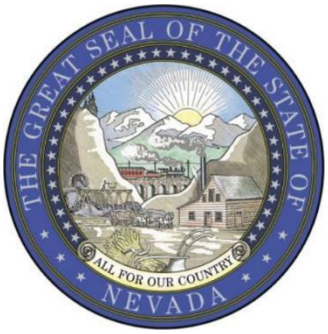
Nevada Substance Use Disorder and Opioid Use Disorder Treatment and Recovery Services Provider Capacity Expansion Strategic Plan



Nevada Division of Health Care Financing and Policy

June 2021

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Table of Contents

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, 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)[1] treatment and recovery services. The project includes 18-month planning grants awarded to 15 states and 36-month demonstration grants potentially for up to five states.

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 for an 18-month planning grant, and was awarded $1.68 million for the planning phase of the demonstration project. The goal of the planning grant is to develop an integrated care system for the treatment of SUD and opioid use disorder (OUD) that is available statewide to all Nevada residents, regardless of urban, rural, or frontier locale, and that also targets pregnant and postpartum women and their infants to address neonatal abstinence syndrome (NAS). The planning grant focus on activities to

- Identify, recruit, and train eligible providers to deliver treatment and recovery services.
- Expand access and provider capacity, especially in rural areas.
- Conduct assessment, engagement, and collaboration with the provider community and key stakeholders.
- Develop 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.

As part of the planning process, DHCFP has developed this *Nevada SUD and OUD Treatment and Recovery Services Provider Capacity Expansion Strategic Plan* (the "Plan") to introduce specific strategies and tactics to expand provider capacity and Medicaid beneficiary access to care; and enhance data collection,

[1] For the purposes of this report, when Substance Use Disorder treatment and recovery services are referenced, the reader can infer that SUD in this context includes Opioid Use Disorder and Stimulant Use Disorder.

analysis, and reporting integrity. This Plan serves as a critical component in the development of a successful demonstration application. This Plan documents the following:

- Strategic planning efforts the state performed to identify tactics to be used to increase access to SUD treatment and recovery services in Nevada. Approach includes evaluation of a comprehensive gap analysis to support development of a strengths, weaknesses, opportunities and threats (SWOT) analysis.
- Identification of Nevada's priorities, goals, and measureable objectives for expanding provider capacity for SUD treatment and recovery services.
- Implementation plan for strategies and tactics.
- Evaluation plan for measuring and monitoring objectives employed to meet state's goals. Evaluation plan will include a comprehensive measurement framework listing all measures that will be used to assess the impact of interventions and tactics implemented.

This Plan builds off of the findings of the *Nevada SUD and OUD Infrastructure Assessment Report (IAR)*, which provides a review of the current policy and infrastructure landscape of the SUD healthcare system in Nevada. The IAR report was completed in August, 2020.

This Plan was developed utilizing information from various sources, including specific DHCFP and Department of Public and Behavioral Health (DPBH) stakeholder discussions (Table 1. Community-Level Stakeholder Engagement Methods Summary), as well as statewide and county-level assessments, epidemiology, and surveillance briefs, provider surveys, data reports, document review, best practices, and other research.

The priorities, goals, objectives, strategies, and tactics presented in this Plan support Nevada's broader aim to increase provider SUD treatment and recovery services capacity and, therefore, Medicaid beneficiary access to care.

About this Plan: Approach

This section outlines the holistic and iterative planning processes used to develop the *2021-2025 Nevada SUD and OUD Provider Capacity Expansion Strategic Plan*. These processes were deployed to identify and prioritize Nevada's anticipated needs and define strategies necessary to expand the state's provider capacity for SUD treatment and recovery services.

In developing this Plan, DHCFP collaborated with several state agencies, community level organizations, and grant project partners that have been involved in the expansion of provider capacity. Through its vendor, Myers and Stauffer LC (Myers and Stauffer) and leveraging outcomes from other grant projects,[2] DHCFP designed this Plan based upon principles of, and best practices for, strategic planning. The Plan considers the current state and the ideal future state of provider capacity for SUD treatment and recovery services. The scope of this Plan reflects the diverse roles Nevada state agencies play in expanding provider capacity. The Plan is intended to serve as a catalyst to drive Nevada's initiatives and as a roadmap to support these efforts across urban, rural, and frontier communities.

To best develop a purposeful Plan, the Nevada SUPPORT Act Core Team used the results of the IAR from stakeholder engagement activities and detailed gap analysis. The Core Team, comprised of representatives from DHCFP and DPBH, identified strategies, tactics, and specific activities that are appropriate to an organization's level of readiness; are built on reliable and relevant data; and were developed with state and community input. DHCFP began a planning process in the third quarter of 2020 that drew from a variety of stakeholder types. The planning activities yielded this Plan, which identifies implementation strategies and reflects Nevada's planning grant inputs and anticipated outputs and outcomes. This Plan also includes an evaluation strategy and a framework for performance measurement to ensure the implementation effectively increases provider capacity and beneficiary access to SUD treatment and recovery services.

Specific planning activities are outlined below. These activities include stakeholder engagement, best practices research regarding workforce development, analysis of relevant state policies, and an examination of relevant data. In addition, DHCFP gathered information to assess Nevada's strengths, weaknesses, opportunities, and threats and emerging issues related to SUD in the state.

[2] Compiled from SOR Annual Progress Reports, 2018-2020, Nevada State Opioid Response Years 1-2 Performance. Compiled from ASTHO OMNI unpublished workgroup minutes, 2019-2021

Strategic Planning Process Overview

The strategic planning process included a number of major steps for DHCFP and its partners. These steps included the following:

1. **Collection and Analysis of Information and Data**
   - Conducted stakeholder engagement activities with state agencies and community groups, and leveraged outcomes from grant-funded projects to gather information from recipients, providers, managed care organizations (MCOs), policymakers, and other stakeholders.
   - Reviewed and generated feedback regarding the IAR, confirming the current and projected state of provider capacity and Medicaid beneficiary access to SUD treatment and recovery services.
2. **Identification of Appropriate Strategies and Tactics for Action**
   - Established various workgroups comprised of the appropriate subject matter experts in areas of focus.
   - Generated a detailed gap analysis to solicit input, confirm the state's direction, and build consensus on the strategies to implement.
   - Evaluated recommended tactics from the IAR and determined tactics to implement.
3. **Development of Strategic Plan and Workplan**
   - Assembled a strategic planning workgroup which included representation from the Core Team. The strategic planning workgroup developed recommendations for a mission statement, vision statement, core values, and guiding principles. The workgroup also defined goals, measurable objectives, specific strategies, and tactics with action steps. Finally, the workgroup identified responsible parties, timelines, and target completion dates. These recommendations were presented to, and approved by, the Core Team.
   - Performed analysis of the current and desired future situation to pinpoint specific strengths, weaknesses, opportunities, and emerging issues or threats.
4. **Development of Guides to Monitor Progress**
   - Developed two companion guides for the Plan, the *Tactical Plan and Measurement Framework*. These guides will assist DHCFP and its partners in documenting and monitoring progress towards goals, as well as allowing for adjustments to tactics as needed.

Stakeholder Engagement

Over the last several years, the state has made a concerted effort to engage stakeholders to solicit input on focus areas of behavioral and mental health; suicide prevention; substance abuse; provider capacity and willingness to provide care; clinical care delivery; social determinants of health (SDOH); health information exchange (HIE) and data governance; professional training preferences; medication-assisted treatment (MAT) policy; and reproductive health. Nevada has continued its commitment to stakeholder engagement in its work to address SUD.

In order to inform work performed under the Nevada SUPPORT Act planning grant, DHCFP and Myers and Stauffer leveraged findings from previous stakeholder engagement forums and implemented a robust stakeholder engagement plan. The stakeholder engagement plan included engaging community-level stakeholders through a public forum, holding interviews, and administering a comprehensive online survey. In addition, state-level stakeholders were engaged through interviews and workgroup sessions. Table 1. Community-Level Stakeholder Engagement Methods Summary summarizes methods used to obtain community and state agency stakeholder feedback during the strategic planning process.

Table 1. Community-Level Stakeholder Engagement Methods Summary

Stakeholder Engagement Summary		
Method/Year	**Description**	**Stakeholders Engaged**
Online Survey 2021	A comprehensive online survey was designed to be completed in eight to ten minutes to solicit input on training interests; MAT services; reimbursement and billing; assessment for social determinants of health (SDOH); use of screening, brief intervention, and referral to treatment (SBIRT); electronic health records (EHR); data sharing; and telehealth.	434 providers responded to the survey, with 256 providers completing the survey (59% completion rate).
Participant Interviews 2021	Focus groups of individuals with SUD in treatment or recovery.	35 stakeholders.
Public Forum 2021	Feedback forum on policy, payment, and other considerations about Nevada's integrated care hub-and-spoke model.	One session held. Over 50 participants, including primarily a general audience along with primary care providers, psychologists, and representatives from special clinics. Addiction treatment centers were represented along with hospitals, community health centers, ambulatory practices, and mental health facilities.

