertise and scope of practice."[313] For policy best practice, national and other state's policies are highlighted below.

[312] HRSA Health Workforce, Projecting the Supply and Demand for Primary Care Practitioners Through 2020. https://bhw.hrsa.gov/health-workforce-analysis/primary-care-2020.
[313] Megan Dormond, MPH, Sara Afayee, MSW University of Michigan School of Public Health Understanding Billing Restrictions for Behavioral Health Providers. November 2016.

Physician Assistant Scope of Practice. PAs may prescribe medication in all 50 states. According to the National Association of Boards of Pharmacy, as of 2012, 40 states have given PAs varying degrees of authority to dispense medications to patients; this can be helpful for patients who live in rural areas.[314]

For best practice recommendations for scope of practice, the AAPA recommends:

- The State should consider allowing PA practice in all specialties and settings.
- PAs should be permitted to provide any medical service that is within the PA's education, training, and experience.
- Medical services considered for expansion for PAs include ordering, performing, and interpreting diagnostic studies; ordering and performing therapeutic procedures; formulating diagnoses; providing patient education on health promotion and disease prevention; providing treatment; and prescribing medical orders for treatment. The importance related to MAT, is this includes the ordering, prescribing, dispensing, administration, and procurement of drugs and medical devices.
- Additional training, education, or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal DEA.315.

Nurse Midwife Scope of Practice. American College of Nurse Midwives describes practice as encompassing a full range of primary health care services for women from adolescence beyond menopause, including the independent provision of primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections.

Nevada statutes do not recognize nurse midwives; however, the administrative regulations do. NAC §632.0605 defines a nurse midwife as a registered professional nurse who has completed an organized formal program of training in the area of pregnancy, childbirth, the postpartum period, care of the newborn, family planning, and the gynecological and primary health needs of women. [316] Pregnant women and new mothers who have OUD are not specified for, nor excluded from, services. Prescribing authority is not cited.

Recommendation: **Broaden Scopes of Practice for Health Care Professionals Providing Behavioral Health Services to People with SUD and OUD**

[314] https://www.ncsl.org/research/health/meeting-the-primary-care-needs-of-rural-america.aspx#State Actions.
[315] AAPA Guidelines for State Regulation of PAs https://www.aapa.org/download/35030/.
[316] https://www.leg.state.nv.us/NAC/NAC-632.html.

- ***Expanding Scope of Practice for APRNs.*** The Nevada state regulation NAC §632.2597 can be updated to add SUD and OUD treatment in the population of focus.
- ***Nurse Midwife Scope of Practice.*** Nevada Medicaid may seek to leverage the ASTHO-OMNI project and encourage nurse midwives use of the Provider Toolkit and/or the CARA brochure that will soon be deployed at OBGYN offices throughout Nevada. Among its varied contents, the Provider Toolkit contains details regarding how to screen women for SUD, referral and treatment information, and billing payment information for SBIRT. The CARA brochure provides the beneficiary's caregiver and family with information regarding how to care for a baby with NAS, community resources, legal rights, etc. Use of the Provider Toolkit and/or CARA brochure with beneficiaries and nurse midwives enable improved health outcomes of mother and baby.[317]

4.2.4.3. Address Provider Enrollment Process

The modernization of MMIS[318] and the move to online for provider enrollment[319] in early 2019 represent big advancements for the state of Nevada.

Recommendation: **Evaluate Provider Enrollment Process**

- The State should evaluate current enrollment procedures, using available data which can include provider stakeholder group input to determine where there are opportunities to improve the provider enrollment process.

4.2.5. Address Policy Limitations

Recommendation: **Policy Review Related to SUD and OUD as a Chronic Condition**

- To expand provider capacity and beneficiary access to SUD and OUD treatment and recovery services, DHHS can examine current program and billing policies to ensure they are not limiting services by the conditions being categorized as acute rather than chronic.

Recommendation: **Policy Review Related to SUD and OUD in Pregnancy**

- In order to increase the number of pregnant women that access SUD and OUD treatment services, and ultimately reduce the incidence of NAS, the State must have policies that intend to reduce harm. As the State policies around SUD and OUD in pregnancy evolve towards more harm

[317] Draft: ASTHO OMNI OBGYN Opioid Toolkit (v4).
[318] http://dhcfp.nv.gov/Resources/NevadaMedicaidUpdate/Nevada_MMIS_Modernization_Project.
[319] https://www.medicaid.nv.gov/providers/enroll.aspx.

reduction principles, it is critical that those policy changes have been promoted, widely distributed, and publicized.

4.2.6. Use of Data to Support Expansion of SUD and OUD Services

Data is vital to drafting effective health care policy, as it provides a snapshot of the region's health care status at any point in time. Funding opportunities typically call for a demonstration of need and measuring effectiveness, which can be accomplished using data. It is important to have an accurate portrayal in order to maximize any opportunities that may arise. This is particularly true for behavioral and integrated care. SUD and OUD are typically accompanied by a myriad of other health conditions and the data can allow for intersectional examination of trends to determine where the strengths and weaknesses lie.

Recommendation: **Improve Data Gathering and Reporting Practices**

- ***Use of an Integrated Care Readiness Tool.*** Nevada Medicaid may consider implementing an integrated care readiness tool, such as the Behavioral Health Integration in Medical Care (BHIMC), formerly known as the Dual Diagnosis Capability in Health Care Settings (DDCHCS), developed by SAMHSA. This tool is used to determine the current status of integrated care in Nevada. The DDCHCS was initially developed for FQHCs to assess the level to where behavioral and physical health are being integrated. Its companion tool, the Dual Diagnosis Capability in Addiction Treatment (DDCAT), is already used by SAPTA to determine the level of integration between SUD and mental health.[320] Other tools include the Organizational Assessment Toolkit for Primary and Behavioral Healthcare Integration developed[321] by SAMHSA-HRSA and the Mental Health, Primary Care and Substance Use Inter-Agency Collaboration Toolkit developed by the Integrated Behavioral Health Project. These tools will allow Nevada to gather and report data that will establish the baseline levels of integrated care in the state, as well determine the capacity for further integration.
- ***Establish Data-Reporting Methodology.*** The State may seek to implement a system-wide data-reporting methodology to be able to assess, in an ongoing manner, the level and amount of integrated care between primary care, mental health, and SUD treatment and recovery. In recent interviews conducted by Myers and Stauffer, stakeholders discussed that they would like to be able to better track services billed by some provider types and whether they are being paid for those claims.[322]

[320] https://www.integration.samhsa.gov/operations-administration/assessment-tools.
[321] https://www.integration.samhsa.gov/operations-administration/oati_overview_final.pdf.
[322] Myers and Stauffer Stakeholder Interview Session #3: Develop PA Requirement, Administrative Barriers, SUD Scope, Provider Capacity, April 14, 2020.

Recommendations: Improve Access to Care Through the Use of Health Care Workforce Data

- ***Data Collection through Licensure Renewal Processes.*** A licensure renewal process is overseen by the state's 26 health licensing boards. There are opportunities to efficiently collect standardized, longitudinal employment, demographic, and practice data on any health profession licensed by the state of Nevada. License renewal processes offer a strategic opportunity to gather information on the entire occupation. Such information can be used to capture existing and calculate projected clinical FTE capacity needed to meet the demand for SUD. Overall, data collection through licensure renewal processes should efficiently identify workforce shortages that ultimately inform resource allocation. [323]
- ***Improve the Accuracy of the HPSA Designation Process in Nevada.*** The federal HRSA recommends that states routinely collect supplemental information, such as provider specialty, practice geography, and patient care hours, in conjunction with licensure renewal processes. Improving the accuracy of the HPSA designation process impacts eligibility for the following: National Health Service Corp., Nursing Corp., Health Center Program, CMS Rural Health Clinic Program, CMS HPSA Bonus Payment Program, J1 Visa Waiver Program, and IHS Loan Repayment Program. [324]
- ***Informing Health Policymaking and Planning.*** The results from health care workforce data collection can be used to inform health policy making and planning. This could lead to the following:
    - Ability to estimate current and projected health workforce supply and demand.
    - Increased health education and training programs.
    - Targeted recruitment, retention, and other health workforce development.
    - Incentive programs.
    - Improved provider networks adequacy.

  A legislative proposal may require state licensing boards to collect data through licensure renewal, broaden stakeholder committee charges with developing discipline-specific data elements, and oversight for management of data for use by both public and private stakeholders. [325]

[323] Health Workforce Data Collection in Nevada through the Licensure Renewal Process, John Packham PhD University of Nevada Reno School of Medicine – White Paper June 2020.
[324] Improving Access to Care through Health Care Workforce Data Collection, John Packham PhD University of Nevada Reno School of Medicine. – Presentation Slides June 2020.
[325] Ibid.

Recommendations: **Define and Document Data Governance for SUPPORT Act**

Establish data governance that:

- Determines which data source to use throughout the grant lifecycle.
- Standardizes the method of data retrieval and reporting parameters by building repeatable processes.
- Creates and maintains consistent query logic for ongoing reporting, including retaining query code for audits and recreation of information, if needed.
- Maintains consistent timing in reporting (that is, the same time lag in reporting services based on date of service).
- Maintains consistent data extrapolation methods (that is, how encounter is summed by extrapolation of FFS data).
- Performs comprehensive quality control and checks on the reported data to ensure consistency and data integrity, as well as identifying assumptions, caveats, and inconsistencies.
- Maintains transparency and auditability of data.

4.2.7. Increase Access to SDOH Resources through Community Partnerships

With use of SDOH gaining recognition among health care stakeholders, community partnerships have emerged as a promising practice to address the social factors that affect an individual's and a population's health. These types of partnerships can facilitate multi-sector collaboration and coordination between health care providers, social workers, and other social support services professionals. Community-based solutions are necessary to achieve health equity across populations as they can address the drivers of health.

Vermont. The Vermont Blueprint for Health is a state-led initiative that strives for sustainable health care reform while providing the community with a continuum of health services. This initiative contains multiple programs: Patient-Centered Medical Homes (PCMH), Community Health Teams, Women's Health Initiative, Hub-and-Spoke, Support and Services at Home, and Self-Management Programs. The Community Health Teams supplement the care provided in the PCMHs, support patient and population health management, and link patients with social and economic services that can help support healthy living. If possible, the teams may be co-located with the practices or be located in a convenient location. The teams can include nurses, behavioral health counselors, social workers, dieticians, and health educators. The Support and Services at Home (SASH) program also connects local health and long-term care systems for Medicare beneficiaries in subsidized housing and in residences in the community. The teams are embedded at the properties and work to connect seniors to social services and supports in their community.

***Arizona*.** Mercy Maricopa Integrated Care, administered by CVS Health (formerly Aetna) is a non-profit health plan located in the state of Arizona that serves as the Regional Behavioral Health Authority for Maricopa County. One of their initiatives, the Comprehensive Community Health Program, was established for Medicaid-enrolled adults with behavioral health disorders that are not severe enough to meet the serious mental illness threshold. CCHP is an integrated health home developed to address the housing needs of its members by assisting them in obtaining and maintaining their housing of choice through Section 8 housing programs. The CCHP is the result of a collaboration between the City of Phoenix Housing Department, United Way, and Mercy Maricopa Integrated Care. The City of Phoenix Housing Department contributes 275 federally-funded Section 8 housing vouchers. United Way funds items and services, such as move-in kits, repair costs, and furniture. Mercy Maricopa Integrated Care provides Medicaid-covered permanent supportive housing-related services and supportive employment services.[326] FY 2018 saw a 28 percent reduction in hospitalizations and a 33 percent reduction in utilization of crisis services.[327]

***Recommendations:* Reinforce and Build Upon SDOH Resources and Reporting**

- ***Continue Investment in Community Programs*.** Though Nevada 2-1-1 provides a robust system for referrals, the 2019 Nevada Capacity Assessment revealed that there is still a shortage of crucial recovery supports, which can result in a relapse for the recovering individuals. The State should consider expanding 2-1-1 data available and increase the functionality of the data so it can be analyzed by client characteristics. This would allow data to be used to identify health disparities and better match them with community programs.
- ***Evaluate Current Community Partnerships.*** The State should review community partnerships and determine if they are being utilized to their full capacity and if there is opportunity for additional collaboration. The state may explore community-based organizations for additional collaboration opportunities. These types of evaluations and collaborations may be fostered in a stakeholder engagement initiative where the state brings together SDOH organizations to discuss what they are doing to address and assist those with SUD and identify areas where they can work together in partnership with the State. Additionally, the State could leverage existing positions like RBHCs to address and assist in these partnerships.
- ***Support an Increase in Needle Exchanges Across the State.*** Increase the number of needle exchanges throughout the State. Many non-profit organizations already provide this service, but the State can work towards strengthening these partnerships (like Trac-B and their work with Southern Nevada Health District). Additionally, these sites are ideal to distribute naloxone,

[326] https://www.kff.org/medicaid/issue-brief/linking-medicaid-and-supportive-housing-opportunities-and-on-the-ground-examples/view/print/.
[327] https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf.

provide education and resources around recovery and MAT, provide or refer to free public health services like HIV tests and Hep. C, and provide resources for additional social support networks.

- ***Continue to Invest in Transportation Programs for Recovering Patients in Rural Nevada.*** The State should support an increase of transportation vouchers provided to assist those seeking treatment, particularly in the Southern Region (Clark County) and Rural Region. It is critical for the state to seek funding to increase the availability of transportation services in rural Nevada. In order to maintain an adequate referral system, it is critical to have sufficient transportation resources to refer individuals to facilitate access to treatment when they request services.
- ***Increase Recovery Assistance Programs.*** Assistance obtaining employment, educational advisement, and parental support are all areas identified in the CAST results. Providing referral to services that support recovery will reduce relapse rates across the state.
- ***Improve Reporting on Member Inquires.*** As the district offices continue to work with the MMIS vendor to increase the capacity to report on member inquires, consideration should be given to how this reporting can be used to identify and intervene on the SDOH that are most reported by recipients.

5. Integrated Primary and Behavioral Health Care

5.1. Programs and Services: Integrated Primary and Behavioral Health Care

Historically, health care services have been siloed throughout the delivery landscape. This fragmented care results in worse health outcomes and increased spending.[328] One proven method of addressing this is implementing the model of care known as integrated care. The aim of integrated care is to provide primary health care and behavioral health care in one setting and to create a team-based approach to health care delivery.[329] Integrating care in this manner allows for those with behavioral health disorders to receive care for their physical needs and those with physical health disorders to receive care for their behavioral health needs.[330] DHCFP is committed to promoting the health and wellbeing of its residents and has begun to make substantial progress toward implementation of the integrated care model throughout the state through a variety of initiatives.

5.1.1. Integrated Care in Nevada

5.1.1.1. Federally-Qualified Health Centers

FQHCs are defined by HRSA as health centers that provide comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations.[331] Their purpose is to provide integrated access to primary health, mental health, SUD, vision, and dental services to communities who might otherwise not have access due to geographic, economic, or cultural barriers.[332] Nevada currently has nine FQHCs that cumulatively have 47 sites and five mobile clinics.[333] They are required to provide primary and preventive services, such as, but not limited to:

- Primary care services, such as physical examinations and health status assessments.
- Early periodic screenings.
- Preventive health services.
- Some diagnostic laboratory and radiology services.
- Family planning services.

[328] Enablers and Barriers in Implementing Integrated Care, 2015.
[329] https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml.
[330] Evolving Models of Behavioral Health Integration in Primary Care, 2010.
[331] http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C2900/MSM_2900_19_06_26.pdf.
[332] https://www.nvpca.org/content.asp?contentid=149.
[333] https://data.hrsa.gov/tools/data-explorer.

- Gynecological exams and prenatal services.
- Vision and hearing screening.
- Dental services.
- Mental and behavioral health services.

To build on the accomplishments of FQHCs, DHCFP released a request for proposal for the FQHC Incubator Project Grant FY18-FY19. These one-time grants were to assist the growth and promotion of expanding services to underserved areas and populations and are designed to develop sustainable models.[334] This particular funding period targeted individuals entering the community after incarceration in the jail system. The goal was to demonstrate increased access to services and improved physical and behavioral health of individuals re-entering their communities. First Med Health & Wellness and Northern Nevada HOPES were the project sub-grantees. The sub-grantees worked with their local jail systems to identify individuals who were medically fragile, high-risk, or in need of medical and behavioral services. The individuals were then linked to health and community services upon release.[335]

- First Med prioritized women between the ages of 25 and 35 who sought reunification with their children. Their model included intensive case management, primary health, behavioral health, and medically managed SUD therapy. All the women were offered medical care, weekly individual therapy sessions, substance abuse counseling, and psychiatric services.[336]
- Northern Nevada HOPES focused heavily on addressing transportation needs. The HOPES transportation van was available to released inmates four days a week and Northern Nevada HOPES ensured alternative transportation was available to inmates released on days when the HOPES van was not available. Northern Nevada HOPES provided linkage to services for 438 recently incarcerated individuals. Of those, the program has provided 654 internal referrals and 93 community referrals.[337]

The FQHC Incubator Project Grant was renewed for two fiscal years to continue Nevada's work toward improving the health care of its vulnerable populations. For this funding period, the target population is school-aged children and youth and their families. The purpose is to establish a medical home in, or in collaboration with, a school-related setting in a designated MUA. NVHCs and Community Health Alliance (CHA) were the project sub-grantees. NVHC has worked with several school districts in Nevada to set up telemedicine within the nurses' stations and connect them to NVHC. CHA has coordinated with the Boys and Girls Club in Northern Nevada and placed coordinators on site to connect children and their families

[334] http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/Funding/FHN/FQHC/FY18-19_RFA_FQHCIncubator_and_Opiod.pdf.
[335] http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/2019GMUAnnualReportADAcompliant.pdf.
[336] Ibid.
[337] Ibid.

to CHA for medical assistance and care. These projects are funded through FY 2021 with the intention that they will continue after the funding has expired.[338]

The goal is to achieve greater health equity among children experiencing health disparities due to socioeconomic barriers. The health care services must include medical, behavioral, dental, and vision care, and non-clinical services that enable individuals to access health care.[339]

Earlier this year, DHCFP revised the MSM chapter 3000, concerning Indian health. The revisions proposed that health services allow tribal or outpatient health clinics of tribal organizations to enroll as FQHCs. The aim is for AIANs to have access to health services other than tribal clinics.[340]

Additionally, the State is increasing capacity through FQHC projects to expand MAT. CASAT is currently working with three FQHCs and will be working with five more in 2021.

- NVHCs joined the project to focus on MAT and SBIRT. During their final assessment, in August 2020, they identified areas of focus to better sustain their nascent MAT program:
    - Incorporate the behavioral health provider at the beginning of the primary care visit.
    - Behavioral health providers will review primary care patient visits each day and identify patients with an SUD diagnosis.
    - Behavioral health providers will make an appointment for the patients identified with an SUD on the same day.
    - Behavioral health providers will coordinate with the front desk team and schedule SUD visits.
- First Person Care Clinic participated in some of CASAT's SBIRT and Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) training sessions; however, due to COVID-19, their priorities shifted and they were not able to execute an MOU with NVPCA.
- In August 2020, Northern Nevada HOPES began utilizing SBIRT to screen adolescent patients, ages 13 to 17, who presented for primary care visits for SUD. The FQHC has reported two critical barriers: delay in provider workflow due to increased screening and delayed behavioral health referrals due to COVID-19. Since the launch of their adolescent screening pilot program, providers screened 85 percent of all adolescent patients, with a positive screen rate of 15 percent. Patients who screened positive received education and referrals and those who screened negative

[338] https://www.leg.state.nv.us/Session/80th2019/Minutes/Senate/FIN/Final/1051.pdf.
[339] http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/FQHC%20Incubator%20Grant%20RFA.pdf.
[340] http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C3000/MSM_3000_20_03_25_ADA-signed.pdf.

received "positive reinforcement". Northern Nevada HOPES plans to move forward and implement SBIRT billing codes in September 2020 along with a sustainability plan for the program.

NVPCA evaluated results from the MAT orientation and MAT virtual site visits and identified opportunities for process improvement: telemedicine visits for OUD treatment during the COVID-19 crisis; the value of integration of OUD treatment and primary care; quality assurance; and staff training and education.

5.1.1.2. Certified Community Behavioral Health Centers

In 2016, the State was selected to participate in the federal Section 223 of the Protecting Access to Medicare Act demonstration program to develop a network of CCBHCs. These entities, a new provider type in Medicaid, are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals, including members of the armed services and veterans. CCBHCs are responsible for providing nine specific service types, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. Under this demonstration, Nevada has certified three CCBHC providers and expanded their scope to allow for the provision of Medicaid state plan services in an integrated setting. This expanded scope includes MAT and ambulatory withdrawal management, primary care services, 24/7 crisis intervention including mobile crisis, psychiatric rehabilitation services, assertive community treatment, and family-to-family peer interventions. Preliminary CCBHC results demonstrate that:

- Results of adult consumer satisfaction surveys, an evidence-based instrument administered by the Mental Health Statistics Improvement Program, indicate positive experiences, the majority of respondents agree or strongly agree with positive care experiences in quality and appropriateness, outcomes, participation in treatment, and access.[341]
- The MAT prescription rate per 100 of the population increased considerably in the two rural counties where CCBHCs were implemented. Specifically, between 2017 and 2018, MAT rates increased by 40.07 percent in Churchill County and 46.67 percent in Elko County.

Although the demonstration program was originally designed as a two-year program, Congress extended it beyond its original end date of June 30, 2019 to November 30, 2020. Building off the success of the demonstration program, Nevada certified an additional six CCBHCs to provide integrated, comprehensive health services with a focus on behavioral health in 2019. These six CCBHCs are covered under a Medicaid SPA which was approved by CMS in March of 2020.

[341] NEV. DEP'T OF HEALTH AND HUMAN SERVS., CCBHC CONSUMER SATISFACTION SURVEY REPORT (February 2020) (on file with State); James A. Shaul et. al., *Toward a National Consumer Survey: Evaluation of the CABHS and MHSIP Instruments*, 28 J. OF BEHAV. HEALTH SERVS. & RES. 3 (2001).

5.1.1.3. Indian Health Programs

Nevada is home to the Wa She Shu (Washoe), Numu (Northern Paiute), Newe (Western Paiute), and Nuwu (Southern Paiute) tribes and has 32 Indian Reservations and Colonies across the state.[342] There are 25 health care facilities affiliated with the Indian Health Services, Tribal Organizations, and/or Urban Indian Organizations (I/T/U). The health and community services available vary from location to location but can include medical health care, mental health care, alcohol and substance abuse services, pharmacy services, health education, and more.[343] As reported in a stakeholder interview, some of the tribal communities have robust referral systems and have expressed interest in learning more about MAT for OUD and have inquired about receiving naloxone for distribution. In collaboration with CASAT, the state will be conducting a Tribal Needs Assessment in 2021.

5.1.1.4. Integrated Mental Health and Substance Use Disorder Services

Mental health disorders often occur simultaneously with SUDs. The 2018 National Survey on Drug Use and Health revealed that approximately 9.2 million American adults aged 18 or older had both a mental illness and at least on SUD in the past year.[344] These dual diagnoses are known as COD and they are treated most effectively when treated together. Nevada has developed and implemented two models to distinguish where this specific type of treatment can be received, as well as the intensity of their services.

Substance Abuse Prevention and Treatment Agency Certification. Nevada's SAPTA provides a certification for behavioral health providers specializing in SUD and co-occurring mental health disorder treatment. In order to receive this certification, the organization must meet the requirements laid out in NAC 458. The organizations are all categorized through the Levels of Care established by the ASAM levels of care. These levels include:

- Level 0.5 – Early Intervention/Prevention.
- Level 1 – Outpatient Services.
- Level 2.1 – Intensive Outpatient Program (IOP).
- Level 2.5 – Partial Hospitalization Program (PHP).
- Level 3 – Outpatient Services provided in a Licensed Level 3 environment.

[342] https://www.leg.state.nv.us/App/NELIS/REL/80th2019/ExhibitDocument/OpenExhibitDocument?exhibitId=36429&fileDownloadName=Pwr.Pnt_2019%20Overview%20of%20Nevadas%20Tribes_State%20of%20Nevada%20Indian%20Commisssion.pdf.
[343] https://www.ihs.gov/forpatients/health care/.
[344] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

The breakdown of Nevada SAPTA certified providers by Level of Care can be found in Table 18.

Table 18. Nevada SAPTA Providers by ASAM Level of Care as of June 3, 2020

Level of Care	Provider Counts
Level 0.5	28
Level 1	111
Level 2.1	74
Level 2.5	18
Level 3	34

Source: https://behavioralhealthnv.org/provider-search-2/.

Additionally, the organization must also complete an assessment using the DDCAT tool in order to determine the level of services available to adolescents and adults who have a dual diagnosis. The instrument was developed by SAMHSA using the ASAM taxonomy, which consists of three categories:

- **Addiction Only Services:** Addiction treatment programs that do not accommodate individuals with mental health disorders.
- **Co-Occurring Capable (COC):** Addiction treatment programs that accommodate individuals with mental health disorders that are relatively stable.
- **Co-Occurring Enhanced (COE):** Addiction treatment programs that accommodate individuals with acute and unstable mental health disorders.[345, 346]

The DDCAT tool is completed during an on-site visit by a SAPTA representative and the resulting score determines whether the organization receives a COC or COE service endorsement for adolescents or adults or both. As of April 2020, there were 173 facilities in Nevada certified by SAPTA, with the majority endorsed as COC services for adults (Table 19).

[345] Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit. SAMHSA.
[346] ASAM Criteria Brochure, 2019.

Table 19. SAPTA Certified Facilities with a COD Service Endorsement

Service Endorsement COD Type	No. of Facilities
Capable – Adult	93
Enhanced – Adult	15
Capable – Adolescent	29
Enhanced – Adolescent	10

Source: https://behavioralhealthnv.org/provider-search-2/.

Substance Abuse Agency Model Clinics. SAAM clinics are a type of specialty clinic that integrate mental health and SUD services. They are authorized by DHCFP and can provide behavioral health counseling, alcohol and drug screening and services, psychotherapy, and evaluation and management services. They can only bill services and codes tied directly to the ASAM Levels of Care. The clinics that provide services tied to Levels 1 through 3 must be SAPTA certified and are included in the Table 20 counts. It appears, "Providers Active" represents providers who are enrolled and provided services during the time period indicated. The county breakdown of these providers is included in Table 20.

Table 20. SAAM Provider Counts by County in CY2020 QTR 1

Provider County	Providers Enrolled	Providers (Active)
Carson City	3	3
Churchill	1	1
Douglas	2	2
Elko	2	1
Humboldt	1	1
Lyon	1	1
Nye	4	4
Urban Clark	44	17
Urban Washoe	17	8
Total	**75**	**38**

Source: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/BHSreports/SAAMdashboards/SAAM-CY2020-Qtr1.pdf.

5.1.2. Opportunities and Recommendations

Below are opportunities and recommendations related to expanding availability of MAT services and increasing accessibility of integrated health care. Additional recommendations are located with the *5.5. Hub-and-Spoke* section of this report.

California. In 2016, the TAPC Safety Net program was launched by the Center for Care Innovations to support safety net clinics in improving the identification and management of SUD. This 18-month program funded by the California Health Care Foundation, assisted 25 health centers to implement, sustain and/or expand the use of MAT services for opioid use. TAPC conducted activities to support participants in designing strategies to develop new or enhance existing MAT programs. Among the resulting lessons learned from the program, are tactics used to shift perspectives about addiction, the provider's role in

treatment, and the use of MAT; as well as development of new and enhanced existing models for program design and implementation.

Recommendation: Expand MAT Services into Additional FQHCs, Rural Clinics, and Primary Care

DHCFP can conduct activities to further expand MAT services into FQHCs and rural clinics. Such activities may include:

- ***Identifying system requirements or changes*** that would need to be made in order for the FQHC or rural clinics to offer MAT services.
- ***Analyzing data*** and presenting providers with reliable information regarding how many beneficiaries in their service area they may be able to serve.
- ***Engaging key stakeholders*** and champions to support expansion of MAT services into specific community health centers.
- ***Leveraging lessons learned*** from programs such as TAPC program to change attitudes regarding the use of MAT and address provider perspectives that addiction medicine is difficult and unappealing.
- ***Tracking outcomes*** in aggregate to identify and showcase success stories of MAT services provided to Medicaid population.
- ***Identifying specific use cases*** and building a compelling but simplified business case for FQHC, rural, and other primary care to offer MAT services.

Recommendation: Employ the Collective Impact Collaboration Method

Among the Nevada SUPPORT Act Planning Grant activities, DHHS may consider employing a social progress collaboration model during the implementation phase to effectively expand provider capacity and beneficiary access to SUD and OUD treatment and recovery services. Various complex public and private social problems have been successfully addressed using the Collective Impact Initiative method.[347] The method is supported by the following five conditions:

1. ***A Common Agenda.*** All participants have a shared vision for changes including a common understanding of the problem and a joint approach to solving it through agreed-upon actions.
2. ***Shared Measurement.*** Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.

[347] http://rhap.org.za/wp-content/uploads/2018/01/Embracing_Emergence_PDF.pdf

3. ***Mutually Reinforcing Activities.*** Participant activities must be differentiated while still being coordinated through a mutually-reinforcing plan of action.
4. ***Continuous Communication.*** Consistent and open communications is needed across the many players to build trust, ensure mutual objectives, and create common motivation.
5. ***Backbone Support*.** Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

There are three pre-conditions for Nevada Medicaid to consider should they use the Collective Impact collaboration method to facilitate tactics during the implementation phase to successfully expand provider capacity, increase integrated health care, and enhance data sharing. These pre-conditions are: 1) identification of an influential champion to command respect and facilitate consensus among groups with diverse opinions; 2) adequate financial resources; and 3) a sense of urgency for change. DHCFP likely meets these pre-conditions through engagement of State and community leadership, access to funding under the SUPPORT Act grant opportunities, and the need for immediate attention to tackle the opioid crisis head on in Nevada.

5.2. Telehealth Approach to Expand Provider Capacity and Enable Integrated Services

Technology-enabled approaches can help to expand provider capacity and competency, as well as increase access to SUD treatment services in Nevada's rural, frontier, and tribal communities. In 2019, Nevada regions reported the need of an "increase in availability and utilization of technology and telehealth resources" to increase SUD treatment capacity.[348] Almost all Nevada residents live in a HPSA and the majority of the state is rural, creating significant issues with access, and telehealth utilization can save rural medical facilities over $180,000 per year.[349] This is aggravated by the unavailability of transportation, cited as a barrier in the 2019 Nevada State Health Needs Assessment and specifically identified in key informant interviews as one of the main barriers in Carson City, Eureka County, Lyon County, Mineral County, and Storey County. Telehealth and supporting health IT can alleviate workforce shortages and bridge distances. Telehealth, health IT, and Project ECHO® approaches are described below.

5.2.1. Telehealth in Nevada

Telemedicine and telehealth are often used interchangeably; however, there is a distinction. Telemedicine refers specifically to remote clinical services, while telehealth can refer to remote non-clinical services.

[348] SAPTA Nevada Capacity Assessment Report, July 2019.
[349] Broadband USA, Nevada Broadband Workshop, September 27, 2019.

Telehealth refers to a broader scope of remote health care services,[350] and has, therefore, emerged as an umbrella term that includes telemedicine. Telehealth can include "services such as those furnished with medical information exchanged from one site to another, through audio and video equipment permitting two-way, real time, interactive communication between the beneficiary and a clinician at different locations," and include services such as screening for mental health, SUD assessment, and individual or group psychotherapy.[351]

Telemedicine offers innovative approaches for treating and reducing the effects of SUDs or OUDs. High levels of satisfaction and acceptance with telemental health have been consistently demonstrated among patients across a variety of populations and services;[352] however, telehealth technologies are still widely underutilized. Highlights of available research include:

- A 2018 analysis assessed the interest and use of 11 applications in a sample of 363 SUD organizations across the U.S. The percentage of patients that had a very high interest in the telehealth technologies was significantly higher than the percentage of facilities that were currently using the technology. For example, 68.4 percent of patients indicated that they were highly interested in text appointment reminders, while 13.2 percent of the facilities were actually utilizing this feature. Additionally, 54.8 percent of patients were highly interested in video-based therapy, while only 20.4 percent of facilities offered teletherapy.[353]
- A VA study of 98,609 patients assessed clinical outcomes with mental health disorders before and after enrollment in telehealth services and found declines in hospital admissions and stays.[354]
- One cohort study of 3,733 participants found that patients treated with telemedicine were more likely or equally likely to be retained in therapy than patients treated in person.[355]
- Assessments based on video conferencing are reliable, with no difference between accuracy and satisfaction, and videoconferencing clinical outcomes are comparable to face-to-face treatment.[356]

[350] American Academy of Family Physicians, https://www.aafp.org/media-center/kits/telemedicine-and-telehealth.html.
[351] Centers for Medicare and Medicaid Services. CMCS Information Bulletin. Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the SUPPORT Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth. April 2, 2020.
[352] Overview of Video Conferencing in Behavioral Health. Mountain Plains ATTC Network. HHS Region 8 Presentation, February 2020.
[353] Molfenter, T, et al. Use of Telemedicine in Addiction Treatment: Current Practices and Organizational Implementation Characteristics. Int. Journal of Telemedicine Applications. March, 11, 2018.
[354] Godleski, L, et al. Outcomes of 98,609 U.S. Department of Veterans Affairs patients enrolled in telemental health services, 2006-2010. Psychiatry Services. 2012, April; 63(4).
[355] Eibl JK, Gauthier G, Pellegrini D, et al. The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. Drug Alcohol Depend. 2017;176:133-8.
[356] Chakrabarti, S. Usefulness of tele psychiatry: A critical evaluation of videoconferencing-based approaches. World Journal of Psychiatry. 2015 September 22; 5(3).

- Telehealth delivery models have a potential to lower health care costs, expand access to care, and are showing increased acceptability among providers, patients, policymakers, and payers.[357]

5.2.1.1. Telehealth Laws in Nevada

Telehealth modalities are increasingly used in treatment of SUDs. Utilization of telehealth can remove barriers of time and distance and can enhance treatment, recovery, and privacy for patients with SUDs. They also offer clinicians ways to increase contact with SUD patients during and after treatment.[358] Legislative and regulatory changes have begun to expand the use of telehealth delivery methods to expand services and increase access to SUD care. The SUPPORT Act §2001 expanded Medicare coverage of telehealth services to beneficiaries in their home, and stipulated that reimbursement must be the same as that for an in-person visit. However, unlike the Medicare program, federal law and regulations do not specifically address telehealth delivery methods or the criteria for implementation in Medicaid, meaning that the states have broad flexibility in designing the parameters of a telehealth program.[359]

Nevada is one of 20 states evaluated as having "progressive" telehealth laws and policies in terms of practice standards and licensure, coverage and reimbursement, eligible patient settings, eligible provider types, eligible technologies, and service limitations.[360] Nevada law requires Medicaid and any health or industrial insurance policy to cover telehealth services to the same extent as services provided in person.

In AB292 of 2015, the Nevada legislature defined telehealth as "the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile, or electronic mail."[361] In order to provide telehealth services, the provider must have a valid Nevada license or certificate, and services must be within the scope of practice and meet care standards. There are no restrictions as to the provider location.

In 2015, Nevada joined the Federation of State Medical Boards' Interstate Medical Licensure Compact for physicians, which allows providers in participating states to apply for an expedited state medical license, thereby making it easier for an out-of-state provider to obtain Nevada licensure and offer telehealth services.

[357] ShigekawaE, Fix M, Corbett G, Roby DH, Coffman J. The current state of telehealth evidence: a rapid review. Health Affairs, 2018; 37(12):1975-1982.
[358] Exploring Telehealth Delivery Methods for Substance Use Disorder Treatment. Medicaid IAP: Reducing Substance Use Disorders. September 10, 2019.
[359] Centers for Medicare and Medicaid Services. CMCS Information Bulletin. Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the SUPPORT Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth. April 2, 2020.
[360] State Telehealth Laws and Medicaid Policies: 50 State Survey Findings. Manatt Health. July 2018.
[361] Fact Sheet. Telehealth in Nevada. Nevada Legislative Counsel Bureau. February 2016.

5.2.1.2. Nevada Telemedicine Policy and Reimbursement[362]

There are a number of key terms related to Nevada telemedicine, including the following:[363]

- **Originating site.** Where the provider is located at the time health care services are delivered.
- **Facility fee.** Amount paid to the originating site for hosting the patient.
- **Distant site.** Any secure location where the telehealth provider is located while delivering health care services by means of telehealth.
- **Live video.** Two-way interaction between patient, caregiver, provider, and another provider using audiovisual telecommunications technology.
- **Store-and-forward.** Technologies that allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email.
- **Remote patient monitoring.** Digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

The Nevada Medicaid program reimburses for live video and store-and-forward services under specific conditions. There is no reimbursement for remote patient monitoring. Nevada Medicaid will reimburse for live video, as long as the services are on par with in-person visits and providers follow applicable policies and practice standards. Telehealth services follow the same prior authorization requirements as in-person services, so individual services may require prior authorization when delivered by telehealth.

Licensed clinical psychologists, LCSWs, and clinical staff may bill and receive reimbursement for psychotherapy, but not for medical evaluation and management services. The distant site provider must be enrolled in Medicaid, and the originating site may bill a facility fee if enrolled in Medicaid; however, store-and-forward services are not eligible for originating site facility fees. If the telecommunication system used is a beneficiary smart phone or home computer, the facility fee may not be billed.[364]

States are explicitly allowing for prescribing controlled substances via telehealth within federal limits, and Medicaid programs are beginning to pay for medication therapy management services provided through telehealth.[365]

[362] 50 State Telehealth Laws and Reimbursement Policies Report. Fall 2019. Centered for Connected Health Policy.
[363] Center for Connected Health Policy. https://www.cchpca.org/.
[364] 50 State Telehealth Laws and Reimbursement Policies Report. Fall 2019. Centered for Connected Health Policy.
[365] SUPPORT ACT Section 1003 Planning Grant: Addressing Provider Capacity for Delivering Substance Use Disorder Treatment. (Webinar)

5.2.1.3. Telehealth Bright Spots

Multi-State Collaborative

In a joint statement made on August 5, 2020, Governors from Colorado, Nevada, Oregon, and Washington announced that their states would be working together to address telehealth issues. Specifically, the states have agreed to collaborate to identify best practices to expand telehealth and benefit residents. The statement cited seven principles to guide the work: 1) Access; 2) Confidentiality; 3) Equity; 4) Standard of Care; 5) Stewardship; 6) Patient Choice; and 7) Payment/Reimbursement. The statement underscores the telehealth experience of each state, and their plan to share best practices and lessons learned from previous experience, and work together to address inequities especially among tribal communities and communities of color.[366]

Telehealth Grants

There are several grant-funded statewide and regional telehealth expansion and optimization programs from which to gather best practices in development of a telehealth program for SUD or OUD treatment:

- NVHC was awarded a two-year incubator grant of over $1 million from DHHS in October 2019 to bring telehealth services to schools. At full implementation, 39 schools in Elko County, Carson City, and Clark County will have access to telehealth.[367]
- The U.S. Department of Agriculture (USDA) awarded $987,745 to support Distance Learning and Telemedicine (DLT) in Nevada in December 2019. The DLT grant supports several current projects:[368]
    - NVHC was approved for $489,070 to connect 10 urban health centers to seven rural schools to support primary and behavioral health services, and to connect its Community Health Pharmacy in Carson City to six rural health centers to implement a remote dispensing system.
    - Renown Health received $228,300 to enhance its existing high-definition telehealth network across 12 sites by adding three new telehealth user sites at remote tribal reservations.

[366] Washington, Colorado, Nevada and Oregon announce coordination on telehealth. Office of Washington Governor Jay Inslee. August 5, 2020. Available at: https://www.governor.wa.gov/news-media/washington-colorado-nevada-and-oregon-announce-coordination-telehealth.
[367] Jeff Munson, Grant to Nevada Health Centers Supports Telehealth Services for Children at School Sites, Nevada Medical Association, October 2, 2019, https://nvdoctors.org/grant-to-nevada-health-centers-supports-telehealth-services-for-children-at-school-sites/.
[368] USDA Invests $987,745 In Distance Learning and Telemedicine Projects, USDA Rural Development, December 17, 2019 https://www.rd.usda.gov/node/16424.

- Hazel Health, which provides school health services, was awarded $270,375 to expand its school telehealth program. Hazel will partner with nine rural schools to offer instant access to medical professionals via two-way video calls. Early findings from Washoe County show a reduction in absences and higher academic achievement.[369]

- There were a number of previous USDA grants supporting telemedicine, such as:
  - Valley Health was awarded a grant of $164,137 in November 2018 to provide three years of telemedicine services to patients at seven rural Department of Corrections' conservation camps in Clark, Elko, Lincoln, Nye, and White Pine counties. Services to be provided will include emergency, cardiac, stroke, psychiatry, and opioid treatment.[370]
  - Renown Health was awarded a grant of $439,312 for their Telehealth and Healthcare Education Expansion program, which will expand telemedicine services to 11 sites in rural counties throughout Nevada. Services will be provided to the following counties: White Pine, Pershing, Nye, Douglas, Lyon, Lander, and Churchill counties. The grant will help to improve health care for rural Nevadans by providing primary care, specialty care, acute services, behavioral health care, and substance abuse treatment.[371]

Broadband Expansion

Nevada continues to make significant investments in expanding broadband access in rural areas, but coverage gaps remain.

In order to support EHR systems, the Federal Communications Commission (FCC) recommends the following minimum bandwidth speeds:[372]

- **Single Physician Practice – four megabits per second (Mbps).**
  - Supports practice management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables non real-time image downloads.
  - Enables remote monitoring.
- **Small Physician Practice (two to four physicians) – 10 Mbps.**

[369] Myers and Stauffer Telehealth Reimbursement, Barriers, Opportunities Interview, April 20, 2020.
[370] Nevada Health IT Roadmap 2020-2024.
[371] Ibid.
[372] FCC. Health Care Broadband in America.

- Supports practice management functions, email, and web browsing.
- Allows simultaneous use of EHR and high-quality video consultations.
- Enables non real-time image downloads.
- Enables remote monitoring.
- Makes possible use of HD video consultations.

- **Nursing home – 10 Mbps.**
  - Supports facility management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables non real-time image downloads.
  - Enables remote monitoring.
  - Makes possible use of HD video consultations.
- **Rural Health Clinic (approximately five physicians) – 10 Mbps.**
  - Supports clinic management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables non-real-time image downloads.
  - Enables remote monitoring.
  - Makes possible use of HD video consultations.
- **Clinic/Large Physician Practice (five to 25 physicians) – 25 Mbps.**
  - Supports clinic management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables real-time image transfer.
  - Enables remote monitoring.
  - Makes possible use of HD video consultations.
- **Hospital – 100 Mbps.**
  - Supports hospital management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables real-time image transfer.

  - Enables continuous remote monitoring.
  - Makes possible use of HD video consultations.

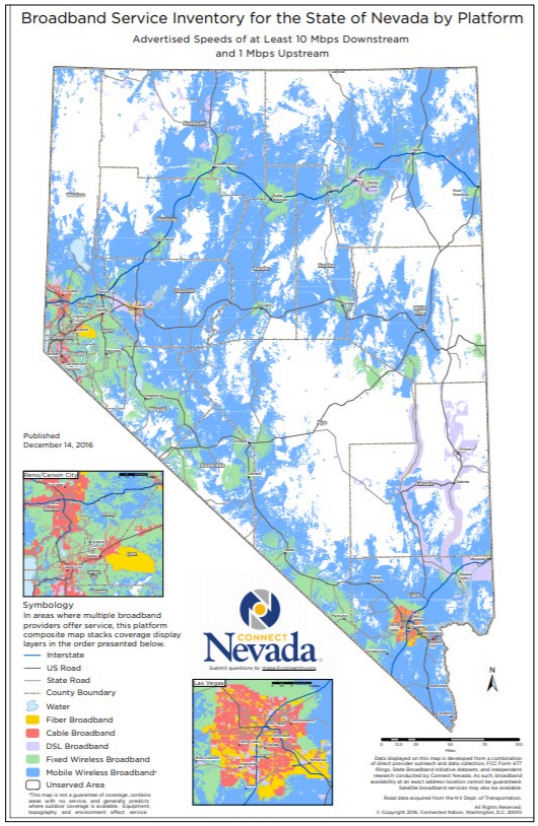
- **Academic/Large Medical Center – 1,000 Mbps.**
  - Supports hospital management functions, email, and web browsing.
  - Allows simultaneous use of EHR and high-quality video consultations.
  - Enables real-time image transfer.
  - Enables continuous remote monitoring.
  - Makes possible use of HD video consultations.

Generally speaking, internet speeds should be at least 15 Mbps download and five Mbps upload in order to support telehealth services such as audio and video conferencing.

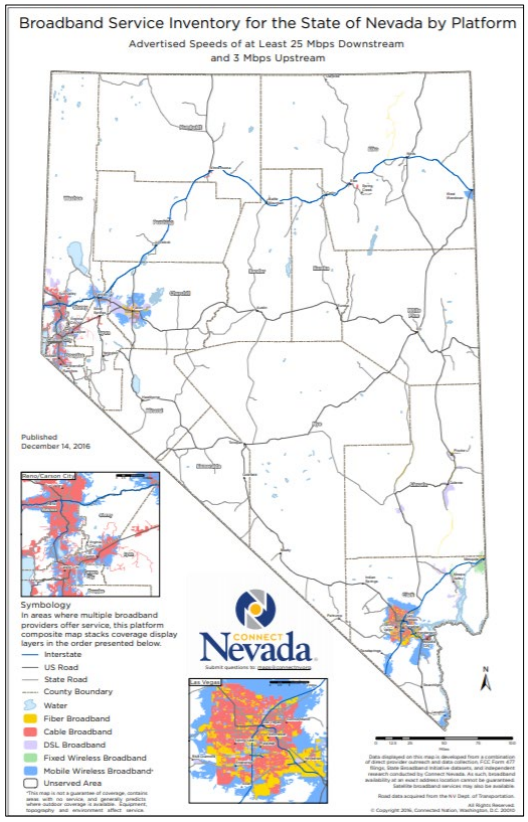
According to the most recent data from Connect Nevada, a subsidiary of Connected Nation, Nevada's state designee for the U.S. Department of Commerce's State Broadband Initiative grant, rural areas of the state still lack access to high speed broadband connectivity.

Figure 27. Nevada Broadband Coverage Comparison

10 Mbps Downstream and 1 Mbps Upstream



25 Mbps Downstream and 3 Mbps Upstream



The State is committed to connecting all rural hospitals, health clinics, and state correctional facilities to a broadband network sufficient to provide telehealth services by 2025.[373]

- A number of efforts to expand broadband focus on rural areas including the following:
    - In December 2019, the FCC awarded over $400,000 to support high-speed satellite internet.
    - In June 2019, the FCC awarded $23.6 million to provide service to more than 12,800 homes and businesses in 11 counties in rural Nevada.[374]

[373] Nevada's Strategic Planning Framework 2016-2020. http://energy.nv.gov/uploadedFiles/energynvgov/content/Programs/Governors%20Planning%20Framework.pdf.
[374] FCC, FCC Authorizes Second Wave of Funding for Rural Broadband from Connect America Fund Auction. Press Release, June 10, 2019, https://docs.fcc.gov/public/attachments/DOC-357886A1.pdf.

- In August 2018, the FCC awarded $29.2 million to expand broadband internet access across rural Nevada. The grant allocated $4.8 million in Washoe County, $3.76 million in Lyon County, $2.57 million in Clark County, $1.47 million in Mineral County, $681,587 in Douglas County, and $525,022 in Storey County in order to provide high-speed internet to more than 14,000 rural homes and businesses over the next 10 years.[375]

5.2.1.4. Current Flexibilities and the Future of Telehealth

The public health emergency resulting from the COVID-19 pandemic has accelerated the interest and utilization of telehealth services, including those related to SUDs and OUDs. While these flexibilities are set to expire when the public health emergency declaration is lifted, industry leaders agree that telehealth will play a much more prominent role in health care delivery in the future. To quote Seema Verma, the current CMS administrator, "I think the genie's out of the bottle on this one," and "there's absolutely no going back" on telehealth.[376]

Specific flexibilities during the public health emergency include:

- SAMHSA and the Drug Enforcement Agency released guidance[377] providing flexibility to prescribe buprenorphine to new and existing patients with OUD via telephone by otherwise authorized practitioners without requiring such practitioners to first conduct an examination of the patient in person or via telemedicine.
- SAMHSA released guidance[378] on 42 CFR Part 2 to ensure SUD treatment services are uninterrupted during the emergency. The guidance describes that disclosure of SUD records without consent is allowable in the event of a medical emergency.
- The Department of Health and Human Service Office of Civil Rights has indicated[379] that it will exercise enforcement discretion and waive penalties for certain Health Insurance Portability and Accountability Act (HIPAA) violations during the COVID-19 crisis for health care providers that utilize FaceTime or Skype video conferencing services (which normally would not meet applicable requirements for security and privacy).

Nevada has issued specific guidance documents related to state-level flexibilities and telehealth opportunities, including:

[375] https://carsonnow.org/story/11/13/2018/nevada-okd-603k-enhance-healthcare-access-15-counties-including-lyon-douglas.
[376] https://www.beckershospitalreview.com/telehealth/the-genie-s-out-of-the-bottle-on-this-one-seema-verma-hints-at-the-future-of-telehealth-for-cms-beneficiaries.html.
[377] https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf.
[378] https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf.
[379] https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html.

- Temporary suspension of the telephonic restriction based on federal guidance.[380]
- Termination of restrictions on the use of telehealth for group therapy.[381]
- Suspension of state licensure requirements for out-of-state licensed health care providers to offer services in Nevada (Emergency Directive 011).[382]
- State guidance, an FAQ about COVID-19, underscores that patients may receive telehealth services in their homes.

As discovered during an interview with state representatives, prior to COVID-19, telehealth in Nevada was utilized on a limited basis, mainly by behavioral health providers, despite the progressive reimbursement policies. Barriers to telehealth utilization include lack of HIPAA-compliant technology, low rate of broadband connectivity in rural areas, low perceived value, limited provider training, and resistance to change. However, COVID-19 has thrust providers into the telehealth space out of necessity, and has generated immediate value for providers and patients.

Many of the current flexibilities will likely remain in place after the emergency declaration is lifted. However, experts agree the exception that allows telehealth to be used to prescribe a controlled substance without the prescribing practitioner having conducted an in person exam will be rolled back and an in-person exam will again be required. In February 2020, the DEA issued a notice of proposed rulemaking which states that "narcotic treatment programs that operate mobile components (in the state that the registrant is registered in) to dispense narcotic drugs in schedules II-V at a remote location for the purpose of maintenance or detoxification treatment would not be required to obtain a separate registration for a mobile component."[383] The proposed rule also waives the requirement of a separate registration at each place of business or professional practice. The rule does not ease federal restrictions on prescribing schedule drugs via telehealth. However, the SUPPORT Act § 3232 requires the DEA to specify a process through which providers can become eligible to prescribe controlled-substances via telehealth.

5.2.2. Opportunities and Recommendations

While the current reimbursement and policy landscape in Nevada supports expansion of telehealth for SUD and OUD treatment, education, training, and infrastructure are cited as key barriers among providers. The recent COVID-19 pandemic has led to states turning to telehealth to maximize contact between

[380] https://www.medicaid.nv.gov/Downloads/provider/web_announcement_2141_20200319.pdf.
[381] https://www.medicaid.nv.gov/Downloads/provider/web_announcement_2142_20200320.pdf.
[382] https://nvhealthresponse.nv.gov/wp-content/uploads/2020/04/2020-04-01.Declaration-of-Emergency-Directive-011-re-Health-Care-Providers.pdf.
[383] https://www.deadiversion.usdoj.gov/fed_regs/rules/2020/fr0226.htm.

patients and providers, which is a major shift in terms of delivery of OUD services. States have been actively restructuring treatment and related policies to support utilization of telehealth for administration of medications for OUD and addressing barriers to telehealth to enable providers to more readily adapt to the rapidly changing environment. The long-term implications of recent easing of restrictions for the use of telehealth during the pandemic are unknown; however, states are already seeing the benefits of telehealth utilization and will need to continue to evaluate how to maintain patient safety and security to support further telehealth expansion in the future.

5.2.2.1 Other State Examples

Removing the need for an in-person initial visit. On July 21, 2020, New Hampshire enacted HB1623, a new law that greatly expands how care providers use telehealth. HB1623 permanently expands the state's definition of telemedicine to include new modalities, including audio-only phones, and requires Medicaid and private payers to reimburse for telehealth services on the same basis that it reimburses for in-person care. The new law also ends restrictions on originating and distance sites for telehealth services and expands the list of care providers to include community mental health providers employed by community mental health programs, and alcohol and other addiction specialist and related professionals. Additionally, it makes permanent several telehealth freedoms passed by emergency measures to deal with the coronavirus pandemic, including reimbursement parity and the ability for providers and patients to collaborate on care through a telephone. New Hampshire's new law also eliminates the requirement for an in-person exam prior to a virtual visit for providers treating patients living with SUD and enables them to use telehealth to prescribe Class II-IV non-opioid controlled drugs. New guidelines also apply to providers employed by or contracted with the Department of Veterans Affairs; treating patients in state hospitals, clinics, correctional facilities and community mental health centers; and those treating patients in substance abuse programs. This piece of legislation is considered an effort to expand treatment options for healthcare providers working with SUD patients, especially in rural areas with limited to no access to care. Other states, including Colorado, Delaware, Florida, Idaho, Indiana, Michigan, Ohio, and West Virginia, have begun to explore the need to permanently update laws around telehealth in accordance to the CARES Act emergency telehealth expansion. [384, 385, 386, 387]

California TeleWell Behavioral Medicine. TeleWell Behavioral Medicine provides psychiatric addiction medicine services using telehealth technology. According to the project website, TeleWell offers MAT to American Indian and Alaskan Native patients with OUD presenting at Urban Indian and tribal health

[384] https://mhealthintelligence.com/news/nh-permanently-extends-telehealth-coverage-including-payment-parity?eid=CXTEL000000458697&elqCampaignId=15308&utm_source=nl&utm_medium=email&utm_campaign=newsletter&elqTrackId=85e1f83fb89d4d2caffd16e03bcea242&elq=a9826de59bb043ba99e02cb7c373618c&elqaid=16079&elqat=1&elqCampaignId=15308.
[385] https://mhealthintelligence.com/news/colorado-expands-telehealth-coverage-includes-home-health-care-services.
[386] https://www.foley.com/en/insights/publications/2020/04/covid19-idaho-suspends-regulations-telehealth.
[387] https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

providers, including clinical assessment, drug screening, induction, prescribing, evaluation and management, psychosocial, co-occurring psychiatric, and discontinuation treatment services. These services can be offered short (one to four sessions) or long (>four sessions) term. The goal of offering this service is to provide MAT services for programs that do not offer MAT in-house; provide a "jump-start" to programs that intend to start their own MAT program, but would like to observe the process before beginning; provide additional capacity to supplement programs that are full; and provide psychiatric services for MAT patients with complex co-occurring conditions.[388]

Bright Heart Health. Bright Heart Health was founded in March 2015 with a mission to connect expert providers with individuals through telemedicine to treat a full spectrum of behavioral health disorders. Bright Heart Health contracts with physicians who have received X-Waiver certification to treat opioid addiction and supports PCPs to provide these vital prescriptions via telehealth. Bright Heart Health provides virtual, live-video SUD outpatient treatment programs that can be discretely accessed on a personal mobile device from the convenience of home. The services removes critical barriers to receiving treatment, such as transportation, disability, distance, work, or childcare. Bright Heart Health reports that 90 percent of patients are still in treatment after 30 days, and 65 percent after 90 days, which is higher than traditional treatment.[389]

Anthem BlueCross California recently contracted with Bright Heart Health to expand access to virtual SUD treatment programs across California.[390] Anthem reports that the Bright Heart telemedicine option has helped increase MAT for member with opioid drug abuse issues from 16 percent to more than 30 percent in California and other states. Highmark Health Partnered with Bright Heart Health to provide comprehensive addiction treatment services for OUD including MAT (including addictions to substances, opiates, alcohol, benzodiazepines, and methamphetamines) via telemedicine in Delaware, Pennsylvania, and West Virginia.[391] The Ohio Mental Health and Addiction Services is supporting and funding, in part, access to Bright Heart Health to the court system to provide and monitor treatment services for offenders.[392]

Boulder Care. Boulder Care offers telehealth addiction treatment and currently accepts new participants in Alaska, Oregon, and Washington regardless of insurance carrier or ability to pay. Each participant is matched with an interdisciplinary care team who collaborate with each patient to create a tailored

[388] California MAT Expansion Project. Tribal MAT Project. Available at: http://www.californiamat.org/matproject/tribal-mat-program/.
[389] Online Treatment For Opioid Addiction Gets A Boost Under Coronavirus Rules: Shots - Health News The federal government has waived a law that required an in-person doctor's visit before patients could be prescribed drugs that quell withdrawal symptoms. That's a boon for patients, counselors say. NPR. April 20, 2020.
[390] Anthem Medi-Cal Managed Care L.A. Care Provider Bulletin January 2020. https://mediproviders.anthem.com/Documents/CACA_CAID_PU_BrightHeartHealthMedAssistTreatProgram.pdf.
[391] Highmark Health FAQs. March 31, 2020. https://content.highmarkprc.com/Files/Region/PA/EducationManuals/bright-heart-health-faqs.pdf
[392] http://www.supremecourt.ohio.gov/JCS/specDockets/COVID19/BHHTelehealth.pdf.

treatment plan. Boulder Care is only one option for virtual mental health care offered by Premera Blue Cross and Blue Shield of Alaska.[393]

***Recommendation:* Enhance Promotion and Education for Providers and Patients on Telehealth**

- ***Provider Training and Education.*** The current telehealth utilization and billing policy supports incorporation of telehealth as a treatment modality within federal limits. Furthermore, providers who have only recently begun to use telehealth given the COVID-19 flexibilities may require specialized training on how to deliver care effectively through telehealth and how to scale telehealth programs. The State should continue to focus efforts on provider training and education to expand telehealth utilization as a component of a broad SUD and OUD prevention and treatment strategy. For example, the Maryland Health Care Commission has developed a Telehealth Virtual Resource Center that provides technology tips and a readiness assessment to encourage adoption of telehealth.[394]
- ***Form a Telehealth Workgroup.*** The State should consider creating a telehealth focused workgroup that includes provider organizations that are champions of telehealth delivery for behavioral health and current SUD and OUD treatment providers in order to develop recommendations, tools, resources, and best practices for provider organizations adopting telehealth and for state policymakers. The state may also consider the creation of a broader statewide telehealth program to drive and monitor telehealth. A program may be created within the existing organization structure of DHHS and can be leveraged to produce a published a strategic plan, leveraging input from key stakeholders such as the Southwest Telehealth Resource Center.
- ***Monitor and Facilitate Applications for Telehealth Infrastructure Grant Programs.*** These efforts should be aimed at strengthening telehealth infrastructure, especially for providers serving rural communities. Examples include USDA DLT Program grants or the FCC COVID-19 telehealth program, which makes emergency funding available during the COVID-19 public health emergency. HRSA and the USDA offer ongoing programs to support telehealth expansion efforts. For example, the Washington Health Care Authority (HCA) has purchased a limited number of Zoom licenses for providers to administer telehealth services, with priority given to those who prescribe for OUD treatment.[395] New Mexico Department of Health established a Telehealth Fund in July 2014 in order develop affordable technical support services and develop a "cash match fund" to support provider participation in these federal grant programs.

[393] Premera BCBS. Mental Health. Available at: https://www.premera.com/visitor/care-essentials/mental-health.
[394] https://mhcc.maryland.gov/mhcc/Pages/hit/hit_telemedicine/hit_telemedicine_virtual_resource.aspx.
[395] https://www.hca.wa.gov/hca-offers-limited-number-no-cost-telehealth-technology-licenses-providers.

- ***Incent Providers in the Rural Setting.*** As telehealth becomes more widely used, certified providers can offer their services to rural patients without having to leave the larger cities in which they work. Enhanced rates or bonus payments can be used to incent the providers. Medical school loans can be paid for or offset by the State for those providers who become certified while serving rural areas.

- ***Permanently Extend Covid-19 Emergency Telehealth Coverage.*** Nevada should consider joining the growing list of states passing legislation to permanently extend telehealth coverage, which includes the expansion of telehealth use in substance abuse treatment. The permanent extension should eliminate the requirement for an in-person exam prior to a virtual visit for providers treating patients living with SUD and enable to use of telehealth to prescribe Class II-IV non-opioid controlled drugs. Enabling telehealth visits to be performed audio-only would be a big win for rural and frontier Nevada where infrastructure for a full telehealth visit might not exist.

- ***Partner with a TeleMAT Service Provider***. TeleMAT programs have been increasingly utilized during the public health emergency and have been shown to be as effective as in-person programs and have yielded increased retention rates among patients. Some payers, including Anthem, have partnered with TeleMAT service providers to expand access to MAT in rural populations especially. A TeleMAT program in conjunction with extension of COVID-19 flexibilities could greatly expand access to and participation in MAT statewide.

- ***Engage Patients to Encourage Utilization.*** As the use of telehealth as become more widespread, certain communities, such as non-English speakers and those with disabilities, have expressed difficulty in implementation. Research and engagement with patient groups experiencing challenges can help make telehealth more accessible, especially among diverse population.

5.3. Data Sharing and Health Information Technology

Integrated care is dependent upon the timely and accurate exchange of health information between the members of an individual's health care team. This is particularly important for patients with co-morbid or co-occurring conditions. Health IT can facilitate this exchange and support clinical activities.[396] Health IT refers to the use of information and communication technologies, including EHRs and HIEs, in caring for patients, tracking diseases and protecting public health, conducting research, and improving the health of individuals and populations.[397] Health IT has become the standard in medical care but has been adopted

[396] Cifuentes, Maribel & Davis, Melinda & Fernald, Douglas & Gunn, Rose & Dickinson, Perry & Cohen, Deborah. (2015). Electronic Health Record Challenges, Workarounds, and Solutions Observed in Practices Integrating Behavioral Health and Primary Care. Journal of the American Board of Family Medicine: JABFM. 28 Suppl 1. S63-72.
[397] Office of the National Coordinator, 2020-2025 Federal Health IT Strategic Plan, https://www.healthit.gov/sites/default/files/page/2020-01/2020-2025FederalHealthIT%20StrategicPlan_0.pdf.

at a much slower rate in behavioral health care settings,[398] mainly due to the lack of financial incentives available to behavioral health providers to adopt EHRs. However, advances in digital technologies have created unique opportunities to address gaps in health care delivery.[399] Federal funding at 90 percent match has also offered states opportunities to develop programs to offset the costs and deliver TA to support connection to HIEs by Medicaid behavioral health and substance abuse treatment providers.[400]

5.3.1 Health Information Exchange in Nevada

An HIE is an organization with agreed-upon operational and business rules that provides services to enable the electronic and secure sharing of health-related information, without the use of a fax machine, U.S. mail, or paper copies of records brought to providers by patients. Connection to an HIE can enable a more holistic view of a patient by offering a way to securely view a patient's longitudinal record, and send and receive critical information over a secure communications network to better coordinate care.

HIE is also a natural complement to telehealth, and will become more important as states continue to support telehealth expansion. As telemedicine creates a virtual consultation between patients and providers to increase access to care, the need for a virtual health record and efficient, secure movement of health data will become more necessary to ensure access to patient information regardless of where the patient or provider is located.

HealtHIE Nevada is currently the only statewide HIE serving Nevada providers. HealtHIE Nevada is certified by the Electronic Healthcare Accreditation Commission for meeting proper privacy and security standards, and offers a variety of data access and sharing tools, some of which are available to providers without an EHR. HealtHIE Chart is an interactive provider portal that contains comprehensive medical records, including labs and radiology reports and radiology images, full clinical histories, admissions and discharges from hospitals, and care summaries from provider organizations and is accessible through web access. In response to the COVID-19 pandemic, HealtHIE Nevada is offering free access for this tool to all eligible Nevada providers.[401]

5.3.1.1 Consent Policy in Nevada

Unlike most states in the nation, current legislation in Nevada[402] requires an "opt in" model for HIE, meaning explicit consent is required in order for patient health information to be stored and/or disclosed

[398] Jessica Kent, How to Integrate Clinical Care with Mental, Behavioral Healthcare, July, 17, 2019. https://healthitanalytics.com/news/how-to-integrate-clinical-care-with-mental-behavioral-health care.
[399] Marsch LA, Campbell A, Campbell C, et al. The application of digital health to the assessment and treatment of substance use disorders: The past, current, and future role of the National Drug Abuse Treatment Clinical Trials Network. *J Subst Abuse Treat*. 2020;112S:4-11.
[400] HHS, CMS, State Medicaid Directors Letter 16-003, February 29, 2016, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD16003.pdf.
[401] HealtHIE Nevada, COVID-19 Access to your Patients' Medical Records, https://healthienevada.org/covid-19-access-to-medical-records/.
[402] Nevada Administrative Code 439.586.

by the HIE. The HIE must also provide patients with a statement of information about the health information that may be retrieved; how HIEs generally share information; and the manner in which information is collected, retrieved and disclosed. Records of consent or refusal to consent must be kept for six years. Consent is valid in Nevada's system until revoked by written notice. The NAC further instructs exchanges to adopt a standard procedure for incorporating both revocations of consent and amendments to records made by authorized users.[403] Within Nevada health care providers can retrieve information without consent in the case of an emergency or if the patient is prohibited from opting out.74 Medicaid and CHIP recipients are prohibited from opting out.[404]

This consent model is a significant barrier to utilization of HealtHIE Nevada, as reported by stakeholders.[405] Most states have aligned utilization of the HIE with HIPAA, 42CFR Part 2, and relevant state laws around sharing of sensitive data and removed requirements for special consent for HIE as a data sharing modality.

Nevada has already seen the impact of relaxing consent requirements for HIE. As a result of the COVID-19 pandemic, HealtHIE Nevada has been able to share data for patients whose default consent has been opt-out, only because they haven't been asked. As a result, 23 new provider organizations have joined the network, and the HIE has seen a 36 percent uptick in health data sharing as of March 2020,[406] and an additional 14 percent on top of that as of August, 2020.[407]

5.3.2 Prescription Monitoring Program Enhancements

The NV PMP has partnered with Appriss Health to integrate NV PMP data into Nevada EHR and Nevada pharmacy management systems via Appriss Health's PMP Gateway platform. Integration is free for providers, and will allow practitioners and pharmacists to access PMP information within their clinical workflows, removing the need to sign onto a separate PMP database, which saves time and reduces administrative burden.

NarxCare® is a PMP platform that offers analytics and care management to help prescribers and dispensers best utilize real-time data from the PMP and run a risk score for dependency or possible overdose. NarxCare offers other tools, such as MAT program locators, to help care teams better meet patient needs. Nevada integrated NarxCare® with the PMP in early 2019.

[403] Nevada Administrative Code 439.586.
[404] Nevada Revised Statute 439.538.
[405] Nevada Health IT Roadmap 2020-2024.
[406] Leventhal, R. HealtHIE Nevada Sees 35% Uptick in Health Data Sharing During Pandemic. Healthcare Innovation. May 29, 2020.
[407] Jason, C. Nevada HIE Partners with Health Org to Boost Data Surveillance. EHR Intelligence. August 4, 2020.

5.3.3 Nevada OpenBeds and 2-1-1 Integration

In 2018, DHHS has purchased access to the OpenBeds Platform for statewide use through a three-year grant from the CDC. OpenBeds is an electronic behavioral health service registry that health care providers can access on a secure, HIPAA-compliant platform, and will create a behavioral health referral network in the state. The system allows for the electronic referral from a hospital or office-based setting to a treatment provider. The end-to-end, closed-loop system will make the referral process more efficient and effective for facilities as it provides de-identified, aggregate data regarding capacity and gaps in care.

Nevada is committed to use of OpenBeds and how it pairs with the Crisis Now model, a crisis care system that aims to avoid delays in treatment, create better outcomes for people experiencing psychiatric crises, and deploy resources appropriately. OpenBeds enables appropriate referrals for all levels of care, and the goal is to place individuals who need inpatient care in an appropriate setting, and will be utilized for all inpatient, resident, and crisis stabilization beds as a means to better integrate crisis care. One specific use case for OpenBeds is for improved discharge planning for patients on a legal 2000 (L2K) hold. However, the aim is to reduce the utilization of L2K as access to intermediate levels of care increases through OpenBeds.

Nevada is also leveraging the OpenBeds platform as a means to publish and promote the CARA POC Form. The OpenBeds software has been rolled out on a regional basis, starting in Washoe County, then will move to northern and central rural systems, then Clark County.

5.3.4 Opportunities and Recommendations

5.3.4.1 Health IT Use Case for Substance Use Disorder Treatment

As the health care system continues to evolve by leveraging health IT to deliver patient-centered, whole person care, applications have emerged to "close the loop" of referrals not only between primary care providers and specialists, but also between clinical and community services. Community care coordination systems support prevention and improve health outcomes through a community-level, system approach that connects individuals to health promotion and support services.[408]

Many Software-as-a-Service technology platforms are emerging that provide electronic community resource directories and can serve as a way to better coordinate care between health and social service providers by offering a means to facilitate and track referral outcomes. While these systems can exist

[408] Community Care Coordination Systems: Technology Supports. Nemours Children's Health System. http://www.movinghealthcareupstream.org/wp-content/uploads/2018/09/FINAL_Nemours_CommCareSysTechSupp.pdf.

outside of a provider's EHR, integration with these systems can facilitate seamless access for providers, which supports ease of adoption and utilization among the key end users.

Additionally, integration with an HIE can further enhance connectivity and data access across disparate networks and EHRs, and leverage existing services critical to the movement of data between providers and closing the loop. The HIE can help connect and create widespread interoperable networks across systems, and can incorporate varying levels of technology-enabled end-users.

Figure 28 illustrates the following patient's journey through a closed-loop system of shared care planning across several providers:

Edgar has struggled with opioid abuse over the last eight years and has been incarcerated several times. He has recently reached the end of a sentence served at the Merrimack County House of Corrections. Twelve months prior to his discharge, Edgar was screened for behavioral health conditions which established that he is additionally suffering from bipolar disorder and is at a high risk for relapse and recidivism. As a high-risk patient, several organizations will participate in Edgar's shared care plan. Thirty days prior to Edgar's release, his documented core standardized assessment and physical exam are sent via direct secure message to New Hampshire Alcohol/Drug Abuse Counselors Association and CATCH Neighborhood housing. These organizations will help Edgar build a support system and find housing during his transition.

Edgar's behavioral health clinician additionally identifies that he would benefit from MAT. Riverbend CMHC is notified by eReferral of Edgar's upcoming release and need for a screening. A request is sent to the State PDMP to obtain a patient history of controlled substances dispensed. After the screening, Riverbend CMHC sends a direct secure message to Merrimack County House of Corrections to close the referral.

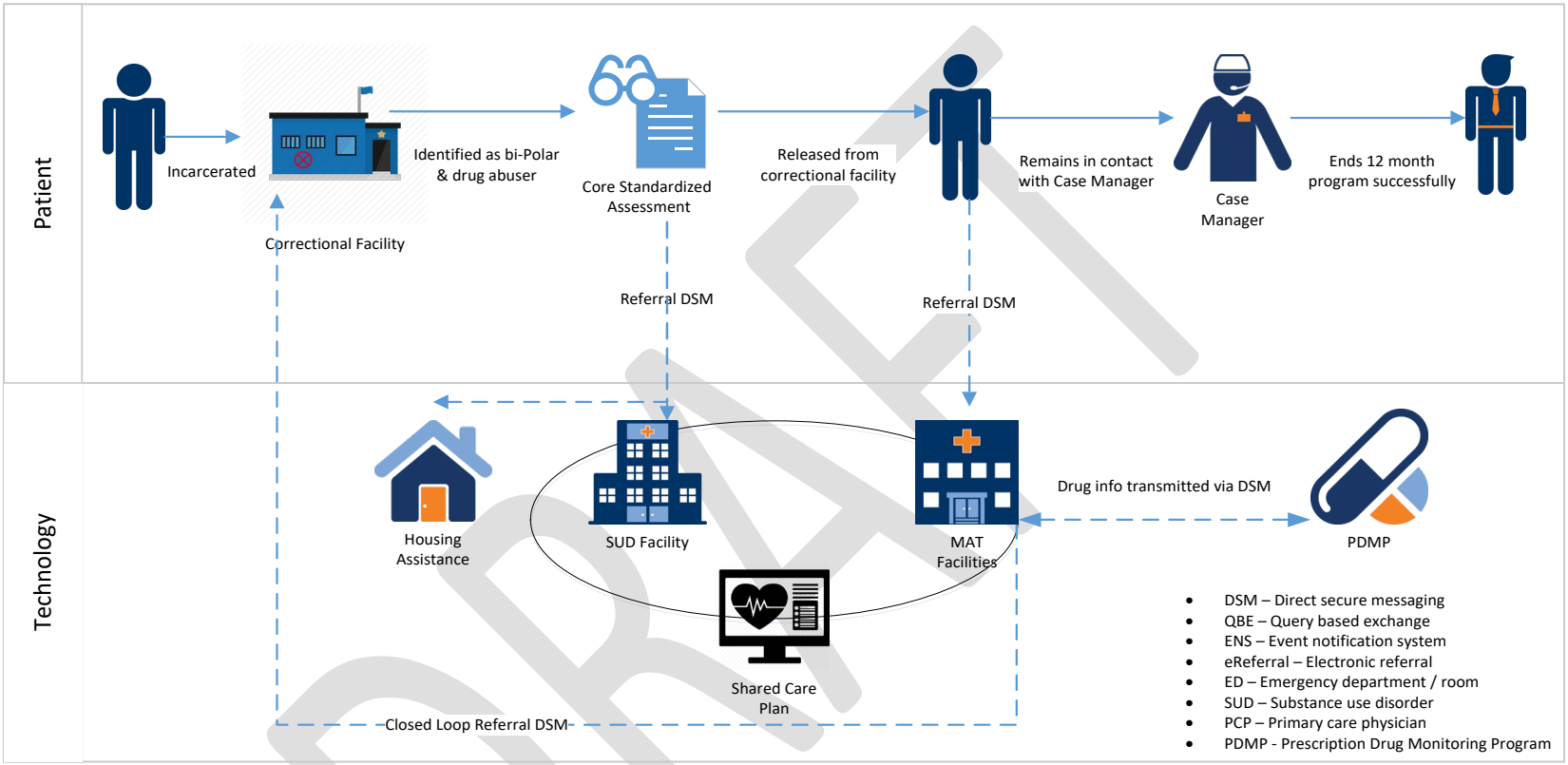
In the 12 months following Edgar's release, he has remained in contact with his case manager who has continued to provide support and connect him with necessary services. At the end of 12 months, he has not relapsed or been in the ED.

Edgar's care is coordinated between facilities via a health IT-enabled system that allows for enhanced shared care planning between all points of care. Key health IT solutions leveraged through the process include those most often offered by HIEs, such as:

1. Direct secure messaging, a national encryption standard for securely exchanging clinical health care data via the internet, with or without an EHR.
2. Query-based exchange, which allows providers to find and/or request information on a patient from other providers, often used in emergency care.
3. Event notification service, which sends an alert to appropriate providers on a patient's care team when admitted or discharged to/from a hospital or ED.

4. E-referral, which enables the seamless transfer of patient information from a primary to a secondary treating provider.

Figure 28. New Hampshire Integrated Care Network Closed-Loop Referral Process Example



Source: Mass HIway.

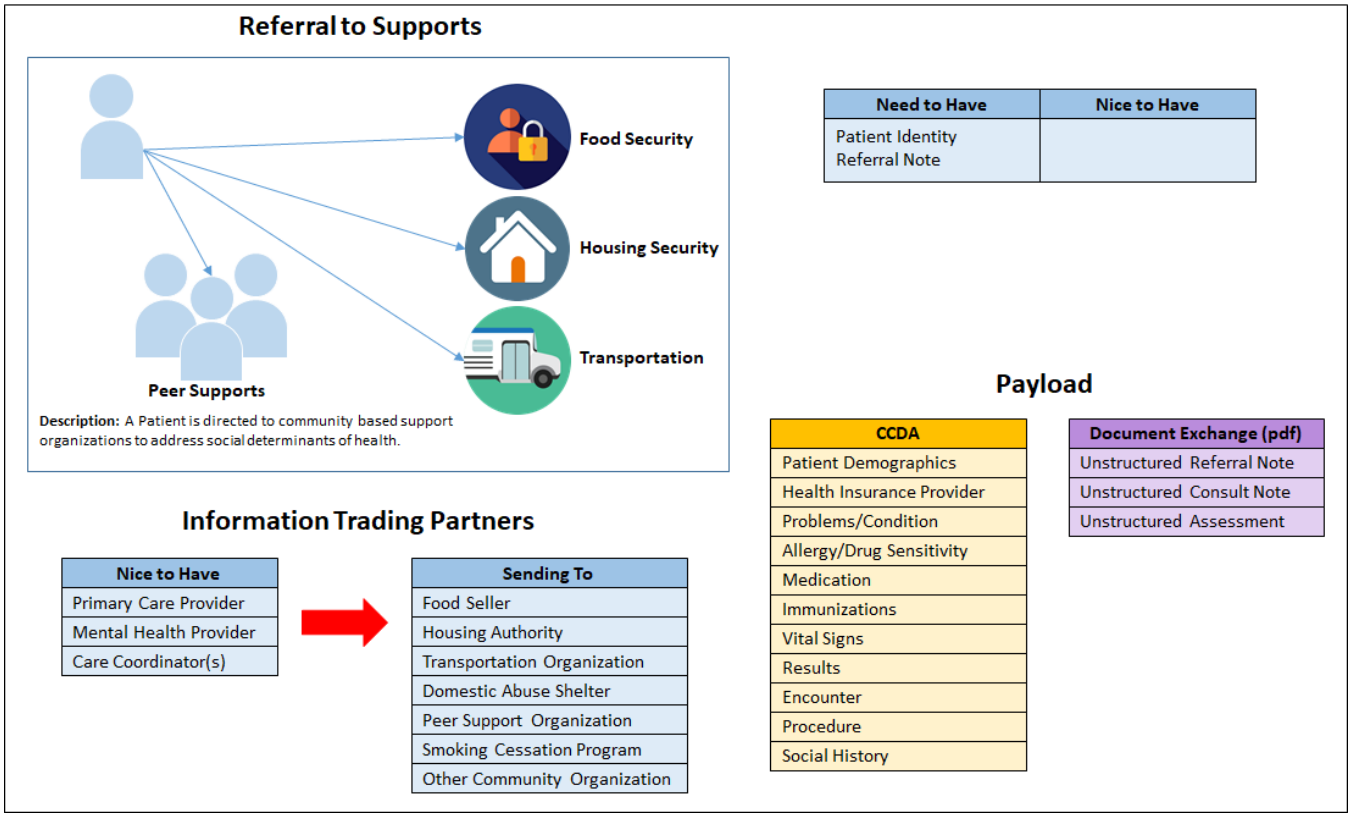
5.3.2.2 State Examples

New Hampshire. New Hampshire's DSRIP demonstration program focused on integrating care to advance treatment for Medicaid beneficiaries with behavioral health needs.[409] The program led to the creation of seven integrated delivery networks (IDNs) across seven regions. IDNs include physical and behavioral health, and community-based social service organizations, and function like traditional provider networks.

[409] New Hampshire Department of Health and Human Services, Building Capacity for Transformation: New Hampshire DSRIP Waiver Program, https://www.dhhs.nh.gov/section-1115-waiver/index.htm.

Figure 29 below, illustrates a formal closed-loop referral from a physical health provider to a community supports organization that is used to initiate, acknowledge, and follow up on supports that address SDOH.

Figure 29. Adapted from New Hampshire Integrated Care Network Closed-Loop Referral Process



Source: New Hampshire DSRIP.

Michigan. As a part of the Michigan State Innovation Model program, the Greater Flint Health Coalition worked with Great Lakes Health Connect (GLHC), an HIE, to deploy a closed-loop referral system to connect health care providers and social service agencies. GLHC helped link 85 providers and more than 40 community-based organizations in the Flint region, with the goal of reducing overutilization of the ED. Recent data shows that since November 2017, ED visits among the attributed Medicaid population in the Flint area have decreased 15 percent.[410] Between 2017 and 2019, more than one million closed-loop referrals have been accessed over the application, and deployment spans across almost 11,300 providers across 824 organizations.[411]

Delaware. Through Delaware Treatment Referral Network (DTRN), the state of Delaware has currently partnered with OpenBeds to address their SUD patient referral concerns. The State has leveraged the OpenBeds platform to facilitate referrals to treatment and social services and is working to integrate with the PDMP. As a result, the State can capture real-time utilization data and referral patterns to identify service gaps, effectively target funding, scale successful services, produce program evaluations, and cross-reference data with other databases. In their efforts to implement behavioral health treatment and referral networks to increase access to care, the state conducted extensive stakeholder outreach with providers, community services, and social workers. Since implementation of DTRN in 2018, Delaware has facilitated more than 52,000 referrals, averaging 600 per week, with a rate of 66 percent responded to within 30 minutes. The system is expanding to include more services to address SDOH, like transportation, job placement, food, and housing. [412]

California. Community Information Exchange (CIE) is an interactive, cloud-based data platform developed by San Diego 2-1-1 designed to allow multiple health and social service providers see a patient's interaction across systems, agencies, and community services.[413] The CIE includes a social risk assessment tool, provides alerts, and facilitates connections across agencies and providers. The model is a coordinated service, which relies upon community partnerships, including 34 social service and health care providers, and is currently supported through grants. Results to date included a reduced number of emergency medical services trips and increased stable housing rates.[414]

Washington. The State may also look to the Medicaid Innovation Accelerator Program (IAP) for guidance on the creation of Data Dashboard Affinity Groups. The Medicaid IAP SUD TA builds Medicaid agencies'

[410] Bill Siwicki, "Via referral tech, HIE reaches 15% reduction in ER utilization among high-risk pop", *Healthcare IT News,* March 5, 2020, https://www.health careitnews.com/news/referral-tech-hie-reaches-15-reduction-er-utilization-among-high-risk-pop.
[411] Ibid.
[412] How States are Leveraging Technology to Implement Behavioral Health Treatment and Referral Networks to Increase Access to Care (Webinar 7/23/2020)
[413] 2-1-1- San Diego: Connecting Partners through the Community Information Exchange. Case Study. August 2018. Kaiser Permanente Community Health.
[414] San Diego: Connecting Partners through the Community Information Exchange. Case Study. August 2018. Kaiser Permanente Community Health.

capacity in the following delivery system reform levers: data analytics, quality measurement, performance improvement, value-based payment and financial simulations. Data Dashboard Affinity Groups provide Medicaid agencies with TA to produce new or revise existing SUD data dashboards.[415] In 2017, Washington HCA received TA under the Medicaid IAP. Through the IAP TA program, the state of Washington was able to establish a data dashboard.

The Washington State data dashboard monitors metrics around OUD treatment and provider capacity focused measures, including but not limited to: MAT-waivered provider capacity per 1,000 Medicaid enrollees with OUD, Percent of active waivered MAT providers prescribing to Medicaid enrollees, Percent of Medicaid enrollees with OUD initiating MAT. States that have participated in programs to establish data dashboards and corresponding affinity groups have a better understanding of the limitations of the data presented, which results in improved scope and expectations.[416]

Recommendation: Increase Data Sharing

Myers and Stauffer prepared a report for the DHHS, Office of Health Information Technology, to examine the landscape of health IT in Nevada for FYs 2020 to 2024. The *Nevada Health Information Technology Roadmap* includes 18 recommended initiatives, and was designed for DHHS and community stakeholders to use as a guide to strengthen and improve the state's health IT infrastructure and governance, and to enhance care coordination statewide through enablement of people, process, policy, and technology. The following recommendations provide DHCFP and its partner agencies with next steps to enable data sharing between providers and support integrated care.

- Review specific Health IT Roadmap initiatives related to behavioral health (initiative 11) and SDOH data sharing (initiative 15) for best practices, approaches, and potential funding.
- Explore the HealtHIE Nevada Chart provider portal, which is currently available at no cost, and consider promotion among providers. Currently, five behavioral health organizations have signed on to enable view access to patient records.
- In accordance with guidance in State Medicaid Director Letter (SMDL) 16-003, financial and TA programs can be funded at a 90 percent federal match rate to support HIE integration by Medicaid behavioral and SUD treatment providers.[417] DHCFP may consider requesting enhanced federal funding participation (FFP) from CMS to provide active Nevada HIE programs with funding to offset Medicaid providers' costs to connect their EHR systems and/or gain portal access in order

[415] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/suddatadashboardsinfosession.pdf.
[416] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/built-dashboard-webinar.pdf.
[417] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD16003.pdf.

to increase data sharing in general and enable closed-loop referrals, specifically. This funding is available until September 30, 2021.

- In addition, DHCFP may consider executing the CMS outcomes-based certification process to access Medicaid Enterprise System enhanced FFP also at the 90/10 match rate for design, development, and implement and 75/25 for ongoing maintenance and operations.[418] This funding may be used to deploy and maintain an interoperable connection between Nevada HIE systems and MMIS in order for Medicaid to receive near or actual real-time beneficiary health care data to determine the effectiveness and utilization of SUD, OUD, and other programs and services.
- The State may consider looking to the Medicaid IAP for guidance on the creation of data dashboard and corresponding Data Affinity Groups. A data dashboard will produce metrics for analysis and thus provide a better understanding of current and future limitations and successes. The State should continue to monitor materials available through IAP, as new materials may provide insights around what CMS is advising other states in the program.

5.4 Project ECHO®

Project ECHO® uses an innovative, hub-and-spoke telehealth consultation and tele-mentoring model to develop knowledge and empower primary care providers in rural or underserved areas. Providers are enabled to deliver appropriate specialty care without requiring the patient to access a specialist directly. The program was launched in 2003 at the University of New Mexico School of Medicine, and there are currently more than 90,000 learners and 800 Project ECHO® programs in more than 40 countries. Project ECHO® Nevada at the UNR School of Medicine was the third site to adopt the model.