Stakeholder Engagement Summary		
Method/Year	**Description**	**Stakeholders Engaged**
Interviews 2020	A standardized phone interview lasting 45 to 60 minutes was conducted to identify the priorities, barriers, and challenges as it related to SUD and OUD benefits, policies, reimbursement, funding, and administrative barriers.	23 state staff.
Listening Sessions 2019	Two listening sessions on Medicaid MAT policy and financing. The sessions allowed the state to give attendees policy updates and ask prescribers and providers guided questions on ways they provide MAT services.	23 providers.
Interviews 2019	Interviews to gather stakeholder feedback in the discussion of strengths, barriers, and solutions to address and improve care in the priority populations. Stakeholders identified priority populations to work with as 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 transition-aged youth, and victims of domestic abuse or sex trafficking.	75 professionals working in health, social services, and other public service positions from all counties in Nevada.
Survey 2018	Purpose of survey was to identify provider preferences for topics for future trainings. Providers identified incorporation of AB474 into workflows and non-opioid pain management strategies, as well as legal considerations with MAT, and pain management.	1,074 health care providers, behavioral health professionals, and addiction specialists.
Interviews, Survey, Discovery Session, Focus Groups 2018	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 were often top barriers for providers.	228 community-level and state-Level stakeholders.

The state has conducted an inclusive stakeholder engagement approach which has provided additional insight and a comprehensive lens for the development of this five-year strategic plan.

Strategic Planning Workgroups and Sessions

SUPPORT Act Core Team and Workgroups

Over the course of the 18-month SUPPORT Act planning demonstration project, the state convened several stakeholder groups to review the recommended tactics as documented in the IAR. The Core Team provided the day-to-day leadership of the SUPPORT Act planning grant project. The SUPPORT Act workgroups included the data considerations workgroup, policy workgroup, and the integrated care and technology workgroup. These three workgroups included state experts on rates and reimbursement, behavioral health policy, program integrity, information services, business processes, managed care and quality assurance, clinical services (from the Department of Public and Behavioral Health), and medical and community-based programs.

Table 2. Strategic Planning Workgroups

Strategic Planning Workgroups		
Method/ Year	**Description**	**Workgroup Members**
Strategic Planning Workgroup 2020	Workgroup developed the mission, vision, and guiding principles. The group reviewed the gap analysis to develop short-, mid-, and long-term strategies.	There is a minimum of six state staff per workgroup session; however, there were often more participants depending on the focus area.
Data Considerations Workgroup 2020 - *Ongoing*	Workgroup functions to ensure state is meeting all CMS SUPPORT Act planning grant reporting requirementsand facilitates data collection, analysis, and integrity to support reporting of baseline metrics.	There is a minimum of four state staff per workgroup session; however, there were often more participants depending on the focus area.
Rates and Reimbursement Workgroup Sessions 2020- *Ongoing*	State staff, with the support of Myers and Stauffer, work on development of an alternative payment model that allows for comprehensive MAT services payments. State is exploring using the Patient-Centered Opioid Addiction Treatment model (P-COAT).	There are Medicaid state rate-setting staff and DPBH staff plus a physician consultant.
Policy Workgroup 2020	State staff, with the support of Myers and Stauffer, reviewed recommendations in the IAR related to SUD and behavioral health policy. Workgroup made recommendations to the Core Team on strategies relating to policy that would further promote the delivery high-quality behavioral health care through a comprehensive healthcare system.	There are Medicaid state policy staff and DPBH staff.

Strategic Planning Workgroups		
Method/ Year	**Description**	**Workgroup Members**
Integrated Care and Technology Workgroup 2020	State staff, with the support of Myers and Stauffer, reviewed recommendations in the IAR related to integrated care and technology services such as telemedicine. Workgroup made recommendations to the Core Team on strategies relating to integrated care and technology that would further promote the delivery high-quality behavioral health care through a comprehensive healthcare system.	Medicaid state policy staff and DPBH staff.
Governance Status Meetings 2020- *Ongoing*	Workgroup in quarterly meetings and ad hoc communications shares progress on SUD initiatives that inform the work under the SUPPORT Act planning grant.	Myers and Stauffer LC Social Entrepreneurs Inc. (SEI) Center for the Application of Substance Abuse Technologies (CASAT)

During the policy considerations and integrated care and technology workgroup meetings, members made decisions on tactics to adopt or not adopt, as well as providing feedback on the priority level of the tactic and potential barriers to the adoption of the tactic. Once tactics were agreed upon by the SUPPPORT Act core team, the data considerations workgroup, policy considerations workgroup, rates and reimbursement workgroup, and integrated care and technology workgroup were merged into the strategic planning workgroup. The strategic planning workgroup responsibilities included review of the gap analysis and determination of immediate- and short-term actionable steps for each tactic. These one-and-a-half-hour meetings occurred weekly over several months in the late summer and fall of 2020. Decisions were documented following each call and distributed to workgroup members the following week.

Development of Mission Statement, Vision Statement, Core Values, and Guiding Principles

The strategic planning workgroup members recognized the importance of creating meaningful mission and vision statements that set an overarching direction. To this end, the mission and vision statements of other key state initiatives were evaluated to ensure alignment with this strategic plan. The workgroup developed the core values and guiding principles to act as guardrails to provide context and guide leadership and the project team to focus on the right decisions, practices, and processes while developing this Plan.

Evaluation of Recommendations, Gap Analysis, and Strategy Selection

Evaluation of Recommendations. Strategic planning workgroup members participated in several working sessions to evaluate proposed recommendations, considering the following factors:

- Priority (rank each proposed recommendation as low, medium, or high priority)
- Prospective timeline required for completion
- Target population
- Cost and feasibility
- Health care community culture and readiness for change

Gap Analysis. The gap analysis review process used three steps to identify gaps:

1. **Analyze the current state.** For each objective, the Nevada core team collaborated with other partners as needed to analyze the current situation.

2. **Identify the projected future state.** Identify the objectives that must be achieved to reach the future state.

3. **Assess needs to bridge the gap.** Once the projected future state and current situation were confirmed, the core team assessed needs to bridge the gap to reach the Nevada SUPPORT Act implementation project objectives.

The comprehensive list of possible gaps were addressed by the Nevada SUPPORT Act core team committee for review. The gaps were grouped into 12 areas of focus:

- Workforce development.
- MAT services.
- Administrative services (includes benefits and utilization management).
- Telehealth.
- Project ECHO®.
- Social determinants of health.
- Health disparities.
- Rates and reimbursement.
- Data integrity and reporting.
- Data sharing and health IT.
- Integrated care and the hub-and-spoke model.
- Items not otherwise classified.

Strategy and Tactic Selection. After the gap analysis and needs assessment were completed, the strategic planning workgroup discussed a variety of conceptual strategies, gathered feedback, validated findings, and confirmed conclusions to assess the following for each adopted strategy and actionable tactic:

- Ways to address gap – what needs to occur to address the gap.
- Responsible party – state department(s), contractors(s) and/or individual(s) assigned to complete action items.
- Estimated time required to address gap – total time needed to address gap.
- Action required:
    - Near term (30 days to 1 year).
    - Medium term (1 to 3 years).
    - Long term (3 to 5 years).
- Parking lot - item for future consideration.
- Status – not started, in process, on hold, completed.
- Target date – date last action item for recommendation should be completed by the responsible party.

The workgroup identified and discussed the feasibility of specific tactics to implement strategies aimed at increasing access to SUD services in the state of Nevada. The collaborative discussions addressed many factors, such as use of available funding and resources, reasonableness of the selected timeline, and the need for possible changes to policy or processes.

Situational Analysis Summary

A summary of the situational analysis conducted throughout the planning involved a three-step process. DHCFP identified, collected, and analyzed key data about the state related to:

1. Working environment.
2. Health status.
3. Funding sources.
4. Existing medical and computer technology.
5. Demographic information and other data.

The data collected was categorized according to strengths, weaknesses, opportunities, and threats that influence the state's likelihood of success with its goals. A matrix was developed for each alternative that is a potential substitute for one of the plan's goals. Finally, the results of the SWOT analysis helped the state with decision-making for determining the best alternative that fits the strategic plan.

Nevada SUPPORT Act Strategic Plan

Mission and Vision

MISSION

It is the State of Nevada's mission to provide Nevadans with a comprehensive service delivery system to increase access to behavioral health services with an emphasis on substance use disorders by providing a coordinated, comprehensive, and whole-person approach.

VISION

The State of Nevada will use high-quality innovative practices and policies to effectively combat the addiction crisis and strengthen communities across the state.

GUIDING PRINCIPLES

Through this *Provider Capacity Expansion Strategic Plan*, Nevada will work collaboratively to:

- Adopt population health strategies to reduce health disparities.
- Reflect patient goals, values, and choices through patient-centered care.
- Continually seek opportunities to reduce barriers to obtaining SUD treatment and recovery services in the health care system.
- Guide policy and practice through data-driven decision-making.
- Deliver comprehensive, coordinated, and integrated services.
- Provide high-quality care that is affordable and timely.
- Foster culturally and linguistically appropriate services.
- Have a well-trained and sufficient workforce to meet community needs.
- Reduce morbidity and mortality in individuals with SUD through the use of evidence-based practices.
- Collaborate across the health care continuum to address public health challenges.