5.4.1 Project ECHO® in Nevada

The goals of Project ECHO® Nevada are to "expand the capacity of health professionals to effectively treat chronic, common, and complex health conditions in underserved populations throughout Nevada,"[419] and to "meet the needs of primary care providers by offering an alternative to costly travel and long waits for patients who need specialty care."[420] Project ECHO® Nevada is available to any community and provider willing to participate and continuing medical education and continuing education credits are available. Clinics are delivered via Zoom, a free teleconferencing system that is supported by the Nevada System of Higher Education telecommunications network.

[418] CMS Health Information Exchange Community of Practice, May 26, 2020.
[419] Project ECHO® Nevada 2019 Annual Report.
[420] Project ECHO®, University of New Mexico School of Medicine, https://med.unr.edu/echo/clinics.

Project ECHO® clinics are led by university-based faculty specialists and community specialists and cover a range of chronic health conditions and services including cardiology, complex pediatrics, palliative care, and first-episode psychosis. Primary care providers at all levels can submit critical cases for review, learn best practices in specialty care, and acquire the expertise necessary to better treat patients with various health conditions, including opioid addiction and substance abuse.

5.4.2 Opportunities and Recommendations

5.4.2.1 Project ECHO© for Pain Management and Medication-Assisted Treatment

In a recent pilot study that sought to test the ECHO® model in practice, members of the Addiction Technology Transfer Center (ATTC) network applied the ECHO model to enhance workforce capacity to deliver clinical supervision for the treatment of SUDs. Forty-eight staff attended at least one ECHO clinic, and 20 attendees completed a follow-up survey. Participants were highly satisfied with 1) the overall intervention; 2) the organization of the clinic and the facilitation of specialist experts; 3) the relevance of the TA to their work; and 4) the impact of the intervention on their effectiveness as supervisors. Results also indicate there were significant self-reported improvements in clinical supervision self-efficacy following participation in the ECHO® clinic.[421]

With the support from the Nevada State Opioid Response grant, Project ECHO® Nevada has created a MAT clinic, first hosted in September 2017. The MAT clinic "has proven to be a reliable and consistent resource for providers who want to learn more or expand their knowledge regarding this practice."[422] Project ECHO® Nevada has also expanded their pain management clinic to enhance knowledge of proper practices for prescribing of controlled substances, alternative therapies, and the psychology of pain. MAT and pain management clinics are held twice a month. Clinic topics have included an overview of MAT, the science of addiction, principles of harm reduction, a summary of the provisions of AB474, steps to proper prescribing, and health alternatives for pain management.

Desert View Hospital was the lead recipient of the Nevada Rural Opioid Overdose Reversal (ROOR) grant, and includes five additional participating critical access hospitals, Project ECHO® Nevada, Nevada Rural Hospital Partners, and DHHS. The goal was to "deliver training on the administration of naloxone to all levels of emergency medical services providers as a result of provisions in Nevada Senate Bill 459 (SB459), which authorized all levels of first responders to administer naloxone to potential opioid overdose

[421] Chaple, M, et al. Using ECHO Clinics to Promote Capacity Building in Clinical Supervision. Am J Prev Med 2018; 54(6S3):S275–S280.
[422] Nevada State Opioid Response, Project ECHO©, https://www.nvopioidresponse.org/project-echo/.

deaths."[423] Project ECHO® Nevada delivered a three-part series on opioid prescribing guidelines from the CDC, evidence-based approaches to pain management, and SB459 changes and implications.

5.4.2.2 Considerations for Project ECHO© Expansion

According to the 2019 Project ECHO® Nevada 2019 Annual Report[424], 493 health care experts hosted clinics for 2,972 distant learners across Nevada, Arizona, California, and Delaware. Experts reviewed 75 case presentations, 13 of which were related to MAT and 19 related to pain management. Nearly 500 participants discussed these specific cases, which contributed to the State's opioid epidemic response effort.

There are opportunities for targeted expansion of Project ECHO® clinics for MAT and opioid addiction treatment. As illustrated in the Annual Report, 20.3 percent of attendees were from rural Nevada. Nye, Esmerelda, and Eureka counties were not represented among attendees, one attendee was from Lander, three were from Lincoln, and seven were from Churchill. However, Churchill had the highest death rate from all opioids, and Lincoln and Nye counties had the first and third highest ED visit rates from all opioids in 2018.[425] Note that these attendee totals are for all ECHO Clinics, and not specific to MAT or pain management; therefore, the lack of statewide representation in these specific clinics is more likely.

Project ECHO® is a successful, scalable, and cost-effective model for provider education and skills development, and can be leveraged to address known barriers to expanding the availability of MAT programs and provider capacity. According to the 2018 Nevada training needs assessment, which included a survey of 1,074 providers, 80 percent said they would likely attend or consider attending a training on AB474, and 72 percent responded that they might attend or would attend a MAT training specific to issues such as legal considerations and pain management issues related to prescribing MAT. How to start prescribing MAT and its use within primary care settings was the next most highly-rated topic.[426] Project ECHO® clinics could allow these providers to learn and build knowledge through direct contact with peers and leaders in the field.

In December 2016, the ECHO Act was signed into law and required that Congress examine "technology-enabled collaborative learning and capacity building models." The report to Congress evaluated several current implementations of ECHO and ECHO-Like Models (EELM). A main finding was that many of these programs existed alongside other mechanisms of telehealth, including direct care telemedicine. A prominent challenge to the expansion and implementation is limited reimbursement and time on both

[423] National Organization of State Offices of Rural Health, Report on Lessons Learned from ROOR Grant Recipients, April 2017, https://nosorh.org/wp-content/uploads/2017/05/ROOR-Report-1.pdf.
[424] Project ECHO® Nevada 2019 Annual Report.
[425] Nevada State Opioid Dashboard, https://opioid.snhd.org/.
[426] Nevada SUPPORT Act Planning Grant Project Narrative.

the part of the specialist, who may be minimally compensated through the various funding streams available. Continuing education credits are the only incentive for the provider participants. These main barriers might be alleviated with the adoption of value-based payment methodologies over FFS.[427]

Support for the Project ECHO Model™ continues to gain traction. The ECHO Act of 2019 proposed in May would provide grants and TA to further develop and evaluate this type of collaborative learning model.[428] In September of 2019, 22 senators cosigned a letter to HHS' Secretary Alex Azar urging the Department to "explore ways to support and sustain the integration of this successful national initiative into the health care delivery system," and to issue official guidance to states on available Medicaid financing to support further deployment of the model.[429]

In the meantime, states are taking various approaches to supporting Project ECHO® programs. Missouri has allocated funds in the state budget, whereas California, Colorado, New Mexico, and Oregon have obtained waivers to use Medicaid funds to support EELM, specifically for pain management in rural areas. Under typical Medicaid rules, providers can only be paid for direct health care delivery.

It is important to underscore that Project ECHO® is distinct from telemedicine, during which the patient is directly involved, and is also not considered an e-consult, when a specialist acts as a consultant on a single case. Participation in ECHO clinics are not a reimbursable service, and are not designed to provide direct care delivery to patients, or in-depth consultation from specialists. While telemedicine and e-consults rely on existing provider capacity to reach more isolated patients, Project ECHO®, and other similar models, offer the potential to create new capacity to address a specific clinical area.[430] Project ECHO® Nevada is a well-established, trusted resource that offers an opportunity to expand provider capacity and training, and may be incorporated into the broader strategy to increase access to MAT and related services.

5.4.2.3 Evaluate Reimbursement or Financing Options for Project ECHO® Case Evaluation

As the Project ECHO development site, New Mexico is advanced in terms of its state support for Project ECHO participation. The New Mexico Human Services Department last year proposed to add a new reimbursement mechanism for providers participating in Project ECHO® at the "spoke" end of the program model for their time spent presenting Medicaid patient cases as a part of an ECHO consultation.

[427] Report to Congress. Current State of Technology-Enabled Collaborative Learning and Capacity Building Models. February 2019. Prepared by the Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE).
[428] The Expanding Capacity for Health Outcomes Act of 2019 (ECHO 2019 Act) Introduced by Senators Schatz (D-HI) and Murkowski (R-AK) https://www.murkowski.senate.gov/imo/media/doc/ECHO%202019%20Act%20One%20Pager.pdf.
[429] United States Senate, Letter to U.S. DHHS Secretary Azar, September 25, 2019, https://www.tomudall.senate.gov/imo/media/doc/Bipartisan%20ECHO%20letter%20to%20HHS.pdf.
[430] Report to Congress. Current State of Technology-Enabled Collaborative Learning and Capacity Building Models. February 2019. Prepared by the Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE).

The rates of which are to be set at 90 percent of the Medicare fee schedule.[431] While these new reimbursement codes have not yet been adopted, it marks an important and necessary step in increasing provider participation in Project ECHO®, and would enable further case review and exchange of clinical information to better support case management. Nevada should monitor development of the Project ECHO® reimbursement policy in New Mexico as it evolves.

The Center for Health Care Strategies has developed a TA tool which outlines several Medicaid financing options. The below examples are those that are already operational; however, the tool also includes opportunities that are not currently being used.

Some states have contractually required its MCOs to support Project ECHO®, or have included outcomes-based incentives to encourage use through 1115 or 1915(b) waiver programs. Funds are either added to capitation rates as a direct service or administrative expense. For example, in New Mexico all MCOs are required to contract with the ECHO institute to support the costs of the expanded primary care provider network, and allocation is provided by the State through the capitation rate on a per-member per-month basis. Missouri has also followed a similar model. Alternatively, Oregon leverages state incentives with the coordinated care organization to support the cost of participation with flexible funds under a three percent claims withhold ties to population-based quality metrics.[432]

Colorado has used Project ECHO® to support a disease management program that providers a "set of interventions designed to improve the health of individuals, especially those with chronic conditions" as a part of a care management model under the authority of SMDL #04-002, which allows for direct medical service or administrative function. The state Medicaid agency in Colorado is contracted with Community Health Center, Inc. in Connecticut to manage the Colorado Chronic Pain program using the ECHO model, and was paid a lump sum based on the number of participants.[433]

***Recommendation:* Expand Use of Project ECHO® to Increase Provider Capacity**

- Strengthen the Partnership with Project ECHO®. Nevada should seek to evaluate and expand the current program. Gather data from Project ECHO® regarding current MAT and pain management clinics to evaluate reach and effectiveness, including number of participants and any participant feedback, to address any areas of opportunity and current known barriers to becoming an OUD treatment services provider.

[431] Codes/Rates for Project ECHO Case Consultations. Available at: https://www.hsd.state.nm.us/uploads/FileLinks/e7cfb008157f422597cccdc11d2034f0/ECHO_CONSULTATION_CODES_OCT_1_2019.pdf.
[432] Center for Health Care Strategies Inc. Medicaid Financing Models for Project ECHO. September 2017.
[433] Center for Health Care Strategies Inc. Medicaid Financing Models for Project ECHO. September 2017.

- Participation in Opioid ECHO. Through the partnership with Project ECHO®, consider expanding to include participation in the Opioid ECHO shared services model. In 2017, 20 states used various sources of funding from HRSA, SAMHSA-STR, and AHRQ for the development of hub sites for the Opioid ECHO, for which a main supporting hub at the ECHO Institute provides expert specialist teams to state spoke sites. Current HRSA-funded participants include University of Washington, Billings Montana Clinic, Western New York, Boston Medical Center, and University of New Mexico. Recent evaluation of the HRSA-funded implementation show that among those who presented a case, 92 percent say input changed their management plan, and 81 percent learned something new from a case presented that would change their care of their own patients.[434] The supporting hub leads development of curriculum and provides IT, evaluation, and administrative support, as well as participant recruitment for all hubs. States are using the ECHO shared-services model to scale-up their workforce to meet the need for prevention, screening, and treatment of OUD. Project implementation includes a three-day immersion training offered monthly, and various tools are available.

5.5 Hub-and-Spoke Model

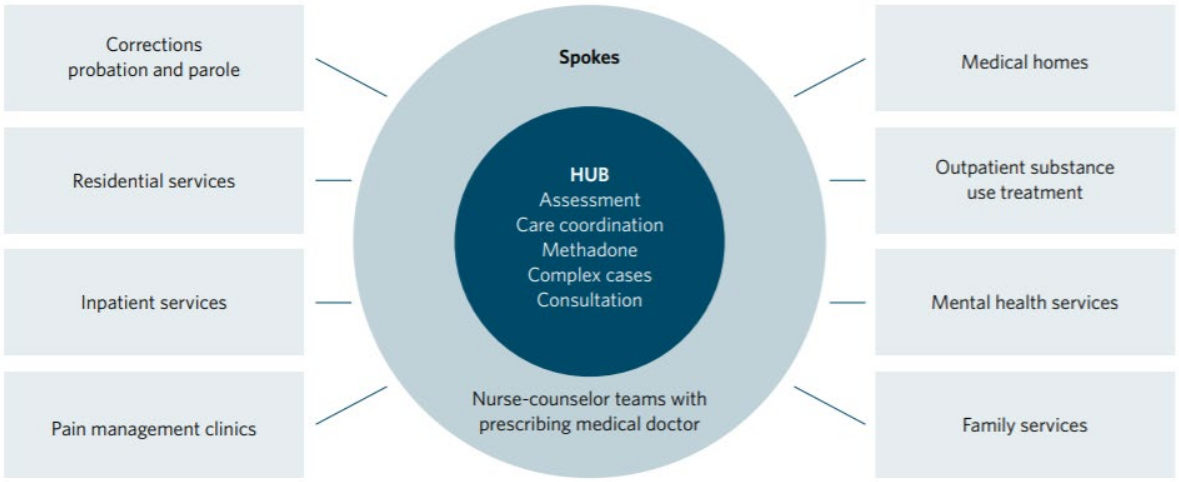
Vermont implemented the Care Alliance for Opioid Addiction in 2013, which is a statewide OUD treatment response model that integrates care across primary, acute, and behavioral health settings. The model expands access to MAT by creating a two systems of care called hubs and spokes as illustrated in (Figure 30).[435] Hub and spoke sites are defined as:

- **Hubs.** Specialty treatment centers located across the state and regulated by SAMHSA as an OTP. These sites initiate treatment, stabilize patients, and provide ongoing consultation to the spoke sites.
- **Spokes.** Community-based prescribers who provide office-based opioid treatment and work with multi-disciplinary staff, such as nurses and care managers. Spokes connect patients to wraparound services that support SDOH, as well as offer counseling and case management services.

[434] Komaromy, M, MD. Scaling Up ECHO to Address the Opioid Epidemic presentation. February, 2018.

[435] Vermont Center on Behavior & Health, University of Vermont, "Vermont Hub-and-Spoke Model of Care for Opioid Use Disorders: An Evaluation," http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_2017_1.pdf.

Figure 30. Hub-and-Spoke Organization Design



Hub-and-spoke networks are highly adaptable, permitting almost any enterprising health care establishment, regardless of its size or mission, to make use of the model. Patients are able to travel between hubs and spokes based on their treatment needs, and trained specialists within the spoke network promotes individual treatment programs to progress at a steady pace locally. There are an increasing number of states creating hub-and-spoke systems under federal grants through the Opioid STR program including California and Washington.

5.5.1 Hub-and-Spoke Model in Nevada

5.5.1.1 Hub-and-Spoke Policy[436]

In 2017, DPBH announced the development of three entities known as Integrated Opioid Treatment Recovery Centers (IOTRCs). The IOTRCs are funded with a two-year federal STR grant to provide integrated primary and behavioral health care for adults and adolescents with OUD. IOTRCs serve as the regional consultants and subject matter experts on OUD treatment, provide MAT and recovery services for adult and adolescent populations, and offer comprehensive services either in-house or through formalized care coordination agreements.[437]

[436] Stephanie Woodard, PsyD. Nevada's Comprehensive Approach to Addressing the Opioid Crisis.
Stephanie Woodard, PsyD. Division of Public and Behavioral Health State of Nevada. Nevada Opioid Crisis Needs Assessment.
[437] http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/ClinicalSAPTA/dta/Grants/IOTRC_Informational_Session_Presentation10.9.17_.pdf.

Using the hub-and-spoke model, the IOTRCs will provide a range of services and supports including MAT, care coordination, counseling, assistance with accessing community resources, and support for long-term recovery.[438] During the STR grant, the IOTRCs have achieved the following accomplishments:

- 4,340 clients received treatment for OUD.
- 1,137 clients received recovery support services.
- 132 percent increase in number of clients receiving MAT.[439]

Currently, only FQHCs, CCBHCs, and OTPs can apply as IOTRC hubs. As hubs, they must provide the required set of services stipulated in the grant either on site or through contracts with other providers. Services required under the grant are largely uniform across hub types, but vary slightly depending on hub provider type.

Grant funds support staff salaries, training opportunities, TA, and residential services. Hubs and spokes are required to participate with Medicaid and bill third-party payers when appropriate. IOTRCs are also required to report on a number of metrics.

The IOTRC grant is administered by SAPTA and managed by CASAT. Medicaid Chapter 400 also requires all programs seeking reimbursement for substance use treatment or co-occurring treatment be certified through SAPTA under NAC 458.

Other than the items listed above and other grant administration requirements, IOTRCs have flexibility in implementing programming given that practices are evidence based.

As the IOTRC grant program ends, Nevada has the opportunity to leverage lessons learned to develop a sustainability plan. The following are examples of some barriers to expanding the model that can be addressed through policy revisions or additions:

- Limited participation from providers in rural and frontier areas.
- Access to program resources in the interior of the state.
- Adequacy of reimbursement structure.
- Infrastructure to support the model.

[438] https://www.nvopioidresponse.org/state-initiatives/.
[439] Ibid.

5.5.1.2 Hub-and-Spoke Infrastructure

The state of Nevada currently has three IOTRC hubs with nine locations and more than 190 spokes serving counties Clark, Washoe, Elko, and Carson City.[440] More than 4,000 patients are receiving treatment for OUD and recovery support services. Below are the current IOTRC hubs and services provided:

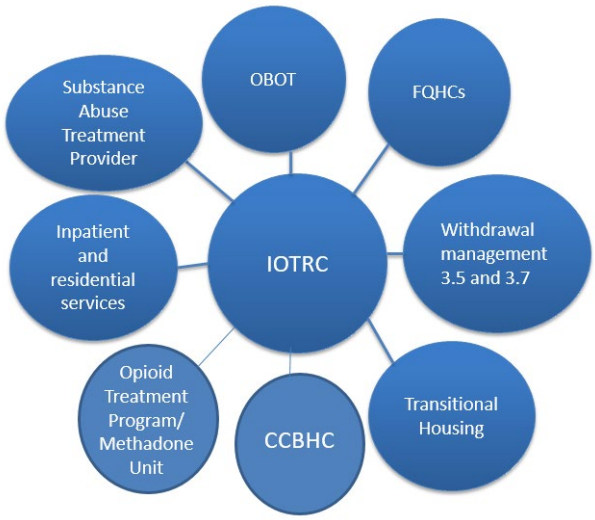
- The Center for Behavioral Health, with hub locations in Las Vegas and Reno, with services including MAT, on-pharmacological outpatient counseling, court/welfare assessments, educational classes, peer recovery, comprehensive services for pregnant patients with OUD, as well as the capacity to dispatch a team to Las Vegas and Reno for mobile recovery outreach.
- The Life Change Center (LCC), with hub locations in Sparks and Carson City, provides services through its various network, including: peer support, case management/care coordination,[441] transportation, MAT, naloxone distribution and overdose education, comprehensive services for pregnant patients with OUD, mental health screenings and treatment, family services, and peer groups. LCC also has capacity to dispatch a team for mobile recovery outreach.
- Vitality Unlimited (VU), with a hub location in Elko, provides the following services through its network, including: adult and adolescent residential care, adult outpatient counseling, naloxone distribution, and MAT. VU also has capacity to dispatch a team to Elko for mobile recovery outreach.

Hubs dispatch Mobile Recovery Outreach Teams to provide care to persons assessed by law enforcement, ER personnel, first responders, and community programs in urban communities and provide mobile services and telemedicine to rural and frontier communities throughout the state.

Nevada also has pilot programs throughout the State with a similar mission to the hub-and-spoke in providing evidence-based MAT. These pilots include: specialty drug courts that route offenders to an OUD program and recovery services, Law Enforcement Assisted Diversion Program that provides recovery resources to pre-booked individuals, and prisons providing MAT care to incarcerated individuals (Figure 31).

[440] https://www.nvopioidresponse.org/integrated-opioid-treatment-and-recovery-centers/.
[441] Stephanie Woodard, PsyD. Nevada's Comprehensive Approach to Addressing the Opioid Crisis.
Stephanie Woodard, PsyD. Division of Public and Behavioral Health State of Nevada. Nevada Opioid Crisis Needs Assessment.

Figure 31. Nevada's Hub-and-Spoke Model



Source: Nevada's Comprehensive Approach to Addressing the Opioid Crisis.

Key infrastructure barriers to expanding the model include:

- Limited operational support for the model.
- Limited access to recovery supports due to statewide shortage of recovery support programs and providers.

5.5.2 Opportunities and Recommendations

5.5.2.1 Hub-and-Spoke Policy

As noted above, the STR program supports many states in exploring integrated SUD care. The hub-and-spoke model itself is recognized as a best practice. States are still understanding how to incorporate lessons learned about expansion from early adopters into their unique systems.

Nevada's hub-and-spoke model was developed using both the Vermont hub-and-spoke model and the Johns Hopkins Collaborative Opioid Prescribing model. It incorporates a number of widely-accepted best practices, such as requiring IOTRCs to provide services along the care continuum, including justice and correctional entities in provider networks, and requiring specific reporting measures. However, Nevada experiences the same provider shortages and lack of participation that challenge other states addressing integrated SUD treatment. Nevada has the additional barrier of limited access to services in rural and frontier areas.

Below, we provide information on operational policy best practices for expanding the hub-and-spoke model.

Continue Regional Focus to Gain Statewide Coverage. Nevada's IOTRC act as "regional consultants and subject matter experts." This is a promising practice to build on by developing state policy that establishes a regional framework as the foundation for the model. Continuing a regional approach would support Nevada in focusing on the specific characteristics of a particular region in developing infrastructure to support the model. Regional visibility may also spur interest from local providers and facilitate greater participation.

Vermont's Act 135 (2012) established a regional system of treatment for opioid addiction in Vermont. Its hub-and-spoke system established "hub clinics" in five geographic regions where existing OTP had the ability to prescribe buprenorphine and methadone treatment. Regions support a "no wrong door policy." Patients enter the hub through primary physicians, EDs, Department of Corrections, and community programs.

Flexibility in Hub Classification to Broaden the Hub Pool and Increase Rural and Frontier Participation. Nevada currently limits hub classification to FQHC, CCBHC, and OTP. However, the three existing IOTRCs within the state are all OTPs. Stakeholders report that there has been limited interest from FQHC and CCBHC applicants. Creating flexibilities around the types of organizations that can apply as hubs and the structure under which hubs can operate would expand the provider pool and potentially attract more providers in rural and frontier areas.

Within Washington's model, hubs can be primary care providers, OBOTs, prisons, OTPs, FQHCs, or full-service behavioral health treatment providers. Each hub is required to have at least five spokes consisting of a minimum of two SUD treatment providers, one mental health provider, and one primary care provider. Washington State's model includes six networks located in urban, rural, and frontier areas. Each hub-and-spoke network includes multiple unique agencies as hubs (primary care, behavioral health, OTP). Networks vary in size from eight to 21 organizations and include direct service providers, such as FQHCs, OTPs, ED induction sites, and telehealth SUD treatment. They also have a broad range of referrals allowing for rapid expansion outside of their hub-and-spoke network.

Sustainable Benefit Structure and Reimbursement. Nevada currently supports the hub-and-spoke model with grant funding. Services are billed to third-party payers when appropriate and billable to Medicaid under the State Plan. Transitioning to a sustainable benefit and funding source may encourage participation and infrastructure building among hubs in rural and frontier areas.

Vermont and Rhode Island support their coordinated care models through the Medicaid health home benefit. Health home services for beneficiaries with OUD is an optional benefit currently supported with increased additional FMAP by CMS. Pursuant to the Medicaid health home benefit option, health home

providers in Vermont and Rhode Island use a multi-disciplinary, team-based approach to deliver a range of services designed to address the chronic care needs of their patients[442], including:

- Comprehensive care management.
- Care coordination.
- Health promotion.
- Comprehensive transitional and follow-up care.
- Patient and family support.
- Referral to community and social services.

In Vermont, funding for the hub-and-spoke system is tied to Section 2703 of the ACA, which allows for Home Health Services as Community Health Teams and provides a bundled, monthly rate (subsidized by Medicaid or a state grant) for one standard clinical service and one medical service per month. An enhanced rate is available for one monthly additional health home encounter (for example, comprehensive care management, care coordination, individual and family support, referral to community services).

Employing NCMs and/or Care Navigators to Support Provider Participation. Vermont and Washington have implemented parts of the Massachusetts NCM to support spokes. In Washington, NCMs and spoke care navigators are funded by the Opioid STR grant and assist with patient management and support by assisting with screening, medication treatment education, care planning, stabilization, maintenance, relapse prevention, and support ongoing care coordination and patient self-management. This reduces the administrative and clinical burden for prescribing physicians. Vermont has trained nurses and counselors embedded in primary care "spokes" to assist primary care providers with assessments and counseling services. These providers are funded through the health home rate.

Recommendation: Update Hub-and-Spoke Policy

Operationalize policy recommendations for hub-and-spoke expansion. The following are items for consideration:

- Establish a Medicaid state plan or waiver benefit that supports the hub-and-spoke model.

[442]Clemens-Cope, Lisa, et al. Experiences of three states implementing the Medicaid health home model to address opioid use disorder—Case studies in Maryland, Rhode Island, and Vermont, The Urban Institute, 2100 M St NW, Washington D.C. 20037, https://www.sciencedirect.com/science/article/pii/S0740547217301952.

- Establish bundled payments, enhanced rates, or Medicaid health homes to sustainably fund the model and maintain existing gain, support building infrastructure for rural and frontier hubs, and specifically target providers who can be designated as hubs in the interior counties.
- Implement the hub-and-spoke model on a regional basis across the state, taking a stepwise approach that allows each region to build capacity as the program grows. Consider engaging and leveraging existing hubs (or more experienced SUD providers) as "mentor agencies" or virtual partners to new hubs in rural and frontier areas to support learning as they build capacity and infrastructure. Offer a pay-for-reporting incentive to encourage participation, requiring regional reporting on infrastructure activities and program growth.
- Expand the IOTRC hub classification beyond CCBHC, FQHC, and OTP to allow a broader category for hub designation to better accommodate underserved communities. Additionally, encourage the inclusion of non-traditional community resources to serve as spokes; and consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs.
- Maximize telehealth treatment options and encourage regional telehealth networks as part of the hub-and-spoke design. Additionally, build on the use of Project ECHO® to include more clinical information sharing and treatment assistance for primary care providers and community partners in rural, frontier, and tribal areas.

5.5.2.2 Hub-and-Spoke Infrastructure

Operational Support and Oversight for the Hub-and-Spoke Model. Under the grant structure, IOTRC have flexibility in operationalizing their programs with limited coordination across hubs. Evidence from other states indicates that operational support for the model is important for expansion. According to stakeholders, Nevada's program does not currently share information across hubs. While each hub runs independently, they all provide a required shared core set of services. Sharing consumer and even operational information, and creating a shared learning environment can support networks in developing Nevada-specific best practices ready for building on as the model expands across the state.

Vermont's Blueprint for Health provides oversight and coordination of hub-and-spoke network activities. The executive committee is made up of third-party health industry professionals and state Medicaid officials, and has a payment implementation workgroup that reviews and creates payment methodology and policy.

The Blueprint developed the Blueprint Hub Regional Profiles based on data from Vermont's all-payer claims database (VHCURES) and the Vermont Clinical Registry. The population in this profile were Medicaid beneficiaries, including those with dual Medicare and Medicaid eligibility, ages 18 to 64 years old with OUD who received the majority of their MAT treatment in a hub.

Because of the various levels of knowledge among the navigators regarding OUD treatment and care, the state of Washington takes a learning collaborative approach to training with ongoing contracts with the Advancing Integrated Mental Health Solutions Center at the University of Washington Alcohol and Drug Abuse Institute.[443]

Access to Hub or Spoke Services. As noted within the section, Nevada has three hubs that provide services to the most populated counties of the state, but rural and frontier areas have little to no access to hubs or spokes.

Washington State currently has 11 hub-and-spoke networks consisting of 47 unique agencies and 79 sites. Within 18 months of introducing its model, networks inducted 4,977 unduplicated patients on OUD medication treatment.[444] Due to the standalone nature of each network, partnerships vary and are based on community need and available resources. Partnerships include tribal health organizations, social services, housing organizations, criminal justice organizations, local fire and rescue, EDs, syringe exchange programs, etc. Spoke care navigators work across networks to facilitate coordinated care within the network and referrals.

Vermont's hub-and-spoke system currently has nine hubs, more than 77 spokes, and more than 6,000 participants. The state of Vermont provides oversight for the program, helping communities monitor treatment needs, waitlist length, average time to treatment, and program performance.

In Vermont, spokes are waivered physicians that are paired with regional hubs and supported by MAT teams. Once a patient is deemed stable after treatment at a hub, they are assessed and referred to a spoke (OBOT) provider for continued treatment. If the patient does have a primary care provider, they are referred to a health home or community program for continued treatment. For areas without an OBOT provider, MAT teams are sent to educate providers and encourage them to become certified.

Both Washington and Vermont use MAT teams to support spokes. MAT teams are embedded with primary care providers and used to support providers by delivering counseling and SUD services. A MAT team consists of an RN and a Master's-level licensed counselor.

Recommendation: **Expand Hub-and-Spoke Infrastructure**

- ***Create an Oversight Body to Support the Expansion of the Hub-and-Spoke Model.*** This body may be composed of one State designee and two representatives from each region (one hub representative, one spoke representative), as well as other stakeholders. This group would meet

[443] Sharon Reifa, Mary F. Brolina, Maureen T. Stewarta, Thomas J. Fuchsc, Elizabeth Speakerb, Shayna B. Mazela. The Washington State Hub and Spoke Model to increase access to medication treatment for opioid use disorders. Journal of Substance Abuse Treatment. 19 July 2019, 33-39.
[444] Ibid.

virtually, gather and disseminate data from hubs, share best practices from across the state, and report out on the progress of the model. This group could also support the implementation of the model by providing regional perspectives and recommendations.

- ***Shared Learning to Support Hub-and-Spoke*.** Provide State-supported shared learning and rapid cycle evaluation data to support hub-and-spoke learning, growth, and change.
- ***Provider Education and Support.*** Offer State-supported provider education and program support for developing hubs specifically in rural and frontier areas.
- ***Expand into Correctional Facilities.*** Expand current pilot efforts to provide MAT services within correctional facilities prior to release. This would require a collaboration and engagement effort with counterparts in the state and local criminal justice systems to help remove lapses in treatment.
- ***Embed MAT Teams at OBOTs to Support Counseling.*** A MAT team consists of a registered nurse and a Master's-level licensed counselor. The MAT team evaluates patient needs, offers clinical support to providers, and counseling to patients.
- ***Engage Non-Traditional Community Resources.*** Encourage non-traditional community resources to serve as spokes. The State should also consider population-specific programs and resources to target the provision of services through existing efforts like women's health programs.
- ***Leverage Project ECHO®.*** Expand the use of telehealth/creative uses for telehealth or the Project ECHO® model to include additional clinical information sharing and treatment assistance for primary care providers and community partners in rural, frontier, and tribal areas.
- ***Focus on Rural and Frontier Areas.*** Target and collaborate with FQHCs in rural and frontier areas to develop a hub-and-spoke model that aligns with current FQHC functions. Create an incentive structure for rural and frontier provider participation as hubs or spokes.
- ***Leverage Community Groups in Underserved Areas.*** Continue to build relationships with community groups to expand the spoke network to reach underserved areas.

6 Benefits and Utilization Management

6.1. Current State

Nevada's scope of SUD services closely aligns with the current ASAM levels of care continuum, including the provision of opioid treatment and withdrawal management services. The Nevada Medicaid program offers SUD services for at least one sub-level for each ASAM level of care, including a number of services that are provided by multiple providers, across delivery systems, and in a variety of settings. The MSM does not indicate that the Nevada Medicaid program covers the following ASAM sublevels:

3.1 Clinically Managed Low-Intensity Residential Services. Provides 24-hour structure with available trained personnel; at least five hours of clinical service per week and preparation for outpatient treatment.

3.7 Medically Monitored Intensive Inpatient Services. Therapeutic services in an ASAM level 3.7 setting require a planned regimen of 24-hour evaluation, care, and treatment in a residential setting. The residential SUD treatment facility must also provide a minimum of 36 hours of SUD therapeutic activities per week.

ASAM levels 3.1 and 3.7 are currently provided as part of the Integrated IOTRCs grant program. Access to services may be limited because of provider capacity and geographic availability. Medicaid coverage or expansion of these services would require that Nevada evaluate their impact under the IOTRC grant, then determine how and whether to incorporate coverage and payment provisions aligned with other Medicaid services. It would also require that the State consider how to build provider capacity in frontier and rural areas.

Nevada's coverage aligns with the ASAM levels of care continuum and meets or exceeds ASAM recommendations. For example, ASAM level 1 addresses outpatient services and establishes a benchmark of "<9 hours weekly for adults and <6 hours weekly for adolescents for recovery or motivational enhancement therapies."[445] Nevada's current outpatient mental health service offerings meet or exceed the baseline weekly amount for an individual beneficiary receiving a basic mix of services comparable to those listed below.

- Unlimited office visits to psychiatrists and advance practice nurses.

[445] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf.

- 26 yearly (bi-weekly) therapy offerings with psychologists, and other licensed professionals such as: marriage and family therapists, LCSWs, clinical professional counselors, and QMHPs.
- Up to two hours per day of skills training and development; prior authorization required.
- Six hours per 90-day period of self-help/peer support; prior authorization required.

One area where Nevada has taken initial steps to increase service capacity is through expanding access to MAT services. As mentioned in Section 3.1, Nevada has taken initial steps to decrease barriers to patients needing MAT services by allowing DATA 2000-waivered CNSs, CRNAs, physicians, PAs, and CNMs to prescribe buprenorphine in office-based settings without having to obtain prior authorization. This change was approved at the April 25, 2019 Drug Use Review board meeting. The approval was given to modify MSM chapter 1200 to remove the prior authorization requirement for substance abuse agents including naloxone, buprenorphine, and a combination drug of buprenorphine and naloxone. With the change, prescribing these drugs only requires a diagnosis code of opioid dependency on the prescription. The removal of prior authorization for buprenorphine went into effect on September 2, 2019. DHHS staff held listening sessions with providers in the fall of 2019 to provide an overview of the DHHS MAT services and plans to solicit feedback from participants on ways to encourage more providers to prescribe MAT or prescribe to the upper limit. Participants who were asked "*What elements essential to the standard of care for MAT have been challenging for reimbursement?"* provided the following insights:

- Some billing codes are not on the fee schedule.
- Restrictions with MCOs is a challenge, citing that each MCO has their own rules which are then arbitrarily enforced.
- When a patient sees provider and behavioral health provider on the same day, providers are reimbursed for only one visit.
- Requirements for prior authorization for FFS are not required for MCOs, which makes it challenging to provide services like psychotherapy for FFS patients.
- MAT patients require a high level of case management services and it is unclear how much is reimbursable at the FQHC level.

As of the time of writing of this report, DHCFP is in the process of creating a new chapter for the MSM outlining MAT services coverage and requirements that allows expanded provider billing capacity. The MSM chapter 1200 on prescribed drugs was updated to reflect the policy change. This MSM chapter does indicate buprenorphine prior authorization approval will be required for all prescriptions over 24 mg. The State confirmed that buprenorphine agents specific to opioid dependency are preferred on the preferred drug list (PDL). Nevada staff further clarified that buprenorphine (as a standalone agent) is currently indicated for pain and OUD and is not on the PDL, meaning there is open access. This was discussed at the recent Silver State Scripts Board Pharmacy and Therapeutics Committee meeting on March 26, 2020 when the board voted to make this drug preferred as well. Of note, the MCOs in Nevada are expected to offer

pharmacy benefits that mirror or exceed FFS. MCOs can design their own pharmacy formulary based on clinical guidelines although utilization of the FFS formulary is preferred.

Balancing benefits management, along with utilization management activities like prior authorization, in the context of SUD treatment requires a different strategy from other chronic illnesses because of the nature of the disease. Continued evaluation, systems coordination, and environmental assessment are essential to ensuring Nevada meets its goals in providing effective SUD services while managing resources. An important factor is ensuring Nevada is providing a full continuum of service options that include intervention and withdrawal management. Diversifying care options, such as the use of DATA 2000-waivered providers and CCBHCs, gives Nevada a broad set of resources to address the individual needs of beneficiaries with SUD, as well as a way to balance the use of more expensive services.

Allowing flexibilities around prior authorization gives providers room to take action to effectively and expediently handle patient needs. Bringing balance to both effectiveness and expedience is important to a growing focus on SUD treatment. Though prior authorizations are used to manage quality, utilization, and cost, they also can present a significant barrier to treatment. In 2018, the American Medical Association surveyed 1,000 physicians on prior authorization and 65 percent reported waiting at least one business day before receiving a prior authorization decision from health plans and 91 percent reported a significant or somewhat negative impact on clinical outcomes as a result of these delays. Serious adverse events, such as death, hospitalization, disability, permanent bodily damage, or other life-threatening events were reported by 28 percent of physicians.[446] Administrative burden is consistently reported as a leading cause of physician burnout as it affects providers' perceptions of their ability to provide quality care.[447, 448] Additionally, a meta-analysis of 59 research studies found that prior authorizations for medications, in general, is negatively associated with medication adherence, clinical outcomes, patient-reported outcomes, health care resource utilization, and economic outcomes.[449] In order to support individuals returning to a healthy state of being, administrative barriers that interfere with recovery must be addressed.

[446] https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf.
[447] https://www.hospitalmedicine.org/globalassets/policy-and-advocacy/letters-to-policymakers-pdf/reducing-administrative-burden.pdf.
[448] The Impact of Administrative Burden on Academic Physicians: Results of a Hospital-Wide Physician Survey, 2017.
[449] https://www.jmcp.org/doi/pdf/10.18553/jmcp.2017.23.8.893.

6.2. Opportunities and Recommendations

Recommendations below may be considered for the State to achieve its goal of eliminating the confusion and challenges faced by providers that may hinder their willingness and ability to provide OUD and SUD treatment and recovery services.

Recommendation: **Improve, Align, or Streamline Nevada's SUD Services Amount, Duration, and Scope**

- ***Alignment with ASAM Requirements.*** This would create limitations based on adult and adolescent age groups. Limiting the benefit in this way may support the State in maintaining an appropriate level of service, while ensuring access to a greater number of beneficiaries. This is particularly important, considering limited provider availability for certain services. Of note, IOP delivered by a PT 17 Specialty 215 is not required to follow the same limitations as the PT 14. PT 14 has a restriction of hours, while PT 17/215 aligns their IOP programs with ASAM criteria.
- ***Consider Completing a Utilization Review.*** The State should consider a utilization review to determine whether there is a need or opportunity to manage the level of services or to provide alternative services, to ensure that more beneficiaries have access to available services. For example, review utilization of outpatient therapy services to determine if a high number of individuals are exceeding the maximum benefit of 26 calendar sessions per year, and consider whether changing the overarching limitation would support increased access to SUD and OUD services.

Recommendation**: Update MAT Services Coverage in MSM Chapters, Billing Guides, and Other Provider Resource Materials**

- ***Update MSM Chapter 1200.*** The MSM chapter 1200 about prescribed drugs dated March 3, 2020, states that all prescriptions of buprenorphine over 24 mg require prior authorization. The link for the prior authorization form does not appear to be active. Although this is a minor change, not having the link to the active form can result in additional time spent by the provider in performing this administrative task.
- ***Update Prior Authorization Form.*** The OptumRx Bunavail®, buprenorphine, buprenorphine-naloxone, Suboxone®, Zubsolv® Prior Authorization Request Form with a revision date of January 2019 remains accessible at: https://www.medicaid.nv.gov/Downloads/provider/FA-73.pdf. This form should be updated to reflect current policy to reduce provider confusion on prior authorization requirements.
- ***Reconcile MSM, Billing Guide, and Edits and Audits in MMIS.*** For example, under the draft MAT policy, providers will bill code H0001 for the alcohol and/or drug assessment. Currently in the MSM chapter, this service is required as requiring a prior authorization; however, this service is loaded in the MMIS system as not requiring a prior authorization.

Recommendation: **Seek Federal Authority to Permit Medicaid Reimbursement for Services Provided In IMD**

- ***Coverage for IMD Services.*** Allowing Medicaid coverage of medically-needed inpatient services provided in an IMD, expands the continuum of care and can facilitate a smooth transition to outpatient treatment including continued access to MAT and other supportive services. Pathways to coverage of IMD services include both Section 1115 as well as State Plan authorities.[450]

Table 1: Key Elements of Section 1115 Waivers vs. SUPPORT Act Option for IMD Payment

Program Element	Section 1115 Waiver	SUPPORT Act
Type of authority	Waiver	State plan option
Length of authority	Initial waivers usually granted for 5 years. States can apply for renewals, usually for 3 years.	Available from October 2019 through September 2023.
Type of IMD services allowed	SUD and/or mental health	SUD only
Length of stay	Varies by waiver: some numeric day limits, some unspecified, some require 30-day statewide average.	30 days per year
Covered inpatient levels of care	Must cover intensive residential/inpatient and medically supervised withdrawal management within 24 months of waiver approval.	Must cover at least 2 of 5 inpatient levels of care.
Covered outpatient levels of care	Must cover outpatient and intensive outpatient services within 24 months of waiver approval.	Must cover all 4 outpatient levels of care.
Institutional to community transitions	Must develop policies to link residential patients to community-based services.	Must ensure that IMD placement will allow for successful community transition.
Evidence-based practices	Must use evidence-based patient assessment and placement criteria and provide access to MAT.	Must follow evidence-based practices, including clinical screening and MAT.
Maintenance of effort	For SUD waivers, CMS encourages states to maintain current funding levels for a continuum of services; waivers should not reduce or divert state spending on behavioral health services. For mental health waivers, CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based services when approving waivers.	Must maintain state and local funding levels for IMD and outpatient services.

Recommendation: **Analyze Prior Authorization Requirements for Outpatient Behavioral Health Services**

The U.S. Surgeon General's "Spotlight on Opioids" states that MAT, along with community-based recovery supports, is the gold standard for opioid addiction treatment and can empower people to recover to healthy lives.[451] As a result, health care professionals are advocating for the complete elimination of prior authorizations for MAT and are calling for all payers and pharmacy benefit companies to end prior

[450] https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/.
[451] The Surgeon General's Spotlight on Opioids. https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf.

authorizations and other prohibitive utilization management procedures for the OUD treatment.[452, 453] In November 2019, a report prepared for the Legal Action Center by RTI International found that in New York, eliminating prior authorizations on medications to treat OUD would result in an 80 percent decrease in deaths due to OUD and a savings of $51.9 million in Medicaid dollars over the span of one year, due to a decrease in emergency room visits and inpatient care.[454] Some states, such as Arkansas and New Jersey, have already removed prior authorizations on MAT for all payers while other states,[455] such as Michigan[456] and Iowa, have removed prior authorizations from their Medicaid plans.[457] It should be noted that there are no prior authorization requirements for the CCBHCs in Nevada who are reimbursed under the Medicaid state plan using a prospective payment system methodology.

Prior authorization requirements for select level 1 outpatient behavioral health services in Nevada compared with three other peer states shows that Nevada is generally more restrictive (Table 21).

Table 21. Prior Authorization Comparison with Other States

Behavioral Health Outpatient Services	Prior Authorization Requirements			
	Nevada	Virginia[458]	Washington[459]	Oregon[460]
Comprehensive biopsychosocial assessment 90791 90792 – with medical services	Y	N	N[461]	N
Individual counseling H0047	Y	Not Found	Not Found	Not Found
Group counseling H0005	Y	N	Not Found	N
Individual psychotherapy 90832 – 30 mins 90833 – 30 mins w/E&M 90834 – 45 mins 90836 – 45 mins w/E&M – 60 mins 90837 90838 – 60 mins w/E&M	Y	N	N	N
Group psychotherapy	Y	N	N	N

[452] https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/risk/LT-CMS-OpioidRFI-101019.pdf.
[453] https://www.end-opioid-epidemic.org/recommendations-for-policymakers/.
[454] https://www.scribd.com/document/438556266/RTIReport-RemovingPriorAuth.
[455] Opioid Task Force Progress Report 2019.
[456] https://www.michigan.gov/som/0,4669,7-192-29942_34762-513562--,00.html.
[457] https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/risk/LT-CMS-OpioidRFI-101019.pdf.
[458] http://vacsb.org/wp-content/uploads/2017/10/ARTS-Reimbursement-Structure-10-6-2017.pdf.
[459] https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20200401.pdf.
[460] Oregon May 2020 Behavioral Health Fee Schedule.
[461] One exam allowed per client, per provider, per calendar year.

Behavioral Health Outpatient Services	Prior Authorization Requirements			
	Nevada	Virginia[458]	Washington[459]	Oregon[460]
90853				
Family psychotherapy 90846 – w/o patient 90847 – w/patient 90849 – multiple family	Y	Not Found	N	N
Peer Support Services H0038	Y	Y[462]	N	N

In their report to Congress on Utilization Management for MAT in Medicaid, the Medicaid and CHIP Payment and Access Commission found that "State Medicaid agencies and MCOs typically apply more utilization management policies—particularly prior authorization—to medications than to counseling services."[463] While Nevada has decreased some of the prior authorization requirements for MAT medication, there is prior authorization required for counseling services.

In order to analyze the effectiveness and efficiency of Nevada's current utilization management requirements, Nevada is encouraged perform an analysis of prior authorization requirements for behavioral health services. Cost containment measures should have the proper medical justification.[464] The list of services and prescription drugs requiring a prior authorization should be reviewed prior to the finalization of the MAT policy and at least annually thereafter, to ensure it is up to date with clinical guidance and historical approval trends. Regular review can assist in identifying therapies that no longer warrant utilization management restrictions.[465]

Myers and Stauffer requested and received from the State's prior authorization contractor, DXC, a prior authorization summary report showing the number of outpatient behavioral health services (including behavioral health rehab and PHP/IOP). The report included the request status of "approved, approved/modified, denied, or technical denial." Both the approved and approved/modified were totaled to determine the overall approval percentage. Status of denial and technical denial were used to calculate the overall denial percentage. It should be noted that the number of technical denials was small for each of the services listed which either resulted in no or little change to the overall percentage. Myers and Stauffer also added to the table the current fee schedule for the CPT and HCPCS codes reviewed to give the State an idea of the fees associated with each code. The State should consider if changes to prior authorization requirements are warranted to confirm ongoing medical necessity after an initial time

[462] Codes T1012 and S9445 are listed as requiring PA. H0038 not listed.
[463] https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf.
[464] https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf.
[465] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

period, the number of visits, or the removal of a requirement all together. A summary of findings is listed below on Table 22.

Table 22. Nevada Prior Authorization Summary for Outpatient Behavioral Health Services[463]

Behavioral Health Outpatient Services by Code	Total # of Prior Authorization Requests	Approval Rate	Denial Rate	Fee Schedule Amount
Comprehensive biopsychosocial assessment				
90791	884	68%	32%	$139.46
90792 – with medical services	107	55%	45%	$113.76
Individual counseling				
H0047	4,354	81%	19%	$57.78
Group counseling				
H0004	6,935	86%	14%	$30.28 (without HQ modifier)
H0005	3,846	79%	21%	$29.85
Individual psychotherapy				
90832 – 30 mins	1,009	87%	13%	$57.78
90833 – 30 mins w/E&M	72	58%	42%	$38.06
90834 – 45 mins	4,867	81%	19%	$73.92
90836 – 45 mins w/E&M	17	18%	82%	$61.72
90837	12,665	76%	24%	$108.15
90838 – 60 mins w/E&M	2	0%	100%	$99.49
Group psychotherapy				
90853	4,036	69%	31%	$29.85
Family psychotherapy				
90849 – multiple family	8	27%	63%	$28.53
90846 – w/o patient	1,570	83%	17%	$81.42
90847 – w/patient	6,899	83%	17%	$97.85
Peer Support Services				
H0038	2,758	77%	23%	$7.88 (without HQ modifier)
Skills training and development				
H2014	9,691	52%	48%	$7.06 (without HQ modifier)
Psychosocial rehabilitation services, per 15 minutes				
H2017	10,620	52%	48%	$14.38 (without HQ modifier)

Analyze Prior Authorization Requirements. In order to analyze the effectiveness and efficiency of Nevada's current utilization management requirements, Nevada is encouraged perform an analysis of prior authorization requirements for behavioral health services. Cost containment measures should have

the proper medical justification.[466] The list of services and prescription drugs requiring a prior authorization should be reviewed prior to the finalization of the MAT policy and at least annually thereafter, to ensure it is up to date with clinical guidance and historical approval trends. Regular review can assist in identifying therapies that no longer warrant utilization management restrictions.[467]

- ***Modify Prior Authorization Requirements for Select Outpatient Behavioral Health Services.*** Nevada currently requires prior authorization for IOP. While the State may not wish to remove prior authorization completely for this service, they may wish to consider modifying the prior authorization requirements. The benefit of requiring prior authorization after an initial time period supports the State in ensuring IOP level of care is appropriate for a beneficiary and encourages providers to revisit how and whether a patient should be advanced on the care continuum based on a real-time assessment.
- Removal of Prior Authorization Requirement for Select Outpatient Behavioral Health Services. As addressed in the *4. Nevada Substance Abuse Health Care System* section of this report, there may be an opportunity where Nevada should consider, after careful analysis, removing a prior authorization requirement from specific outpatient behavioral health services. Several therapy services (individual, group, and family), do not require PA from the MCOs in Nevada if services are received in network. PA is only required if the rendering provider is not in their network. Nevada's FFS system requires prior authorization for these services. In an effort to reduce administrative burden and confusion for providers, the State may wish to consider removing prior authorization requirements for select BH outpatient services. Additionally, decreasing the total number of prior authorizations can assist the State to reduce its own administrative burden and support cost containment.
- ***Key Findings Based on Review of the Nevada Prior Authorization Summary Data for Outpatient Behavioral Health Services with a Decision Date Between April 1, 2019 and April 1, 2020:***
    - Requests for individual and group counseling, as well as individual and group psychotherapy, highlighted in orange in Table 22, had a prior authorization denial rate that ranged from 14 to 24 percent for the time period reviewed. This percentage included claims with a status of "denied" or "technical denial" with the technical denial representing a very small percentage of the overall denials. Specific denial reasoning is not known.
    - The State's contractor, DXC, processed per month an average of 7,209 outpatient behavioral health prior authorization's during the 12-month review period. This equates

[466] https://www.ama-assn.org/system/files/2019-06/principles-with-signatory-page-for-slsc.pdf.
[467] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

to approximately 360 outpatient behavioral health prior authorization requests processed per day.

- HCPCS codes H2014 and H2017, highlighted in yellow in Table 22, both had a denial rate of 48 percent for the review time period. This may indicate the need for provider training on the appropriateness of the billing of these codes.

Recommendation: **Streamline Utilization Management Activities with the MCOs**

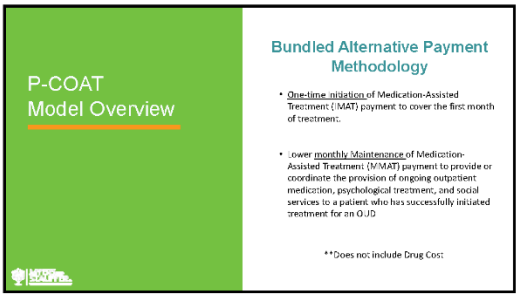
- ***MCO Workgroups.*** Form a workgroup with MCOs to evaluate alignment opportunities across managed care and FFS for utilization management policies relating to SUD and OUD treatment services. For example, assessment of preferred drug lists, drug quantity limits, lifetime maximums, under- and over-utilization reports for SUD and OUD services, prior authorization trends, member reconsideration outcomes, and others.
- ***MCO Contract Language Considerations.*** Consider contract language to upcoming procurement that requires the contractor to perform and report on their review of utilization patterns and access to care, specifically related to SUD and OUD treatment services.

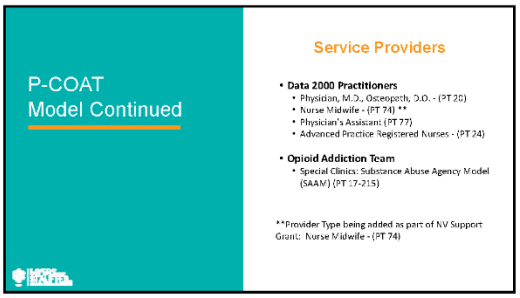
7. Rates and Reimbursement

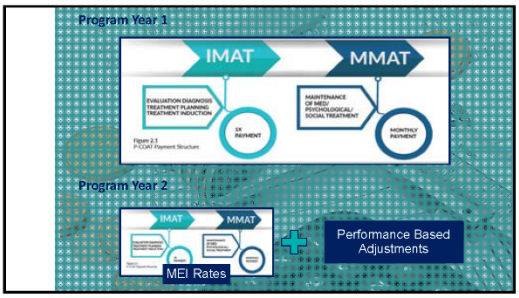
See *Appendix A* for the initial fiscal projection.

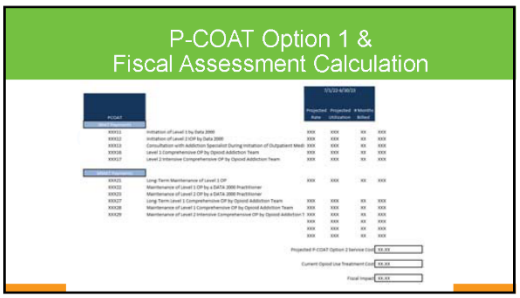
Appendix A: Fiscal Projection

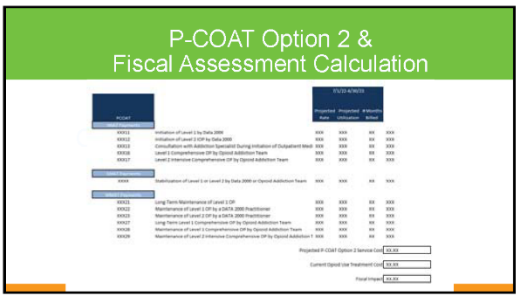
Initial Fiscal Impact Assessment Presentation

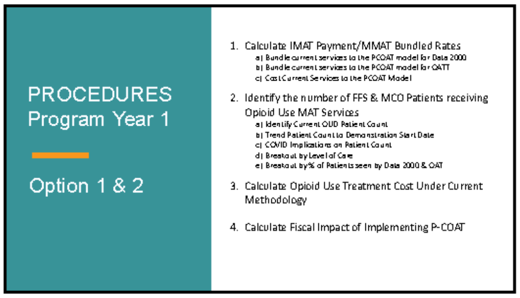


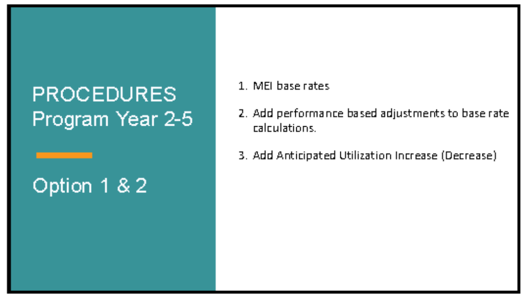


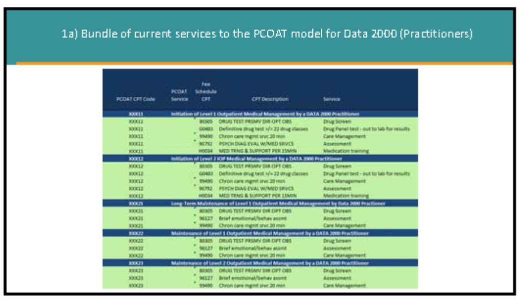


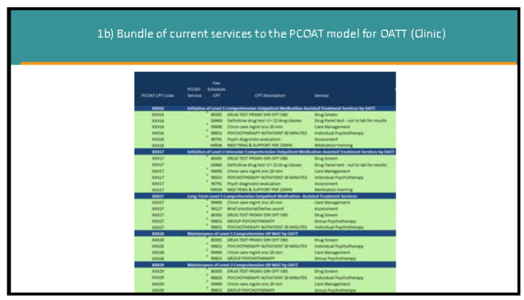


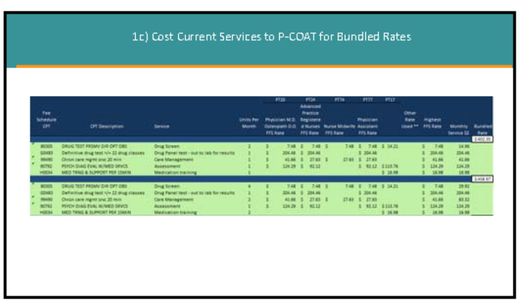


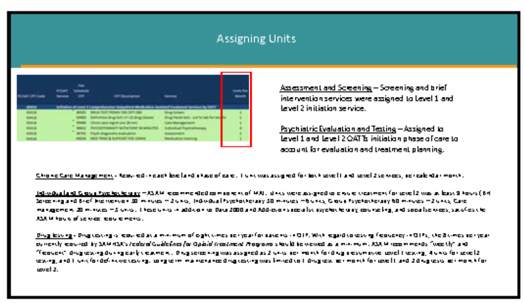

PROCEDURES
Program Year 1
Option 1 & 2
1. Calculate IMAT Payment/MMAT Bundled Rates
a) Bundle current services to the PCOAT model for Data 2000
b) Bundle current services to the PCOAT model for OATT
c) Cost Current Services to the PCOAT Model
2. Identify the number of FFS & MCO Patients receiving Opioid Use MAT Services
a) Identify Current OUD Patient Count
b) Trend Patient Count to Demonstration Start Date
c) COVID Implications on Patient Count
d) Breakout by Level of Care
e) Breakout by % of Patients seen by Data 2000 & OAT
3. Calculate Opioid Use Treatment Cost Under Current Methodology
4. Calculate Fiscal Impact of Implementing P-COAT

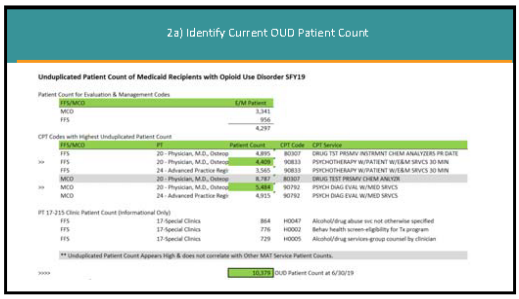

PROCEDURES
Program Year 2-5
Option 1 & 2
1. MEI base rates
2. Add performance based adjustments to base rate calculations.
3. Add Anticipated Utilization Increase (Decrease)

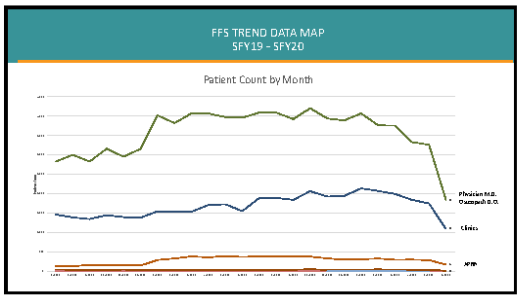

1a) Bundle of current services to the PCOAT model for Data 2000 (Practitioners)

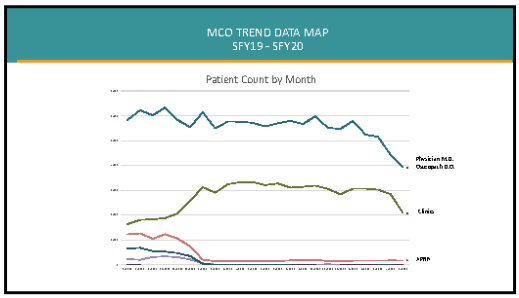

1b) Bundle of current services to the PCOAT model for OATT (Clinic)

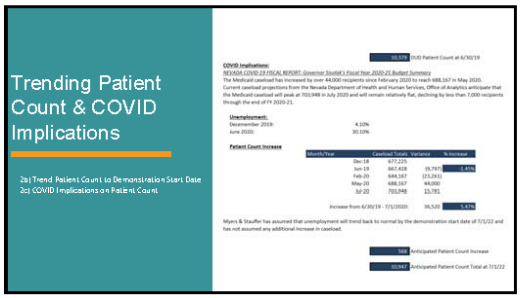

1c) Cost Current Services to P-COAT for Bundled Rates

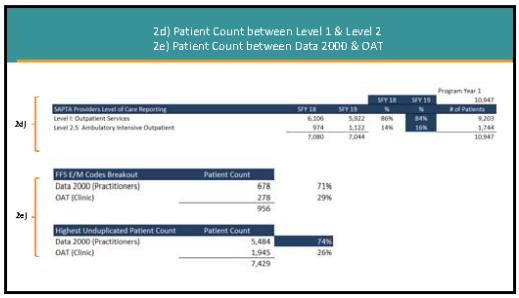

Assigning Units
Assessment and Screening – Screening and brief intervention services were assigned to Level 1 and Level 2 initiation service.
Psychiatric Evaluation and Testing – Assigned to level 1 and level 2 OATTs initiation phase of care to account for evaluation and treatment planning.

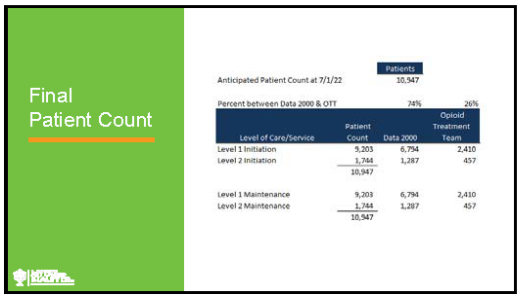

2a) Identify Current OUD Patient Count
Unduplicated Patient Count of Medicaid Recipients with Opioid Use Disorder SFY19


FFS TREND DATA MAP
SFY19 - SFY20
Patient Count by Month


MCO TREND DATA MAP
SFY19 - SFY20
Patient Count by Month


Trending Patient Count & COVID Implications
2a) Trend Patient Count to Demonstration Start Date
2c) COVID Implications on Patient Count


2d) Patient Count between Level 1 & Level 2
2e) Patient Count between Data 2000 & OAT

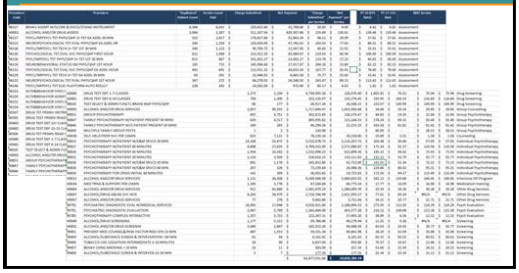

Final Patient Count

Calculation of Opioid Use Treatment Cost Under Current Methodology

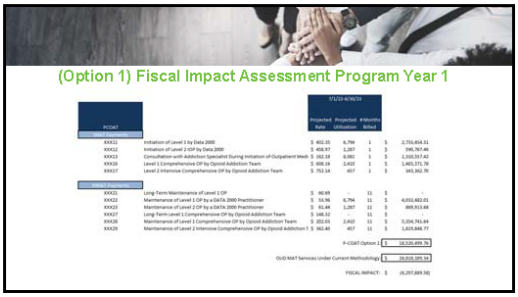
- Myers & Stauffer requested and was provided both FFS & MCO services by CPT code with an Opioid Use Diagnosis Code for FY19

MAT Services Included in from CPT Utilization
Assessment
Biofeedback
Counseling
Drug Screening
Group Counseling
Group Psychotherapy
Individual Psychotherapy
Intensive OP Program
Medication training
Psych Evaluation
Screening

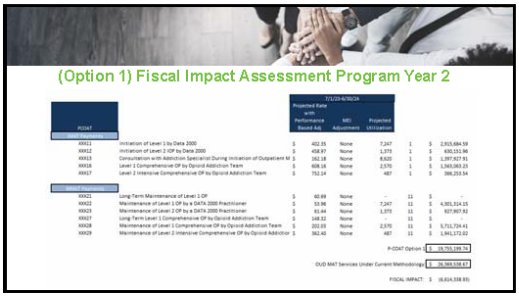
SFY19 Opioid Use Treatment Cost



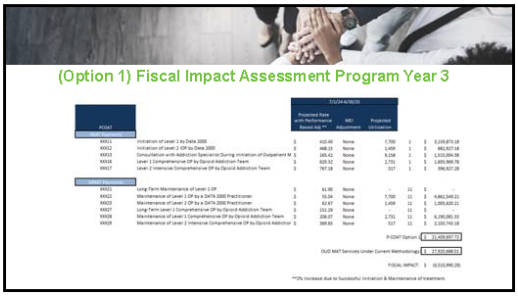
(Option 1) Fiscal Impact Assessment Program Year 1



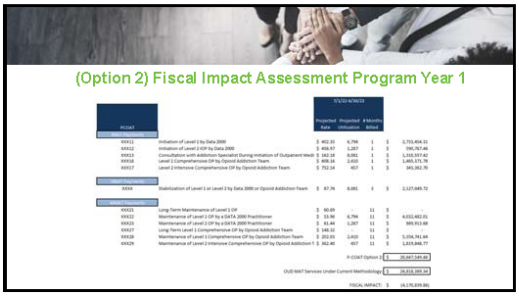
(Option 1) Fiscal Impact Assessment Program Year 2

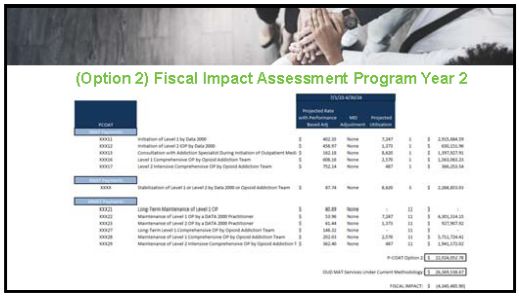


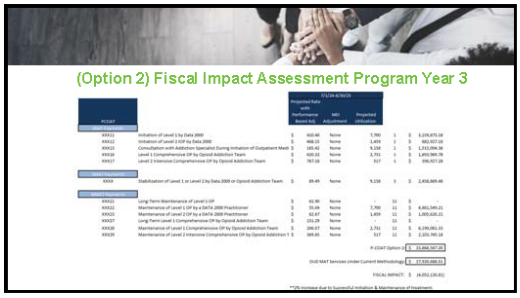
(Option 1) Fiscal Impact Assessment Program Year 3

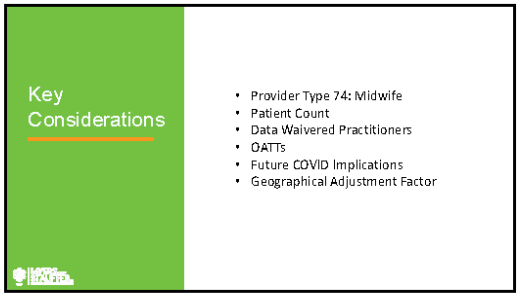


(Option 2) Fiscal Impact Assessment Program Year 1




(Option 2) Fiscal Impact Assessment Program Year 2


(Option 2) Fiscal Impact Assessment Program Year 3


Key Considerations
Provider Type 74: Midwife
Patient Count
Data Waivered Practitioners
OATTs
Future COVID Implications
Geographical Adjustment Factor

Nevada SUD OUD Reimbursement Analysis

Substance Use Disorder (SUD) Opioid Use Disorder (OUD) in Nevada: Reimbursement Analysis

Nevada Department of Health Care and Financing Policy

July 2020

TABLE OF CONTENTS

July 24, 2020

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Background

SUD/OUD Providers

Based on an analysis of the Nevada Medicaid Services (MSM) and billing manuals, the provider types (PT) currently billing the Nevada Medicaid program for substance use disorder (SUD)/opioid use disorder (OUD) includes:

- Hospital Inpatient - (PT 11)
- Hospital Outpatient - (PT 12)
- Psychiatric Inpatient Hospital - (PT 13)
- Behavioral Health Outpatient Services - (PT 14)
- Specialty Clinics - (PT 17)
- Physician - (PT 20)
- Advanced Practice Registered Nurses (APRN) - (PT 24)
- Psychologists - (PT 26)
- Indian Health Services and Tribal Clinics - (PT 47)
- Physician Assistant - (PT 77)
- Behavioral Health Rehabilitative Treatment - (PT 82)

Current Reimbursement

Providers are currently paid based on the Nevada Medicaid fee schedules rates, and services are billed by the current procedural terminology (CPT) code associated with the related SUD service. Nevada fee-for-service (FFS) rates were developed at 90 percent of the Medicare physician fee schedule. Current fee schedules are published on the Nevada Division of Helath Care Financing and Policy (DHCFP) website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Medication-Assisted Treatment

One of the goals of the Nevada Support Act is to create a comprehensive medication-assisted treatment (MAT) policy, integrate treatment networks and increase access in the primary care setting. Nevada identified the Patient-Centered Opioid Addiction Treatment (P-COAT) concept, an American Society of Addiction Medicine (ASAM) model, as the alternative payment option for comprehensive MAT Services. The two reimbursement options presented in this document were developed around the ASAM model and adjusted to meet the unique needs of the State as established in policy by DHCFP.

The complete ASAM model is documented at: https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2

Analysis of Two Reimbursement Options

OPTION 1: Patient-Centered Opioid Addiction Treatment (P-COAT)

P-COAT was designed to support office-based opioid treatment with buprenorphine or naltrexone, appropriate outpatient psychological and/or counseling therapy services, and appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient's condition. Nevada's provider type 17-215, Substance Abuse Agency Model clinics, are organizations able to deliver all three outpatient services and identified within Nevada's model as the Opioid Addiction Treatment Teams (OATT). Most physician practices can only provide medical treatment and care management services and would need to collaborate with addiction specialists or behavioral health organizations for the full range of medical, psychological, and social support services in a coordinated manor. Nevada's Data 2000 waivered practitioners are physician practices able to provide medical treatment with some support services. Referrals to an addiction specialist or OATT would be used to ensure coordinated and appropriate services.

Eligible Patients

Patients must be diagnosed with an OUD that meets Level 1 or Level 2 ASAM criteria determined appropriate for office-based addiction treatment programs, and agree to initiate MAT services. They must explicitly agree to receive all services from the OATT for a period of at least one month.

Eligible Providers

The following provider types were identified to expand SUD services through the P-COAT model and were included in development of reimbursement Options 1 and 2:

- Specialty Clinics: Substance Abuse Agency Model (SAAM) - (PT 17-215)
- Physician, M.D., Osteopath, D.O. - (PT 20)
- APRN - (PT 24)
- Psychologists - (PT 26)
- Nurse Midwife - (PT 74) **
- Physician Assistant - (PT 77)

***Added to the MSM as a qualified provider as part of Nevada Support Act Project.*

Psychologist, Provider Type 26, was identified by Nevada as provider type to be included in the P-COAT model. Psychologist are not qualified to be Data 2000 waivered and could not be classified as such. They can be qualified as an addiction specialist; however, Nevada Medicaid does not currently enroll addiction specialist as a separate provider type. The ASAM model, which offered three different options to make payments, was adjusted to reflect the fact that addiction specialists are not separately enrolled.

The model does offer consultation by an addiction specialist to a Data 2000 practitioner during initiation of outpatient medical management to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. Consultation between Data 2000 practitioners and OATTs was created to allow for comprehensive referral to the OATT. They can accept referrals for MAT services like psychotherapy, but would be unable to bill the P-COAT bundled rate; rather, they would bill under current payment mechanisms.

Payment Methodology

The P-COAT model bundles Level 1 and Level 2 SUD services into two comprehensive payments, allowing services to be provided by a Data 2000 practitioner, an addiction specialist, or an OATT. Nevada Medicaid does not currently enroll an addiction specialist as a separate provider type. The ASAM model, which offered three different options to make payments, was adjusted to reflect the fact that addiction specialists are not separately enrolled. The model offers consultation by an addiction specialist to Data 2000 practitioners during initiation of outpatient medical management to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. Consultation between Data 2000 practitioners and OATTs was created to allow for comprehensive referral to the OATT.

Bundled Payment 1 is a bundle of services to "Initiate" MAT (IMAT). This is a one-time payment allowed once during a six-month period. This payment supports evaluation, diagnosis, and treatment planning for a patient with an OUD. The IMAT phase of treatment is inclusive of the first month of outpatient MAT for the patient. This payment is adequate to cover the costs of these services and is significantly higher than monthly payments for ongoing treatment ("Maintenance" MAT [MMAT]).[1] Of note, this bundled payment includes care coordination which is currently not a reimbursable service under Nevada Medicaid.

Bundled Payment 2 is a bundle of services to MMAT. This monthly payment allows for the coordination of the provision of ongoing outpatient medication, psychological treatment, and social services to a patient who has successfully initiated treatment for an OUD. Monthly payments could continue if the patient was determined to be appropriate for continued therapy.[1] Of note, this bundled payment includes care coordination which is currently not a reimbursable service under Nevada Medicaid.

[1] https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2

Bundled payments do not include payment for the evaluation and management of office visits and medication. Billing and payment for these services fall under the current reimbursement methodology for each provider.

Performance-Based Adjustments

The P-COAT model also allows physician practices and OATT base rates to be adjusted based on performance, quality, spending, and outcome measures. Each measure would be calculated separately for patients receiving Level 1 and Level 2 outpatient services. If multiple physician practices are part of the same OATT, they could elect to have their performance measured jointly.

See Attachment 3 for Performance Based Payment Structure[2]

Payments for Technology-Based Treatment and Recovery Support Tools

In addition to performance-based adjustment, OATTs that use technology-based treatment and recovery support tools would be eligible for an add-on payment equal to approximately five to 10 percent of the standard payment. This payment may be temporary, would support testing and startup costs, and may be negotiated to reflect actual costs after initiation and utilization of the tool.

Provider Grouping under P-COAT

Nevada's P-COAT provider grouping would include Data 2000 practitioners and OATTs. (See *Attachment 2* for definitions and qualifications associated with the grouping of providers.) Nevada Data 2000 qualified practitioners include physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse-midwives[3]. Nevada provider types assigned to the P-COAT provider groupings are shown below. [2]

Data 2000 Practitioners

- Physician, M.D., Osteopath, D.O. - (PT 20)
- Nurse Midwife - (PT 74)
- Physician Assistant (PT 77)
- APRN - (PT 24)

OATTs

[2] https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2
[3] https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2

- Specialty Clinics: SAAM - (PT 17-215)

Data 2000 pratitioners must be prescribing and supervising the patient's medication treatment as well as have a collaborative agreement with an Addiction Specialist.

For Data 2000 practitioners, payments for psychotherapy, counseling, and social services related to initiation of treatment would be made separately under the current payment system. Because a physician is not equipped to provide the full scope of medical, psychological, and social care, all behavioral and social services coordinated by the physician are delivered and paid for separately according to current payment methods. The Data 2000 practitioner could still bill for and receive standard evaluation and management (E/M) services payments for face-to-face visits with the patient in addition to the MM-IMAT payment. The practitioner would not bill for other non-face-to-face care management or collaborative care services during the month in which the MM-IMAT payment was made. Those services are already included in the IMAT and MMAT rates. E/M payments will be paid outside of the P-COAT services bundle.

For OATTs, payments for psychotherapy, counseling, and other social services are included. The organization that bills for a comprehensive payment for maintenance of MAT (C-MMAT) would not bill or be paid separately for any of the above services to the patient that are related to opioid addiction treatment during the month in which the MMAT payment is billed. Other services related to addiction (e.g., laboratory tests other than drug testing covered under the bundled payment, emergency department visits, hospitalizations, etc.) that are received by the patient during the month covered by the MMAT payments would be paid separately. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the MMAT payments. The C-MMAT payment will replace E/M payments for office visits related to addiction treatment. If a patient with addiction visits the physician or practitioner who is delivering MAT for a health problem other than addiction, that visit and any other services related to that problem would be paid for separately under the regular physician fee schedule (or under an alternative payment model (APM) designed for those other health problems), even if the visit or service occurred on the same day as a visit for addiction-related care.

OPTION 1I: Patient-Centered Opioid Addiction Treatment (P-COAT)

Option 2 breaks the first month initiation phase into induction and stabilization phases and allows the stabilization bundled rate to be billed the first three months. Option 1 does not include a stabilization bundled rate.

Eligible patients, eligible providers, performance-based adjustments, payments for technology-based and recovery support tools, and provider grouping is the same with both Option 1 and Option 2.

Payment Methodology

Option 2 bundles Level 1 and Level 2 SUD services into three comprehensive payments, allowing services to be provided by a Data 2000 practitioner, an addiction specialist, or an OATT.

Bundled Payment 1 is a bundle of services to IMAT. This is a one-time payment, allowed once during a six-month period. This payment supports evaluation, diagnosis, and treatment planning for a patient with an OUD. The IMAT phase of treatment is inclusive of the first month of outpatient MAT for the patient. This payment is adequate to cover the costs of these services and is significantly higher than monthly payments for ongoing treatment (MMAT).[4]

Bundled Payment 2 is a bundle of services for "Stabilization" of MAT (SMAT). This monthly payment allows for stabilization of the provision of ongoing outpatient medication, psychological treatment, and social services to a patient who has successfully initiated treatment for an OUD. The payment is limited to three monthly payments as stabilization could take several weeks and up to three months.

Bundled Payment 3 is a bundle of services to MMAT. This monthly payment allows for the coordination of the provision of ongoing outpatient medication, psychological treatment, and social services to a patient who has successfully initiated treatment for an OUD. Monthly payments could continue if the patient was determined to be appropriate for continued therapy. [5]

These bundled payments do not include payment for the evaluation and management of the office visit and medication. Billing and payment for these services fall under the current reimbursement methodology for each provider.

P-COAT Bundled Payment Methodology

Program Year 1

The P-COAT model is an APM that bundles individual SUD services into two payments. The bundled payments would come as a one-time IMAT payment to cover the first six months of treatment, and a lower monthly MMAT payment to provide or coordinate the provision of ongoing outpatient medication, psychological treatment, and social services to a patient who has successfully initiated treatment for an OUD. These payments would continue based on need and patient participation.[6] Rates will be calculated based on expected cost of all services provided within each phase of care.

[4] https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2
[5] https://www.asam.org/docs/default-source/advocacy/asam-ama-p-coat-final.pdf?sfvrsn=447041c2_2
[6] https://pbn.decisionhealth.com/Blogs/DetailPrint.aspx?id=200706

One-time IMAT Payment + Monthly MMAT Payment

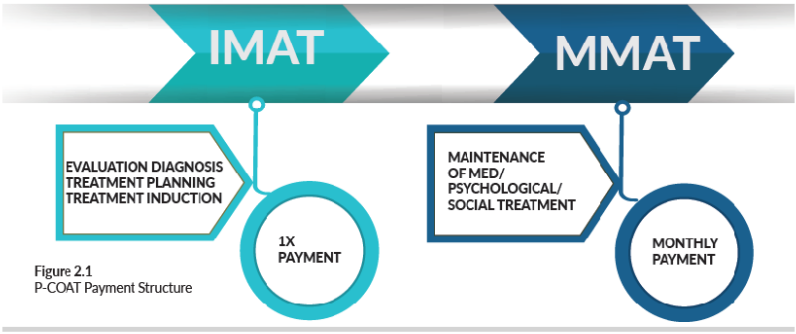

Figure 2.1
P-COAT Payment Structure

Source: ASAM P-COAT Brief

Program Year 2

After Program Year 1, an assessment of performance will be done and performance-based payment adjustments will be made on both IMAT and MMAT payments. Program year 2 base rates are also adjusted by the Medicare Economic Index (MEI).

Note: Option B in the ASAM P-COAT model is for the participation of an addiction specialist. Option B has been removed from CPT structure as it was not adopted in the development of Nevada's P-COAT alternative payment options.

P-COAT Option 2 Rate CPT Structure

Nevada-specific CPT codes will need to be developed for P-COAT bundled rates. A placeholder procedure code has been used in the chart below.

P-COAT Option 2 – Adds Stabilization Phase to CPT Structure

Billing Code	Service	Description
XXX11	IMAT	Initiation of Level 1 Outpatient Medical Management by a Data 2000 Practitioner
XXX12	IMAT	Initiation of Level 2 Intensive Outpatient Program (IOP) Medical Management by a Data 2000 Practitioner
XXX13	IMAT Consult	Consultation with Addiction Specialist During Initiation of Outpatient Medical Management
XXX16	IMAT	Initiation of Level 1 Comprehensive Outpatient MAT Services
XXX17	IMAT	Initiation of Level 2 Intensive Comprehensive Outpatient MAT Services

ANALYSIS OF TWO REIMBURSEMENT OPTIONS

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Billing Code	Service	Description
XXX21	MMAT	Long-Term Maintenance of Level 1 Outpatient Medical Management
XXX22	MMAT	Maintenance of Level 1 Outpatient Medical Management by a Data 2000 Practitioner
XXX23	MMAT	Maintenance of Level 2 Outpatient Medical Management by a Data 2000 Practitioner
XXX27	MMAT	Long-Term Level 1 Comprehensive Outpatient MAT Services
XXX28	MMAT	Maintenance of Level 1 Comprehensive Outpatient MAT Services
XXX29	MMAT	Maintenance of Level 2 Intensive Comprehensive Outpatient MAT Services
XXXXX	SMAT	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Addiction Team

Nevada P-COAT Initial Fiscal Impact Assessment

In order to analyze the initial fiscal analysis of implementing P-COAT, Option 1, and Option 2, the following steps were completed to estimate expenditures for Program Years 1 through 3.

Program Year 1

1. Calculate IMAT payment/MMAT bundled rates by bundling current MAT services to the P-COAT model for Data 2000 practitioners and OATTs for Level 1 and Level 2 services. Services and units were identified using ASAM guidance and criteria, Nevada Medicaid service grids, and FFS and managed care organization (MCO) utilization data. ASAM Level 2 services consist of nine or more hours of service a week, or six or more hours for adults and adolescents, respectively. Level 1 services are less than nine hours.

   The following comprehensive MAT services were included for evaluation, diagnosis, and treatment planning:

   a. Assessment and Screening – Screening and brief intervention services were assigned to Level 1 and Level 2 initiation service.

   b. Psychiatric Evaluation and Testing – Assigned to Level 1 and Level 2 OATTs initiation phase of care to account for evaluation and treatment planning.

   c. Chronic Care Management – Required in each level and phase of care. 1 unit was assigned for both Level 1 and Level 2 services, per calendar month.

   d. Individual and Group Psychotherapy – ASAM recommended component of MAT. Units were assigned to ensure treatment for Level 2 was at least nine hours (behavioral health screening and brief intervention) 30 minutes – two units, individual psychotherapy 30 minutes – six units, group psychotherapy 60 minutes – two units, care management 20 minutes – three units. These units, in addition to Data 2000 and addiction specialist psychotherapy, counseling, and social services, satisfies the ASAM hours of service requirements.

   e. Drug Testing – Drug testing is required at a minimum of eight times per year for patients in opioid treatment programs (OTP). With regard to testing frequency in OTPs, the eight times per year currently required by the Substance Abuse and Mental Health Services Administration's *Federal Guidelines for Opioid Treatment Programs* should be viewed as a minimum.[7] ASAM recommends "weekly" and "frequent" drug testing during early

[7] https://www.asam.org/docs/default-source/quality-science/the-asam-appropriate-use-of-drug-testing-in-clinical-addiction-medicine-full-document.pdf?Status=Tempandsfvrsn=700a7bc2_2

treatment[8]. Drug screening was assigned as two units per month for drug presumptive Level 1 testing, four units for Level 2 testing, and one unit for definitive testing. Long-term maintenance drug testing was limited to one drug test per month for Level 1, and two drug tests per month for Level 2.

2. Estimate the cost of current services under the P-COAT model. Current physician fee schedule rates were utilized in lieu of cost information to estimate the Medicaid cost of CPT services for the initial fiscal impact. The highest fee schedule rate between all provider types was used.
3. Identify the number of FFS and MCO patients receiving opioid use MAT services.
    a. In order to identify the State's current OUD patient count, OUD FFS and MCO utilization data was obtained for the most recent complete state fiscal year (SFY), 2019. (See *Attachment 5* for diagnosis codes used to identify OUD utilization data.) The unduplicated patient count from FFS and MCO E/M codes was compared to the highest patient count, combining FFS and MCO, in all services with an OUD diagnosis. The unduplicated patient count of PT 20 Physician drug test services was high compared to other MAT service patient counts. It also exceeds the highest patient count in the trend data from Fiscal year (FY) 2019 to FY 2020. The unduplicated patient count for 80307 drug testing was 8,787 for SFY 2019. Because we could not ascertain drug testing could be directly correlated with MAT services, this patient count was not included in the analysis.

[8] https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-pocketguide.pdf?sfvrsn=0#:~:text=with%20OUD%2C%20the%20patient%20should%20receive%20a%20multidimensional,bio-psycho-social-spiritual%20illness%2C%20for%20which%20the%20use%20of%20medication%28s%2

Unduplicated Patient Count of Medicaid Recipients with Opioid Use Disorder SFY19

Patient Count for Evaluation & Management Codes

FFS/MCO	Patient Count
MCO	3,341
FFS	956
	4,297

CPT Codes with Highest Unduplicated Patient Count

	FFS/MCO	PT	Patient Count	CPT Code	CPT Service
	FFS	20 - Physician, M.D., Osteopath, D.O.	4,895	80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE
>>	FFS	20 - Physician, M.D., Osteopath, D.O.	4,409	90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
	FFS	24 - Advanced Practice Registered Nurses	3,565	90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
	MCO	20 - Physician, M.D., Osteopath, D.O.	3,787	80307	DRUG TEST PRSMV CHEM ANLYZR
>>	MCO	20 - Physician, M.D., Osteopath, D.O.	5,484	90792	PSYCH DIAG EVAL W/MED SRVCS
	MCO	24 - Advanced Practice Registered Nurses	4,915	90792	PSYCH DIAG EVAL W/MED SRVCS
	PT 17-215 Clinic Patient Count (Informational Only)				
	FFS	17-Special Clinics	864	H0047	Alcohol/drug abuse svc not otherwise specified
	FFS	17-Special Clinics	776	H0002	Behav health screen-eligibility for Tx program
	FFS	17-Special Clinics	729	H0005	Alcohol/drug services-group counsel by clinician

** Unduplicated Patient Count Appears High & does not correlate with Other MAT Service Patient Counts. Excluded from calculation.