CORE VALUES

Respect. Uphold a culture that protects the dignity of every person without prejudice or limitation.

Partnerships. Continue to develop and nurture partnerships with colleagues, state agencies, stakeholders, and members that support the state's SUD and population health initiatives.

Innovation. Improve health outcomes through the use of enhanced Medicaid health care delivery systems and alternative payment models.

Data-Driven Culture. Promote a data-driven culture to continually monitor and evaluate member outcomes.

Situational Analysis Summary

The activities and actions described in this Plan, (including, but not limited to, development of the IAR, significant stakeholder engagement, comprehensive gap analysis, and an examination and evaluation of qualitative and quantitative data) were conducted to determine Nevada's strengths and challenges, its opportunities for growth and improvements, and potential emerging issues or threats that may negatively affect its work to expand provider capacity.

STRENGTHS

Strengths are those internal factors that support and illustrate extraordinary performance of a healthcare organization (i.e., IT infrastructure, providers, and services). Nevada must build on its accomplishments and assets when planning to expand the capacity of SUD providers:

- **Commitment to Stakeholder Engagement**. Nevada is committed to continuing an open dialogue with providers and recipients. This is evidenced by the continued efforts by the state to elicit stakeholder input on focus areas such as behavioral and mental health; suicide prevention; substance abuse; provider capacity and willingness; social determinants of health (SDOH); health information exchange (HIE) and data governance; medication assisted treatment (MAT) policy; and reproductive health.
- **Increased SUD Capacity through use of Federally Qualified Health Clinics (FQHCs)**. In 2020, five Nevada FQHCs received SBIRT training and implementation, while three FQHCs were on-boarded for MAT education and implementation. Nevada plans to continue to engage additional FQHCs to increase access to SUD treatment and recovery services.
- **Emphasis on Harm Reduction Efforts.** Harm reduction activities in Nevada include naloxone distribution through "Patrol Leave Behind" programs for law enforcement and first responders who leave kits on site at the scene of overdose; HIV and hepatitis C education and testing; and 14 hospitals which have committed to implement suicide prevention efforts and adopt the Crisis Now model for behavioral health care.
- **Expansion of Peer Recovery Support Specialist Services.** Nevada recognizes the importance of peer services in recovery and therefore developed an OUD-specific module for peer recovery support specialist training. Nevada also has a telephone service called a "warmline" staffed by trained peers in recovery who work to connect individuals to care, support, and available resources.

- **Support for Use of Screening, Brief Intervention, and Referral to Treatment** (**SBIRT)**. Nevada added provider types, specifically physicians, advanced practice registered nurses (APRN), physician assistants (PA), and nurse midwives to those who can be reimbursed for SBIRT services. Additionally, SBIRT billing codes have been added to the medication-assisted treatment (MAT) policy to provide further guidance to providers on billing practices.

- **Implementation of a New MAT Policy.** Nevada created a policy opening MAT-related evaluation and management codes, which expands billing to additional Medicaid provider types, specifically physicians, advanced practice registered nurses (APRN), physician assistants (PA), and nurse midwives.

- **Expansion of Project ECHO® Training Resources**. Project ECHO® Nevada is a telementoring program to expand the capacity of health professionals to effectively treat chronic and complex health conditions, particularly in rural and underserved populations throughout Nevada. Project ECHO® hosts a variety of clinics covering such topics as complex pain management and MAT.[3]

- **Advances in Integrated Care**. In recent years, Nevada established certified community behavioral health centers (CCBHCs) under Section 223 of the Protecting Access to Medicare Act (PAMA). The integration of behavioral health with physical health care is the cornerstone of the CCBHC care model. The success of this demonstration has resulted in Nevada adding additional CCBHCs under its state plan.

- **Additional Population of Focus for SUD Treatment**. Nevada increased educational opportunities and created resource guides for treatment of pregnant women with OUD and infants born with neonatal abstinence syndrome (NAS).

- **Ongoing Dedication to Telehealth**. Nevada's telehealth policies have demonstrated progress, in terms of establishing standards for practice and licensure, coverage, and reimbursement, including eligible patient settings, provider types, technologies, and service limitations. Nevada recently co-created a Western State Compact with Washington, Oregon, and Colorado to address telehealth access and coverage.

[3] https://med.unr.edu/echo.

CHALLENGES

Challenges are those internal factors that hinder the work of, and negatively affect the performance of, a healthcare organization. These factors may include mismanagement of resources, lack of financial resources, incompetent healthcare professionals, and outdated equipment. Nevada, like other states building systems to address the health of citizens with SUD, faces known infrastructure challenges and systemic changes representing exceptional difficulties. These challenges include the following:

- **Funding for SUD Treatment and Recovery Services.** Nevada relies heavily on grant dollars to implement programs that increase access to these services; however, there is concern regarding the long-term sustainability of these grant programs.
- **Limited or No Reimbursement for Critical Healthcare Services**. In Nevada there is no reimbursement for care coordination of MAT services or residential SUD treatment in institutions for mental diseases.
- **Health Care Provider Shortage.** Out of the 16 counties in Nevada, 11 are designated as health professional shortage areas. 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.
- **Diminished Capacity for Current Providers.** The substance abuse treatment field faces many human resource management challenges due to the fact that clinicians have high caseloads, administrative barriers, low pay, and often face both resistance to treatment and relapse among their clients.
- **Lack of MAT Providers.** Although Nevada has seen an increase in providers that are waivered to provide MAT through the use of buprenorphine, not all providers prescribe. Of those who do prescribe, few prescribe to their upper limit. 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.[4] [5]
- **Lack of Available Data to Support Delivery System Evaluation.** Nevada lacks a consistent and accessible source of information regarding its healthcare and public health workforce, including detailed data on current and projected health workforce supply and demand.[6] State-level data

[4]Manuscript: Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment; Rebecca L Haffajee (2019).
[5] *Draft* Introduction to MAT Policy.
[6] 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.

related to the current use of integrated physical and behavioral health care[7] in Nevada is not readily identifiable and, therefore, the level of integrated care within the state cannot be determined at this time.

- **Federal Regulations Governing MAT and Telehealth**. Access to buprenorphine is limited due to federal rules and restrictions, such as the requirement to obtain a federal DEA waiver to prescribe, limits on the number of patients that can be treated, and requirement for an in-person visit before prescribing via telehealth. While restrictions have been lifted due to COVID-19, most are expected to revert after the pandemic ends.

OPPORTUNITIES

Opportunities are those factors that are external to healthcare organizations and represent room for improvement. Examples of opportunities include collaboration with other organizations for better services; plans for better organization and management; new funding programs for better infrastructure; effective training; and informative programs for community development. Nevada has identified the following opportunities to pursue and further strengthen and enhance the SUD treatment and recovery landscape in Nevada.

- **Leverage Existing Assets.** Employ available assets to increase the number of providers and expand their capacity to provide SUD treatment and recovery support services. Nevada will build upon existing training resources and create new resources in order to increase the number of providers and/or their capacity to provide SUD treatment and recovery services.
- **Reduce Provider Administrative Barriers**. Nevada will work to remove and reduce confusion and challenges faced by providers due to administrative barriers that may hinder their willingness and ability to provide treatment and recovery services.
- **Expand Reimbursement Opportunities.** Nevada will develop reimbursement initiatives based on a comprehensive review of Nevada's reimbursement landscape to leverage the existing workforce and reinforce high-quality service through recognition in reimbursement.
- **Increase Individual Access to Critical Levels of Care for OUD and Other SUD Treatment and Recovery.** Nevada is focused on increasing the number of providers who will prescribe buprenorphine, used as part of MAT, to address a critical care gap in Nevada, as well as identifying opportunities and policy needs to support access through telehealth.

[7] https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc.

- **Implement Comprehensive Prevention Strategies to Address OUDs and SUDs.** Nevada is actively working to expand its already broad SUD and OUD prevention strategy. Ongoing and new efforts include provider training and education; use of technology (such as the Prescription Monitoring Program); data collection and analysis; applying harm reduction principles; and addressing social determinants of health and health disparities.
- **Improve Care Coordination and Transitions Between Levels of Care.** Nevada will build on the gains made in their integrated care programs and technology platforms to further advance care coordination and data sharing. A next step for Nevada is to employ an alternative payment model that will provide reimbursement for care coordination services.
- **Establish Coordinated, Multi-Disciplinary Workgroup to Accurately Identify and Regularly Monitor Provider Capacity.** Nevada will identify and monitor provider capacity by addressing and resolving challenges to collecting, analyzing, reporting, and monitoring SUD and OUD provider data.
- **Assign Specific State Analytics Resources to Generate Templated and Ad Hoc SUD and OUD Reports.** Nevada will continue to work to ensure that SUD data is well-coordinated, synchronized, and automated. This SUD reporting will be available with sets of common reports, thus significantly reducing or eliminating monitoring and reporting cost and burden.

EMERGING ISSUES OR THREATS

Threats are those external factors which potential risks or dangers that could harm the quality of work and performance of healthcare organizations. Threats may include economic instability, rapidly changing technology, budget deficits, unnecessary political intervention, and political insecurity. Nevada has identified the following emerging issues or threats to consider during the implementation of this Plan. These include the following:

- **Increased Amphetamine Prescriptions**. While prescribing for opioids has been declining in recent years in Nevada, conversely, the prescribing of stimulants has been on the rise.
- **Knowledge Deficit in Health Care Community on Hub-and-Spoke Model**. Hub providers need to be aware of spoke providers and the services they offer. Healthcare systems (hospitals, providers, community organizations) need education on programs available in the community (hubs and spokes).
- **Impact of COVID-19 Public Health Emergency.** COVID-19 has maintained national attention, shifting state priorities for the past year. Changes in priorities and protocols may impact the long-term success of established and newly deployed programs and initiatives. The pandemic is also attributed to increased unemployment, negative mental health impacts, social isolation, and a rise in substance abuse.

- **Lack of Consistency in Evidence-Based Practice Implementation.** The Association of State and Territorial Health Officials (ASTHO) program, the Opioid Use Disorder, Maternal Outcome, Neonatal Abstinence Syndrome Initiative (OMNI), is currently disseminating numerous deliverables, including the Reference Guide for Labor and Delivery Complicated by Substance Use, but may face challenges in achieving practice change as health systems across the state report having varying procedures for addressing pregnant women with SUD and their infants.
- **Increased Use of Telehealth and Security and Privacy Risks**. In a recent provider survey, 227 of 240 respondents (94 percent), noted that their use of telehealth has increased due to the expansion of coverage as a result of the COVID-19 pandemic. The rapid rise in telehealth utilization and relaxation of regulations have contributed to greater cybersecurity risks.[8] There are significant privacy risks for providers who do not have the appropriate IT resources or infrastructure in place.
- **Limited Governance of Health Information Technology.** A statewide, public-private governance model is a critical component of development and advancement of an effective health IT strategy. Advancing interoperability and harnessing the potential for health IT and health information exchange to support integrated care models is difficult without collaborative governance.
- **Lack of Coordinated Approach to Implement Changes to Part 2 Data.** The Coronavirus Aid, Relief, and Economic Security (CARES) Act fundamentally changes the consent process for Part 2 data, and aligns use and disclosure of SUD data with Health Insurance Portability and Accountability Act (HIPAA) after patient consent is obtained. As such, health information exchange organizations and providers must implement new policies, procedures, and practices to comply with these forthcoming changes.

[8] Mohammad S Jalali, Adam Landman, William J Gordon, Telemedicine, privacy, and information security in the age of COVID-19, *Journal of the American Medical Informatics Association*, Volume 28, Issue 3, March 2021, Pages 671–672.

Strategic Plan Framework

This Plan includes three top priorities and goals, each of which includes specifics objectives, strategies, and tactics. Taken together, these should not be viewed as sequential, but as interdependent with the collective purpose of expanding SUD and OUD provider capacity and improving Medicaid beneficiary health outcomes using data-driven insights.

Priority: Expand Provider Capacity

GOAL 1

Strengthen Nevada's health care infrastructure to expand provider capacity for SUD and OUD treatment and recovery services.

Objective 1.1: Reduce or eliminate provider administrative barriers.

Objective 1.2: Increase overall capacity of providers offering SUD and OUD treatment and recovery support services in Nevada.

Objective 1.3: Increase availability of reimbursement opportunities to expand services across the care continuum.

Priority: Enhance Access to Care

GOAL 2

Increase Nevadans' access to, and delivery of, SUD and OUD treatment and recovery services.

Objective 2.1: Increase number of individuals assessed for need of, and eligibility for, SUD and OUD treatment and recovery services.

Objective 2.2: Increase individuals' access to essential levels of care for SUD and OUD treatment and recovery services.

Objective 2.3: Increase number of prevention strategies to prevent opioid and substance use disorders.

Objective 2.4: Improve care coordination and transitions between levels of care.

Priority: Facilitate Data-Driven Decision-Making

GOAL 3

Improve Nevada's data collection, integrity, and reporting infrastructure and capabilities to enable data-driven insights and decision-making.

Objective 3.1: Improve data infrastructure to accurately monitor provider capacity.

Objective 3.2: Improve ability to generate accurate, timely, and reliable SUD and OUD provider capacity data reporting.

Objective 3.3: Increase access to near real-time SUD and OUD provider capacity and related data.

Goals, Objectives, Strategies, and Tactics

This sections outlines 2021-2025 strategic goals and objectives, as well as the strategies and tactics for each objective.

GOAL 1

Expand Provider Capacity

Strengthen Nevada's health care infrastructure to expand provider capacity for SUD and OUD treatment and recovery services.

GOAL 2

Enhance Access to Care

Increase Nevadans' access to, and delivery of, SUD and OUD treatment and recovery services.

GOAL 3

Facilitate Data-Driven Decision-Making

Improve Nevada's data collection, integrity, and reporting infrastructure and capabilities to enable data-driven insights and decision-making.

The strategies and tactics outlined below are the actionable steps to be taken over the next five years (2021-2025) to achieve Nevada's overall goal to increase access to SUD and OUD treatment and recovery services across the state.

GOAL 1:

Expand Provider Capacity

Strengthen Nevada's health care infrastructure to expand provider capacity for SUD and OUD treatment and recovery services.

OBJECTIVES OVERVIEW		
Objective 1.1. Reduce or eliminate provider administrative barriers.	**Objective 1.2.** I ncrease overall capacity of providers offering SUD a nd OUD treatment and recovery support services in Nevada.	**Objective 1.3.** Increase availability of reimbursement opportunities to expand services across the care continuum.

Objective 1.1.

Reduce or eliminate provider administrative barriers.