10,379 OUD Patient Count at 6/30/19

4. Trend patient count to demonstration start date.

    a. Medicaid patient count was requested from July 2018 through May 2020 for the provider types included in the P-COAT model. Through 2019, Nevada saw a flatening out of patient counts. Because there was no strong upward correlation in SUD patients each month, no further inflation to the OUD population was added to the patient count from June 30, 2019.

NEVADA P-COAT INITIAL FISCAL IMPACT ASSESSMENT

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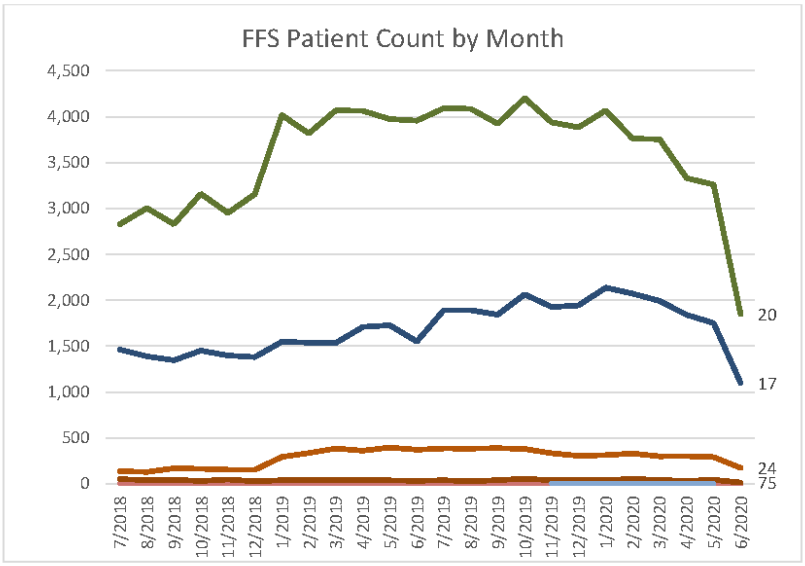

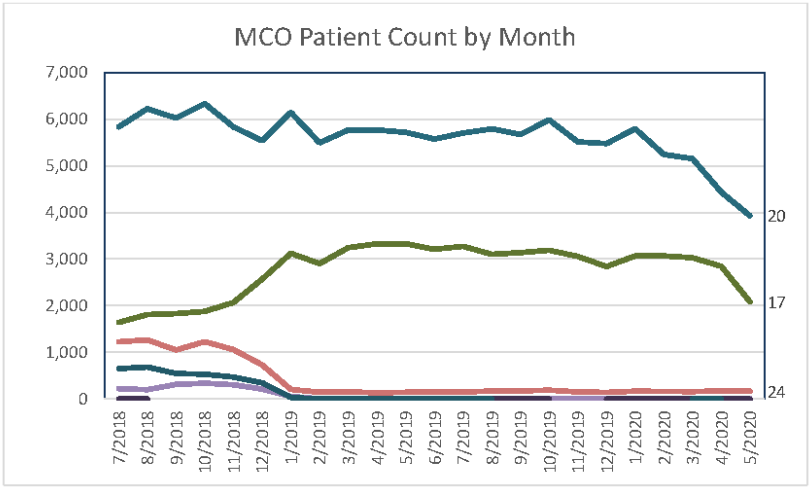

b. COVID-19 is expected to have significant implications on Nevada's patient count between the data used in this analysis and a demonstration start date of July 1, 2022. Unemployment rose from 4.10 percent in December 2019, and to 30.10 percent in June 2020. As Nevadans lose employer-sponsored health insurance and become uninsured, Medicaid's patient count will continue to rise. Nevada Governor Sisolak's FY 2020 – 2021 budget summary disclosed the Medicaid caseload (unduplicated patient count) has increased by over 44,000 recipients since February 2020 to reach 688,167 in May 2020. Current caseload projections from the Nevada Department of Health and Human Services, Office of Analytics anticipate that the Medicaid caseload will peak at 703,948 in July 2020 and will remain relatively flat, declining by less than 7,000 recipients through the end of FY 2020 – 2021. A caseload data report from the Office of Analytics for the time period of December 2018 through July 2020 was analyzed to calculate the percent increase in caseload from June 2019 to July 2020.

Unemployment:

Decemember 2019:	4.10%
June 2020:	30.10%

Patient Count Increase

Month/Year	Caseload Totals	Variance	% Increase
Dec-18	677,225		
Jun-19	667,428	(9,797)	-1.45%
Feb-20	644,167	(23,261)	
May-20	688,167	44,000	
Jul-20	703,948	15,781	
Increase from 6/30/19 - 7/1/2020:		36,520	5.47%

Myers & Stauffer has assumed that unemployment will trend back to normal by the demonstration start date of 7/1/22 and has not assumed any additional increase in caseload.

568	Anticipated Patient Count Increase (5.47%)
10,947	Anticipated Patient Count Total at 7/1/22

5. Separate patient count by Level 1 and 2 services.

a. The Nevada Medicaid Management Information System does not identify a patient's level of care between Level 1 and Level 2. In order to determine the patient count between Level 1 and Level 2, Nevada's Treatment Episode Data Sets (TEDS) reporting data was used. TEDS data is collected on the state's public and private behavioral health treatment programs and documents patient caseload by level of care. A comparison between SFY 2018 and 2019 was made that documented unduplicated patient counts by level of care. SFY 2019 percentages were used to breakout patient count by Level 1 and 2 services.

			SFY 18	SFY 19
SAPTA Providers Level of Care Reporting	SFY 18	SFY 19	%	%
Level I: Outpatient Services	6,106	5,922	86%	84%
Level 2.5 Ambulatory Intensive Outpatient	974	1,122	14%	16%
	7,080	7,044		

6. Breakout by percent of patients seen by Data 2000 and OATTs.
    a. The percentage of patients seen by practitioners or OATTs was calculated using FFS E/M code utilization by patient count and the highest unduplicated patient count in all utilization data of SUD services.

FFS E/M Codes Breakout	Patient Count	
Data 2000 (Practitioners)	678	71%
OAT (Clinic)	278	29%
	956	

Highest Unduplicated Patient Count	Patient Count	
Data 2000 (Practitioners)	5,484	74%
OAT (Clinic)	1,945	26%
	7,429	

7. Calculate opioid use treatment cost under current methodology for Program Year 1 through 3.
    a. Program Year 1: Current MAT services were identified by adding the Medicaid payments of CPT services associated with MAT for SFY 2019. (See *Attachment 4* for CPT codes included in current MAT services.)
    b. Program Years 2 through 3: MAT services from Program Year 1 were increased by the percent increase in patient count.
8. Calculate fiscal impact of implementing P-COAT.
    a. P-COAT service cost = bundled rates * projected patient count * # of months compared to service cost under current methodology.

Program Year 2 – 3

1. Base rate inflation.
    a. Due to the current economic situation in Nevada and anticipated rate cuts, the base rates were not inflated for Program Years 2 and 3.
2. Add performance-based adjustments to base rates calculations.
    a. Per the ASAM model, most physician practices would be expected to be rated as "good" on all measures, and would receive the standard payment amounts with no adjustments. No adjustments were made to base rates for performance-based adjustments for Program Year 2. Program Year 3 rates were adjusted two percent due to assumed successful initiation and maintenance of treatment.
3. Add anticipated utilization increase (decrease) and change in levels of care due to effective treatment.
    a. The plan for this grant is to increase SUD/OUD providers by 20 percent. A 20 percent increase in patient count was utilized to estimate the anticipated increase in utilization in Program Years 2 and 3.

b. It was assumed that patients receiving Level 1 care would stay in effective treatment through Program Years 2 and 3. Patients receiving Level 2 care would phase into Level 1 treatment over three years.

Fiscal Impact Key Considerations

Provider Type 74: Midwife

Provider Type 74 Midwife is being added a part of the Nevada Support Act. The Nevada Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) Perinatal Health Initiative has been underway since November 2018. One of their goals is to increase engagement, outreach, and treatment for pregnant/postpartum women and non-pregnant women of child bearing age.[9] Part of that strategy is to include MAT policy and Screening, Brief Intervention, and Referral to Treatment billing codes into a toolkit for ease of use by provider staff in hospital neonatal intensive care, obstetrics, and pediatrics units. At this time, it is unknown the number of providers who will become MAT waivered and their projected utilization estimates as a result of the ASTHO OMNI project.

Patient Count

The model requires patients to explicitly agree to receive all of their addiction-related services from the members of the OATT for a period of at least one month. The initial fiscal projection assumes all patients receiving OUD services as of June 30, 2019 were MAT patients who would agree to continued treatment by their practitioner or OATT.

Patients in MAT may stay in treatment for months, years, several years, or even a lifetime.[10] The initial fiscal assessment has assumed each patient will receive one month of initiation services, and 11 months of maintenance and continue treatment throughout Program Years 2 and 3.

Per the ASAM model, Data 2000 practitioners would not deliver medication treatment for patients requiring ASAM Level 2 IOP services, but would refer such patients to an addiction specialist. The initial fiscal projection assumes practitioners would deliver Level 2 IOP services, due to unavailability of an addiction specialist within the state, and would consult with an addiction specialist.

Data-Waivered Practitioners

192 providers are waivered to provide buprenorphine in Nevada; however, not all prescribe. For those who do prescribe, very few prescribe to their upper limit. The capacity for providers to expand utilization may increase due to training and education as part of the Nevada Support Act and ASTHO OMNI project. The plan for this grant is to increase SUD/OUD providers by 20 percent. A 20 percent

[9] Nevada ASTHO Omni Action Plan, February 2020
[10] https://www.samhsa.gov/medication-assisted-treatment/treatment

adjustment factor was added to account for the increase in OUD patients as a result of training and education.

Future COVID Implications

According to the Boston Medical Center, "The evolving situation [COVID-19] is raising concerns that heightened anxiety may push people out of recovery. Lockdowns and decreased access to treatment centers due to social distancing is likely to disrupt distribution of crucial treatment medications. And all of it boils down to the real potential for a surge in overdoses and overdose deaths".[11] Nevada should continue to monitor overdoses and increased patients needing re-initiation into treatment, impacting P-COAT payments.

OATT

Provider Type 17-215, Substance Abuse Agency Model clinics have been identified as the OATT provider in the P-COAT APM. SFY 2019 utilization data showed more Medicaid OUD treatment services provided by Data 2000 Practitioners than OATTs, a statistic inconsistent with ASAM and national data. It is assumed that OATTs (PT 17-215 clinics) in Nevada may not be billing Medicaid at capacity, impacting actual treatment utilization percentages between provider types. For Program Year 2 through 3, OUD treatment between OATTs and Data 2000 practitioners was not adjusted, as Nevada utilization does not currently support a change.

Geographical Adjustment Factor

A geographical adjustment for the P-COAT model was calculated but not shown as an add-on in the fiscal assessment. Rates were costed using the highest FFS rates and not actual cost data between rural and urban providers.

Calculation of the adjustment factor was done based on the most recent complete Bureau of Labor Statistics data, May 2019. Healthcare Practitioners and Technical Occupations were used and the lowest mean salary was used to calculate a multiplier for the other geographical areas.

area_title	occ_title	a_mean	Multiplier
Nevada nonmetropolitan area	Healthcare Practitioners and Technical Occupations	86,830	1.0000
Carson City, NV	Healthcare Practitioners and Technical Occupations	89,380	1.0294
Las Vegas-Henderson-Paradise, NV	Healthcare Practitioners and Technical Occupations	91,570	1.0546
Reno, NV	Healthcare Practitioners and Technical Occupations	93,300	1.0745

[11] https://www.bmc.org/healthcity/population-health/preventing-next-wave-opioid-crisis-during-covid-19

Strategic Planning Reimbursement Considerations

1. Stakeholder engagement with providers may be necessary to ensure comprehensive MAT services included in Nevada's APM adequately support treatment.
2. Nevada Medicaid does not currently enroll an addiction specialist as a separate provider type. An analysis of expansion benefits by enrolling an addiction specialist individually versus requiring licensing under a specialty clinic should be completed.
3. P-COAT cost estimation for the initial fiscal projection was done utilizing the physician fee schedule rates as reasonable provider cost information was limited and not sufficient to cost out services. To ensure adequate cost of services is covered, Nevada should consider a provider cost survey when setting bundled rates for the demonstration.
4. Per ASAM, the P-COAT model does not exclude participation by special populations, including pregnant women. However, providers may choose to exclude from this model those patients who have more complex needs or may need a different level of service not provided by this model. Nevada should evaluate whether the P-COAT bundled services meet the needs of the prenatal population.
5. The initial fiscal projection does not include add-payments for technology-based treatment and recovery support tools (e.g., telehealth) as identification and utilization is still unknown. ASAM guidance suggests an eligible add-on payment equal to approximately five to 10 percent of the standard payment. This payment may be temporary to support testing and startup costs and may be negotiated to reflect actual costs after initiation and utilization of the tool.
6. The State should continue to monitor telehealth flexibilities provided by CMS during COVID to add a comprehensive telehealth add-on adjustment.
7. An action item of the ASTHO OMNI Project Plan (2.4.g) is to implement integrated hub-and-spoke treatment model under P-COAT. DHCFP should consider implementation of this action item as part of the Nevada Support Act.

Attachment I

Level 1 and Level 2 Outpatient Service Requirements

ASAM Criteria and Standards

Level 1: Outpatient Services

Level 1 is appropriate in many situations as an initial level of care for patients with less severe disorders, for those who are in early stages of change, as a "step down" from more intensive services, or for those who are stable and ongoing monitoring or disease management is appropriate. Adult services for Level 1 programs are provided less than nine hours per week, and adolescent services are provided less than six hours per week. Individuals recommended for more intensive levels of care may receive more intensive services.

Therapies: Level 1 outpatient services may offer several therapies and service components, including individual and group counseling, motivational enhancement, family therapy, educational groups, occupational and recreational therapy, psychotherapy, MAT, or other skilled treatment services.

Level 2: Intensive Outpatient

Level 2 programs provide essential addiction education and treatment components and have two gradations of intensity. Level 2.1 intensive outpatient programs provide nine to 19 hours of weekly structured programming for adults, or six to 19 hours of weekly structured programming for adolescents. Programs may occur during the day or evening, on the weekend, or after school for adolescents.

Level 2.1: Intensive Outpatient Programs

Therapies: Level 2.1 intensive outpatient services include individual and group counseling, educational groups, occupational and recreational therapy, psychotherapy, MAT, motivational interviewing, enhancement and engagement strategies, family therapy, or other skilled treatment services.

Attachment 2

P-COAT Provider Groups

Data 2000 Practitioner

- A physician or other qualified healthcare professional with a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000. This practitioner could bill for IMAT/SMAT/MMAT payments to support MAT (using buprenorphine or naltrexone) and care management services for the patient.

Opioid Addiction Treatment Team

OATTs would consist of:

- A physician or other qualified healthcare professional with a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000. This practitioner could bill for IMAT/SMAT/MMAT payments to support MAT (using buprenorphine or naltrexone) and care management services for the patient.
- A physician who specializes in addiction medicine who would be available for consultative support, including telephonic/electronic support to the waivered practitioner via telephonic or electronic communication links. This addiction specialist could bill for payments to support consultations with the Data 2000 practitioner. An addiction specialist would need to be board certified in addiction medicine by the American Board of Addiction Medicine, the American Board of Preventive Medicine, American Osteopathic Association, ASAM, or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology.
- One or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an OUD, and who have contracts or collaboration agreements with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. Providers of these services would be paid using existing billing codes or other payment methods that support their services.
- One or more nurses, social workers, pharmacists, or other healthcare or social services professionals who have the training and skills necessary to help individuals with an OUD to address non-medical needs, and who have a contract or collaboration agreement with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. Providers of these services would be paid using existing billing codes or other payment methods that support their services.

ATTACHMENT 3
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Attachment 3

Performance-Based Adjustments to IMAT Payments

	Performance on Successful Initiation of Treatment		
Performance on Utilization of Services:	**Poor on Either Measure**	**Good on Both Measures**	**Excellent on Both Measures**
Poor on Either Measure	-4%	-2%	0%
Good on Both Measures	-2%	0%	+2%
Excellent on One and Good on Other	0%	+2%	+4%

Performance-Based Adjustments to MMAT Payment

	Performance on Successful Maintenance of Treatment		
Performance on Utilization	**Poor on Either Measure**	**Good on Both Measures[32]**	**Excellent on Both Measures**
Poor on Either Measure	-4%	-2%	0%
Good on Both Measures	-2%	0%	+2%
Excellent on One and Good on Other	0%	+2%	+4%

ATTACHMENT 4

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Attachment 4

Coding For MAT Program Services

The following CPT and Healthcare Common Procedure Coding System codes represent conditions diagnosed by the MAT provider related to opioid abuse and opioid dependence.

Procedure Code	Procedure	MAT Service
80305	DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	Assessment
80306	DRUG TST PRSMV READ INSTRMNT ASSTD DIR OPT OBS	Assessment
80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	Assessment
90785	PSYCHOTHERAPY COMPLEX INTERACTIVE	Assessment
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	Assessment
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	Assessment
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Assessment
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	Assessment
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	Assessment
90836	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN	Assessment
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	Assessment
90838	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN	Assessment
90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	Assessment
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	Assessment
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	Assessment
90849	MULTIPLE FAMILY GROUP PSYTX	Assessment
90853	GROUP PSYCHOTHERAPY	Drug Screening
96020	TEST SELECT & ADMN FUNCTL BRAIN MAP PHYS/QHP	Drug Screening
96116	NEUROBEHAVIORAL STATUS XM PHYS/QHP 1ST HOUR	Drug Screening
96127	BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	Drug Screening
96130	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	Drug Screening
96131	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	Drug Screening
96132	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	Drug Screening
96133	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	Drug Screening
96136	PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	Group Counseling
96137	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	Group Psychotherapy
96138	PSYCL/NRPSYCL TST TECH 2+ TST 1ST 30 MIN	Group Psychotherapy
96139	PSYCL/NRPSYCL TST TECH 2+ TST EA ADDL 30 MIN	Group Psychotherapy
96146	PSYCL/NRPSYCL TST ELEC PLATFORM AUTO RESULT	Group Psychotherapy
96150	HLTH&BEHAVIOR ASSMT EA 15 MIN W/PT 1ST ASSMT	Counseling
96152	HLTH&BEHAVIOR IVNTJ EA 15 MIN INDIV	Individual Psychotherapy
96153	HLTH&BEHAVIOR IVNTJ EA 15 MIN GRP 2/>PTS	Individual Psychotherapy

ATTACHMENT 4

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Procedure Code	Procedure	MAT Service
96154	HLTH&BEHAVIOR IVNTJ EA 15 MIN FAM W/PT	Individual Psychotherapy
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	Individual Psychotherapy
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	Individual Psychotherapy
99407	BEHAV CHNG SMOKING > 10 MIN	Individual Psychotherapy
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	Individual Psychotherapy
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	Intensive OP Program
G0480	DRUG TEST DEF 1-7 CLASSES	Medication training
G0481	DRUG TEST DEF 8-14 CLASSES	Other Drug Services
G0482	DRUG TEST DEF 15-21 CLASSES	Other Drug Services
G0483	DRUG TEST DEF 22+ CLASSES	Other Drug Services
H0001	ALCOHOL AND/OR DRUG ASSESS	Psych Evaluation
H0002	ALCOHOL AND/OR DRUG SCREENIN	Psych Evaluation
H0004	ALCOHOL AND/OR DRUG SERVICES	Psych Evaluation
H0005	ALCOHOL AND/OR DRUG SERVICES	Screening
H0007	ALCOHOL AND/OR DRUG SERVICES	Screening
H0015	ALCOHOL AND/OR DRUG SERVICES	Screening
H0034	MED TRNG & SUPPORT PER 15MIN	Screening
H0038	SELF-HELP/PEER SVC PER 15MIN	Screening
H0047	ALCOHOL/DRUG ABUSE SVC NOS	Screening
H0049	ALCOHOL/DRUG SCREENING	Screening

ATTACHMENT 5

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Attachment 5

Substance Use Diagnosis ICD-10 Codes

The following diagnosis codes represent conditions diagnosed by MAT providers related to opioid abuse and opioid dependence.

Diagnosis Code	Conditions
3040	Opioid type dependence
30400	OPIOID DEPENDENCE-UNSPEC
30401	OPIOID DEPENDENCE-CONT
30402	OPIOID DEPENDENCE-EPIS
30403	OPIOID DEPENDENCE-REMISS
3047	Opioid/ other drug dep
30470	OPIOID/OTHER DEP-UNSPEC
30471	OPIOID/OTHER DEP-CONT
30472	OPIOID/OTHER DEP-EPIS
30473	OPIOID/OTHER DEP-REMISS
3055	Opioid abuse
30550	OPIOID ABUSE-UNSPEC
30551	OPIOID ABUSE-CONTINUOUS
30552	OPIOID ABUSE-EPISODIC
30553	OPIOID ABUSE-IN REMISS
F11	OPIOID RELATED DISORDERS
F111	OPIOID ABUSE
F1110	Opioid abuse, uncomplicated
F1111	Opioid abuse, in remission
F1112	OPIOID ABUSE WITH INTOXICATION
F11120	Opioid abuse with intoxication. uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication. unspecified
F1114	Opioid abuse with opioid-induced mood disorder
F1115	OPIOID ABUSE WITH OPIOID-INDUCED PSYCHOTIC DISORDER
F11150	Opioid abuse w opioid-induced psychotic disorder w delusions
F11151	Opioid abuse w opioid-induced psychotic disorder w hallucin
F11159	Opioid abuse with opioid-induced psychotic disorder, unsp
F1118	OPIOID ABUSE WITH OTHER OPIOID-INDUCED DISORDER
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder

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Diagnosis Code	Conditions
F1119	Opioid abuse with unspecified opioid-induced disorder
F112	OPIOID DEPENDENCE
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F1122	OPIOID DEPENDENCE WITH INTOXICATION
F11220	Opioid dependence with intoxication. uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence w intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid- induced mood disorder
F1125	OPIOID DEPENDE NCEWITH OPIOID-INDUCEDPSYCHOTIC DISORDER
F11250	Opioid depend w opioid-induc psychotic disorder w delusions
F11251	Opioid depend w opioid-induc psychotic disorder w hallucin
F11259	Opioid dependence w opioid- induced psychotic disorder, unsp
F1128	OPIOID DEPENDE NCEWITH OTHER OPIOID-INDUCED DISORDER
F11281	Opioid dependence with opioid- induced sexual dysfunction
F11282	Opioid dependence with opioid- induced sleep disorder
F11288	Opioid dependence with other opioid- induced disorder
F1129	Opioid dependence with unspecified opioid -induced disorder
F119	OPIOID USE, UN SPECIFIED
F1190	Opioid use, unspecified uncomplicated
F1192	OPIOID USE, UN SPECIFIED W ITH INTOXICATION
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11921	Opioid use, unspecified with intoxication delirium
F11922	Opioid use, unsp w intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified

PCOAT Costing and Rate Bundling

Mapping of PCOAT Services

PCOAT CPT Code	PCOAT Service	Fee Schedule CPT	CPT Description	Service	Units Per Month	PT20 Physician M.D. Osteopath D.O. FFS Rate	PT24 Advanced Practice Registered Nurses FFS Rate	PT74 Nurse Midwife FFS Rate	PT77 Physician Assistant FFS Rate	PT17	Other Rate Used **	Highest FFS Rate	Monthly Service $$	Bundled Rate
XXX11	**Initiation of Level 1 Outpatient Medical Management by a DATA 2000 Practitioner**													$ 402.35
XXX11	Initiation of Level 1 Outpatient Medical Management by a	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	2	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 7.48	14.96	
XXX11	Initiation of Level 1 Outpatient Medical Management by a	G0483	Definitive drug test >/= 22 drug classes	Drug Panel test - out to lab for results	1	$ 204.46	$ 204.46		$ 204.46			$ 204.46	204.46	
XXX11	Initiation of Level 1 Outpatient Medical Management by a	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	41.66	
XXX11	Initiation of Level 1 Outpatient Medical Management by a	90792	PSYCH DIAG EVAL W/MED SRVCS	Assessment	1	$ 124.29	$ 92.12		$ 92.12	$ 113.76		$ 124.29	124.29	
XXX11	Initiation of Level 1 Outpatient Medical Management by a	H0034	MED TRNG & SUPPORT PER 15MIN	Medication training	1					$ 16.98		$ 16.98	16.98	
XXX12	**Initiation of Level 2 IOP Medical Management by a DATA 2000 Practitioner**													$ 458.97
XXX12	Initiation of Level 2 IOP Medical Management by a DATA 2	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	4	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 7.48	29.92	
XXX12	Initiation of Level 2 IOP Medical Management by a DATA 2	G0483	Definitive drug test >/= 22 drug classes	Drug Panel test - out to lab for results	1	$ 204.46	$ 204.46		$ 204.46			$ 204.46	204.46	
XXX12	Initiation of Level 2 IOP Medical Management by a DATA 2	99490	Chron care mgmt srvc 20 min	Care Management	2	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	83.32	
XXX12	Initiation of Level 2 IOP Medical Management by a DATA 2	90792	PSYCH DIAG EVAL W/MED SRVCS	Assessment	1	$ 124.29	$ 92.12		$ 92.12	$ 113.76		$ 124.29	124.29	
XXX12	Initiation of Level 2 IOP Medical Management by a DATA 2	H0034	MED TRNG & SUPPORT PER 15MIN	Medication training	2					$ 16.98		$ 16.98	16.98	
XXX13	**Consultation with Addiction Specialist During Initiation of Outpatient Medical Management**													$162.18
XXX13	Consultation by Addiction Specialist During Initiation of O	99492	Psychiatric collaborative care management	Consultation	1						$162.18	$162.18	$162.18	
XXX16	**Initiation of Level 1 Comprehensive Outpatient Medication-Assisted Treatment Services by OATT**													$ 608.16
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	2	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 14.21	28.42	
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	G0483	Definitive drug test >/= 22 drug classes	Drug Panel test - out to lab for results	1	$ 204.46	$ 204.46		$ 204.46			$ 204.46	204.46	
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	41.66	
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Individual Psychotherapy	4	$ 55.77	$ 41.33	$ 55.77	$ 41.33	$ 57.78		$ 57.78	231.12	
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	90791	Psych diagnostic evaluation	Assessment	1					$ 85.52		$ 85.52	85.52	
XXX16	Initiation of Level 1 Comprehensive Outpatient Medicatior	H0034	MED TRNG & SUPPORT PER 15MIN	Medication training	1					$ 16.98		$ 16.98	16.98	
XXX17	**Initiation of Level 2 Intensive Comprehensive Outpatient Medication-Assisted Treatment Services by OATT**													$ 752.14
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	4	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 14.21	56.84	
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	G0483	Definitive drug test >/= 22 drug classes	Drug Panel test - out to lab for results	1	$ 204.46	$ 204.46		$ 204.46			$ 204.46	204.46	
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	41.66	
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Individual Psychotherapy	6	$ 55.77	$ 41.33	$ 55.77	$ 41.33	$ 57.78		$ 57.78	346.68	
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	90791	Psych diagnostic evaluation	Assessment	1					$ 85.52		$ 85.52	85.52	
XXX17	Initiation of Level 2 Intensive Comprehensive Outpatient M	H0034	MED TRNG & SUPPORT PER 15MIN	Medication training	2					$ 16.98		$ 16.98	16.98	
XXX21	**Long-Term Maintenance of Level 1 Outpatient Medical Management by Data 2000 Practioner**													$ 60.69
XXX21	Long-Term Maintenance of Level 1 Outpatient Medical Mai	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	1	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 14.21	14.21	
XXX21	Long-Term Maintenance of Level 1 Outpatient Medical Mai	96127	Brief emotional/behav assmt	Assessment	1	$ 4.82	$ 3.57	N/A	$ 3.57	$ 3.40		$ 4.82	4.82	
XXX21	Long-Term Maintenance of Level 1 Outpatient Medical Mai	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	41.66	
XXX22	**Maintenance of Level 1 Outpatient Medical Management by a DATA 2000 Practitioner**													$ 53.96
XXX22	Maintenance of Level 1 Outpatient Medical Management I	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	1	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21		$ 7.48	7.48	
XXX22	Maintenance of Level 1 Outpatient Medical Management I	96127	Brief emotional/behav assmt	Assessment	1	$ 4.82	$ 3.57	N/A	$ 3.57	$ 3.40		$ 4.82	4.82	
XXX22	Maintenance of Level 1 Outpatient Medical Management I	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63			$ 41.66	41.66	

XXX23	Maintenance of Level 2 Outpatient Medical Management by a DATA 2000 Practitioner												$ 61.44
XXX23	Maintenance of Level 2 Outpatient Medical Management I	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	2	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21	$ 7.48	14.96	
XXX23	Maintenance of Level 2 Outpatient Medical Management I	96127	Brief emotional/behav assmt	Assessment	1	$ 4.82	$ 3.57	N/A	$ 3.57	$ 3.40	$ 4.82	4.82	
XXX23	Maintenance of Level 2 Outpatient Medical Management I	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63		$ 41.66	41.66	
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication- Assisted Treatment Services												$ 148.32
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication-	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63		$ 41.66	41.66	
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication-	96127	Brief emotional/behav assmt	Assessment	1	$ 4.82	$ 3.57	N/A	$ 3.57	$ 3.40	$ 4.82	4.82	
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication-	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	1	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21	$ 14.21	14.21	
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication-	90853	GROUP PSYCHOTHERAPY	Group Psychotherapy	1	22.84	16.93	N/A	16.93	29.85	$ 29.85	29.85	
XXX27	Long-Term Level 1 Comprehensive Outpatient Medication-	90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Individual Psychotherapy	1	$ 55.77	$ 41.33	$ 55.77	$ 41.33	$ 57.78	$ 57.78	57.78	
XXX28	Maintenance of Level 1 Comprehensive OP MAT by OATT												$ 202.03
XXX28	Maintenance of Level 1 Comprehensive Outpatient Medica	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	2	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21	$ 7.48	14.96	
XXX28	Maintenance of Level 1 Comprehensive Outpatient Medica	90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Individual Psychotherapy	2	$ 55.77	$ 41.33	$ 55.77	$ 41.33	$ 57.78	$ 57.78	115.56	
XXX28	Maintenance of Level 1 Comprehensive Outpatient Medica	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63		$ 41.66	41.66	
XXX28	Maintenance of Level 1 Comprehensive Outpatient Medica	90853	GROUP PSYCHOTHERAPY	Group Psychotherapy	1	22.84	16.93	N/A	16.93	29.85	$ 29.85	29.85	
XXX29	Maintenance of Level 2 Comprehensive OP MAT by OATT												$ 362.40
XXX29	Maintenance of Level 2 Intensive Comprehensive Outpatie	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	4	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21	$ 7.48	29.92	
XXX29	Maintenance of Level 2 Intensive Comprehensive Outpatie	90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	Individual Psychotherapy	4	$ 55.77	$ 41.33	$ 55.77	$ 41.33	$ 57.78	$ 57.78	231.12	
XXX29	Maintenance of Level 2 Intensive Comprehensive Outpatie	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63		$ 41.66	41.66	
XXX29	Maintenance of Level 2 Intensive Comprehensive Outpatie	90853	GROUP PSYCHOTHERAPY	Group Psychotherapy	2	22.84	16.93	N/A	16.93	29.85	$ 29.85	59.70	

*Medicare CPT Payment Summary 2019

XXXXX	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Addiction Team												$ 87.74
XXXXX	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Ad	80305	DRUG TEST PRSMV DIR OPT OBS	Drug Screen	2	$ 7.48	$ 7.48	$ 7.48	$ 7.48	$ 14.21	$ 7.48	14.96	
XXXXX	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Ad	99490	Chron care mgmt srvc 20 min	Care Management	1	$ 41.66	$ 27.63	$ 27.63	$ 27.63		$ 41.66	41.66	
XXXXX	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Ad	99408	AUDIT/DAST 15-30 MIN	Assessment						$ 31.12	$ 31.12	31.12	

PCOAT Fiscal Projection

Unduplicated Patient Count of Medicaid Recipients with Opioid Use Disorder SFY19

Patient Count for Evaluation & Management Codes

FFS/MCO	E/M Patient
MCO	3,341
FFS	956
	4,297

CPT Codes with Highest Unduplicated Patient Count

	FFS/MCO	PT	Patient Count	CPT Code	CPT Service
	FFS	20 - Physician, M.D., Osteop	4,895	80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE
>>	FFS	20 - Physician, M.D., Osteop	4,409	90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
	FFS	24 - Advanced Practice Regi	3,565	90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN
	MCO	20 - Physician, M.D., Osteop	8,787	80307	DRUG TEST PRSMV CHEM ANLYZR
>>	MCO	20 - Physician, M.D., Osteop	5,484	90792	PSYCH DIAG EVAL W/MED SRVCS
	MCO	24 - Advanced Practice Regi	4,915	90792	PSYCH DIAG EVAL W/MED SRVCS

PT 17-215 Clinic Patient Count (Informational Only)

FFS	17-Special Clinics	864	H0047	Alcohol/drug abuse svc not otherwise specified
FFS	17-Special Clinics	776	H0002	Behav health screen-eligibility for Tx program
FFS	17-Special Clinics	729	H0005	Alcohol/drug services-group counsel by clinician

** Unduplicated Patient Count Appears High & does not correlate with Other MAT Service Patient Counts.

10,379 OUD Patient Count at 6/30/19

COVID Implications:

NEVADA COVID-19 FISCAL REPORT: Governor Sisolak's Fiscal Year 2020-21 Budget Summary

The Medicaid caseload has increased by over 44,000 recipients since February 2020 to reach 688,167 in May 2020. Current caseload projections from the Nevada Department of Health and Human Services, Office of Analytics anticipate that the Medicaid caseload will peak at 703,948 in July 2020 and will remain relatively flat, declining by less than 7,000 recipients through the end of FY 2020-21.

Unemployment:

Decemember 2019:	4.10%
June 2020:	30.10%

Unemployment:

Decemember 2019:	4.10%
June 2020:	30.10%

Patient Count Increase

Month/Year	Caseload Totals	Variance	% Increase
Dec-18	677,225		
Jun-19	667,428	(9,797)	-1.45%
Feb-20	644,167	(23,261)	
May-20	688,167	44,000	
Jul-20	703,948	15,781	
Increase from 6/30/19 - 7/1/2020:		36,520	5.47%

Myers & Stauffer has assumed that unemployment will trend back to normal by the demonstration start date of 7/1/22 and has not assumed any additional increase in caseload.

568	Anticipated Patient Count Increase
10,947	Anticipated Patient Count Total at 7/1/22
1.56%	Anticipated Opioid Use Population Percentage

					Program Year 1	Program Year 2	Program Year 3
			SFY 18	SFY 19	10,947	11,677	12,407
SAPTA Providers Level of Care Reporting	SFY 18	SFY 19	%	%	# of Patients	# of Patients	# of Patients
Level I: Outpatient Services	6,106	5,922	86%	84%	9,203	9,817	10,430
Level 2.5 Ambulatory Intensive Outpatient	974	1,122	14%	16%	1,744	1,860	1,976
	7,080	7,044			10,947	11,677	12,407

FFS E/M Codes Breakout	Patient Count	
Data 2000 (Practitioners)	678	71%
OAT (Clinic)	278	29%
	956	

Highest Unduplicated Patient Count	Patient Count	
Data 2000 (Practitioners)	5,484	74%
OAT (Clinic)	1,945	26%
	7,429	

Implementation of Patient-Centered Opioid Addiction Treatment

Biennium Fiscal Projection Calculation

Demonstration Start Date is unknown: 36 months (Anticipation: July 1, 2022)

Option 1

		Program Year 1					
			Patients				
Anticipated Patient Count at 7/1/22			10,947				
Percent between Data 2000 & OTT			74%	26%			
Level of Care/Service		Patient Count	Data 2000	Opioid Treatment Team			
Level 1 Initiation		9,203	6,794	2,410			
Level 2 Initiation		1,744	1,287	457			
		10,947					
Level 1 Maintenance		9,203	6,794	2,410			
Level 2 Maintenance		1,744	1,287	457			
		10,947					
				7/1/22-6/30/23			
PCOAT			Projected Rate	Projected Utilization	# Months Billed		
IMAT Payments							
XXX11	Initiation of Level 1 by Data 2000		$ 402.35	6,794	1	$	2,733,454.31
XXX12	Initiation of Level 2 IOP by Data 2000		$ 458.97	1,287	1	$	590,767.46
XXX13	Consultation with Addiction Specialist During Initiation of Outpatie		$ 162.18	8,081	1	$	1,310,557.42
XXX16	Level 1 Comprehensive OP by Opioid Addiction Team		$ 608.16	2,410	1	$	1,465,371.78
XXX17	Level 2 Intensive Comprehensive OP by Opioid Addiction Team		$ 752.14	457	1	$	343,362.70
MMAT Payments							
XXX21	Long-Term Maintenance of Level 1 OP		$ 60.69	-	11	$	-
XXX22	Maintenance of Level 1 OP by a DATA 2000 Practitioner		$ 53.96	6,794	11	$	4,032,482.01
XXX23	Maintenance of Level 2 OP by a DATA 2000 Practitioner		$ 61.44	1,287	11	$	869,913.68
XXX27	Long-Term Level 1 Comprehensive OP by Opioid Addiction Team		$ 148.32	-	11	$	-
XXX28	Maintenance of Level 1 Comprehensive OP by Opioid Addiction Tear		$ 202.03	2,410	11	$	5,354,741.64
XXX29	Maintenance of Level 2 Intensive Comprehensive OP by Opioid Addi		$ 362.40	457	11	$	1,819,848.77
					P-COAT Option 1:	$	18,520,499.76
					OUD MAT Services Under Current Methodology:	$	24,818,389.34
					FISCAL IMPACT:	$	(6,297,889.58)

Program Year 2					
Anticipated Patient Count at 7/1/23			10,947	% Increase in Patient Population	
20% Increase in SUD Treatment Divided by 3 yea		2,189	730		
			11,677	6%	
Percent between Data 2000 & OTT		74%	26%		
Level of Care/Service	Patient Count	Data 2000	Opioid Treatment Team		
Level 1 Initiation	9,817	7,247	2,570		
Level 2 Initiation	1,860	1,373	487		
	10,947				
Level 1 Maintenance	9,817	7,247	2,570		
Level 2 Maintenance	1,860	1,373	487		
	10,947				

7/1/23-6/30/24					
Projected Rate with Performance Based Adj		MEI Adjustment	Projected Utilization		
$	402.35	None	7,247	1	$ 2,915,684.59
$	458.97	None	1,373	1	$ 630,151.96
$	162.18	None	8,620	1	$ 1,397,927.91
$	608.16	None	2,570	1	$ 1,563,063.23
$	752.14	None	487	1	$ 366,253.54
$	60.69	None	-	11	$ -
$	53.96	None	7,247	11	$ 4,301,314.15
$	61.44	None	1,373	11	$ 927,907.92
$	148.32	None	-	11	$ -
$	202.03	None	2,570	11	$ 5,711,724.41
$	362.40	None	487	11	$ 1,941,172.02
				P-COAT Option 1	$ 19,755,199.74
				OUD MAT Services Under Current Methodology:	$ 26,369,538.67
				FISCAL IMPACT:	$ (6,614,338.93)

Program Year 3					
Anticipated Patient Count at 7/1/24	11,677			% Increase in Patient Population	
20% Increase in SUD Treatment	730				
	12,407			6%	
Percent between Data 2000 & OTT	74%	26%			
Level of Care/Service	Patient Count	Data 2000	Opioid Treatment Team		
Level 1 Initiation	10,430	7,700	2,731		
Level 2 Initiation	1,976	1,459	517		
	10,947				
Level 1 Maintenance	10,430	7,700	2,731		
Level 2 Maintenance	1,976	1,459	517		
	10,947				

7/1/24-6/30/25					
Projected Rate with Performance Based Adj **	MEI Adjustment	Projected Utilization			
$ 410.40	None	7,700	1	$	3,159,873.18
$ 468.15	None	1,459	1	$	682,927.18
$ 165.42	None	9,158	1	$	1,515,004.38
$ 620.32	None	2,731	1	$	1,693,969.78
$ 767.18	None	517	1	$	396,927.28
$ 61.90	None	-	11	$	-
$ 55.04	None	7,700	11	$	4,661,549.21
$ 62.67	None	1,459	11	$	1,005,620.21
$ 151.29	None	-	11	$	-
$ 206.07	None	2,731	11	$	6,190,081.33
$ 369.65	None	517	11	$	2,103,745.18
			P-COAT Option 1	$	21,409,697.72
			OUD MAT Services Under Current Methodology:	$	27,920,688.01
			FISCAL IMPACT:	$	(6,510,990.29)

**2% Increase due to Successful Initiation & Maintenance of treatment.

Option 2

Program Year 1

	Patients		
Anticipated Patient Count at 7/1/22	10,947		
Percent between Data 2000 & OTT		74%	26%
Level of Care/Service	Patient Count	Data 2000	Opioid Treatment Team
Level 1 Initiation	9,203	6,794	2,410
Level 2 Initiation	1,744	1,287	457
	10,947		
Level 1 Maintenance	9,203	6,794	2,410
Level 2 Maintenance	1,744	1,287	457
	10,947		

PCOAT		7/1/22-6/30/23 Projected Rate	Projected Utilization	# Months Billed		
IMAT Payments						
XXX11	Initiation of Level 1 by Data 2000	$ 402.35	6,794	1	$	2,733,454.31
XXX12	Initiation of Level 2 IOP by Data 2000	$ 458.97	1,287	1	$	590,767.46
XXX13	Consultation with Addiction Specialist During Initiation of Outpatie	$ 162.18	8,081	1	$	1,310,557.42
XXX16	Level 1 Comprehensive OP by Opioid Addiction Team	$ 608.16	2,410	1	$	1,465,371.78
XXX17	Level 2 Intensive Comprehensive OP by Opioid Addiction Team	$ 752.14	457	1	$	343,362.70
SMAT Payments						
XXXX	Stabilization of Level 1 or Level 2 by Data 2000 or Opioid Addiction T	$ 87.74	8,081	3	$	2,127,049.72
MMAT Payments						
XXX21	Long-Term Maintenance of Level 1 OP	$ 60.69	-	11	$	-
XXX22	Maintenance of Level 1 OP by a DATA 2000 Practitioner	$ 53.96	6,794	11	$	4,032,482.01
XXX23	Maintenance of Level 2 OP by a DATA 2000 Practitioner	$ 61.44	1,287	11	$	869,913.68
XXX27	Long-Term Level 1 Comprehensive OP by Opioid Addiction Team	$ 148.32	-	11	$	-
XXX28	Maintenance of Level 1 Comprehensive OP by Opioid Addiction Tear	$ 202.03	2,410	11	$	5,354,741.64
XXX29	Maintenance of Level 2 Intensive Comprehensive OP by Opioid Addi	$ 362.40	457	11	$	1,819,848.77
				P-COAT Option 1	$	20,647,549.48
				OUD MAT Services Under Current Methodology:	$	24,818,389.34
				FISCAL IMPACT:	$	(4,170,839.86)