Nevada will increase provider willingness and ability to provide SUD and OUD treatment and recovery services by reducing the administrative confusion and challenges they currently face.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.1.1. CONDUCT COMPREHENSIVE POLICY AND PROCEDURE REVIEWS AND INITIATE CHANGES. Mitigate barriers by conducting regular reviews of MAT and SUD policies and procedures to identify necessary changes or clarifications.	• **1.1.1.NT- 1. Evaluate and Enhance MAT and SUD Policies and Billing Guides.** Conduct an annual review of MAT and SUD policies and billing guides from date of last update (June 2020) to determine changes necessary to increase provider capacity and reduce or remove administrative barriers. • **1.1.1.NT-2. Expand Scope of Practice for Advanced Practice Registered Nurses (APRNs).** Initiate discussions with the Nevada State Board of Nursing to add SUD and OUD services and individuals with SUD and OUD to the scope of practice for APRNs.	• **1.1.1.MT-1. Expand MAT Policy Regarding Partial Opioid Agonist Drugs.** Update the MAT policy to allow Medicaid reimbursement to providers who prescribe Partial Opioid Agonist. • **1.1.1.MT-2. Update MAT Policy to Deliver Services in OTPs and IOTRCs.** Convene a state-led workgroup to recommend updates to the MAT policy addressing delivery of MAT services in opioid treatment programs (OTPs) and integrated opioid treatment and recovery centers (IOTRCs).	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.1.2. CONDUCT BEHAVIORAL HEALTH AND ADDICTION HEALTH BENEFITS REVIEW. Nevada's scope of SUD and OUD services closely aligns with the current ASAM levels of care continuum, including the provision of opioid treatment and withdrawal management services. However, services may not reflect current or future utilization, and there may be opportunities for restructuring and increasing access.	• **1.1.2 NT-1. Continuously Update Substance Abuse Bulletin**. Most recent bulletin was updated in 12/2020 to provide information on medications and services for SUD, including SBIRT and MAT. • **1.1.2.NT -2. Continue to Ensure SUD and OUD Benefits Are Understood by Providers.** Make available trainings, website, and social media campaign targeting providers to explain current benefits for SUD and OUD treatment and recovery services.	• **1.1.2.MT-1. Continue Annual Assessment of Administrative Burden Concerning Nevada SUD and OUD Providers.** Regularly assess the amount, duration, and scope of Nevada's SUD and OUD services and use assessments to consider and determine necessary changes to benefits. For example, an area of focus to assess is the peer recovery support services.	
1.1.3. EVALUATE PRIOR AUTHORIZATION REQUIREMENTS FOR MENTAL HEALTH AND SUD AND OUD TREATMENT SERVICES. Assess current state to eliminate and/or decrease prior authorization requirements in order to reduce administrative burden for providers.	• **1.1.3.NT-1. Revise Specific Prior Authorization Requirements.** Remove or modify prior authorization for services related to outpatient behavioral health services and peer recovery support supports to increase access to care. • **1.1.3.NT- 2. Provide Training for Providers About Prior Authorization.** DHCFP to provide regular prior authorization trainings to assure providers take advantage of reduced requirements.	• **1.1.3.MT-1. Conduct Annual Review of Prior Authorization Requirements.** DHCFP to perform an annual review of prior authorization requirements to determine whether changes are necessary. • **1.1.3.MT-2. Track Utilization Data with Changes in Prior Authorization Requirements.** Convene a workgroup to examine the fee-for-service and MCO utilization management requirements to identify opportunities for alignment. Analysis may include assessment of over- and under-utilization patterns, review of prior authorization requirements, and monitoring and oversight.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.1.4. DEVELOP BRAIDED OR BLENDED PAYMENT STRUCTURE TO SUSTAIN SUD AND OUD SERVICES FUNDING. A braided or blended payment structure can provide a framework to pay both Medicaid and non-Medicaid covered services in a systematic and cost-saving fashion.	• **1.1.4.NT-1. Reduce Administrative Burden for Provider Reimbursement**. Establish inter-department coordination to determine the most effective reimbursement methodology to minimize provider requirements for management of grant funds.	• **1.1.4.MT-1. Develop Policy on Selected Reimbursement Methodology.** Develop policy that outlines how the state will operationalize payment from grant funding and state funding in one claims processing and reimbursement system. • **1.1.4.MT-2. Test Relevant MMIS System Edits.** Conduct comprehensive testing of MMIS system functionality to ensure edits in system are functioning correctly before go-live for selected reimbursement methodology. • **1.1.4.MT-3. Conduct Provider Training.** DHCFP to provide trainings regarding edits to the MMIS system made to support reimbursement of grant funding.	• **1.1.4.LT-1. Conduct Audits of Relevant Edits to the MMIS.** Conduct regularly scheduled auditing of the MMIS to ensure payments are being paid under the correct financial authority. • **1.1.4.LT-2. Conduct Analysis of Financial Trend Reports.** Review analysis of financial trend reports to determine whether service changes are being attributed to the correct funding source. • **1.1.4.LT-3. Ongoing Provider Communication and Training.** DHCFP to provide ongoing communications and trainings regarding braided or blended payment structure as needed to support reimbursement of grant funding.
1.1.5. UTILIZE SUD and OUD BRAIDED FUNDING OPPORTUNITIES. Use of braided funding opportunities will support levels of ASAM services will be funded under a sustainable funding source.	• **1.1.5.NT-1. Create Braided Model Using Block Grants.** Determine and document the ways in which DHCFP and DPBH can use block grants to create a braided or blended model.	• **1.1.5.MT-1. Convene Funding Opportunities Workgroup.** Convene a DHCFP and DPBH workgroup to review funding opportunities and develop a braided model to align specific goals, determine use of funds, target specific populations, and identify performance indicators regarding comprehensive SUD treatment and prevention. • **1.1.5.MT-2. Continue Evaluation of Braided Funding Opportunities.** Explore grants, waivers, and other mechanisms.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.1.6. STREAMLINE PROVIDER NETWORK MANAGEMENT PROCESSES. Reduce or eliminate the administrative burden for providers such as physicians, nurse practitioners, and others who engage in multiple credentialing processes.		• **1.1.6.MT-1. Deploy Centralized Credentialing Capabilities.** DHCFP to develop and implement centralized credentialing process to streamline process. • **1.1.6.MT-2. Update MCO Contract Language.** DHCFP to update language in MCO contract(s) as required to reflect compliance with state credentialing process.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.1.7. CONTINUE ENGAGEMENT OF PROVIDER AND RECIPIENT STAKEHOLDERS. Engage providers and Medicaid and CHIP recipients to identify actual or perceived barriers to providing SUD treatment. Data collected from providers can be used to create critical policy or program changes to increase provider capacity.	• **1.1.7.NT-1. Assess Provider Willingness.** Continue provider stakeholder engagement activities to assess willingness and perceived barriers to offering MAT. • **1.1.7.NT-2. Focus Stakeholders on Key Topics.** Engage stakeholders on topics such as telehealth, health IT and HIE, billing and reimbursement, integrated care, and the hub-and-spoke model as needed to make informed decisions. • **1.1.7.NT-3. Advance Recipient-Focused Promotions**. Recipients, as part of a recent engagement activity, identified barriers to care including: lack of housing options, transportation, food security, and financial difficulties in accessing services Increase efforts in promotion of services available to recipients to address SDoH needs. Consider adding a link to Nevada 2-1-1, Access Nevada and other resources under Programs, Grants and Services here: http://dhcfp.nv.gov/Pgms/Home/. • **1.1.7.NT-4. Promote SUD and OUD Benefits Available to Recipients.** 1. Update *Welcome to Nevada Medicaid and Nevada Check Up (NCU)* manual to include specific information on MAT and other SUD recovery services. 2. Update the provider search functionality on the DHCFP website to allow for SUD and OUD as a	• **1.1.7.MT-1. Engage Patient Advocacy Partners.** Leverage partnership with patient advocacy and other groups to regularly gather success stories from patients recovering from SUD.. • **1.1.7.MT-2. Establish a Stakeholder Engagement Season.** Streamline stakeholder engagement targeting Medicaid providers into an annual series. This outreach approach is used by other states to reduce engagement fatigue with providers and increase response rates. • **1.1.7.MT-3. Identify Potential New Partnerships.** State to work with CASAT and targeted organizations to assess current community partnerships to determine if they are being utilized to their full capacity. Focus on areas including SDOH and health disparities. • **1.1.7.MT-4.Leverage Current Knowledge and Relationships with Regional Behavioral Health Coordinators.** Engage businesses and community-based organizations that are likely to interact with vulnerable populations to promote community resources and SUD treatment training programs.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	searchable focus area under Provider Category and/or Provider Specialty. Add CCBHCs to provider listing. 3. Highlight CCBHC program on DHCFP Member page. 4. Highlight CCBHC, Hub and Spoke, and telehealth services available on DHCFP Member page.		

Objective 1.2.

Increase overall capacity of providers offering SUD and OUD treatment and recovery support services in Nevada.

Nevada will build upon existing resources in order to increase the number of providers and their capacity to provide SUD and OUD treatment and recovery services. The strategies below leverage available assets to measurably expand provider capacity over time.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.2.1. INCREASE NUMBER OF TRAINED SUD TREATMENT PROVIDERS. Take action to assure that effective training reaching providers.	• **1.2.1.NT-1. Promote SUD Trainings, Including Training about MAT.** Promote provider trainings that address known barriers to providing MAT services and make the trainings available in various formats. • **1.2.1.NT-2. Increase Awareness of Available Training about MAT.** Leverage CASAT's relationship with the medical education community to encourage providers to receive MAT treatment services training. • **1.2.1.NT-3. Utilize Project ECHO Trainings.** Employ Project ECHO training clinics and recordings on pain management and other topics relevant to SUD and OUD treatment.	• **1.2.1.MT-1. Continue to Evaluate Provider Training.** Continue to conduct annual evaluations of SUD and OUD training formats, content, and outcomes and analyze the need for expansion. • **1.2.1.MT-2. Maintain Online Resources.** Keep the Nevada behavioral health website up to date as new resources, policies, and protocols become available state- and nationwide. • **1.2.1.MT-3. Address Culturally and Linguistically Appropriate Services in SUD Trainings.** Enhance current SUD provider trainings to include culturally tailored and linguistically appropriate services targeting	• **1.2.1.LT-1. Evaluate Web-Based MAT Resources.** Initiate annual reviews of SUD and OUD provider resources on Nevada's behavioral health website (toolkits, training resources, fact sheets, referral best practices, community and public resources, national sources, etc.). • **1.2.1.LT-2. Use Testimonials and Success Stories.** Collect provider testimonials and success stories from the field for use to reduce stigma and encourage providers to consider providing treatment services. • **1.2.1.LT-3. Leverage Workforce Assessment completed by the Office of Analytics, Primary Care**

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	• **1.2.1.NT-4. Workforce Trainings.** Update workforce training to use culturally specific early intervention and harm reduction techniques. • **1.2.1.NT-5. Education to FQHCS.** Provide education to FQHCs on billing for SUD and OUD services within the scope of State Plan approved FQHC providers within their current reimbursement methodology.	underserved communities and vulnerable populations. Provide recommended next steps to DHCFP leadership based on national CLAS standards. • **1.2.1.MT-4. Create a Cultural Awareness Training Package.** Assess evaluations of the SUD provider training course to compile a comprehensive cultural awareness training package to include historical trauma, health disparities, and tribal education.	**Association and other entities.** Use data from workforce studies to determine workforce needs to achieve specific outcomes.
1.2.2. INCREASE AVAILABILITY AND USE OF MAT AND OTHER SERVICES FOR OUD TREATMENT ACROSS NEVADA. 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.[9] [10]	• **1.2.2.NT-1. Increase Number of OTPs Providing MAT.** Offer MAT providers training and, potentially, incentives for participation in the patient-centered opioid addiction treatment (PCOAT) model. • **1.2.2.NT-2. Promote New Programs for Special Populations.** Promote the creation of new programs that coordinate care for individuals who are recommended for substance abuse treatment rather than incarceration. • **1.2.2.NT-3. Engage Provider Associations to Promote SBIRT and MAT Induction services.** Coordinate with provider associations to	• **1.2.2.MT-1. Create Emergency Medicine Reference Guide.** Convene a workgroup to create an emergency medicine reference guide for providers who assist Medicaid patients receiving emergency care related to SUD. Reference Guide will include services that are allowable in the ED under the Medicaid program.. • **1.2.2.MT-2. Implement Emergency Medicine Reference Guide.** Distribute emergency medicine reference guide to hospitals and providers. • **1.2.2.MT-3. Showcase Washoe County MAT for Jail Inmates.** Hold	• **1.2.2.LT-1. Evaluate Emergency Medicine Reference Guide.** Conduct evaluation with patients and providers to determine the guide's utilization and effectiveness. • **1.2.2.LT-2. Consider Wider Dissemination of Case Manager Programs.** Assess the outcomes of programs providing case managers to law enforcement agencies, such as the program with Las Vegas law enforcement and the potential for dissemination.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	promote Medicaid allowable services of SBIRT and MAT induction in emergency departments.	webinar series for counties across Nevada about the implementation of MAT for inmates with SUD by the Washoe County sheriff's office.	
1.2.3. PROVIDE CONTINUITY OF CARE FROM TREATMENT TO RECOVERY SERVICES. Fragmented care results in worse health outcomes and increased spending.[11] Nevada is committed to promoting continuity of care throughout the state through a variety of programs and mechanisms.	• **1.2.3.NT-1. Continue Care Coordination Services at Certified Community Behavioral Health Centers (CCBHC).** CCBHCs will continue to provide care coordination services with various entities including, but not limited to: schools, child welfare agencies, therapeutic foster care providers, juvenile and criminal justice agencies, Indian Health Service youth regional treatment centers, and other social and human services. • **1.2.3.NT-2. Leverage Public Safety Programs.** Promote public safety programs, like Patrol Leave Behind programs, that enable law enforcement and first responders to leave naloxone kits on site.	• **1.2.3.MT-1. Support Federally Qualified Health Centers (FQHC) Expansion Program.** Continue support of expansion of SUD services provided by FQHCs. • **1.2.3.MT-2. Engage Peer Recovery Support Specialists.** Apply existing communication mechanisms to encourage providers to include peer recovery support specialists in their team for the transition from OTP to OBOT. • **1.2.3.MT-3. Expand Mobile Opioid Outreach Capacity.** Seek funding to expand reach of mobile opioid outreach teams. • **1.2.3.MT-4. Track Outcomes for Pharmacy Pilot Funded by State Opioid Response (SOR) Grant.** Track progress made in the SOR-funded pilot program, which works with identified chain pharmacies to dispense naloxone to good Samaritans without accessing insurance.	• **1.2.3.LT-1. Apply FQHC Practices to Rural Health Clinics (RHCs).** Conduct assessment of SUD practices at FQHCs to determine necessary adaptations for RHCs**.**

[11] Enablers and Barriers in Implementing Integrated Care, 2015.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.2.4. APPLY PROMOTIONS TO EXPAND PROVIDER CAPACITY FOR SUD AND OUD TREATMENT AND RECOVERY SERVICES.	• **1.2.4.NT-1. Promote SUD as a Chronic Condition and Use Training to Counter Stigma.** In order to reduce provider stigma-related issues and implicit bias, DPBH and its partners will offer online training to counter the effects of stigma and ways providers can play a role. DPBH will initiate a campaign targeting providers in primary care practices. • **1.2.4.NT-2. Identify Provider Champions.** Engage current clinical champions to locate physicians, with significant experience treating patients with SUD or OUD, who are willing to serve as consultants or mentors to peers providing MAT and SUD services. • **1.2.4.NT-3. Provide education on continuum of SUD services available.** Provide training via listserv, campaigns, brochure, quick reference guide etc. to providers and recipients to reduce the siloed and restrictive functionality among treatment and rehabilitation centers.	• **1.2.4.MT-1. Create Financial Incentives.** Develop a financial incentive program that allows for monetary awards for providers who meet pre-defined threshold(s). • **1.2.4.MT-2. Address system impact.** Team will work with BPMU to ensure data integrity is maintained before and after making provider enrollment changes.	
1.2.5. INCREASE AVAILABILITY OF PEER RECOVERY SUPPORT SERVICES.	• **1.2.5.NT-1. Increase Awareness of Peer-Led Warmlines.** Work with agency and community partners to promote existing 24/7 peer-led warmlines designed to connect individuals who are not in acute crisis with services.	• **1.2.5.MT-1. Expand Internship Programs.** Expand internship programs, similar to Foundations for Recovery's Washoe County program, to help those working towards certification gain experience while serving their communities.	• **1.2.5.LT-1. Promote Scholarship Opportunities.** Continue state support of scholarships for peer recovery and support specialists working towards certification.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.2.6. IMPLEMENT TOOLS FOR RECOVERY SUPPORT STATEWIDE. These support tools can be used by the provider and patient together to determine a treatment and recovery plan that can best meet the patient's needs.	• **1.2.6.NT-1. Identify Prioritized Recovery Support Tools.** DPBH will convene a state-led workgroup, including key providers of SUD and OUD services to select recovery support tools for statewide use.	• **1.2.6.MT-1. Develop Recovery Support Tools.** Develop statewide recovery support tool(s), such as a tool to determine the level of risk for relapse. • **1.2.6.MT-2. Reimburse for Use of Recovery Support Tools.** Provide reimbursement to providers for use of recovery support tools. For example, payment for use of a recovery support tool could be incorporated into the PCOAT model.	
1.2.7. DRIVE AWARENESS OF AVAILABLE RESOURCES TO PROVIDERS TO SUPPORT THEIR DELIVERY OF SUD AND OUD TREATMENT AND RECOVERY SERVICES. Continue use of resources developed by Nevada to ensure providers have clinical resources readily available to support them in the delivery of SUD and OUD services.	• **1.2.7.NT-1. Promote the *Reference Guide for Reproductive Health Complicated by Substance Use* in the Outpatient OBGYN setting.** Use current promotional mechanisms to advance statewide implementation of the *Guide*. • **1.2.7.NT-2. Expand Use of the Reference Guides.** Engage the Nevada Hospital Association and Rural Hospital Association for further promotion of the reference guides	• **1.2.7.MT-1. Employ Medical Education Materials.** Develop and promote use of continuing medical education materials addressing opioid overdose response, intersection of suicide and prevention, AB239 updates, and other materials targeting treatment of SUD and OUD.	
1.2.8. EXPAND GRADUATE MEDICAL EDUCATION (GME) PROGRAM. Expand existing GME programs in Nevada to community-based primary care settings, such as FQHCs, RHCs, and tribal health centers**.**		• **1.2.8.MT-1. Fund GME Program.** Seek funding opportunities such as grants and waivers to support expansion of GME program. • **1.2.8.MT-2. Expand GME Program.** Increase support for SUD provider types by expanding the type and number of providers to participate in the GME program.	• **1.2.8.LT-1. Propose State Plan Amendment.** Draft SPA to expand eligibility to additional provider types for participation in the GME program.
1.2.9. PROMOTE USE OF PROJECT ECHO® TO MAKE SUD AND	• **1.2.9.NT-1. Use Project ECHO® Clinics.** Continue routine Project		• **1.2.9.LT-1. Identify Funding to Reimburse for Project ECHO®**

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
OUD TREATMENT AND RECOVERY SERVICES MORE ACCESSIBLE. The goals of Project ECHO® are to expand capacity of health professionals to effectively treat chronic, common, and complex health conditions, and avoid costly travel and long waits for patients who need care.	ECHO® clinics for topics including MAT and alternatives to pain management.		**Utilization.** Explore avenues to offer reimbursement for participation in Project ECHO, such as including Project ECHO® as a managed care service or as part of an integrated care model.

Objective 1.3.

Increase availability of reimbursement opportunities to expand services across the care continuum.