Program Year 2					
Anticipated Patient Count at 7/1/23			10,947	% Increase in Patient Population	
20% Increase in SUD Treatment Divided by 3 ye		2,189	730		
			11,677	6%	
Percent between Data 2000 & OTT		74%	26%		
Level of Care/Service	Patient Count	Data 2000	Opioid Treatment Team		
Level 1 Initiation	9,817	7,247	2,570		
Level 2 Initiation	1,860	1,373	487		
	10,947				
Level 1 Maintenance	9,817	7,247	2,570		
Level 2 Maintenance	1,860	1,373	487		
	10,947				

7/1/23-6/30/24					
Projected Rate with Performance Based Adj		MEI Adjustment	Projected Utilization		
$	402.35	None	7,247	1	$ 2,915,684.59
$	458.97	None	1,373	1	$ 630,151.96
$	162.18	None	8,620	1	$ 1,397,927.91
$	608.16	None	2,570	1	$ 1,563,063.23
$	752.14	None	487	1	$ 366,253.54
$	87.74	None	8,620	3	$ 2,268,853.03
$	60.69	None	-	11	$ -
$	53.96	None	7,247	11	$ 4,301,314.15
$	61.44	None	1,373	11	$ 927,907.92
$	148.32	None	-	11	$ -
$	202.03	None	2,570	11	$ 5,711,724.41
$	362.40	None	487	11	$ 1,941,172.02
				P-COAT Option 1	$ 22,024,052.78
				OUD MAT Services Under Current Methodology:	$ 26,369,538.67
				FISCAL IMPACT:	$ (4,345,485.90)

Program Year 3					
Anticipated Patient Count at 7/1/24		11,677			% Increase in Patient Population
20% Increase in SUD Treatment		730			
		12,407			6%
Percent between Data 2000 & OTT		74%	26%		
Level of Care/Service	Patient Count	Data 2000	Opioid Treatment Team		
Level 1 Initiation	10,430	7,700	2,731		
Level 2 Initiation	1,976	1,459	517		
	10,947				
Level 1 Maintenance	10,430	7,700	2,731		
Level 2 Maintenance	1,976	1,459	517		
	10,947				

7/1/24-6/30/25					
Projected Rate with Performance Based Adj	MEI Adjustment	Projected Utilization		
$ 410.40	None	7,700	1	$	3,159,873.18
$ 468.15	None	1,459	1	$	682,927.18
$ 165.42	None	9,158	1	$	1,515,004.38
$ 620.32	None	2,731	1	$	1,693,969.78
$ 767.18	None	517	1	$	396,927.28
$ 89.49	None	9,158	3	$	2,458,869.48
$ 61.90	None	-	11	$	-
$ 55.04	None	7,700	11	$	4,661,549.21
$ 62.67	None	1,459	11	$	1,005,620.21
$ 151.29	None	-	11	$	-
$ 206.07	None	2,731	11	$	6,190,081.33
$ 369.65	None	517	11	$	2,103,745.18
			P-COAT Option 1	$	23,868,567.20
			OUD MAT Services Under Current Methodology:	$	27,920,688.01
			FISCAL IMPACT:	$	(4,052,120.81)

Current OUD Utilization and Cost

Procedure Code	Procedure	"Duplicated" Patient Count	Service Count Paid	Charge Submitted	Net Payment	"Charge Submitted" per Service	"Net Payment" per Service	PT 20 (FFS Rate)	PT 17-215 Rate	MAT Service
96127	BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	6,366	8,421	$ 259,633.60	$ 33,708.86	$ 30.83	$ 4.00	$ 4.82	$ 4.82	Assessment
H0001	ALCOHOL AND/OR DRUG ASSESS	3,064	3,287	$ 511,107.54	$ 429,307.66	$ 155.49	$ 130.61	$ 139.46	$ 139.46	Assessment
96137	PSYCL/NRPSYCL TST PHYS/QHP 2+ TST EA ADDL 30 MIN	532	1,817	$ 174,627.86	$ 52,863.24	$ 96.11	$ 29.09	$ 37.81	$ 37.81	Assessment
96133	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	244	1,259	$ 230,434.00	$ 97,742.43	$ 183.03	$ 77.63	$ 86.51	$ 86.51	Assessment
96138	PSYCL/NRPSYCL TST TECH 2+ TST 1ST 30 MIN	340	1,123	$ 90,769.72	$ 12,367.56	$ 80.83	$ 11.01	$ 33.41	$ 33.41	Assessment
96130	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP FIRST HOUR	812	1,068	$ 233,912.29	$ 65,084.87	$ 219.02	$ 60.94	$ 100.69	$ 100.69	Assessment
96136	PSYL/NRPSYCL TST PHYS/QHP 2+ TST 1ST 30 MIN	813	847	$ 101,452.37	$ 23,062.27	$ 119.78	$ 27.23	$ 40.83	$ 40.83	Assessment
96116	NEUROBEHAVIORAL STATUS XM PHYS/QHP 1ST HOUR	165	715	$ 145,986.68	$ 17,017.87	$ 204.18	$ 23.80	$ 82.22	$ 82.22	Assessment
96131	PSYCHOLOGICAL TST EVAL SVC PHYS/QHP EA ADDL HOUR	492	691	$ 115,931.32	$ 34,833.34	$ 167.77	$ 50.41	$ 76.60	$ 76.60	Assessment
96139	PSYCL/NRPSYCL TST TECH 2+ TST EA ADDL 30 MIN	83	291	$ 22,048.02	$ 6,881.58	$ 75.77	$ 23.65	$ 33.41	$ 33.41	Assessment
96132	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP 1ST HOUR	267	272	$ 66,278.03	$ 24,248.50	$ 243.67	$ 89.15	$ 113.42	$ 113.42	Assessment
96146	PSYCL/NRPSYCL TST ELEC PLATFORM AUTO RESULT	228	242	$ 14,562.00	$ 972.40	$ 60.17	$ 4.02	$ 1.82	$ 1.82	Assessment
96152	HLTH&BEHAVIOR IVNTJ EA 15 MIN INDIV	31	203	$ 14,154.00	$ 527.94	$ 69.72	$ 2.60	$ 16.92	$ 16.92	Assessment
96150	HLTH&BEHAVIOR ASSMT EA 15 MIN W/PT 1ST ASSMT	47	137	$ 12,360.76	$ 279.64	$ 90.22	$ 2.04	$ 18.46	$ 18.46	Assessment
96153	HLTH&BEHAVIOR IVNTJ EA 15 MIN GRP 2/>PTS	2	3	$ 225.00	$ 4.78	$ 75.00	$ 1.59	$ 4.02	$ 4.02	Assessment
96154	HLTH&BEHAVIOR IVNTJ EA 15 MIN FAM W/PT	2	2	$ 70.00	$ -	$ 35.00	$ -	$ 16.62	$ 16.62	Assessment
80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	21,593	63,361	$ 14,591,765.22	$ 2,238,058.23	$ 230.30	$ 35.32	$ 39.91	$ 39.91	Drug Screening
80305	DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	7,618	33,378	$ 1,171,023.15	$ 374,861.42	$ 35.08	$ 11.23	$ 7.48	$ 7.48	Drug Screening
G0483	DRUG TEST DEF 22+ CLASSES	3,568	10,144	$ 6,289,267.87	$ 1,512,708.62	$ 620.00	$ 149.12	$ 204.46	$ 204.46	Drug Screening
G0482	DRUG TEST DEF 15-21 CLASSES	3,958	9,839	$ 3,356,287.38	$ 1,504,955.76	$ 341.12	$ 152.96	$ 157.72	$ 157.72	Drug Screening
80306	DRUG TST PRSMV READ INSTRMNT ASSTD DIR OPT OBS	1,632	5,449	$ 182,465.21	$ 36,012.54	$ 33.49	$ 6.61	$ 9.98	$ 9.98	Drug Screening
G0480	DRUG TEST DEF 1-7 CLASSES	1,372	3,234	$ 4,734,005.58	$ 228,070.40	$ 1,463.82	$ 70.52	$ 75.94	$ 75.94	Drug Screening
G0481	DRUG TEST DEF 8-14 CLASSES	758	1,300	$ 252,130.97	$ 135,376.45	$ 193.95	$ 104.14	$ 116.84	$ 116.84	Drug Screening
96020	TEST SELECT & ADMN FUNCTL BRAIN MAP PHYS/QHP	86	177	$ 26,917.24	$ 26,548.23	$ 152.07	$ 149.99	$ 149.99	$ 149.99	Drug Screening
H0005	ALCOHOL AND/OR DRUG SERVICES	2,657	49,555	$ 1,717,649.47	$ 1,453,956.84	$ 34.66	$ 29.34	$ 29.85	$ 29.85	Group Counseling
90853	GROUP PSYCHOTHERAPY	855	6,751	$ 302,672.69	$ 130,279.47	$ 44.83	$ 19.30	$ 22.84	$ 22.84	Group Psychotherapy
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS	639	4,517	$ 805,095.82	$ 313,144.53	$ 178.24	$ 69.33	$ 92.40	$ 92.40	Group Psychotherapy
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS	169	283	$ 46,294.26	$ 23,153.25	$ 163.58	$ 81.81	$ 81.42	$ 81.42	Group Psychotherapy
90849	MULTIPLE FAMILY GROUP PSYTX	1	2	$ 120.00	$ -	$ 60.00	$ -	$ 28.53	$ 28.53	Group Psychotherapy
H0038	SELF-HELP/PEER SVC PER 15MIN	823	7,121	$ 76,130.34	$ 39,218.80	$ 10.69	$ 5.51	$ 1.58	$ 1.58	Counseling
90833	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 30 MIN	14,168	53,472	$ 5,533,078.73	$ 2,110,207.72	$ 103.48	$ 39.46	$ 57.05	$ 57.05	Individual Psychotherapy
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	4,688	27,835	$ 4,769,333.00	$ 2,571,089.87	$ 171.34	$ 92.37	$ 110.56	$ 110.56	Individual Psychotherapy
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	1,934	10,542	$ 1,532,098.23	$ 615,899.36	$ 145.33	$ 58.42	$ 73.93	$ 73.93	Individual Psychotherapy
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	1,110	3,939	$ 516,616.15	$ 133,111.83	$ 131.15	$ 33.79	$ 55.77	$ 55.77	Individual Psychotherapy
90836	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 45 MIN	891	1,176	$ 165,832.60	$ 62,722.60	$ 141.01	$ 53.34	$ 72.15	$ 72.15	Individual Psychotherapy
90838	PSYCHOTHERAPY W/PATIENT W/E&M SRVCS 60 MIN	207	326	$ 73,239.84	$ 26,086.36	$ 224.66	$ 80.02	$ 95.31	$ 95.31	Individual Psychotherapy
90839	PSYCHOTHERAPY FOR CRISIS INITIAL 60 MINUTES	141	209	$ 36,052.82	$ 19,723.83	$ 172.50	$ 94.37	$ 115.49	$ 115.49	Individual Psychotherapy
H0015	ALCOHOL AND/OR DRUG SERVICES	1,121	26,208	$ 4,249,566.08	$ 3,660,835.02	$ 162.15	$ 139.68	$ 140.45	$ 140.45	Intensive OP Program
H0034	MED TRNG & SUPPORT PER 15MIN	1,185	3,776	$ 67,104.84	$ 60,773.34	$ 17.77	$ 16.09	$ 16.98	$ 16.98	Medication training
H0004	ALCOHOL AND/OR DRUG SERVICES	912	43,880	$ 1,561,479.19	$ 1,284,099.76	$ 35.59	$ 29.26	$ 30.28	$ 30.28	Other Drug Services
H0047	ALCOHOL/DRUG ABUSE SVC NOS	4,242	34,979	$ 2,714,746.99	$ 2,421,959.27	$ 77.61	$ 69.24	#N/A	#N/A	Other Drug Services
H0007	ALCOHOL AND/OR DRUG SERVICES	77	276	$ 9,442.86	$ 5,731.44	$ 34.21	$ 20.77	$ 21.71	$ 21.71	Other Drug Services
90792	PSYCHIATRIC DIAGNOSTIC EVAL W/MEDICAL SERVICES	16,993	17,948	$ 4,916,921.80	$ 2,188,804.53	$ 273.95	$ 121.95	$ 124.29	$ 124.29	Psych Evaluation
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION	5,067	5,799	$ 1,265,464.00	$ 603,577.28	$ 218.22	$ 104.08	$ 115.38	$ 115.38	Psych Evaluation
90785	PSYCHOTHERAPY COMPLEX INTERACTIVE	1,357	5,715	$ 222,247.31	$ 37,493.20	$ 38.89	$ 6.56	$ 12.32	$ 12.32	Psych Evaluation
H0049	ALCOHOL/DRUG SCREENING	1,177	5,313	$ 59,786.46	$ 49,179.94	$ 11.25	$ 9.26	#N/A	#N/A	Screening
H0002	ALCOHOL AND/OR DRUG SCREENIN	3,440	3,847	$ 165,552.20	$ 94,448.56	$ 43.03	$ 24.55	$ 30.77	$ 30.77	Screening
99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN	487	1,553	$ 59,331.34	$ 49,841.98	$ 38.20	$ 32.09	$ 35.08	$ 35.08	Screening
99409	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN	61	94	$ 6,161.42	$ 6,161.42	$ 65.55	$ 65.55	$ 60.62	$ 60.62	Screening
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	28	90	$ 6,837.04	$ 959.86	$ 75.97	$ 10.67	$ 12.46	$ 12.46	Screening
99407	BEHAV CHNG SMOKING > 10 MIN	10	11	$ 583.00	$ 257.34	$ 53.00	$ 23.39	$ 24.32	$ 24.32	Screening
99408	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN	5	7	$ 177.39	$ 177.35	$ 25.34	$ 25.34	$ 31.12	$ 31.12	Screening
				$ 63,477,031.68	$ 24,818,389.34					

Non-MAT P-COAT Services Excluded:								
H2011	CRISIS INTERVEN SVC, 15 MIN	1,409	132,129	$ 5,309,878.72	$ 3,235,242.42	$ 40.19	$ 24.49	Non MAT Service
H0020	ALCOHOL AND/OR DRUG SERVICES	1,635	262,017	$ 1,153,724.04	$ 1,059,114.30	$ 4.40	$ 4.04	Methodone Administration
G0438	PPPS, INITIAL VISIT	7,120	7,175	$ 2,099,320.46	$ 611,294.34	$ 292.59	$ 85.20	Annual Wellness Visit
G0101	CA SCREEN;PELVIC/BREAST EXAM	8,472	8,529	$ 873,622.55	$ 280,973.14	$ 102.43	$ 32.94	Non MAT Service
G0108	DIAB MANAGE TRN PER INDIV	1,453	3,509	$ 348,984.51	$ 63,998.32	$ 99.45	$ 18.24	Non MAT Service
G0513	Prolonged preventive service, first 30 minutes	55	530	$ 22,493.33	$ 19,883.33	$ 42.44	$ 37.52	Non MAT Service
H0035	MH PARTIAL HOSP TX UNDER 24H	43	388	$ 76,793.19	$ 31,201.30	$ 197.92	$ 80.42	Non MAT Service
G0514	Prolonged preventive service, each ADDL 30 min	52	369	$ 16,134.57	$ 13,434.57	$ 43.73	$ 36.41	Non MAT Service
G0109	DIAB MANAGE TRN IND/GROUP	47	199	$ 7,554.00	$ 3,092.91	$ 37.96	$ 15.54	Non MAT Service
90840	PSYCHOTHERAPY FOR CRISIS EACH ADDL 30 MINUTES	26	41	$ 3,168.53	$ 1,766.99	$ 77.28	$ 43.10	Non MAT Service
G0433	ELISA HIV-1/HIV-2 SCREEN	8	8	$ 149.36	$ 75.20	$ 18.67	$ 9.40	Non MAT Service
90845	PSYCHOANALYSIS	2	2	$ 204.69	$ 159.38	$ 102.35	$ 79.69	Non MAT Service
90876	INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 45 MIN	2,643	106,711	$ 11,786,971.87	$ 9,841,644.72	$ 110.46	$ 92.23	Other Psychiatric Services
90875	INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 30 MIN	15	41	$ 6,394.00	$ 1,547.70	$ 155.95	$ 37.75	Other Psychiatric Services
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	2,115	6,693	$ 1,494,007.24	$ 607,457.50	$ 223.22	$ 90.76	Evaluation & Management
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	1,676	4,274	$ 529,596.21	$ 238,418.46	$ 123.91	$ 55.78	Evaluation & Management
99211	OFFICE OUTPATIENT VISIT 5 MINUTES	511	1,501	$ 41,958.31	$ 26,968.15	$ 27.95	$ 17.97	Evaluation & Management
99212	OFFICE OUTPATIENT VISIT 10 MINUTES	352	672	$ 34,226.06	$ 23,030.99	$ 50.93	$ 34.27	Evaluation & Management
99204	OFFICE OUTPATIENT NEW 45 MINUTES	519	527	$ 161,441.99	$ 67,873.44	$ 306.34	$ 128.79	Evaluation & Management
99203	OFFICE OUTPATIENT NEW 30 MINUTES	432	436	$ 61,450.70	$ 32,467.44	$ 140.94	$ 74.47	Evaluation & Management
99205	OFFICE OUTPATIENT NEW 60 MINUTES	291	295	$ 64,082.95	$ 39,088.27	$ 217.23	$ 132.50	Evaluation & Management
99202	OFFICE OUTPATIENT NEW 20 MINUTES	214	233	$ 16,887.97	$ 11,212.47	$ 72.48	$ 48.12	Evaluation & Management
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	150	159	$ 28,069.56	$ 15,565.71	$ 176.54	$ 97.90	Evaluation & Management
99201	OFFICE OUTPATIENT NEW 10 MINUTES	9	9	$ 407.61	$ 267.43	$ 45.29	$ 29.71	Evaluation & Management
99219	INITIAL OBSERVATION CARE/DAY 50 MINUTES	56	68	$ 23,115.00	$ 5,899.19	$ 339.93	$ 86.75	Observation
99220	INITIAL OBSERVATION CARE/DAY 70 MINUTES	34	36	$ 21,884.48	$ 5,825.56	$ 607.90	$ 161.82	Observation
99217	OBSERVATION CARE DISCHARGE MANAGEMENT	18	19	$ 6,032.60	$ 1,295.10	$ 317.51	$ 68.16	Observation
99225	SBSQ OBSERVATION CARE/DAY 25 MINUTES	8	17	$ 5,840.16	$ 1,129.11	$ 343.54	$ 66.42	Observation
99218	INITIAL OBSERVATION CARE/DAY 30 MINUTES	14	14	$ 3,571.00	$ 944.53	$ 255.07	$ 67.47	Observation
99226	SBSQ OBSERVATION CARE/DAY 35 MINUTES	6	6	$ 1,346.00	$ 485.57	$ 224.33	$ 80.93	Observation
99224	SBSQ OBSERVATION CARE/DAY 15 MINUTES	1	1	$ 102.00	$ 25.81	$ 102.00	$ 25.81	Observation
Q3014	TELEHEALTH FACILITY FEE	3,502	25,252	$ 844,781.71	$ 676,373.33	$ 33.45	$ 26.78	Telehealth
90901	BIOFEEDBACK TRAINING ANY MODALITY	95	399	$ 30,987.86	$ 4,140.72	$ 77.66	$ 10.38	Biofeedback
90911	BIOFDBK TRNG PERINL MUSC ANORECT/URO SPHX W/EMG	7	8	$ 2,512.00	$ 561.77	$ 314.00	$ 70.22	Biofeedback

Appendix B: Acronym List

Acronym	Term
AAPA	AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
ACA	AFFORDABLE CARE ACT
ACOG	AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AHEC	AREA HEALTH EDUCATION CENTER
AIAN	AMERICAN INDIANS AND ALASKA NATIVES
AIMS	ADVANCING INTEGRATED MENTAL HEALTH SOLUTIONS
AMA	AMERICAN MEDICAL ASSOCIATION
AOS	ADDICTION ONLY SERVICES
APRN	ADVANCED PRACTICE REGISTERED NURSE
ARTS	ADDICTION AND RECOVERY TREATMENT SERVICES
ASAM	AMERICAN SOCIETY OF ADDICTION MEDICINE
ASTHO	ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
ATTC	ADDICTION TECHNOLOGY TRANSFER CENTER
BHECN	BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA
BHIMC	BEHAVIORAL HEALTH INTEGRATION IN MEDICAL CARE
CAPTA	CHILD ABUSE PREVENTION AND TREATMENT ACT
CARA	COMPREHENSIVE ADDICTION AND RECOVERY ACT
CASAT	CENTER FOR THE APPLICATION OF SUBSTANCE ABUSE TECHNOLOGIES
CAST	CALCULATING FOR AN ADEQUATE SYSTEM TOOL (PG 47)
CBD	CANNABIDIOL
CBH	CENTER FOR BEHAVIORAL HEALTH
CBHC	COMMUNITY BEHAVIORAL HEALTH CENTER
CCBHC	CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC
CDC	CENTERS FOR DISEASE CONTROL
C-FNP	CERTIFIED FAMILY NURSE PRACTITIONER
CHA	COMMUNITY HEALTH ALLIANCE
CHOP	CHILDRENS HOSPITAL OF PHILADELPHIA
CMS	CENTERS FOR MEDICARE AND MEDICAID SERVICES
CNM	CERTIFIED NURSE MIDWIFE
CNS	CLINICAL NURSE SPECIALIST
COCOM	COLLABORATIVE CARE MODEL
COD	CO-OCCURRING DISORDERS
COE	CO-OCCURRING ENHANCED
CPC	CERTIFIED PROFESSIONAL COUNSELOR

Acronym	Term
CPS	CHILD PROTECTIVE SERVICES
CPT	CURRENT PROCEDURAL TERMINOLOGY
CRNA	CERTIFIED REGISTERED NURSE ANESTHETIST
DATA	DRUG ADDICTION TREATMENT ACT
DCFS	DIVISION OF CHILD AND FAMILY SERVICES
DDCAT	DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT
DDCHCS	DUAL DIAGNOSIS CAPABILITY IN HEALTH CARE SETTINGS
DDS	DECISION SUPPORT SYSTEMS
DEA	DRUG ENFORCEMENT ADMINISTRATION
DHCFP	NEVADA DEPARTMENT OF HEALTH CARE FINANCING AND POLICY
DHHS	NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DLT	DISTANCE LEARNING TELEMEDICINE
DO	DOCTOR OF OSTEOPATHY
DPBH	NEVADA DEPARTMENT OF PUBLIC AND BEHAVIORAL HEALTH
DSM	DIRECT SECURE MESSAGING
E&M	EVALUATION AND MANAGEMENT
ECHO	EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES
ED	EMERGENCY DEPARTMENT
EELM	PROJECT ECHO AND ECHO-LIKE MODELS
EHNAC	ELECTRONIC HEALTHCARE ACCREDITATION COMMISSION
EHR	ELECTRONIC HEALTH RECORD
EMS	EMERGENCY MEDICAL SERVICE
ENS	EVENT NOTIFICATION SERVICE
FAANP	FELLOWS OF THE AMERICAN ASSOCIATION OF NURSE PRACTITIONERS
FAMIS	FAMILY ACCESS TO MEDICAL INSURANCE SECURITY
FASD	FETAL ALCOHOL SPECTRUM DISORDER
FCC	FEDERAL COMMUNICATIONS COMMISSION
FFS	FEE FOR SERVICE
FMAP	FEDERAL MEDICAL ASSISTANCE PERCENTAGES
FQHC	FEDERALLY QUALIFIED HEALTH CENTERS
FTE	FULL-TIME EQUIVALENT
FY	FISCAL YEAR
GAO	U.S. GOVERNMENT ACCOUNTABILITY OFFICE
GAP	GOVERNOR'S ACCESS PLAN
GFLC	GREATER FLINT HEALTH COALITION
HBAI	HEALTH BEHAVIOR ASSESSMENT AND INTERVENTION
HCPCS	HEALTHCARE COMMON PROCEDURE CODING SYSTEM

Acronym	Term
HEALTH IT	HEALTH INFORMATION TECHNOLOGY
HIDTA	HIGH INTENSITY DRUG TRAFFICKING AREAS
HIE	HEALTH INFORMATION EXCHANGE
HIPAA	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
HIS	INDIAN HEALTH SERVICES
HPSA	HEALTH PROFESSIONAL SHORTAGE AREA
HRSA	HEALTH RESOURCES AND SERVICES ADMINISTRATION
IDN	INTEGRATED DELIVERY NETWORKS
IOP	INTENSIVE OUTPATIENT PROGRAM
IOP	INTENSIVE OUTPATIENT TREATMENT
IOTRC	INTEGRATED OPIOID TREATMENT RECOVERY CENTERS
IP	INPATIENT ADMISSIONS
LADC	LICENSED ALCOHOL AND DRUG COUNSELORS
LARC	LONG-ACTING REVERSIBLE CONTRACEPTION
LCC	LIFE CHANGE CENTER
LCSW	LICENSED CLINICAL SOCIAL WORKER
MACPAC	MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION
MAT	MEDICATION-ASSISTED TREATMENT
MCO	MANAGED CARE ORGANIZATION
MD	MEDICAL DOCTOR
MFT	MARRIAGE AND FAMILY THERAPY
MHPAEA	MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT
MHSIP	MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM
MMIS	MEDICAID MANAGEMENT INFORMATION SYSTEM
MOM	MATERNAL OPIOID MISUSE MODEL
MROT	MOBILE RECOVERY OUTREACH TEAMS
MSM	MEDICAID SERVICES MANUAL
MTD	METHADONE TREATMENT
MUA	MEDICALLY UNDERSERVED AREA
NAC	NEVADA ADMINISTRATIVE CODE
NAS	NEONATAL ABSTINENCE SYNDROME
NCM	NURSE CARE MANAGER
NVHC	NEVADA HEALTH CENTERS
NHSC	NATIONAL HEALTH SERVICE CORPS
NIDA	NATIONAL INSTITUTE ON DRUG ABUSE
NP	NURSE PRACTITIONER
NRS	NEVADA REVISED STATUTES

Acronym	Term
NSBN	NEVADA STATE BOARD OF NURSING
NSHE	NEVADA SYSTEM OF HIGHER EDUCATION
OBGYN	OBSTETRICIAN-GYNECOLOGIST
OBHO	OUTPATIENT BEHAVIORAL HEALTH ORGANIZATION
OBOT	OFFICE-BASED OPIOID TREATMENT
OMH	OFFICE OF MENTAL HEALTH
OMNI	OPIOID USE DISORDER, MATERNAL OUTCOMES, AND NEONATAL ABSTINENCE SYNDROM INITIATIVE
OTP	OPIOID TREATMENT PROGRAMS
OUD	OPIOID USE DISORDER
PA	PHYSICIAN ASSISTANT
PCMH	PATIENT-CENTERED MEDICAL HOME
P-COAT	PATIENT-CENTERED OPIOID ADDICTION TREATMENT
PCP	PRIMARY CARE PROVIDER
PHP	PARTIAL HOSPITALIZATION PROGRAM
PMP	PRESCRIPTION MONITORING PROGRAM
QMHP	QUALIFIED MENTAL HEALTH PROFESSIONAL
QTR	QUARTER
RBHC	REGIONAL BEHAVIORAL HEALTH COORDINATORS
RFP	REQUEST FOR PROPOSAL
RN	REGISTERED NURSE
ROOR	RURAL OPIOID OVERDOSE REVERSAL
SAAM	SUBSTANCE ABUSE AGENCY MODEL
SAAS	SOFTWARE AS A SERVICE
SAMHSA	SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SAPTA	SUBSTANCES ABUSE PREVENTION AND TREATMENT AGENCY
SBIRT	SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT
SDOH	SOCIAL DETERMINANTS OF HEALTH
SEI	SOCIAL ENTREPRENEURS INC.
SMFM	SOCIETY FOR MATERNAL-FETAL MEDICINE
SOP	SCOPE OF PRACTICE
SSA	SOCIAL SECURITY ACT
STR	STATE TARGETED RESPONSE
SUD	SUBSTANCE USE DISORDER
SUPPORT	SUBSTANCE USE DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES
URN	UNIVERSITY OF NEVADA RENO

Acronym	Term
USDA	UNITED STATES DEPARTMENT OF AGRICULTURE
VHCURES	VERMONT'S ALL-PLAYER CLAIMS DATA BASE
VU	VITALITY UNLIMITED

Appendix C: Nevada SUD Service Providers & SUPPORT Act Expansion

Provider Types Currently Allowed to Provide and Bill for SUD Services:

· Hospital Inpatient - (PT 11)
· Hospital Outpatient - (PT 12)
· Psychiatric Inpatient Hospital - (PT 13)
· Behavioral Health Outpatient Services - (PT 14)
· Special Clinics: Certified Behavioral Health Clinics (CCBHC) (PT 17-188)
· Special Clinics: Substance Abuse Agency Model (SAAM) (PT 17-215)
· Physician, M.D., Osteopath, D.O. - (PT 20)
· Advanced Practice Registered Nurses - (PT 24)
· Psychologists - (PT 26)
· Indian Health Services (IHS) and Tribal Clinics (PT 47)
· Physician's Assistant (PT 77)
· Behavioral Health Rehabilitative Treatment (PT 82)

Provider Types **Identified for Expansion of SUD through PCOAT Policy

· Special Clinics: Substance Abuse Agency Model (SAAM) (PT 17-215)
· Physician, M.D., Osteopath, D.O. (PT 20)
· Advanced Practice Registered Nurses (PT 24)
· Psychologists (PT 26)
· Nurse Midwife (PT 74)**
· Physician's Assistant (PT 77)

Provider Types **Identified for Expansion of SUD through Current MAT Policy

· Physician, M.D., Osteopath, D.O. (PT 20)
· Advanced Practice Registered Nurses (PT 24)
· Nurse Midwife (PT 74)**
· Physician's Assistant (PT 77)

Provider Types **Identified for Expansion of SUD through SBIRT Policy

· Special Clinics: Substance Abuse Agency Model (SAAM) (PT 17-215)
· Physician, M.D., Osteopath, D.O. (PT 20)
· Advanced Practice Registered Nurses (PT 24)
· Nurse Midwife (PT 74)**
· Physician's Assistant (PT 77)

****Being added to MSM as qualified provider as part of NV Support Act Project.**

Appendix D: Training Gap Analysis

Substance Use Disorder & Opioid Use Disorder in Nevada: Training Gap Analysis

Nevada Department of Health Care and Financing Policy

xxxx 2020

Review Draft

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REVIEW DRAFT
JUNE 15, 2020

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Training Gap Analysis

REVIEW DRAFT
July , 2020

Introduction

There is a critical need to increase and expand substance use disorder (SUD) and opioid use disorder (OUD) treatment services in Nevada. In 2018, only 31.5% of Medicaid beneficiaries diagnosed with SUD or OUD received related services statewide.[1] Much of this can be attributed to lack of provider capacity. There are currently 192 providers that are waivered to provide MAT through the use of buprenorphine, a significant rise from the previous year; however, not all providers prescribe. Of those who do prescribe, few prescribe to their upper limit. There are 15 OTPs within Clark, Washoe, and Carson City. Capacity is available overall; however, connection to high-quality, integrated services remain a challenge in the state, especially in rural and frontier communities.[2]

Nevada's geography and health care provider shortage contribute to the challenge of SUD and OUD service capacity. Ninety percent (90%) of Nevada's population is concentrated Clark County, Washoe County, and Carson City. The number of licensed alcohol, drug, and gambling counselors has declined from 45.0 to 42.1 per 100,000 since 2008.[3] On the other hand, the number of health care providers who are DATA-waived to prescribe buprenorphine has increased from 98 in 2013 to 250 in 2018.[4]

There is a growing consensus that primary care providers are on the frontline in identification and management of SUD and OUD. However, expanding the number of physicians that are able to safely and effectively prescribe the various medications that have been incorporated into medication-assisted treatment (MAT) continues to be a challenge. One major barrier is the lack of provider education or hands-on experience during clinical training; the average 4 year medical school curriculum rarely offers adequate training in treatment of SUD and OUD.[5] Other barriers include difficulty integrating MAT into the provider workflow and traditional treatment model, lack of consumer and provider knowledge, lack of staff and multidisciplinary training, and stigma. Collectively, these barriers may surpass that of reimbursement and regulatory concerns. Extensive and ongoing education and training initiatives for providers are needed to both expand and retain the workforce able to deliver MAT services.

The purpose of this document is to catalog the current training and education initiatives related to increasing provider capacity, and offer recommendations the state may consider to enhance those initiatives as a part of the SUPPORT Act Grant demonstration application.

[1] Nevada SUPPORT Act Planning Grant Narrative
[2] Woodard, S, PsyD, Carter, K, Long, Yenh. Nevada's Evolving Opioid Crisis: Successes and Challenges presentation.
[3] Griswold et al., 2017
[4] Levi, et al., 2013; SAMHSA, 2018
[5] Levin FR, Bisaga A, Sullivan MA, Williams AR, Cates-Wessel K. A review of a national training initiative to increase provider use of MAT to address the opioid epidemic. *Am J Addict*. 2016;25(8):603-609. doi:10.1111/ajad.12454

Training Needs Assessment

In February 2018, 1,074 health care providers responded to a providers' needs assessment survey designed to facilitate the successful implementation of Nevada's State Targeted Response to Opioids (STR) grant project. Information gathered from the assessment was used to guide development of opioid-related trainings.

Findings

Respondents: A few boards represented the licensing of the majority of survey respondents:

- Nevada State Board of Medical Examiners (Physician 59%; Physician Assistant 9%)
- Board of Nursing (Advanced Practice Nurses 22%)
- Board of Pharmacy (16%)
- Osteopathic Medicine Board (DO 6%; PA 2%)

Training Topics of Interest: Most noteworthy responses include:

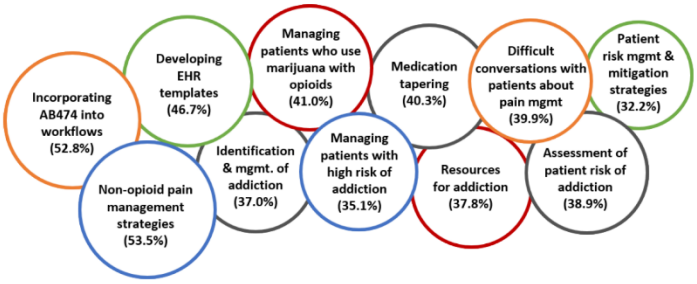
- Approximately 80% would likely attend or consider attending an AB474 training
- 72% would attend or consider attending a MAT training
- 64% very likely to or might attend a training on co-prescribing naloxone.

"Non-opioid pain management" and "Incorporating AB474 into workflows" were the most frequently identified topics for potential training. Providers also rated other topics of high interest. As represented in Figure 1[6], these included:

- "Developing electronic health record templates,"
- "Managing patients who use marijuana with opioids,"
- "Tapering medication,"
- "Difficult conversations with patients about pain management"

[6] Nevada Opioid State Targeted Response Training Needs Assessment – Providers Training Survey Report, February 2018

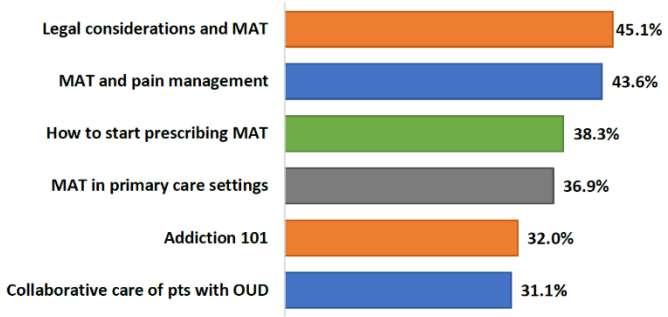
Figure 1. Provider Assessment of Training Attendance for AB474 Topics



Providers were asked to rate topics on their importance and rated "Legal considerations and MAT" and "MAT and pain management" as the most important to address, followed by "How to start prescribing MAT," and "MAT in primary care settings" (Figure 2).

Additional comments written in by respondents suggest that some providers are not interested in MAT trainings due to 1) not understanding what MAT is; 2) not agreeing with its use; or 3) not knowing what is meant by the federal "DATA 2000 Waivered" provision (Drug Addiction Treatment Act of 2000).[7]

Figure 2. Provider Assessment of Topic Importance

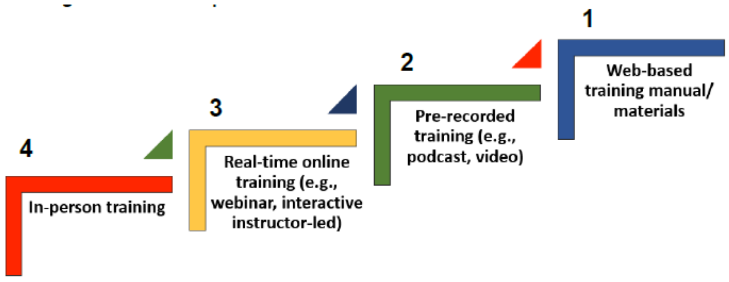


Training Logistics: Respondents also had the opportunity to provide insight on ideal training times and formats.

[7] SUPPORT Act grant narrative

- 48% preferred trainings to be held after work.
- 53% preferred trainings to be 1 hour or less.
- Mode preferences were 1) web-based training manual/materials; 2) pre-recorded training (video); 3) real-time online training (webinar); and 4) in-person training.

Figure X: Preferred Modes of Training



Data from the training needs assessment provided information on 1) what trainings the provider community would most likely participate in and 2) logistical considerations when developing a training program.

Training and Educational Resources and Initiatives

Training in SUD services can expand and enhance the workforce. One study found employer-provided training for SUD counselors has been associated with job satisfaction, retention, and employee mental health.[8] Providers need to keep up with national standards; for example, national standards for SUD treatment were issued by the Joint Commission, and are effective July 1, 2020. For MAT and opioid treatment programs, there are also national guidelines.[9]

To bring a new practice to scale, such as making MAT accessible to more individuals, requires training. There are many national and state accreditation and certification programs for individuals working in SUD services. For trainings generally to be considered best practice, they need to address current and research-based topics; include specific audiences; employ a variety of adult learning methods; address participants' knowledge, attitudes, and skills; outline training goals and outcomes; and require evaluation.

[8] Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Incentive-Related Human Resource Practices for Substance Use Disorder Counselors: Salaries, Benefits, and Training. Alcoholism treatment quarterly, 29(3), 230–244. https://doi.org/10.1080/07347324.2011.586290
[9] https://www.jointcommission.org/-/media/tjc/documents/standards/prepublications/1015_prepublication_report_sud_3_11_2020.pdf

For trainings of providers of SUD services to be effective, they must exceed these elements and be integral to the implementation or expansion of SUD services. Looking specifically at training of providers of SUD treatment, trainings need to emphasize interactive and experiential teaching more than didactic components. Outside of the training environment, learning needs to be reinforced and supplemented by educational resources. One report concluded that for training physicians to treat SUD they must be provided with interactive training experiences, contact with patients who have benefited from treatment, and a supportive administrative environment, all of which "almost certainly will lead to substantial improvement in the treatment of patients with substance use disorders."[10]

Resources at the National Level

Best practices exist for specific clinical practices for the treatment of individuals with SUD. The documentation describing these include practice guidance, such as guidance from Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocols related to SUD[11] or evidence-based clinical practice guidelines for managing SUD, such as that from the Department of Veteran Affairs and Department of Defense.[12]

There are also best practices for target populations, such as the best practices for adolescent SUD treatment which are outlined by National Institute of Drug Abuse (NIDA).[13] However, even when documentation of best practices and evidence-based practices exists, a corresponding training may not be widely available. However, there are national training programs from trusted resources that be utilized as a part of a statewide training program, and are described below:

Centers for Disease Control and Prevention

The CDC offers interactive trainings for healthcare providers about applying the CDC guidelines for prescribing opioids for pain and pain management. They also offer stand-alone trainings to meet Drug Addiction Treatment Act of 2000 waiver (DATA 2000) requirements to dispense buprenorphine. [14]

[10] Polydorou, S., Gunderson, E. W., & Levin, F. R. (2008). Training physicians to treat substance use disorders. *Current psychiatry reports*, *10*(5), 399–404. https://doi.org/10.1007/s11920-008-0064-8
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741399/
[11] https://store.samhsa.gov/?f[0]=series:5557
[12] https://www.healthquality.va.gov/guidelines/MH/sud/
[13] https://www.counseling.org/docs/default-source/vistas/article_43.pdf?sfvrsn=9ca17c2c_12 Best Practices: Substance Use Disorder Treatment for Adolescents. Angela L. Colistra, Charles E. Crite, Jr., James E. Campbell, and Adam Brickner
[14] https://www.cdc.gov/drugoverdose/training/online-training.html

American Society of Addiction Medicine

In partnership with National Drug Court Institute (NDCI), ASAM offers numerous trainings to address SUD in specific populations and settings. Together NDCI and ASAM offer training for SUD treatment professionals working with clients involved in the justice system. [15]

Providers Clinical Support System

PCSS is made up of a coalition of 23 leading national organizations representing healthcare providers and other key stakeholders on the frontlines of the opioid crisis. A project developed by SAMHSA, PCSS adds clinical mentoring to training modules for practitioners to address the complex issues of SUD. It's a national project that trains health professionals to provide evidence-based medication-assisted treatments to patients with OUD. A pilot project within PCSS provided technical assistance about implementation, based on the observation that, in spite of MAT success, local healthcare teams are often unsure how to implement and manage MAT. [16] [17]

PCSS also offers MAT Waiver training for physicians, advance practice registered nurses, physician assistants, and medical students. The training is no cost and is available in a variety of formats which fulfills the 8 hour requirement for physicians and the 24 hour requirement for APRNs. Harvard has partnered with PCSS and SAMSHA to approve two of their OUD courses to count toward the 24 hour requirement.[18]

State Initiatives

New Mexico

Based in New York City, Kognito is a technology company that provides clients with access to an evolving series of professional development and public education simulations on topics such as mental health, substance use, chronic disease, family relations, medication adherence, and patient-provider communications. Kognito combines the science of learning, art of conversation, and power of game technology to engage users in role-play conversations with virtual humans, allowing them to try difference approaches, get personalized feedback and gain confidence and skills to lead similar conversations in real-life. Covid-19 has brought about a renewed interest in online training and educational simulation programs like Kognito are gaining recognition.

[15] . https://www.ndci.org/resource/training/treatment-provider-training/
[16] https://www.samhsa.gov/providers-clinical-support-system-pcss
[17] https://pcssnow.org/education-training/pcss-implementation/
[18] Amiercan Academy of Addiction Psychiatry. Education and Training. Available at: https://www.aaap.org/clinicians/education-training/

The New Mexico Department of Health Youth Suicide Prevention Initiative utilizes Kognito and has produced positive outcomes, particularly in rural and frontier regions where SUD and mental healthcare are generally scarce. An educator from the Mexico Department of Health facilitates training via Kognito simulation and is able to train public school staff (teachers and administrative staff) on how to address at-risk youth. This has saved the Mexico Department of Health expenses where the trainer would have previously had to drive 6 hours for a training session in rural or frontier New Mexico. Other areas of the public sector are benefiting from Kognito. The U.S. Department of Veterans Affairs uses Kognito to train veterans of how to have difficult conversations with their fellow servicemen on topics like depression, addiction, and suicide. [19]

Massachusetts

Shatterproof, a national nonprofit dedicated to ending the devastation of addiction, partnered with the Massachusetts Medical Society to pilot a Rating System for Addiction Treatment Programs, and gather insights and reactions from healthcare professionals with the goal of addressing and reducing stigma associated with OUD. The aim was to help healthcare professionals increase their efforts in screening and treating patients with OUD, while also empowering those suffering with the disease to come forward and seek care. Insights were gathered through research and extensive stakeholder engagement via surveys, interviews, thought leader discussions and focus groups.

The survey results yielded that the majority of providers (primarily primary care providers (PCP), obstetrics and gynecology (OBGYN), and emergency medicine (EM)) felt they lacked experience and training needed to successfully treat OUD. Of the data-driven recommendations, one of the most popular concepts included training that gave direct guidance on how to manage and treat a patient's OUD with some variation in interest by specialty. OBGYN's reported wanting training specific to screening and treating women with OUD and EM physicians wished to see specialty specific training on how to create a safety plan for patients with OUD (such as carrying naloxone, using sterile syringes, and not injecting alone). Training to reduce stigma towards OUD for office and hospital staff was requested among 33% EM, 34% PCP, 50% OBGYN, 28% Pediatrics, 51% Addiction Medicine, 29% Psychiatry, and 35% Social Work. [20]

Massachusetts medical schools are also taking steps to incorporate MAT training into medical education. Medical schools in the state have incorporated training about buprenorphine prescribing into its newly required additional opioid training requirements as well as continuing medical education requirements.

[19] https://kognito.com/?topics=Substance%20Use
[20] Opportunities to Increase Screening and Treatment of Opioid Use Disorder Among Healthcare Professionals; Shatterproof

This will generate a more OUD-informed workforce. While national graduate school accreditation requirements would have the greatest impact, states can step in and address this gap.[21]

California

The state developed a toolkit to expand the capability of primary care teams to confidently and willingly provide SUD services that are becoming fully integrated with primary care. The focus of the toolkit is in three areas: shifting attitudes of providers, increasing the awareness of SUD, and accelerating access to integrated SUD treatment. To implement these focus areas, the toolkit says to connect SUD services to the mission of the office, to learn from other providers, to give clear directions, to provide support, to raise awareness, to build skills of the providers, to clarify the process, and finally to measure the impact of the work.[22]

Treating Addiction in Primary Care (TAPC), a project with 25 federally qualified community health centers (FQHC) in California, demonstrated training as an essential implementation element. TAPC technical assistance and implementation support were provided through a contract with the Center for Care Innovations. The project's evaluation was extensive and specifically reviewed training, webinars, Project ECHO (Extension for Community Healthcare Outcomes), in-person events, site visits, and expert coaching. Barriers and facilitators to addiction medicine were examined throughout the evaluation.

The impact of the TAPC implementation on patients and providers was strongly positive:

- The number of patients on prescription intervention for addiction increased 2.84 to 2.96 times or 748 to 1,150 new patients for SUD;
- There was a 1.72 to 1.90 times increase in waivered prescribers equating to 70 new prescribers writing for patients with SUD.

Results from TAPC acknowledged that provider readiness was impacted by participants in various stages of MAT adoption. Participants in the early stage of implementation needed support to identify a logical starting place and to establish implementation plans. Some dealt with logistical issues, identifying clinical champions, and establishing relationships with non-traditional community partners. Clinics that were more advanced in implementation were focused on scaling up and expansion to support an increase in patients and address staff turnover. It should be noted that many expansion clinics were still focusing energy on provider readiness and reducing stigma. Overall recommendations included: prepare training manuals and procedures with a defined chain of command and identified care team roles; in planning for training, consider the importance of workforce retention and supervision; offer financial incentives to

[21] Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019)
[22] https://www.chcf.org/wp-content/uploads/2019/01/CIN-Toolkit-3-Strategies-to-Help-Primary-Care-Teams-Treat-Substance-Use-Disorders.pdf

offset the time required for completing required waiver training; anticipate implementation issues such as the need for more care coordination, unreimbursed services, and low pay turnover. [23] [24]

UCLA Integrated Substance Abuse Programs (ISAP) partnered with the California Department of Health Care Services (DHCS) to conduct evidence based training events throughout California over a three year period in effort to improve the quality of SUD services. Technical Assistance is offered to agencies and counties. Training topics include: Addressing Challenging Client Situations with Cultural Humility, Co-Occurring Disorders 101, Ethics/Confidentiality, Effecting Change through the Use of Motivational Interviewing: Interactive Training for Skill Development, Providing Culturally Responsive Services to LGBT Individuals, SBIRT, and Treatment Planning. [25] [26]

The California Hub and Spoke System (CA H&SS), otherwise known as the Medication Assisted Treatment (MAT) Expansion Project, is being implemented throughout California as a way to improve, expand, and increase access to MAT services across the state. Through a two-year SAMHSA-funded State Targeted Response (STR) Opioid Grant Program, CA's DHCS has awarded 19 Hubs across the state of CA to partner with community health providers to expand access to care. The MAT Expansion Project encompasses the CA H&SS and Tribal MAT Project. With implementation support through regionalized Learning Collaboratives and ongoing training and mentorship opportunities, CA H&SS aims to deal with the opioid crisis in California through a collaborative effort of relevant stakeholders.[27]

The MAT Waivered Prescriber Support Initiative (WPSI) is funded by the SAMSHA State Opioid Response Grant to the California DHCS. WPSI consultants include selected physicians willing to serve as champions across the state to improve and enhance treatment. Each consultant has experience prescribing buprenorphine and other medications and can be accessed to mentor other X-waivered prescribers seeking additional consultation. Online learning opportunities include: live web trainings, enduring self-paced education, and Getting Paid for MAT: Sustainable Reimbursement Series. In the Getting Paid for MAT: Sustainable Reimbursement Series, attendees learn about reimbursement of telehealth for SUD treatment and recovery, reimbursement for MAT costs, and compliance. Course reference materials are made public. The MAT WPSI website also includes a public-facing website that includes Factsheets and Toolkits: Buprenorphine Quick Start Guides, Primary Care Toolkits, Emergency

[23] https://www.careinnovations.org/wp-content/uploads/TAPC-1.0_Final-Program-Summary.pdf
[24] https://www.careinnovations.org/wp-content/uploads/TAPC-1.0_Final-Evaluation-Report.pdf
[25] *http://www.uclaisap.org/sudta/index.html*
[26] *http://www.uclaisap.org/*
[27] http://www.californiamat.org/matproject/california-hub-spoke-system/#:~:text=The%20California%20Hub%20and%20Spoke%20System%20%28H%26SS%29%20aims,in%20a%20rural%20state%20with%20little%20treatment%20infrastructure.

Room Toolkits, Jails and Prison Implementation Toolkits, Factsheet Addressing Myths about MAT, and links to additional informational websites.[28]

Maine

Three years ago, 30 to 60% of hospital visits and 30 to 40% of primary care visits in Maine were related to alcohol, yet most health care providers are not trained on discussing the health consequences of their substance abuse with patients. To create awareness and fill the gap, the Lunder-Dineen Health Education Alliance of Maine, in collaboration with Massachusetts General Hospital, partnered with stakeholders across Maine to create an innovative pilot program. The program, Time to Ask, included training for providers and expert consultation to assist primary care practices in making this transformation. The program targeted physicians, physician assistants, nurse practitioners, medical assistants, and social workers. Phase 1 findings revealed that the program had a positive impact on primary care health professionals' knowledge, and skills, and attitudes, while promoting practice change. Although alcohol abuse is treated differently than OUD, states could benefit from implementing a similar campaign to address the importance of knowing how primary care can appropriately discuss OUD with patients.[29] [30]

Training and Education Opportunities in Nevada

Different organizations offer various accredited trainings and resources in different formats to expand provider knowledge and capacity in SUD and OUD treatment and related behavioral health modalities. This section is an overview of the current educational and training resources available to Nevada providers.

Center for the Application of Substance Abuse Technologies (CASAT)

Since 1993, the Center for the Application of Substance Abuse Technologies (CASAT) has provided culturally focused, research-based technology transfer and training/technical assistance (TA) activities that address the needs of families and individuals with SUD and co-occurring disorders. CASAT's mission is to improve SUD prevention, treatment, and recovery services by helping states, jurisdictions, tribes, communities, organizations, college students, and the workforce effectively implement and sustain research-based practices. CASAT is building the foundation for SBIRT implementation.

Foundational trainings provide the workforce with opportunities to understand approach, rationale, evidence-based, and appropriate implementation approaches. The objective of the trainings is not to

[28] http://www.uclaisap.org/MATPrescriberSupport/html/wpsi-consultants.html
[29] https://lunderdineen.org/alcohol-use-time-ask
[30] https://giving.massgeneral.org/maine-alcohol-initiative/

enforce practice change but is necessary to influence future work. Skills-based training is delivered in different modalities including; skills-based webinar, in-person trainings, ongoing video recordings, and include post-training practice and feedback. [31]

Funding sources for CASAT include the Nevada Division of Public and Behavioral Health and the Substance Abuse Prevention and Treatment Agency (SAPTA) through the Substance Abuse Prevention and Treatment Block Grant from the Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMHSA).[32]

Continuing education hours (CEHs) are approved through the National Association for Addiction Professionals, National Board for Certified Counselors (NBCC), and the International Certification and Reciprocity Consortium (IC&RC) for provider participation in various trainings from CASAT. Continuing education credits are awarded through the Nevada Board of Examiners for Alcohol, Drug, and Gambling Counselors, the Nevada State Board of Nursing, Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors, and the State of Nevada Board of Examiners for Social Workers. Some boards have limits on how many continuing education units (CEUs) providers can earn through online venues.

CASAT Training provides a selection of in-person workshops, webinars, and online-study materials to accommodate busy provider schedules. All in-person workshops are full day commitments and begin at 9:00AM and end at 4:30PM. Webinars are live workshops conducted over the internet via Zoom. Online video training consists of a recorded online video training and an assessment you must pass in order to verify your attendance and earn your certificate. [33]

At the time of report writing, all in person workshops had been suspended due to the Covid-19 public health emergency, therefore no schedule was available. Current topics for live webinars include suicide prevention, management of benzodiazepine disorder, and motivational interviewing. There is a robust library of online, on-demand video trainings covering a wide array of topics including practice techniques for treating pregnant women with OUD, prescription drug abuse, Nevada law, medication assisted therapy, and naloxone/narcan administration training.

There are additional self-paced courses as part of the newly launched MyCASAT online training platform, some of which consist of several longer self-paced module-based courses.[34] Current courses include topics

[31] Screening Brief Intervention and Referral to Treatment (SBIRT) and Motivational Interviewing in Health Promotion and Outreach (doc 048)
[32] Center for the Application of Substance Abuse Technologies. About Us. https://training.casat.org/about_us
[33] https://casat.org/training/
[34] https://casat.org/training/

such as providing peer support services, promoting awareness of motivational incentives (PAMI), and multicultural awareness.

MyCASAT also includes "teachSBIRT", a 4 module self-paced course designed to increase awareness of trends in drug use and medical conditions associated with drug use, and build a foundational understanding of intervention strategies. SBIRT, or Screening, Brief Intervention, and Referral to Treatment is an evidence-based, comprehensive, and integrated approach to the delivery of intervention and treatment services for persons with SUDs, or those at risk of developing these disorders, and is designed to be used in various settings.[35] TeachSBIRT is one of the pre-developed online courses included in the "Adopt SBIRT" program, which is the training and technical assistance component of the Nevada Opioid State Targeted Response Initiative.[36]

Adopt SBIRT

Adopt SBIRT aims to serve Nevada's healthcare system with expertise and resources to provide training and technical assistance, implementation, workflow, educational materials, screening tools, video demonstrations, online courses and other resources to promote SBIRT for Opioid Use Disorders (OUDs) and other SUDs.

Adopt SBIRT is supported by the Nevada Division of Public and Behavioral Health Bureau of Behavioral Health, Prevention, and Wellness through funding provided by the Nevada State Targeted Response to the Opioid Crisis Grant awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Adopt SBIRT is overseen by CASAT and partners with a national cohort of content experts to achieve its training aims. Adopt SBIRT / CASAT's goal is to develop tailored training curricula and implementation coaching to increase staff knowledge, attitudes, skillfulness, and behaviors and possibly improve patient outcome.[37]

Adopt SBIRT includes additional free, self-paced, online courses in motivational interviewing and SBIRT for specific health professionals. There are also workflow resources and video demonstrations to support workflow integration of SBIRT in practice. SBIRT training through the STR/SOR project can also be delivered in small or large group settings and offers an opportunity for peer-based learning. Technical assistance through the Adopt SBIRT project can be delivered by phone, email, video conference, or in

[35] Substance Abuse and Mental Health Services Administration. Programs. SBIRT. https://www.samhsa.gov/sbirt/about
[36] Nevada State Opioid Response, STR Project. Training and Technical Assistance. https://www.nvopioidresponse.org/adopt-sbirt/training-and-technical-assistance/
[37] SBIRT and Motivational Interviewing Training and TA Proposal document

person and may include workflow, reimbursement, staff coaching, motivational interviewing, and SBIRT in special populations.[38]

The intent is for this education to occur in two modalities: self-study by means of examining print materials and pre-developed online courses, and tailored foundational courses. Online courses include: Teach SBIRT, UCLA's 4-Hour SBIRT Training, and UMKC SBIRT for Health and Behavioral Health Professionals: How to Talk to Patients about Substance Use, and A Tour of Motivational Interviewing: An Inter-Professional Road Map for Behavior Change. CASAT will facilitate the Tailored Foundational Courses via web-based video, provider webinars, and in-person training. [39]

Of note, the original proposal described the need for an "oversight committee" as an essential component of the project. The committee would include provider leaders and other key stakeholders to refine and tailor the approach, evaluate effectiveness, and finalize the SBIRT protocol and workflow for each site.[40]

The Association of State and Territorial Health Officials (ASTHO)

The Association of State and Territorial Health Officials (ASTHO) partnered with the CDC to start an Opioid Use Disorder, Maternal Outcomes and Neonatal Abstinence Syndrome Initiative (OMNI). ASTHO OMNI is working with 16 states to provide opportunities to develop policy and establish collaborative environments where states/communities can learn from one another and share best practices for pregnant and post-partum women exposed to OUD in order to improve health outcomes. Nevada is one of the 16 states participating. The Nevada ASTHO OMNI Perinatal Health Initiative started in November 2018. Their areas of focus include: provider awareness and training, access to and coordination of quality services.[41]

Provider Toolkits

The Provider Toolkits encompasses two toolkits: Inpatient and Outpatient. These were developed to address the assessment, care, and monitoring of pregnant women with SUD and their infants.

OBGYN Outpatient Toolkit

Formally named the Provider Reference Guide for Reproductive Health Complicated by Substance Use, this toolkit is designed for OBGYN practice settings. The content includes: an introduction to SBIRT, how

[38] Nevada State Opioid Response, STR Project. Training and Technical Assistance. https://www.nvopioidresponse.org/adopt-sbirt/training-and-technical-assistance/
[39] Screening Brief Intervention and Referral to Treatment (SBIRT) and Motivational Interviewing in Health Promotion & Outreach (PDF)
[40] Adopt SBIRT / CASAT's goal is to develop tailored training curricula and implementation coaching to increase staff knowledge, attitudes, skillfulness, and behaviors and possibly patient outcome.[40]
[41] ASTHO OMNI Action Plan

to use SBIRT, management after SBIRT, instruction for follow-up care, intrapartum pain control and clinical protocol, and postpartum clinical pathways. The toolkit also incorporates additional resources in the appendix. While the toolkit has been finalized by ASTHO OMNI, it is currently in phase 1 of distribution. Implementation phase 1 is limited to select large practices in Clark County. [42] [43]

The current approach to current approach to implementation focuses on three identified priorities: a tailored training plan for large volume practices serving high need populations; potential adoption sites receive an email including a PDF of the reference guide toolkit, a link to an instructional video, and a link to the readiness assessment; and a future planned ECHO series that corresponds with SBIRT in the OBGYN setting.[44]

Inpatient Toolkit

The Inpatient Toolkit is currently in progress and will be designed for Labor and Delivery (L&D) and postpartum inpatient settings. The toolkit was initially planned to cover NICU and Pediatric protocols, however, it was decided that those would be better addressed in a future NICU Toolkit. Eight areas of focus are identified for this toolkit: current policy/protocol for screening pregnant women for opioid use disorder, NICU admission criteria for NAS, breastfeeding policy/protocol for opioid positive women and women engaged in MAT, non-pharmacological options utilized for NAS infants on the postpartum floor, discharge criteria for opioid positive babies on the postpartum floor, long acting contraception (LARC), pain management protocols, medication assisted treatment. It has been identified that there's a need for broad training and education for hospital staff on the full pharmaceutical range of LARC options to prevent future unplanned substance exposed pregnancies. [45] [46]

CARA Packet

The CARA Packet, formerly referred to as the Family Toolkit, is a collaborative effort between DPBH and DCFS to develop and maintain an up-to-date guide for parents and caregivers. Educational materials for both the provider and the family are included in the packet and will be distributed to hospitals throughout the state. The packet includes the CARA Plan of Care (POC) Form, CARA Fact Sheet, Neonatal Abstinence Syndrome (NAS) Handout, and Family Education Brochure. [47]

- The POC Form is a form to be completed by a hospital representative with the family for all infants known or believed to be born with fetal alcohol spectrum disorder (FASD), affected by substance

[42] ASTHO OMNI Provider Reference Guide for Reproductive Health Complicated by Substance Use
[43] ASTHO OMNI Core Team, Practice Standards and Provider Education, and CARA Workgroup Meeting Minutes March-July 2020
[44] Ibid
[45] Ibid
[46] ASTHO OMNI Inpatient Framework
[47] ASTHO OMNI Core Team, Practice Standards and Provider Education, and CARA Workgroup Meeting Minutes March-July 2020

use, or experiencing symptoms of withdrawal. The form will also be integrated into OpenBeds, a behavioral health referral tool, which will generate data collected from hospitals to be used in reporting.[48]

- A fact sheet for health care providers will be incorporated into the packet and will outline the goals of CARA, how Nevada defines a substance affected infant, who decides is an infant is affected, what are the CPS reporting requirements, refusal of the CARA POC, submission of the CARA POC, and CPS' involvement in the process after discharge. [49]
- The NAS Handout is intended for families and caregivers but is also a helpful resource for hospital staff. The handout explains symptoms of NAS, treatment of NAS, and long-term expectations of an infant impacted by NAS.[50]
- The Family Education Brochure is the guide for parents and caregivers and should be provided with the completion of the POC. The brochure includes: explains the CARA POC, the role of the care team, basic information on Nevada laws on CPS reporting, services available for mother and baby, impacts of SUD on infants, and information on marijuana and breastfeeding.[51]

Distribution of the CARA Packet is expected statewide. ASTHO OMNI is working with CASAT on implementation and it is expected that individual TA will be provided to hospitals on an as-needed basis. Whether the materials are printed and distributed or distributed via PDF link is largely dependent on budget.

Project ECHO

Project ECHO® is a successful, scalable, and cost-effective model for provider education and skills development, and can be leveraged to address known barriers to expanding the availability of MAT programs and provider capacity. In Nevada, Project ECHO® is available to any community and provider willing to participate and CME and CE credits are available. Clinics are delivered via Zoom, a free teleconferencing system that is supported by the Nevada System of Higher Education telecommunications network.

Project ECHO® Nevada is a beneficiary of a federal award from SAMHSA, through which the program has established and supported clinics in pain management and MAT. Project ECHO's Pain Management Clinic helps to enhance knowledge of proper practices for prescribing of controlled substances, alternative

[48] ASTHO OMNI CARA Plan of Care Form 2020
[49] ASTHO OMNI Core Team, Practice Standards and Provider Education, and CARA Workgroup Meeting Minutes March-July 2020
[50] Ibid
[51] ASTHO OMNI CARA Family Education Brochure Final 2020

therapies, and the psychology of pain. MAT and pain management clinics are held twice a month. Clinic topics have included an overview of MAT, the science of addiction, principles of harm reduction, a summary of the provisions of AB474, steps to proper prescribing, and health alternatives for pain management.[52] In 2019, nearly 500 participants discussed a total of 32 patient cases (19 in pain management and 13 in MAT).[53]

Desert View Hospital was the lead recipient of the Nevada Rural Opioid Overdose Reversal (ROOR) grant, and includes five additional participating critical access hospitals, Project ECHO® Nevada, Nevada rural hospital partners and the Nevada DHHS. The goal was to "deliver training on the administration of naloxone to all levels of EMS providers as a result of provisions in Nevada Senate Bill 459 (SB459), which authorized all levels of first responders to administer naloxone to potential opioid overdose deaths."[54] Project ECHO® Nevada delivered a three-part series on opioid prescribing guidelines from the CDC, evidence-based approaches to pain management, and SB459 changes and implications.[55]

Nevada Medical Association

New prescribing requirements from controlled substances under Nevada Law were established from the 2017 legislative session (AB 474 and SB 59). The bill had five requirements for Nevada Physicians and Physician Assistants: two units of CME per licensing cycle required for all licensed prescribers, mandated registry and use of Prescription Drug Monitoring Program (PDMP), new prescription requirements for patient identification, new prescribing guidelines for controlled substances, and overdose reporting.

The Nevada State Medical Association and Nevada Division of Public and Behavioral Health issued an AB474 Toolkit for prescribers of controlled substances. The toolkit includes best practices, forms (informed consent and prescription medication agreement), risk assessment tools (SOAPP-R validation and POMI prescription opioid misuse index), resources for overdose reporting, training for DOs by the Board of Osteopathic Medicine, and Project ECHO. [56] [57]

Nevada Primary Care Association

The NVPCA has hosted the "Medication for Addiction Treatment DATA 2000 Waiver" training. This 8-hour course covers treating opioid use disorder using interactive, case-based learning, and evidence-based

[52] NV SUPPORT Act Infrastructure Assessment Report 2020
[53] Project ECHO Nevada 2019 Annual Report. Available at: https://med.unr.edu/echo/about
[54] National Organization of State Offices of Rural Health, Report on Lessons Learned From Rural Opioid Overdose Reversal Grant Recipients, April 2017, https://nosorh.org/wp-content/uploads/2017/05/ROOR-Report-1.pdf
[55] NV SUPPORT Infrastructure Assessment Report 2020
[56] https://nvdoctors.org/practice-resources/prescribing-opioids/
[57] http://dental.nv.gov/Home/Features/AB_474/

practices. This course will provide the required 8 hours needed to obtain the waiver to prescribe buprenorphine in office-based treatment of opioid use disorders. ASAM is an approved provider by CSAT/SAMHSA of DATA 2000 training.

Evaluation and Reach of Select Trainings

Myers and Stauffer received limited amount of evaluation data from the available Nevada sources. Below is a snapshot of available evaluation data of select trainings related to SUD and OUD treatment services in Nevada.

CASAT Trainings

Table 1 includes CASAT's 2019 trainings specifically focused on relevant SUD/OUD education listed in the "CASAT 2019 Trainings" Excel spreadsheet. The table shows the number of people registered for each session type, the date offered (which is not applicable to the online video option), and how many people attended the sessions.

Generally, attendance rates for both in-person and webinar offerings from CASAT are high, however, both registration and attendance numbers may be low especially for webinars which offer the opportunity for higher attendance capacity. Most online videos, which are available at any time, also show limited engagement, however some of are not free of charge. This table does not capture the estimated number of providers that may have been alerted to the training, nor does it capture the target number of attendees by training as this information was not included in the dataset.

Table 1: 2019 CASAT Select Training Offerings, Types, and Attendance Rates

Name	Start Date	Type	Registered	Attended	Rate
Addressing Substance Abuse From an Attachment Perspective: Promoting Security and Repair	11/8/2019	In-Person	34	30	88%
Adolescent Motivational Interviewing	4/5/2019	In-Person	15	16	107%
	3/22/2019	In-Person	38	37	97%
Clinical Supervision for Alcohol and Drug Counselors 2-day	5/23/2019	In-Person	21	21	100%
	5/30/2019	In-Person	11	11	100%
	10/23/2019	In-Person	10	10	100%
	10/31/2019	In-Person	7	7	100%

Training Gap Analysis

Name	Start Date	Type	Registered	Attended	Rate
Clinical Supervision Refresher Special Topics: Motivational Interviewing for Supervisors	8/9/2019	In-Person	15	15	100%
	11/8/2019	In-Person	37	37	100%
Cultural Diversity in Native American Country: Addiction, Trauma, and Sexual Violence		Online Video	6	6	100%
	1/24/2019	In-Person	34	33	97%
	1/25/2019	In-Person	8	8	100%
	5/1/2019	Webinar	43	13	30%
Discovering Pathways to Recovery (CC)		Online Video	39	35	90%
Drug Trends in Northern Nevada		Online Video	38	34	89%
How to Become a Substance Abuse Counselor in Nevada		Online Video	54	20	37%
	2/6/2019	Webinar	79	45	57%
How To Write a Recovery Friendly Workplace Policy Training		Online Video	48	24	50%
Improving MAT Access and Quality Through Collaborative Care: The CoOp Model		Online Video	17	13	76%
Leveraging Technology to Engage Students in Recovery (CC)		Online Video	7	7	100%
MAT Medication Assisted Therapy (CC)		Online Video	26	17	65%
Methamphetamine and Its Impact on Brain and Behavior: Best Practices for Delivering Effective Treatment	10/10/2019	In-Person	52	47	90%
		Online Video	4	3	75%
	10/11/2019	In-Person	16	15	94%
Mindfulness and its Role in Recovery (CC)		Online Video	73	66	90%
Misused Drugs		Online Video	56	32	57%

Training Gap Analysis

Name	Start Date	Type	Registered	Attended	Rate
Motivational Interviewing Training 2-Day	5/16/2019	In-Person	53	52	98%
	5/2/2019	In-Person	18	18	100%
Multicultural Competency/Diversity Training for Substance Abuse Clinicians - Department of Corrections	7/9/2019	In-Person	25	23	92%
NAC 458 Updates		Online Video	46	30	65%
Naloxone/Narcan Administration Training for Law Enforcement (cc)		Online Video	927	832	90%
Naltrexone Training	3/1/2019	Webinar	4	2	50%
New Ethical Dilemmas in the Digital Age: Telehealth Technologies and Treatment		Online Video	43	41	95%
Opioid Management, Medication Assisted Treatment (CC)		Online Video	43	38	88%
Opioid Overdose Education & Naloxone Distribution (OEND)	7/25/2019	In-Person	21	24	114%
Overdose Education and Naloxone Distribution to Prevent Fatal Opioid Overdoses (CC)		Online Video	21	18	86%
Overview of ASAM Criteria for the Management of Client Care		Online Video	10	6	60%
	9/17/2019	Webinar	65	44	68%
Peer Recovery Support Specialist Ethics (CC)		Online Video	62	58	94%
Prescription Drug Abuse (CC)		Online Video	31	29	94%
Prescription Medication Safety		Online Video	2	3	150%
Principles of Detoxification - Withdrawal Management Module 1		Online Video	155	1	1%

Training Gap Analysis

Name	Start Date	Type	Registered	Attended	Rate
Principles of Detoxification - Withdrawal Management Module 2		Online Video	155	1	1%
Principles of Detoxification - Withdrawal Management Module 3		Online Video	154	0	0%
Principles of Detoxification - withdrawal management module 4		Online Video	148	45	30%
Quality Assurance Training for SAPTA Certification	12/4/2019	In-Person	7	7	100%
Signs and Symptoms of Substance Use, Gambling and Mental Health Issues - Recovery Friendly Workplace Training		Online Video	1070	975	91%
Suboxone/Sublocade Training	2/8/2019	Webinar	5	5	100%
Substance Use, HIV, and Youth: What Clinicians Need to Know		Online Video	24	22	92%
Supporting Women in Recovery: A Trauma -Informed Approach to Substance Use Treatment		Online Video	1	2	200%
	11/5/2019	Webinar	143	83	58%
Sustaining Healthy Remission with Co-occurring Disorders for Rural Clinics	4/24/2019	Webinar	66	56	85%
Teen Addiction: Gambling, Drugs, and Mental Health (CC)		Online Video	28	25	89%
The Science and Practice of Treating Pregnant Women with Opioid Use Disorder	12/2/2019	In-Person	50	34	68%
		Online Video	0	1	200%
	12/3/2019	In-Person	33	26	79%
		Online Video	1	0	0%
Trauma-Informed Care, Substance Use, and Co-Occurring Disorders	2/28/2019	In-Person	53	51	96%
	2/21/2019	In-Person	10	10	100%

Training Gap Analysis

Name	Start Date	Type	Registered	Attended	Rate
Treatment Planning Part 1		Online Video	37	28	76%
Treatment Planning Part 2		Online Video	33	27	82%
Tribal Medication Assisted Treatment (MAT)	5/22/2019	In-Person	4	1	25%
	8/28/2019	In-Person	11	9	82%

Table Source: CASAT Post-Training Evaluations and Accompanying 2019 Spreadsheet of Training Activities

Table 2 includes post-training CASAT evaluations for select In-Person trainings. The evaluations include questions related to attendee demographic information (gender, race/ethnicity, education, licensure, and primary employment setting), general evaluation ranking, and free form comments. The evaluations offer insight on overall satisfaction, in addition to requests for follow-up training topics and goals for future trainings. It is important to note that post-training evaluations are distributed after in-person classes and live webinars and not for recorded online videos.

From the analysis of 2019 SUD-focused courses, the majority of participants are Social Workers, Counselors, and Staff, not medical providers (MD, DO, NP, PA). There were several classes tailored to fieldwork like nurses, law enforcement officers, first responders, and government agencies (like Department of Corrections and Department of Justice).

Overall, there were trends in the feedback analyzed from the post-training evaluations. Participants in the CASAT post-training evaluations consistently stated that they'd like to receive more supplemental materials relating to the training topic, and more handouts and presentations that they can use as a reference post-training. Attendees of more culturally-focused courses (i.e. Cultural Diversity in Native American Country: Addiction, Trauma, and Sexual Violence) wished for more culturally sensitive classes focusing on race, ethnicity, religion, and gender. Additionally, most responses received requested additional training in a topic CASAT might already offer, however the respondent was unaware. Finally, many respondents cited that the trainings will impact their behavior in practice.

Table 2: 2019 CASAT Select Training Offerings and Evaluation Data

Name	Evaluation Data
Addressing Substance Abuse From an Attachment Perspective: Promoting Security and Repair	• Marriage and Family Therapists (55%); Alcohol and Drug Counselors (41%); and Social Workers (26%). The majority of attendees indicated that their employment setting is a solo/group private practice. • Overall feedback was positive with the only negative remarks focusing on technical difficulties or wanting more time for the materials. • **Participants noted that the new information learned from the course will shape/change the way they approach clinical work with couples and/or family.** • Some of the recommendations for future activities similar to this topic include: Family Systems (step-parenting and post-divorce adjustments), Animal Assisted Therapy, addiction specific to teens and elderly, and Eye Movement Desensitization and Reprocessing (EMDR) advanced workshops.
Clinical Supervision for Alcohol and Drug Counselors 2-day	• Master's Degree (100%); Addictions Professional (43%); Educators (14%), Pharmacists (14%), Psychologist (14%). Most worked in a Mental Health Clinic or Treatment Program. • Evaluations of the course were positive and received no additional comments.
Clinical Supervision Refresher Special Topics: Motivational Interviewing for Supervisors	• The majority of professionals in attendance had counseling backgrounds like Alcohol and Drug Counselor, Clinical Professional Counselor, and Marriage and Family Therapist. 29% reported Addiction Treatment Programs to be their primary employment setting and another 29% indicated Private Practice to be their employment setting. • Overall feedback was positive. **53% of those polled stated the training enhanced their skills in the topic area. Many participants noted that their new knowledge will be applied to how they supervise the practice.**
Cultural Diversity in Native American Country: Addiction, Trauma, and Sexual Violence	• Bachelor's Degree or a Master's Degree (100%); Alcohol, Drug and/or Gambling Counselor (24%); and Marriage and Family Therapist (18%). • Most of the attendees reported a positive experience with this training course however some stated they were either neutral or dissatisfied with the quality of the training materials and that the material wasn't useful in the treatment of SUD. • Participants commented that they were hoping for more handouts and educational materials. They were expecting to learn more about clinical interventions on how to work with tribal communities and engage them in treatment. • Many attendees were caught off guard at the focus on historical trauma, however reported that the information learned will help them better counsel their clients who deal with multigenerational issues.

Training Gap Analysis

Name	Evaluation Data
How To Write a Recovery Friendly Workplace Policy Training	• The majority of attendees had Bachelor's degrees while a minority held Masters or above. Government (24%); Addictions Treatment Program (19%), and Hospital or Hospital-Affiliated Clinic (19%). • Participants responded positively to the training content and remarked that **the material was informative and very helpful for nurses looking to become substance abuse counselors through the Nevada State Board of Nursing.** • Attendees commented that they would like to see a follow-up course on ethics. • 5 attendees reported that the knowledge learned in the course will drive them to become certified as soon as possible.
Methamphetamine and Its Impact on Brain and Behavior: Best Practices for Delivering Effective Treatment	• Overall the attendees were "Very Satisfied" with the quality of the training. • The demographics for this training encompassed Social Workers LCSW (41%), Alcohol and Drug Counselor (30%), Marriage and Family Therapist (18%), Clinical Professional Counselor (9%), Prevention Specialist (5%), Nurse or Nurse Practitioner (4%), Community Health Worker (4%). • Some feedback included: would like to see studies on long term recovery of a decade+, information of permanent psychosis, and more content of dealing with meth use in youth.
Multicultural Competency/Diversity Training for Substance Abuse Clinicians - Department of Corrections	• Alcohol, Drug and/or Gambling Counselor (83%); employment setting to be a Correctional Facility (96%). • The majority of feedback was positive but some reported that they wished additional material and topics were covered including: power dynamics among staff, dealing with personal bias, and more gender-centric topics. **Attendees reported that the knowledge gained from participating in the training will impact how they ask questions and their greater personal awareness.**
Opioid Overdose Education & Naloxone Distribution (OEND)	• 33% identified themselves as a Prevention Specialist (33%); Employment setting as a local law enforcement department (60%); government (20%); and 20% probation/parole office (20%). • Feedback from the course was positive and attendees reported that **they will be able to apply knowledge gained to their current practice.** It's important to note that the majority of participants did not respond to the evaluation.
Peer Recovery Support Specialist Ethics (CC)	• Over 45% of participants did not hold any official or clinical licensure; 52% of those participants reported that their primary employment setting is an Addiction Treatment Program. • Many attendees polled indicated that the training **will impact their "opening dialog concerning balance in wellness" and overall communication with clients.**

Name	Evaluation Data
Supporting Women in Recovery: A Trauma - Informed Approach to Substance Use Treatment	• Peer Recovery Support Specialist (25%); Social Worker (25%); Addiction Counselor (13%); Clinical Professional Counselor (30%). Employment setting as Domestic Violence Organization (30%), Addictions Treatment Program (20%), and 10% Recovery Support Program (10%). • Evaluation comments indicated that participants would like to see more content on working with survivors in shelters or advocacy setting. Many stated they'd like to see more topics looking at how women respond to trauma and addiction. • Many reported that Adult Children of Alcoholics, Intimate Partner Violence, and How Children Respond would be a great follow-up course.
The Science and Practice of Treating Pregnant Women with Opioid Use Disorder	• The audience for this training included: MDs and DOs, Pas and APNs, and RNs and APRNs. • Overall feedback was positive. There were a couple areas participants wished they covered better including: standard of care for the treatment of pregnant women with OUD, and medication options available for OUD including evidence for each treatment in pregnancy. **• 66.7% of attendees reported that their participation in the training will result in changes in their practice.** • Patient compliance issues, lack of time to assess/counsel patients, and lack of administrative resources were the three biggest barriers to implementation reported by attendees. • Some of the recommendations for future activities on this topic included: Prenatal Mood Disorders, Treatment Options for Meth and Pregnancy, Postpartum Depression and the Impact on Patients with OUD and Treatment for MAT.
Trauma-Informed Care, Substance Use, and Co-Occurring Disorders	• The majority of attendees for these trainings report working as Alcohol, Drug, and/or Gambling Counselors. And the top two places of employment were Addiction or Correctional Facilities. • Participants reported that they will now be able to address trauma from the moment the patient calls the receptionist through the discharge process. **• The majority of attendees stated that their participation in this training will directly impact how they address trauma in their area of practice moving forward.** • Additional topics participants wished were covered more include: trauma-informed care in the justice system, working with court-ordered clients, and enhancing self-care.

Table Source: CASAT Post-Training Evaluations and Accompanying 2019 Spreadsheet of Training Activities

Adopt SBIRT Related Trainings

Adopt SBIRT Self-Paced Online Course Evaluation

Since SOR funding began, 108 individuals have completed the self-paced online course. A total of 60 participants returned the evaluation. One-third (32%) indicated their licensure/certification as a Nurse; 9% a Peer Recovery and Support Specialist; 8% as an Alcohol and Drug Counselor; 7% a Clinical Social Worker; 5% a Marriage and Family Therapist; 5% as a Community Health Worker; 5% a Counselor; 3% a Nurse Practitioner; 3% a Medical Assistant; and 22% as Not Licensed or Certified. Twenty-six percent (26%) indicated that their principal employment setting was a Community Health Center. 19% a Hospital/Hospital Affiliated Clinic; 9% an Addictions Treatment Program; 7% a Solo/Group Private Practice; 5% a Community/Faith-based Service Organization; 5% Not currently employed and 33% Other.

Tables 3 and 4 offer an illustrative example of how the Adopt SBIRT courses are evaluated by participants. Table 3 captures respondents satisfaction with the course, and Table 4 examines how well respondents felt the course met the objectives.

Table 3: Adopt SBIRT Satisfaction Evaluation Data

To what extent do you agree with the following statements?	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Overall, I am satisfied with the quality of the training.	0% (0)	0% (0)	0% (0)	61% (36)	39% (23)
The training concepts were presented clearly.	0% (0)	0% (0)	0% (0)	54% (32)	46% (27)
The content will be useful to me professionally.	0% (0)	0% (0)	0% (0)	61% (36)	39% (23)
I would recommend to this training to others.	0% (0)	0% (0)	6% (1)	58% (34)	42% (25)

Table 4: SBIRT Evaluation of Achievement of Objectives

How successful was the training in addressing the following areas?	Very Unsuccessful	Unsuccessful	Neutral	Successful	Very Successful
The difference between individuals with substance use disorders versus those participating in risky drinking.	3% (2)	0% (0)	0% (0)	63% (38)	33% (20)
Screening tools used to assess patients for risky alcohol and other drug.	3% (2)	0% (0)	0% (0)	63% (32)	43% (26)
Screening skills with an evidence-based tool.	3% (2)	0% (0)	0% (0)	50% (30)	47% (28)

The effective use of brief intervention strategies and techniques to motivate clients to change their behavior.	3% (2)	0% (0)	0% (0)	57% (34)	40% (24)

Adopt SBIRT Training of Trainers Evaluation

An Adopt SBIRT TOT was held in March 2020. There were twelve respondents to the evaluation survey. Eighteen percent (18%) indicated their licensure/certification as a Nurse; 9% a Nurse Practitioner; 9% Physician; 9% an Alcohol and Drug Counselor; 9% a Marriage and Family Therapist; 9% as Not Licensed or Certified; and 36% Other. Table 5 captures respondents satisfaction with the course, and Table 6 examines how well respondents felt the course met the objectives. Both were mostly positive.

Preparing your Health Center for SBIRT Implementation Online Learning Series Evaluation

The *Preparing your Health Center for SBIRT Implementation* online learning series has been conducted twice, once February-April 2019 and once September-October 2019. Thirty-three individuals attended the series, with 22 respondents completing the evaluation survey. Twenty-seven percent (27%) indicated their licensure/certification as an Alcohol and Drug Counselor; 27% a Clinical Social Worker; 13% a Professional Counselor; 7% a Nurse; 7% a Nurse Practitioner; 7% a Marriage and Family Therapist; 7% Other; and 7% as Not Licensed or Certified. Principal employment setting was identified as a Community/Faith-based Service Organization (29%); a Hospital/Hospital Affiliated Clinic (24%); a Community Health Center (24%); a Solo/Group Private Practice (10%); an Addictions Treatment Program (5%); and 10% Tribal/Indian Health Service.

Project ECHO Trainings

There are two main clinics offered from Project ECHO related to SUD and OUD treatment and services, MAT Clinic and Pain Management Clinic.

Medication-Assisted Treatment Clinic

The following data represents the total number of evaluations received for the MAT Clinics conducted between January and December 2019. The total number of evaluations received is 88. The survey data collected illustrates that these trainings can drive changes in practice, however there are barriers that need to be addressed.

Table 6 illustrates how participants in Project EHCO MAT clinics evaluate whether or not the training will drive behavior change in practice or enhanced knowledge.

Table 6. Project ECHO MAT Clinic Performance Evaluation

As a result of my participation in this CME activity:	Strongly Agree 5	Agree 4	Unsure 3	Disagree 2	Strongly Disagree 1
A. My knowledge increased	34.1% (30)	62.5% (55)	3.4% (3)	0.0% (0)	0.0% (0)
B. My ability to provide appropriate care to my patients improved	28.7% (25)	60.9% (53)	10.4% (9)	0.0% (0)	0.0% (0)
C. I will make changes in my practice	23.3% (30)	45.3% (29)	31.4% (27)	0.0% (0)	0.0% (0)
D. I feel a decreased sense of professional isolation	40.2% (033	51.2% (42)	7.3% (6)	1.3% (1)	0.0% (0)

When asked about barriers to implementing changes in practice as a result of the course, 9% noted there were no barriers. The top barriers cited were:

- Lack of time to counsel patients (23.2%)
- Lack of time to assess patients (19.2%)
- Insurance/reimbursement issues (17.1%)

When asked about other potential topic areas for future clinics, respondents requested:

- What is required to become licensed to participate in MAT as an APRN
- Veterans and teens opioid use
- Counselor and prescriber coordination
- Polysubstance use

Overall satisfaction with the information, time for questions and answers, relevance to practice, and logistics were mostly positive. Only one respondent was dissatisfied with the video connection.

Pain Management Clinic

The Pain Management Clinic was also offered several times between January and December 2019. The total number of evaluations received was 61. Table 7 illustrates how participants in Project EHCO Pain Management clinics evaluate whether or not the training will drive behavior change in practice or enhanced knowledge.

Table 7. Project ECHO Pain Management Clinic Performance Evaluation

As a result of my participation in this CME activity:	Strongly Agree 5	Agree 4	Unsure 3	Disagree 2	Strongly Disagree 1
A. My knowledge increased	45.9% (28)	52.5% (32)	1.6% (1)	0.0% (0)	0.0% (0)
B. My ability to provide appropriate care to my patients improved	43.3% (26)	33.3% (20)	23.4% (14)	0.0% (0)	0.0% (0)
C. I will make changes in my practice	38.3% (23)	25.0% (15)	35.0% (21)	1.7% (1)	0.0% (0)
D. I feel a decreased sense of professional isolation	73.1% (38)	23.1% (12)	1.9% (1)	1.9% (1)	0.0% (0)

When asked about barriers to implementing changes in practice as a result of the course, 13% noted there were no barriers and 16% noted they did not plan on making changes in practice. The top barriers cited were:

- Lack of time to assess patients (13%)
- Lack of time to counsel patients (12%)
- Insurance/reimbursement issues (10%)

Recommendations

Training must be part of a comprehensive program that acknowledges the challenges of implementation and dissemination. Training must be directly supported by organizational structure, lines of authority, decision-making, and business practices.[58] A literature review of MAT models of care in primary care settings acknowledged the implementation challenges including stigma, lack of institutional support, lack

[58] https://trainingindustry.com/articles/content-development/training-best-practices-and-organizational-success/

of prescribing physicians, and lack of expertise,[59] all of which need to be addressed organizationally as well as with training.