Nevada is anticipated to have federal approval of 1115 SUD IMD Waiver to allow for Nevada Medicaid coverage of medically-needed inpatient services provided in Institutions for Mental Diseases (IMD), and will explore value-based care options and other tactics available in Medicaid.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.3.1. PURSUE MEDICAID COVERAGE OF SERVICES PROVIDED IN IMD FACILITIES.	• **1.3.1.NT-1. Submit IMD Waiver.** DHCFP to submit an 1115 waiver for coverage for specific ASAM services provided in an IMD (Levels of Care 3.1, 3.2, 3.3, 3.5, and 3.7). Waiver will also include inpatient and outpatient services for pregnant women and their babies/children.	• **1.3.1.MT-1. Perform Outcomes Reporting.** DHCFP to evaluate and monitor activities and outcomes as required upon approval of the 1115 waiver.	• **1.3.1.LT-1. Identify Need for Waiver Renewal.** DHCFP to evaluate need to request renewal of 1115 waiver for coverage for services provided in an IMD.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.3.2. ENHANCE SUD AND OUD REIMBURSEMENT. Develop sufficient reimbursement policies for SUD and OUD services to ensure a sustainable workforce.	• **1.3.2.NT-1. Conduct Rates Analysis.** Utilize quadrennial rate reviews surveys and SAPTA rate review to determine whether reimbursement rates for SUD services are sufficient to sustain and expand workforce and service capacity**.** • **1.3.2.NT-2. Review Medical and SUD Provider Rate Methodologies.** Ensure methods used to determine usual, customary, and reasonable charges for MH/SUD are applied consistent with methodologies and evidentiary standards for establishing medical/surgical benefits payments. Those rates should be evaluated for sufficiency to secure and promote access to care and provider participation • **1.3.2.NT-3. Update Reimbursement Policy and Perform Provider Training.** Update reimbursement policy to allow medical providers to bill for integrated behavioral health services. Upon completion of updated reimbursement policy, perform training for medical providers to ensure medical providers are aware of the requirements to bill for behavioral health services.	• **1.3.2.MT-1. Complete an annual review.** Review legal authority, regulatory requirements, and enforcement actions.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.3.3. EXPAND PROVIDER TYPES ELIGIBLE FOR REIMBURSEMENT OPPORTUNITIES. Expanding provider types permitted to bill for SUD and OUD services will increase overall provider capacity.	• **1.3.3.NT-1. Add Provider Types to MSM Chapter 400.** Add Licensed Alcohol and Drug Counselor as QMHP to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services. • **1.3.3.NT-2. Address system impact**. Team to work with BPMU to ensure data integrity is maintained before and after making provider enrollment changes.	• **1.3.3.MT.1. Expand FQHC provider capacity to treat SUD and OUD**. Pursue State Plan Authority in 2023 to allow FQHCs to expand the types of providers they can utilize to provide and bill for SUD treatment services.	• **1.3.3.LT-1. Justice-Involved Medicaid Beneficiaries.** Explore policies to fund a level of treatment for individuals that are justice-involved that ensures continuum of care 30 days prior to and post-release.
1.3.4. DEVELOP AND IMPLEMENT VALUE-BASED PAYMENT MODEL. Development of a value-based alternative payment model will reinforce high-quality service through recognition in reimbursement.	• **1.3.4.NT-1. Take Steps to Implement PCOAT Model.** Determine procedures and policies that must be in place to implement patient-centered opioid addiction treatment (PCOAT) model.	• **1.3.4.MT-1. Implement PCOAT.** Complete implementation of the PCOAT model.	
1.3.5. OFFER MEANINGFUL FINANCIAL INCENTIVES OUTSIDE OF THE PCOAT MODEL. Linking financial rewards to evidence of higher quality of care aligns providers with state goals to improve clinical outcomes.	• **1.3.5.NT-1. Identify Need for Financial Incentives.** DHCFP to analyze data for insights regarding current provider capacity levels to determine need for financial incentives outside of PCOAT.	• **1.3.5.MT-1. Develop Financial Incentive Program Model.** DHCFP to develop a model that includes financial and non-monetary forms of incentives, such as training stipends, tuition assistance and loan forgiveness, to increase SUD and OUD treatment provider recruitment and retention.	• **1.3.5.LT-1. Conduct Financial Incentive Program Review.** Perform regular review of financial incentive program to determine impact on SUD and OUD provider capacity.
1.3.6. IMPROVE ACCESS TO CARE USING TECHNOLOGY. Driving use of telehealth and other distance services technologies is a way to expand SUD and OUD treatment services in rural communities and among special populations**.**	• **1.3.6.NT-1. Enhance Broadband Infrastructure.** The state will continue to monitor current broadband infrastructure programs and target outreach to rural communities with extended telehealth coverage.	• **1.3.6.MT-1. Interview Key Informants.** Conduct key informant interviews with providers to address the ongoing barriers and challenges, as well as advantages, in telehealth utilization.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
1.3.7. USE FUNDING AVAILABLE UNDER THE AMERICAN RESCUE PLAN. Expand access to mobile crisis intervention services. These services will be reimbursed at an 85 percent enhanced federal matching rate for three years.	• **1.3.7.NT-1. Identify required steps to expand coverage mobile crisis intervention services as a Medicaid reimbursable service.** DHCFP to determine if the addition of these services require a State Plan Amendment or just an update to policy.	**1.3.7.MT-1. Implementation of next steps to expand mobile crisis intervention services**. State to implement expansion for coverage mobile crisis intervention services using agreed-upon mechanisms.	

GOAL 2:

Enhance Access to Care

Increase Nevadans' access to, and delivery of, SUD and OUD treatment and recovery services.

OBJECTIVES OVERVIEW

Objective 2.1.	Objective 2.2.	Objective 2.3.	Objective 2.4.
Increase number of individuals assessed for need of, and eligibility for, SUD and OUD treatment and recovery services.	Increase individuals' access to essential levels of care for SUD and OUD treatment and recovery services.	Increase number of prevention strategies to prevent opioid and substance use disorders.	Improve care coordination and transitions between levels of care.

Objective 2.1.

Increase number of individuals assessed for need of, and eligibility for, SUD and OUD treatment and recovery services.

Increase use of SBIRT screening for Medicaid and CHIP beneficiaries.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.1.1. ADVANCE WIDESPREAD USE OF SBIRT. SBIRT codes were activated early in 2020 for a number of provider types: physicians, advanced practice registered nurses, physician assistants, and nurse midwives. Currently, work to promote the use of SBIRT has been ongoing statewide and a limited number of providers completed SBIRT training.	• **2.1.1.NT-1. Increase Awareness of the Availability of SBIRT Training.** Utilize established mechanisms to increase awareness of SBIRT training among providers of adult and adolescent health care. • **2.1.1.NT-2. Assess Effectiveness of SBIRT Training.** Conduct an evaluation of the effectiveness of SBIRT training and the adequacy of the training's content regarding clinical and billing practices. • **2.1.1.NT-3. Continue to Engage Stakeholders and Analyze Claims Data to Develop SBIRT Promotion.** Assess provider use of SBIRT through analysis of claims data and research with stakeholders to develop promotional strategies to expand providers. • **2.1.1.NT-4. Continue SBIRT Utilization Reporting and Analysis.** Continue to update the dashboard of utilization of SBIRT in primary care, EDs, and other service settings to identify needs for additional outreach or training for specific provider types or settings. • **2.1.1.NT-5. Target Provider Types and Settings to Promote SBIRT.** Promote SBIRT to pediatricians and family	• **2.1.1.MT-1. Coordinate Training with Managed Care Organizations (MCOs).** Implement provider training on SBIRT in coordination with MCOs. • **2.1.1.MT-2. Promote Use of Inpatient and Outpatient Reference Guides to Expand Use of SBIRT in OBGYN Settings.** Continue to support the use of the ASTHO-OMNI reference guides in inpatient and outpatient OBGYN settings for statewide adoption of best practices, including prenatal and neonatal screening. • **2.1.1.MT-3. Leverage Existing Inpatient and Outpatient Reference Guides to Create New Resource Materials.** Use current reference guides to create new resource materials expanding screening targets to additional care settings, including primary care and emergency medicine.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	medicine practitioners to expand SBIRT use among adolescents. • **2.1.1.NT-6. Develop Collateral Material to Further Adoption of SBIRT.** To promote the adoption of SBIRT, tailor the Nevada CARA Plan of Care flow chart for use in the implementation of pediatric SBIRT in FQHCs and develop other collateral that supports the program.		

Objective 2.2.

Increase individuals' access to essential levels of care for SUD and OUD treatment and recovery services.

Increase access to treatment and recovery services for all age-appropriate Medicaid and CHIP beneficiaries.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.2.1. ENCOURAGE USE OF MAT SERVICES IN THE HOSPITAL EMERGENCY DEPARTMENT (ED) SETTING. The initiation of MAT services is not currently being provided in EDs across Nevada. It has been shown that initiating buprenorphine induction in the ED prior to discharge or hospital admission serves as an opportunity to engage patients in treatment.[12] Initiation of MAT in the ED is an opportunity to further expand MAT delivery.	• **2.2.1.NT-1. Engage Provider Associations and Large Health System Networks.** Work with health care provider associations and large health systems to promote MAT induction services in the ED setting.	• **2.2.1.MT-1. Report Use of MAT Services in the ED.** Create a dashboard of data-driven metrics to assess use of induction of MAT in EDs with findings used to adjust outreach or training. • **2.2.1.MT-2. Develop and Distribute a MAT Toolkit for Emergency Medicine Use.** Convene a workgroup develop the *Nevada Emergency Medicine Toolkit*, including a plan for statewide distribution.	• **2.2.1.LT-1. Evaluate Use of MAT Toolkit for Emergency Medicine Use.** Upon distribution of the MAT Toolkit for Emergency Medicine, engage providers to determine how toolkit is being utilized.