State health departments often fund training to expand the skills of existing providers working with individuals with SUD or OUD, or to encourage providers to start to work with these individuals. These trainings need to be part of an overall implementation plan that considers provider and community readiness, dissemination, and sustainability. Maintaining and developing the health care workforce is necessary in order to provide comprehensive and quality care to all Nevada residents. Targeting workforce development barriers must be a priority in order to improve both the quality of and access to health care services.[60]

As the state seeks to enhance and coordinate training opportunities, it's important to ensure the program design and implementation will help the state achieve the stated goals of the demonstration. Specific goals of the Nevada SUPPORT Act Grant are:

1. Increase access to SUD and OUD treatment and recovery services by increasing the number of providers eligible to provide some level of SUD services.
2. Conduct community engagement activities across the state and gather information which will be used to improve the education materials and training activities available to Medicaid SUD providers.
3. Create a comprehensive MAT strategy and develop a corresponding chapter in the Nevada State MSM.
4. Eliminate the confusion regarding which providers are eligible to provide MAT and other challenges faced by providers that may hinder their willingness and ability to provide treatment and recovery services.
5. Focus on expansion of OUD treatment for the sub-population of pregnant and postpartum women and their infants to address NAS.

The below are recommendations for consideration and inclusion in the demonstration project.

[59] Chou R, Korthuis PT, Weimer M, et al. Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Dec. (Technical Briefs, No. 28.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK402352/
[60] https://bhw.hrsa.gov/shortage-designation/application-review-process

Recommendation: **Convene a Training Committee**

There exists a rich body of resources at the federal and state level to support provider training and educational needs for the state to help increase and enhance provider capacity to deliver SUD and OUD treatment services.

The state should consider convening a collaborative committee to develop, implement, and evaluate trainings specific to the goal of increasing the availability of providers that deliver MAT services. Given its role in training and educational delivery, CASAT may serve as the lead on the committee and must continue to engage with ASTO, Project ECHO, and the Nevada Medical Association. The goal of the committee is to collectively oversee training delivery and enhancements throughout the demonstration, and serve as a collaborative body for development and oversight of a coordinated, statewide training program.

This committee would be charged with ensuring that trainings leverage known best practices and evaluating the applicability of other innovative approaches to training development and delivery.

The committee would also be charged with developing partnerships as an overall strategy to continue expansion of services. For example, training would be more effective if mandated as a part of graduate school education, similar to training commonly incorporated for other medications with complicated dosing (e.g., warfarin), and offered as a part of continuing medical education. This would require a partnership with leading medical schools in the state.

DHCFP may consider how it can partner with medical schools to support implementing more education options to train future physicians. SUD education should be required for primary care, behavioral health fields, and OB-GYN. In addition, every doctor should receive education on best practices for prescribing opioids. Finally, coordination with medical schools can present training and education services to providers in high-need areas of southern Nevada.

Recommendation: **Establish Concrete Objectives and a Measurement Framework**

The committee should create a list of specific learning objectives and desired outcomes for the training program that align with the overall state goals and strategy for the demonstration. By establishing the desired outcomes, the committee can better determine which are the core or foundational trainings that must be incorporated and promoted as a part of an overall strategy.

Learning outcomes connect the practice gap with the training need, and objectives are more task oriented. Table X illustrates proposed learning outcomes and objectives that align with the overall goals of the grant.

Table X: Example Learning Outcomes and Objectives

Learning Outcome	Learning Objective
Knowledge based: At the conclusion of the activity, participants will demonstrate knowledge of the waiver process and MAT program	Outline what is included in a MAT program and the steps to obtaining a waiver.

components by completing a post-assessment and scoring ≥85%	
Skills based: Correctly identify required actions for assessment and management of patients with SUD/OUD by case review.	Present the clinical process and workflow to assess, refer, or manage a patient with SUD/OUD
Performance based: Participants report utilization of a standard assessment or other evidence based protocol in practice.	Define all of the components of the SBIRT.

Another component of the measurement framework to consider would be desired reach of the trainings or utilization of the toolkits and resources, specifically among the targets of change. Table X1 illustrates elements of a potential measurement framework that can be applied to the final training package or program.

Table X1: Example Measurement Framework

Objective	Measure	Target	Frequency	Source
By end 2021, participation in OUD treatment core courses by Primary Care (PA, APRN) and OBGYN physicians will increase 25%	Number of PCPs and OBGYN that have attended specific trainings	25% increase	Quarterly	Attendance, registration, and evaluation data
By end 2021, the state will hold 8 training sessions with FQHCs	Number of sessions held with FQHCs	8	Bi-monthly	Event data
By end 2021, participants in specific trainings will demonstrate a 15% score improvement on pre and post assessments	Score comparison on pre and post assessment	15% increase	Quarterly	Pre and post assessment data
By end 2021, engagement with the Primary Care Toolkit will increase by 35%	Number of clicks/downloads or printed copies distributed	35% increase	Quarterly	Website engagement data or administrative data
By end 2021, the state will host at least 4 training sessions in partnership with provider associations	Number of training sessions held with associations (CRNAs, PAs, etc.)	4	Quarterly	Event data

Recommendation: **Develop Training Programs and Training Packages**

Across all sources, there exists a multitude of trainings and educational resources for all provider types that cover MAT delivery, pain management, telehealth, and related behavioral health services. However, there needs to be a targeted, clear training pathway for providers that are eligible to deliver MAT services, especially for primary care and OBGYN providers. The overall training program and packages must be designed to assist the state in achieve the specific grant goals.

The committee could engage with primary care and OBGYN providers or associations to gather additional feedback on what courses or topics may be necessary. The goal is to offer training packages with courses designed to meet certain industry needs and challenges. Training packages could be developed utilizing both national and state resources.

As new trainings are developed, the state must consider tactics to enhance educational and training practices to change provider attitudes and reduce stigma, pertinent to increase provider willingness to offer SUD and OUD treatment and recovery services.[61] [62] Such tactics can include: promotion of success stories showing how effective and transformative addiction treatment can be, as well as presenting dramatic outcomes that are achievable and have been proven to result in an increase in provider satisfaction.[63]

The state should also consider ways to better utilize peer-to-peer learning, such as the Project ECHO model, and leverage provider champions in foundational trainings. Increased peer-to-peer training and utilization of provider champions could increase provider and professional buy-in. Similarly to the California model, the state could assemble a group of consultants, including selected physicians with ample experience prescribing buprenorphine and other medications, to mentor waivered providers seeking additional consultation.

Finally, **many evaluation responses received requested additional courses that already exist. In addition to targeted training packages, CASAT could build in a way to recommend classes to take after completion of the attended class.** For example, someone who just watched the online video "Teen Addiction: Gambling, Drugs, and Mental Health" might also be interested in watching "Substance Use, HIV, and Youth: What Clinicians Need to Know".

Foundational training package. A basic training package targeting potential prescribers could include:

- MAT Medication Assisted Therapy

[61] Manuscript: Training Physicians to Treat Substance Use Disorders; Soteri Polydorou MD
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741399/
[62] Manuscript: Undergraduate Medical Education in Substance Abuse: A Review of Quality of the Literature; Devyani Kothari MD
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3148085/
[63] https://www.careinnovations.org/wp-content/uploads/TAPC_v5.pdf

- Opioid Management and MAT
- Pain Management
- Nevada Law (AB474 and AB439)
- Becoming a DATA 2000 Provider
- Treatment of Pregnant Women with SUD and OUD

The basic training package must address the known barriers or key topics, such as "Legal considerations and MAT", "MAT and pain management", "How to start prescribing MAT," and "MAT in primary care settings. Many providers may still not know what MAT is, what's incorporated in the modality, reimbursement policies, or the process of obtaining the necessary waiver.

Once the state adopts the new MAT policy, providers will need a training that includes an overview of the updated MSM chapter 1200, prior authorization requirements and process, eligible providers, and a detailed guide on the reimbursement rates and billing process.

AB239 requires that a provider review the state's prescription drug monitoring program report and perform a risk assessment before prescribing a controlled substance. The law also includes guidance on the treatment of acute pain and associated conditions. Comprehensive knowledge of pain management strategies and training about pain management competencies that cross disciplines are known barriers to implementation of the law.

Integrated care training program. Consider developing a training program solely focused on the principles and workflows of integrated care. Nevada Medicaid could develop a program for physicians facing the opioid epidemic, recognizing Nevada's unique landscape (rural, frontier, and tribal communities). Particular efforts for American Indian and Alaska Natives would be incorporated. Nevada Medicaid may consider adding to the types of trainings currently offered by CASAT to include technical workflows and principles of integrated care. Based on attendee post-training evaluations, participants are open to more in-depth management trainings.[64]

Treatment Planning. **Nevada providers reported they did not know the proper behavioral health resources needed to perform multidisciplinary treatment planning and care.** This training could cover the various treatment plans, the roles and responsibilities of care team members, treatment plan components, and the ASAM assessment and dimensions.

Training Package to Address Stigma**:** This package could include courses specific to reducing stigma, raising awareness of SUD, and increasing provider willingness. Courses in the package could include:

[64] 2019 CASAT Training Evaluations

Misused Drugs, MAT Therapy, SUD and Co-Occurring Disorders, Addressing Stigma among Colleagues, How to Become Waivered. This package could also include additional resources like the Toolkits.

***Training Packages for Specialized Fields*:** In their course evaluation forms, **many participants reported they'd like to see additional training related to the topic or field. However, often times, CASAT already offers courses related to the topics. It might be beneficial for CASAT to put together field specific packages so professionals can identify course they might not have known they qualify to take.** Occasionally law enforcement, correction officers, and first responders register for CASAT courses and they report that they'd like more training in areas that would benefit their work. Courses in a Law Enforcement Package could include: Misused Drugs, Understanding SUD and Co-Occurring Disorders, Drug Trends in Nevada, Nevada Law, Overdose Education, and Naloxone Distribution. Additional packages could cater to those working with youth, social workers, and counselors.

Long Acting Reversible Contraception (LARC) Training: In December 2019, Nevada published the Community Engagement in Reproductive Health Services Report (also referred to as the LARC Report). Results from the report were gathered from a five month extensive stakeholder engagement initiative. **It was concluded that there is a dire need for LARC training across the state.** Training should target OBGYN, Primary Care, and Pediatrics and include providers, licensed professionals, and staff. The report identified three priorities: encourage continuing education of OBGYN professionals about the efficacy of post-partum and post-abortion LARC placement; emphasize cultural competency by reproductive health providers, including office staff, to ensure culturally sensitive care; and expand education on reproductive health to Pediatricians as they can address parents of infants as well as young women of reproductive age. Offering these trainings to providers can help prevent future substance exposed infants.[65]

***Cultural Awareness Package*: Every feedback form received from trainings related to ethics and cultural sensitivity included requests for more training.** CASAT should consider packaging courses that address race, ethnicity, religion, gender, and culture. Existing courses to include: Cultural Diversity in Native American Country, Tribal MAT, Multicultural Competency and Diversity Training, and Trauma-Informed Care for Women in Recovery. Additional courses could be added based on feedback to further address addiction in tribal groups and approaching ethics in SUD.

Telehealth in SUD Treatment: While the current reimbursement and utilization policy supports incorporation of telehealth as a treatment modality within federal limits, it is still underutilized. **Providers need training on compliant infrastructure and telehealth solutions, allowable uses of telehealth, how to engage and education patients, and proper billing procedures.** Having a representative from a healthcare organization that is an early adopter of telehealth to share best practices may generate

[65] http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/Community%20Action%20Plan%20%20%202%204%202020%20(002).pdf

additional interest. This topic is especially important as the state policies continue to evolve during the Covid-19 crisis.

Pain Management and AB239: AB239 requires that a provider review the state's prescription drug monitoring program report and perform a risk assessment before prescribing a controlled substance. The law also includes guidance on the treatment of acute pain and associated conditions. Comprehensive knowledge of pain management strategies and training about pain management competencies that cross disciplines are known barriers to implementation of the law.

Recommendation: **Create and Promote Toolkits**

Nevada Medicaid may consider sponsoring a workgroup to design a Primary Care Toolkit that outlines screening best practices, explains state and national protocols, and provides resources for community SDOH services that might benefit the treatment of the patient. This toolkit would look very familiar to the ASTHO OMNI OBGYN (inpatient and outpatient) Toolkit but instead of focusing on pregnant and postpartum women and their infants, it would target primary care teams. The state may also consider a similar toolkit for emergency medicine.

The toolkits should be promoted and incorporated into available trainings, and serve as a means to help providers implemented what they've learned in practice. Toolkits should be disseminated as providers complete or engage with specific trainings.

Recommendation: **Use a Single Source for Training Information and Resources**

Nevada may create a public-facing website for providers looking for resources on substance use treatments, and may be housed under CASAT. The aim is to create a sole source for providers to access national and state trainings, educational resources, and other opportunities to expand their knowledge and capacity.

The website could also include a map of MAT waivered providers, outpatient facilities, behavioral and mental health providers specializing in SUD, MAT-waivered OB-GYNs, and relevant contact information for community organizations addressing social determinants of health (SDOH). A website for Nevada providers can also reference resources such as 211, as well as the ASTHO OMNI educational toolkits to lay a foundation for a broader Primary Care or Emergency Care Toolkit.

Nevada may consider developing a family and consumer social marketing campaign. The campaign could feature health communications that increase public awareness of the risk associated with prescription

opioids and reduce the negative public stigma associated with SUD and OUD. Such a campaign can reduce public stigma and lead to increased provider buy-in.[66]

Recommendation: **Develop, Implement, and Evaluate an Outreach Strategy**

The state should also consider an outreach strategy to engage and promote trainings to the targets of change, such as primary care providers, PAs, OBGYNs, or APRNs. Components of the outreach strategy could include:

- Creating a clear set of outreach goals, for example, an increase of registrations or downloads of specific training materials.
- Developing a cohesive message and description to be used across all organizations.
- Determining the best distribution channels. To facilitate this, the state may cultivate or leverage relationships with statewide professional societies or medical schools to better communicate and promote training participation among the targets of change.

Recommendation: **Implement a Standard Approach to Engagement and Evaluation**

The state should consider development and implementation of a multipronged approach for collecting feedback from the community to ensure trainings are developed and evaluated based on community needs, and develop relationships with the community to allow more opportunities for peer-to-peer learning.

- **Develop communications templates and a promotional strategy:** The state must develop communications and promotional information geared towards the target providers, such as primary care providers, OBGYN, APRNs, and physician assistants to drive awareness and participation in the trainings. This could be done through partnerships with professional associations.
- **Conduct a yearly feedback and training development forum:** CASAT has a vast community of providers and professional staff (counselors, social workers, nurses, first responders, etc.) that could provide valuable input informing future class schedules and potentially policy and protocol updates. The state should also consider a follow up to the 2018 training needs assessment to gather compressive feedback on trainings, mode of delivery, content, and resource availability. For example, some online videos are only accessible for cost. The state should examine if this is a significant barrier to utilization.

[66] Meeting Report; Closing the Gaps in Opioid Use Disorder Research, Policy, and Practice: Conference Proceedings (Addiction Science & Clinical Practice 2018); Matthew A Miclette, Jared A Leff.

- **Create standard instrument to collect evaluation data:** Through the collaborative, the state can create a standard evaluation tool that can be used across sources to evaluate trainings. The Kirkpatrick Model is one of the most basic and widely adopted models for analyzing and evaluating the results of training programs. The model includes 4 levels of training evaluation: 4) Results; 3) Behavior; 2) Learning; and 1) Reaction. The evaluation approach should be considered as a foundational component of designing the training program. In order to apply the model, start with the results first, or the intended outcomes.[67] Other, more intensive models include the Phillips ROI Methodology or the CIPP evaluation model.
- **Continue requesting post-training evaluations:** CASAT currently asks for post-training evaluations upon completing in-person courses. These evaluations are a valuable source for the state to understand who is attending these trainings and what type of work they do. CASAT should use the data to decide which courses to create next and how the current curriculum should evolve.
- **Implement a process for post-training evaluations for webinars and online videos:** Currently, CASAT only requests a post-training evaluation form upon completion of the in-person classes. With more courses being held online, it would benefit CASAT and the state to see additional feedback from attendees in other formats. CASAT should consider integrating an evaluation form post live webinar and online videos. If the course offers any CEUs, evaluation data could be gathered through a required post training assessment.

Conclusion

The need for training is critical to expanding and enhancing the healthcare workforce to increase access to SUD and OUD treatment services in Nevada. While national resources exist, there are also numerous opportunities for provider training offered in Nevada. However, there are several needs in order to scale training to support the demonstration project including 1) increased collaboration among the organizations; 2) development of a cohesive training program designed for the targets of change; 3) utilization of a standardized measurement and evaluation framework; and 4) implementation of an outreach strategy.

[67] The Kirkpatrick Model. Kirkpatrick Partners. Our Philosophy. Available at: https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model

Appendix E: Stakeholder Engagement Gap Analysis

NV SUPPORT ACT – STAKEHOLDER ENGAGEMENT GAP ANALYSIS

INTRODUCTION

Stakeholder engagement activities are a crucial component in the effort to increase provider capacity to screen for and treat substance use disorders (SUD). When stakeholders are involved in the evaluation of programs and policies related to their field, they are better engaged and become more willing. Stakeholder engagement initiatives and provider outreach programs can lead to early buy-in, successful program design, and long-term support of the program. The data gathered from participants can help inform policy, attribute successes, identify champions, identify barriers and challenges, as well as locate opportunities and inform recommendations.[1]

Nevada has implemented numerous stakeholder engagement initiatives over the past five years that address SUD and relevant fields. There are opportunities to continue and develop efforts to gather data, measure successes, and identify areas for improvement.

SUMMARY OF FINDINGS

The "Nevada Stakeholder Engagement Activities" table details activities that have occurred between 2015 and 2020. Initiative participants were not limited to medical providers, but also included members of the communities served, relevant professionals, social workers, case managers, and representatives of the state. The majority of these stakeholder engagement initiatives informed major reports and deliverables. Myers and Stauffer considered results from these stakeholder engagement activities in the formulation of recommendations relating to provider capacity, utilization, and care coordination.

Many of the results pointed to opportunities in state systems and patient care, as well as for providers and the workforce. Some of the results shed light on systemic issues in health care: lack of community resources, regional poverty, lack of engagement in the rural and frontier setting, and lack of training and education on the long-term effects of trauma. Stakeholder insights helped to inform Nevada's needs assessments, regional capacity assessments, and State Targeted Response to the Opioid Crisis grant reports. Myers and Stauffer utilized those reports to outline recommendations in the recent infrastructure assessment report.

Table 1: Nevada Stakeholder Engagement Activities

Date	Summary of Activity	Ownership	Results
2015	• Survey, Focus Group • Participants: 288 • Data collected help inform the Nevada Substance Abuse, Mental Health, and Suicide Prevention Needs Assessment Report • Participants: Providers, SUD Professionals, Mental and Behavioral Health Professionals	UNR	Stakeholder outreach focused on suicide prevention, mental and behavioral health, and substance abuse. Participants included professionals, as well as advocates and survivors of suicide loss and their families. Stakeholder feedback informed the 2015 NDPBH needs assessment and addressed access to clinical care and services addressing the social determinants of health (SDOH).
2016	• Survey • Respondents: number unknown • Data collected informed the Nevada Primary Care Organization (PCO) Needs Assessment, in collaboration with Medical and Osteopathic licensing boards • Respondents: Providers	DPBH	Stakeholder survey responses informed the Primary Care Needs Assessment in 2016. The priority of the document was to present information that would help address the need for increased primary care capacity. Stakeholders identified health insurance as a major concern for all population domains, being a key barrier to health access, in addition to the limited number of providers accepting Medicaid. Additional factors identified were the high volume of paperwork required and lack of transportation (particularly in Clark County). PCO made recommendations to DHCFP and DPBH for amendments

[1] https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm2.html

Date	Summary of Activity	Ownership	Results
			to the state plan and Medicaid rates (including rate increases for inpatient psychiatric services, reimbursement for APRN in school-based health, and rate increases for APRNs).
2016	• Interviews, Workgroups, Focus Groups, Surveys • Stakeholders were engaged to support in the creation and development of the SHIP. Input helped identify where existing projects can be leveraged. • Participants: agencies, institutional representation, and MCOs	DHHS	The following initiatives were identified for potential coordination: Paramedicine Efforts, Balancing Incentive Program (BIP), Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD), Medicaid Electronic Health Record Incentive Program, Million Hearts Campaign, Certified Community Behavioral Health Clinics (CCBHCs), Children's Heart Center Healthy Hearts Program, National Governors Association (NGA), Medicaid Transformation Project, Project ECHO, Peer Support Specialists, Public Health Programs (SAPTA/SAMHSA, Nevada WIC, Obesity Prevention and School Health Program, and more).
2017	• Online Survey • Respondents: 71 • Results helped inform the 2017 Nevada Opioid Needs Assessment. • Respondents: Waivered Providers	CASAT	The survey results indicated that of the responses received 47% were certified for 30 patients, 30% were certified for 100 patients, and 23% were certified for 275 patients. The "actual prescribing" rates indicated that the majority of waivered providers were operating under their prescribing limit or not prescribing at all: 21% reported none, 53% reported 1-30, 18% reported 31-100, and 8% reported 101-275. Reasons for not prescribing at capacity included insufficient reimbursement rates, lack of time and resources, and workplace constraints.
2017	• Interviews, Town Halls • Attendees: 64 • Results informed the SAPTA Situational Analysis. • Attendees: Industry Professionals, Policy Makers, Advocates	SEI	The stakeholders helped SEI identify six priority issues: (1) State capacity, (2) Lack of compliance, (3) Lack of workforce to meet demand, (4) Service gaps, (5) Insufficient funding and sustainable resources, (6) Insufficient public education and information. The stakeholders provided recommendations and opportunities for the state (including the Department of Corrections), consumer, workforce, providers, and system-wide.
2017-2018	• Interviews, Trainings, Socialization Sessions • Attendees: 200 • Informed the 2018 Nevada Data Governance document. • Attendees: State-Level Stakeholders (all five DHHS divisions engaged)	MSLC	Using results, developed a Master Data Management (MDM) plan with detailed business, technical, functional, and non-functional requirements, as well as an RFP that may be used by DHHS to procure a robust and comprehensive system supporting Master Client Index (MCI), Master Provider Directory (MPD) and connection with the state Health Information Exchange (HIE). Conclusions from stakeholder engagement and the final report directly resulted in the creation of the Office of Analytics.
2018	• Survey • Respondents: 1,074 • The creation of a Training Needs Assessment designed to guide development of opioid-related trainings to facilitate successful implementation of Nevada's Opioid State Targeted Response grant. • Respondents: Healthcare Providers, Behavioral Health Professionals, Addiction Specialists	CASAT	Responses received helped inform future areas of focus for CASAT trainings. Incorporation of AB474 into Workflows and Non-Opioid Pain Management Strategies were areas providers identified they wanted more training in, as well as Legal Considerations with MAT and MAT and Pain Management. Providers requested more online training and CASAT delivered more online trainings on their 2019 schedule.
2018	• Interview • Data collected helped inform the Nevada SAPTA 2018 Needs Assessment. • Informants: Providers, SUD Professionals, Mental and Behavioral Health Professionals	SEI	Feedback gathered from Key Informants helped to inform the 2018 SAPTA Needs Assessment. The process helped SAPTA identify critical issues and gaps that need attention, as well as assets or emerging successes. Stakeholder engagement was intended to outline deficits and strengths, and insights for future planning and opportunities. Feedback included critical gap for youth

Date	Summary of Activity	Ownership	Results
			and teens with co-occurring disorders, SUD stigma with impacts on both providers and the public, the distance of inpatient facilities affects treatment (especially in youth), systems that are competitive prevent patient recovery and lead to more relapses, cultural competency should be prioritized for professionals, communities can be strong but the system can still be fragmented, lack of resources and assistance for rural providers is causing rapid burnout.
2018	• Survey, Focus Group • Participants: 158 • Gathered input from individuals directly affected by behavioral health policies in Nevada. Data informed the 2018 Washoe Regional Behavioral Health Policy Board Final Report. • Participants: Providers, Professionals, Case Managers	Washoe Regional Behavioral Health Policy Board	Results from this Stakeholder Engagement Activity lead to the categorization of six areas of concern: Housing, Provider, Medicaid, Resource, System, and General. Participants in the focus groups were asked to answer questions about what changes were needed to improve behavioral health in Washoe County and what resources could support these changes. Results of the Stakeholder Engagement were outlined and presented to the Washoe County Behavioral Health Policy Board and informed recommendations included in the report.
2018	• Interviews, Survey, Discovery Session, Focus Groups • Participants: 228 • Informed the Nevada Health IT Roadmap. • Participants: Community-Level Stakeholders, State-Level Stakeholders	MSLC	Engagement activities produced three common themes: (1) expand and improve patient access to care, (2) enhance data exchange capabilities and improve data quality, (3) reduce provider burden associated with electronic data sharing and reporting. Stakeholders recognized their need for access to relevant electronic health information exchange for better patient care. The findings showed that costs, workflow redesign, and data relevancy are often top barriers for providers. Also providers need more technical assistance to adopt, exchange, and use electronic health data.
2019	• Survey • Respondents: number unknown • The results helped inform the state and regional capacity assessments.	SEI	Stakeholder feedback informed Nevada's capacity reports. Results identified overall status of provider and system capacity both statewide and regionally. The CAST Tool categorized areas for Nevada to emphasize in addressing capacity.
2019	• Telephone Survey, Focus Group • Attendees: 378 • Assessed community health needs and informed the Clark County Community Health Needs Assessment. • Participants: Community Members, County Citizens	Dignity Health	The final product, which utilized stakeholder feedback, identified and prioritized significant health needs of the community served by Dignity Health in Clark County. The priorities identified were intended to guide hospitals' community health improvement programs and community benefit activities. The identified prioritized needs include Access to Care, Motor Vehicle and Pedestrian Safety, Violence Prevention, Substance Use, and Mental Health. There are recommendations dispersed throughout the report that outline what can be done to improve community health.
2019	• Interviews • Attendees: 75 • Gathered insight from a wide range of professionals working in health, social services, and other public service positions in each county across Nevada. Results helped inform the 2019 Nevada State Health Needs Assessment. • Attendees: Community and Public Health, Human and Social Services, and Medical Providers	DHHS	Stakeholders identified priority populations: individuals with behavioral health issues, seniors, children, low income families, minority populations, homeless populations, veterans, individuals with intellectual and developmental disabilities, individuals with chronic disease, young adults and transitional aged youth, and victims of domestic abuse/sex trafficking. The report cited stakeholder feedback in the discussion of strengths, barriers, and solutions to address and improve care in the priority populations. 33% responded that above all significant health issues, behavioral/mental health and substance abuse are the most important/critical.
2019	• Listening Sessions • Attendees: 23 • The Nevada DHCFP held two listening sessions on Medicaid MAT Policy and Financing. The	DHCFP	Feedback from providers was considered in the creation of updated MAT policy. Providers and prescribers represented both large health systems and small clinics, behavioral health institutions, women's health centers, SUD treatment facilities, and pharmacies. When SUD

Date	Summary of Activity	Ownership	Results
	sessions allowed the state to give attendees policy updates and ask prescribers and providers in attendance a few guided questions on how they provide MAT services. • Attendees: Providers, Prescribers		service providers in Nevada were surveyed by the state, the most commonly cited barrier for waivered providers was reimbursement. Maintaining 30 active patients at one time per licensed provider is cited as an impossibility among rural and frontier doctors. Providers stated that they wish to see FQHCs involved in MAT, as well as Family Counseling and Social Work interns, and Emergency Medicine visits.
2019	• Focus Groups, Presentation Sessions • Attendees: 100+ • During a five-month process, a community stakeholder group heard presentations on a variety of reproductive health topics, reviewed data, convened focus groups, and engaged in conversations to identify innovative approaches that could help Nevada, particularly Clark County, improve outcomes. • Results informed the Community Engagement in Reproductive Health Services, Community Action Plan (otherwise known as the LARC Report). • Attendees: Community health workers, OB-GYNs, Doulas	DHHS, Clark County	Stakeholders identified six major areas of focus and detailed strategies to improve access to reproductive health services: increasing access to community reproductive health care, expanding health insurance coverage, promoting long-acting contraceptives (LARC) usage, encouraging provider education, preventing congenital syphilis, and improving reproductive health literacy.
2019	• Survey • Respondents: 26 (out of 332) • Gathered provider and agency demographics in order to better understand waiver usage, overall utilization, and opportunities. • Respondents: Agency Representatives, Behavioral Health, Recovery Centers, Large and Small Healthcare Providers	CASAT	The survey requested basic and demographic information, such as provider type, MCO, type of treatment provided (MAT and Behavioral Health or Behavioral Health Only). CASAT only received 26 out of 342 requested.
2020	• Survey • To gain feedback on the working definition of "affected by" as it relates to substance use and the plan of care form. • To gain insights on CARA Plans of Care (POC). • Attendees: 42 • Respondents: OBGYN/Providers, Nurses, Social Workers, Administrative Staff.	ASTHO OMNI	The survey collected responses from OBGYNs and providers focused on women's health from hospitals, rural health systems, and OBGYN practices. The survey gathered data around how many CARA Plans of Care had been initiated by their hospital (18% claimed 11-20, 11% claimed 21-30, 11% claimed 0-5, and 9% claimed 41-50). ASTHO OMNI learned that 86% respondents indicated that a social worker typically offers the POC, followed by 39% nursing staff. Additionally, the survey gained feedback on the new definition of "affected by" proposed by ASTHO OMNI to better define women impacted by substance abuse. Overall it was noted that the new definition would increase CARA POCs offered. The final component of the survey gathered respondents recommended revisions for the CARA POC Form.

Myers and Stauffer was recently made aware of several planned stakeholder engagement initiatives including a tribal needs assessment and an outreach initiative from the Primary Care Association. The Veterans Association will be collaborating with Project ECHO on a survey to understand Covid-19's impact on providers. Dignity Health is also working on a survey to understand the impact Covid-19 has had on their programs. Additionally, Myers and Stauffer is considering a post-implementation survey after DHHS distributes the new MAT policy and SBIRT protocol.

CONCLUSIONS OF STAKEHOLDER ENGAGEMENT ACTIVITES

The table above was created following an analysis of stakeholder engagement activities, which related to SUD and occurred from 2015 to the start of 2020. The results from these stakeholder engagement activities were intended to outline deficits, strengths, and insights for future planning and opportunities.

The activities cover a wide span of topics including:

- Behavioral and mental health
- Suicide prevention
- Substance abuse
- Provider capacity and provider willingness
- Clinical care delivery
- SDOH services
- HIE and data governance
- Professional training preferences
- MAT policy
- Reproductive health

In total, more than 2,700 people participated the engagement efforts including:

- Providers: primary care, addiction specialty, psychiatrists, OB-GYN, emergency medicine, prescribers. Providers included both waivered and non-waivered providers.
- Industry professionals: SUD, behavioral, and mental health
- Government agency representatives and policy makers
- Institutional representatives from higher education, research facilities, and large health systems
- Managed Care Organizations (MCOs)
- Patient advocates
- Case managers and social workers
- Community members, patients, family, and caregivers
- Allied health professionals

From the 17 evaluated initiatives, analysis identified the following conclusions:

- Insufficient billing and reimbursement rates remained consistent barriers.
- Many waivered providers are operating under their prescription limit: they report operating at capacity is nearly impossible, particularly in rural and frontier regions.
- When providers and professionals are surveyed they tend to report administrative burdens, lack of time and resources, workplace restraints, and lack of care for high-risk populations. These factors greatly contribute to decreased provider capacity and provider willingness to provide SUD services.

- The most high-risk populations for SUD were identified and prioritized in several initiatives and listed as seniors, children and youth, low-income families, minority populations, homeless individuals, veterans, individuals with disabilities, individuals with chronic illness, and victims of abuse and sex trafficking. Lack of available care for high-risk populations emphasizes a need for more collaborative efforts with organizations that address SDOH and increased training on cultural competency for those working in the field.
- In the 2019 Needs Assessment 33% of stakeholders responded that above all significant health issues, behavioral, mental health, and substance abuse are the most critical.

A review of the results of the activities identified information gaps in subject areas including telehealth, billing and reimbursement, hub and spoke, and integrated care. Many of these topics were identified as "issues" by respondents but remained surface level, given survey limitations. Stigma around SUD is another topic identified that could be explored in greater detail as it may help further inform ways to increase provider capacity and willingness. There are additional opportunities to follow up with these stakeholders in continuing engagement efforts.

Next Steps: DHCFP and Myers and Stauffer, in collaboration with CASAT, may choose to put together a survey for waivered and non-waivered providers and industry professionals. This survey could incorporate topics missing from previous surveys, follow up on identified barriers, and gather updated information on the status of provider willingness. Content for the survey may include:

- Demographic and geographic information, including but not limited to provider or professional, specialty, licensure, waivered (Y/N), eligible for waiver (Y/N), practice location, urban/suburban/rural/ frontier practice.
- Experience working with tribal population (Y/N). If so, describe.
- Experience working with the following high-risk populations: seniors, children and youth, low-income families, minority populations, homeless individuals, veterans, individuals with disabilities, individuals with chronic illness, and victims of abuse and sex trafficking. If so, describe.
- Questions to assess waivered provider prescribing status and performance
- Questions for non-waivered eligible providers: Have you considered obtaining a DATA 2000 waiver? If yes, please explain what has prevented you from doing so. What resources are necessary to best refer your patients to needed treatments and care? Which of these resources are currently available to you?
- Question for providers: Does your practice setting utilize SBIRT and universal screening when screening patients for SUD?
- Question regarding SDOH: Do you feel you have enough knowledge on available SDOH resources to refer patients to community services? Does your patient assessment identify SDOH needs?
- Questions to address Telehealth: Does your practice utilize telehealth? Has your practice increased use of telehealth since the emergency expansion of coverage due to Covid-19?
- Questions to address reimbursement gaps: What are the specific financial barriers to reimbursement? Options include (a) rates do not cover cost, (b) one-time limited grant funding causes sustainability issues with integrated care programs and practices, (c) unable to bill for performed services, (d) financial barriers to integrated care such as a lack of referral payment to addiction specialists.
- Questions to address HIE: What are the EHR limitations between behavioral health and PCAs?

- Questions to assess training needs: Do you have access to valuable and relevant training course material? Do you utilize CASAT for training and education courses? What additional training materials would you like to see?

Myers and Stauffer is available to help the state with development of a survey, necessary outreach, and analysis of the results. Aside from providing direction for DHHS planning, the responses to a survey like this would help inform future stakeholder engagement activities, many of which are outlined in the opportunities section of this report.

LIMITATIONS

The conclusions from the stakeholder engagement activities were developed through an analysis of documents and reports obtained in the creation of the Nevada infrastructure assessment report. It is possible that additional stakeholder activities occurred and that Myers and Stauffer did not have access to their results. It is important to also note that the results of the reviewed activities, in many cases came from final reports and deliverables. There could be limitations in the conclusions from results not obtained in raw data.

BEST PRACTICES

As stated previously, stakeholder engagement initiatives can have big benefits including early buy-in, successful program design, and long-term support of programs.[2] Described below are models of best practices for stakeholder engagement for programs for SUD services from other states.

Massachusetts: Shatterproof partnered with the Massachusetts Medical Society to gather insights and reactions from healthcare professionals with the goal of addressing and reducing stigma associated with OUD. The aim was to help healthcare professionals increase their efforts in screening and treating patients with OUD, while also empowering those suffering with the disease to come forward and seek care. Insights were gathered through research and extensive stakeholder engagement through surveys, interviews, thought leader discussions, and focus groups. At the center of the study was feedback gathered from primary care, emergency medicine (EM), and obstetrics/gynecology (OB-GYN) identifying barriers that prevent them from screening and treating patients with OUD. Focus groups included physicians, nurse practitioners (NP), physician's assistants (PA), and registered nurses (RN). There were five target groups: (1) EM physicians, NPs, and PAs; (2) EM and RNs; (3) primary care physicians, NPs, and PAs; (4) OB-GYN physicians, NPs, and PAs; and (5) primary care and OB-GYN RNs.[3]

The conclusion of the comprehensive stakeholder engagement effort was that there's a large need for increased education and training to help providers feel confident in treating patients with OUD. Stakeholders also identified opportunities to institute a statewide effort for a "warm-handoff program" to ensure continuity of care for individuals admitted to emergency departments due to overdose; provider training for creating treatment plans that grant them ownership over the process while focusing on getting the patient into the appropriate treatments; and system-wide adoption of an on-call technical assistance program that provides phone consultation on how to screen, treat, and manage patients with OUD. [4]

California: In 2016, the California Health Care Foundation funded the Center for Care Innovations to augment the grants to California health centers, believing funding alone is not sufficient to expand MAT. In response, the Center for Care Innovations launched the Treating Addiction in the Primary Care Safety Net (TAPC) program. The 18-month program was designed to augment the grants with tailored technical assistance. Specifically, TAPC helped 25 health centers implement, sustain, or expand the use of MAT services. Program activities included in-person and virtual learning events, individualized team coaching, and site visits to health centers with best practices related to MAT services. Throughout the program, participants were engaged to assess general attitudes around

[2] https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm2.html
[3] Opportunities to Increase Screening and Treatment of Opioid Use Disorder Among Healthcare Professionals, Shatterproof 2019
[4] Ibid

the use of MAT. With the TAPC's strategies to address participants and provide increased education and technical assistance, the result was a nearly three-fold increase in the number of patients on addiction medicine across the cohort. [5]

Delaware: The state is leveraging technology to implement behavioral health treatment and referral networks to increase access to care. Delaware identified significant gaps in the appropriate transferal of patients with SUD to necessary treatment options. Delaware Treatment Referral Network (DTRN) is powered by OpenBeds to facilitate the exchange between treatment, support, and referral. Extensive stakeholder outreach was performed throughout the process of adoption, implementation, and expansion. Stakeholder engagement with representatives of community services, social workers, and providers is ongoing. The state, DTRN, and OpenBeds worked closely with stakeholders in every step of the implementation process in effort to further improving care. One major component of this ongoing initiative includes Emergency Department education. Additionally, providers and users of the platform are consulted on the development of new features and functionality and most recently the integration with the prescription drug monitoring program (PDMP). The state considers providers to be the "true owners of the platform" and therefore makes key decisions based on feedback received. Off-campus user retreats with presentations and breakout sessions have been well received. Since go-live in September 2018 and due to the extent of stakeholder engagement, Delaware has seen over 52,000 referrals through their DTRN system and averaging more than 600 per week. [6]

OPPORTUNITIES FOR STAKEHOLDER ENGAGEMENT DURING THE IMPLEMENTATION PHASE

The following activities are to be conducted during the first part of the demonstration grant phase:

Stakeholder Engagement to Address Workforce Shortage. As recommended in the Myers and Stauffer infrastructure assessment report, the state may want to consider ongoing engagement with both currently waivered providers and providers considering obtaining MAT waivers. This continued engagement would keep the state informed of the issues faced by these providers, potentially highlight opportunities for pilot programs, and give the state the opportunity to facilitate collaborations. The format may include surveys, focus groups, discovery sessions, interviews, or a combination of all. Engagement efforts can include

- **Yearly Engagement Initiative for Waivered Providers:** Assignment of state/contractor staff to perform outreach and regular check-in with waivered providers. An ongoing outreach initiative provides the state a set of data to review over time. Information gathered should include number of patients treated under the provider waiver so the state can track their usage and prescribing rates, see if they have improved over time, identify how many of the waivered providers are prescribing at the height of their license, and potentially compare the data against new policies and protocols.
- **Stakeholder Initiative to Promote Provider Willingness:** A detailed outreach initiative could engage providers eligible for waivers who have yet to obtain them. This should include primary care and OB-GYN, as their area of practice presents a large opportunity for growth. Information gathered could identify barriers, and serve as an opportunity to gauge stakeholder awareness of available resources, such as toolkits and trainings. The state may want to consider moving forward with a discovery session type event to bring providers together to address stigma and collaborate on solutions.

[5] Treating Addiction in the Primary Care Safety Net: Implementing Medication-Assisted Treatment and the Lessons Learned, Center for Care Innovations.
[6] Presentation: How States are Leveraging Technology to Implement Behavioral Health Treatment and Referral Networks to Increase Access to Care. (07/23/2020)

- **Stakeholder Engagement to Address Emergency Medicine Willingness.** The state should consider re-engaging providers of emergency medicine and their corresponding hospital administration to better understand their willingness or hesitation to provide SUD services. In the past, buy-in for MAT induction in the ED has been low, but there's an opportunity for stakeholder engagement activities aimed to explore the low level of interest and what incentives the state might be able to provide in regards to treatment of SUD.
- **Topic-Focused Engagement:** There are opportunities to engage stakeholders on topics such as telehealth, health IT and HIE, billing and reimbursement, integrated care, and the hub and spoke model. It would be beneficial to gather information on telehealth adoption and usage to address SUD. Additionally, it would be beneficial for the state to address Health IT and HIE from a SUD perspective, including EHR utilization, information exchange between the treating providers, SDOH and community resources, and care coordination. From the stakeholder engagement analysis, it is apparent that providers generally struggle with billing and reimbursement, but further exploration could help better define what providers need. These topics might be optimally discussed in a discovery session or focus group.

Stakeholder Engagement to Address SDOH. As recommended in the Myers and Stauffer infrastructure assessment report, the state could benefit from the evaluation of current partnerships to determine if they are being utilized to their full capacity and if there is opportunity for additional collaboration. The state may explore additional collaboration opportunities with community-based organizations that address SDOH. These types of evaluations and collaborations may be fostered in a stakeholder engagement initiative where the state brings together organizations to discuss how they are assisting individuals with SUD. Potential partnerships between the community-based organizations and the state could be identified.

Stakeholder Engagement as a Toolkit Implementation Follow-Up. Once the ASTHO OMNI OB-GYN provider toolkits and CARA brochure (formerly known as the Family Toolkit) have been distributed, it would be beneficial to gather metrics on adoption. A provider survey could be distributed to gather the rate of adoption among OB-GYNs, as well as SBIRT adoption, and practice change. Should the state determine to create a primary care toolkit and emergency medicine toolkit, as recommended in the infrastructure assessment report, the same procedure to evaluate adoption of toolkit practices should be followed.

Stakeholder Engagement Initiative to Address Patients with SUD. Nevada should plan an initiative that centers on SUD patients and the care they receive. Gaining feedback from patients in treatment will result in qualitative data around services the system provides. There's an additional opportunity to expand on the ASTHO OMNI project by engaging pregnant women with SUD on policy and protocol, as well as on their experience with prenatal and postpartum treatment. Topics of focus should include initial prenatal screening for SUD, their referral experience, availability of MAT and community resources, CARA plan of care, post-delivery discharge process, CPS interaction, and postpartum care for SUD.

Gather Metrics for Comparative Data Analysis. Metrics could inform future initiatives and identify successes and opportunities. Stakeholder engagement is a valuable tool to promote buy-in, but it can also yield important data that can be used to shape new policy and evaluate the efficacy of protocols.