[12] 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.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.2.2. ADDRESS NEEDS OF SPECIAL POPULATIONS. Expand availability of OUD treatment for the sub-populations of 1) pregnant and postpartum women and their infants to address neonatal abstinence syndrome; 2) duty military and veterans; 3) adolescents and young adults; 4) tribal communities; 5) dual-eligibles; 6) people living in rural areas and 7) justice-involved populations.	• **2.2.2.NT-1. Promote SBIRT with Adolescent and Young Adult Populations.** Promote SBIRT for primary care visits for adolescents. Provide FQHCs with resources for referring adolescents and young adults, including treatment and recovery services. • **2.2.2.NT-2. Initiate Outreach to Tribal Representatives.** State agencies to collaborate with tribal representatives and continue outreach efforts for tribal communities to participate in SUD needs assessment surveys and focus groups to ensure their needs are known and addressed. • **2.2.2.NT-3. Update Children's Mental Health Crisis Hotline.** Ensure appropriate addiction resources are included in the children's mental health crisis hotline**.** • **2.2.2.NT-4. Promote enrollment of Dual Eligible Special Needs Plans (D-SNPs) which provide additional coordinated services for those with the highest needs**. DHCFP to work with D-SNP Health plans to strategize how to increase enrollment. • **2.2.2.NT-5. Maintain Distribution of Naloxone Kits.** Continue to monitor progress made by the state opioid response (SOR) grant program in the distribution of naloxone kits to support special populations, including individuals who are justice-involved.	• **2.2.2.MT-1. Support Families Impacted by Substance Abuse**. Promote availability of resources from Families First Prevention Services Act and Money Follows the Person programs to providers as possible patient and family support resources. • **2.2.2.MT-2. Leverage Grant Project Successes.** Evaluate the outcomes from the ASTHO- OMNI and SOR grant projects for pregnant and postpartum women and their infants and apply successes for future initiatives addressing SUD in additional identified special populations. • **2.2.2 MT-3. Evaluate outcomes from efforts to support SUD treatment to the justice-involved population and consider how this can be replicated for long-term sustainability.** Careful monitoring of on-going programs for the justice-involved (examples: MAT Re-Entry Court, Washoe County Sheriff MAT program). • **2.2.2.MT-4. Evaluate D-SNP contracts.** Assess D-SNP contracts and determine specific language to include on ensuring whole-person care. Also consider language on how D-SNPs should be required to work with SUD and OUD treatment providers.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	• **2.2.2.NT-6. Expand access to SUD service in the rural and frontier areas.** Develop plan for expansion of mobile MAT treatment for rural and frontier communities. • **2.2.2.NT-7. Leverage CCBHC work with active duty military and veterans.** CCBHCs to work with the state to develop a training opportunity where they provide their lessons learned and other insights on what is required to provide tailored care for active duty military and veterans. • **2.2.2.NT-8. Increase visibility/promotion of SUD treatment services for active duty military and veterans**. Update the https://behavioralhealthnv.org/get-help/ website to include CCBHCs as a service providers for veterans. **2.2.NT-9. Seek Medicaid Eligibility Expansion.** State to seek legislative approval for presumptive eligibility for pregnant women and expanding eligibility to lawfully residing pregnant women who have not met the 5 year residency requirement. • **2.2.NT-10. Increase access to home and community based services (HCBS) through use of American Rescue Plan Act (ARPA) of 2021 funding**.		

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.2.3. LEVERAGE FQHC MAT EXPANSION PROJECT. Apply current SOR grant work with three Nevada FQHCs to provide MAT services. The state plans to work with an additional five FQHCs to provide MAT services in 2021.	• **2.2.3.NT-1. Expand Delivery of SUD Services at FQHCs.** Analyze results from CASAT's assessment of FQHCs readiness for MAT to determine approach to effectively expand MAT services. • **2.2.3.NT-2. Identify Training Needs for SUD Services at FQHCs.** Continue outreach to FQHCs to identify training needs.	• **2.2.3.MT-1. Assess RHCs Interest and Readiness to Provide Integrated Care Services.** Communicate with RHCs to gauge their interest in providing SUD services and their readiness to provide integrated care with primary care. • **2.2.3.MT-2. Provide Technical Assistance to FQHCs for MAT Expansion.** Provide ongoing technical assistance to FQHCs and any other MAT expansion project providers.	• **2.2.3.LT-1. Adapt Approach to Rural Health Clinics (RHCs).** Assess current efforts with FQHCs to determine approaches to be adapted for RHCs. • **2.2.3.LT-2. Continue Support for Mobile Opioid Recovery Outreach Teams**. Establish necessary mechanisms (funding, resources, research, etc.) to continue support for Mobile Opioid Recovery outreach teams.
2.2.4. ENGAGE RECIPIENTS. Increase outreach to recipients to assess their SUD and OUD service needs.	• **2.2.4.NT-1. Create Marketing and Communications Campaigns to Combat Stigma.** Develop campaigns targeting recipients to increase understanding of SUD as a chronic condition and to reduce provider stigma-related issues and implicit bias. Future marketing campaigns will partner with existing media strategies to maximize impact. Promote informative webpage highlighting the effects of stigma and the relationship between trauma and substance use disorder. • **2.2.4.NT-2. Expansion of SUD prevention efforts geared to local youth and school districts**. Partner with coalitions to build off of their successes in engaging with local youth and school districts in high quality prevention efforts.	• **2.2.4.MT-1. Conduct Regular Recipient Research and Report.** Engage recipients who are receiving treatment and recovery services and those seeking services to determine recipients' overall satisfaction with services. Use data collected for annual report, including comparative analysis to determine impacts related to provider capacity. • **2.2.4.MT-2. Enhance Online Information Resources.** Develop web and mobile-based real-time information portal regarding available prevention, treatment, and recovery services that are searchable by types, locations and other information.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.2.5. INCREASE USE OF TELEHEALTH FOR TREATMENT AND RECOVERY SERVICES. Substance use disorders are chronic and treatment requires that providers stay connected to patients over a long period of time. Telehealth helps address geographic and stigma-based barriers to treatment access. The COVID-19 pandemic has effectively forced increased utilization of telehealth, and evidence is growing to support its role in assisting recovery and treatment. However, more needs to be done to fully incorporate the modality in practice.	• **2.2.5.NT-1. Participate in Multi-State Collaborative.** Participate in multistate collaborative (specifically the Western States Compact) and engage with stakeholders to continue to build a statewide telehealth strategy that addresses areas such as flexible opportunities for providing low cost and accessible telehealth and telemental health usage, broadband issues, and integration with the medical education system. • **2.2.5.NT-2. Publicize Telehealth Resources.** Increase distribution of, and access to, telehealth resources and information (such as what is covered and reimbursable) by updating the state's telehealth website, creating linkages to other programs, and adding telehealth information to relevant provider bulletins. • **2.2.5.NT-3. Analyze Telehealth Data.** Add a modifier to examine utilization of telehealth services, platforms, and those via telephone. Examine data on telehealth use for peer recovery supports. Evaluate and consider billing issues such as how distant sites and originating sites bill for telehealth services, billing when the originating site is in the patient home, and non-covered services. • **2.2.5.NT-4. Explore Telehealth Flexibilities** Assess the national developments related to permanent implementation of certain flexibilities at the state level and continue to monitor federal guidance and opportunities to inform development of a statewide	• **2.2.5.MT-1. Assess Nevada Telehealth Utilization.** Conduct an assessment of Nevada telehealth utilization by providers and patients for the delivery of behavioral health services. • **2.2.5.MT-2. Engage Telehealth Champions.** Interview telehealth champions such as NVHC and Renown Health to support CASAT's efforts in developing and enhancing telehealth trainings, best practices (including MAT delivery via telehealth), treatment guidelines, and other resources for providers. Champions will also help identify barriers in provider and patient utilization of telehealth. • **2.2.5.MT-3. Examine Cost Savings and Increased Access Related to Telehealth.** Conduct an analysis of cost savings related to transportation, billing, and other factors, and any increase in utilization of BH services, as a result of increased telehealth utilization. • **2.2.5.MT-4. Incorporate Telehealth and Hub and Spoke.** Redesign telehealth capabilities into a hub and spoke service model parallel to Nevada's SUD and OUD treatment and recovery services.	• **2.2.5.LT-1. Launch Statewide Telehealth SUD and OUD Treatment Program in 2026.** Nevada Medicaid managed care organizations will launch comprehensive telehealth addiction treatment programs, for example, by partnering with a TeleMAT service provider.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	telehealth law (anticipated by June 2021).		
2.2.6. PERFORM REVIEW OF PROVIDER CONTRACTS TO ASSESS INCLUSION OF LANGUAGE THAT IS PATIENT-CENTERED. Ensure prescriptive contract language is used in provider contracts to promote patient-centered care.	• **2.2.6.NT-1. Create Contract Review Workgroup.** Workgroup will determine the key review elements required to assess patient-centered care language. • **2.2.6.NT-2. Contract Review Workgroup reports findings.** Workgroup will provide a report of findings to DHCFP leadership. Report will also include recommendations to add/remove/edit language in contracts that may result in barriers to patients.	• **2.2.6.MT-1. Add value-based component to SUD and OUD treatment and recovery provider contracts.** Workgroup (including CASAT) to make recommendations to leadership on quality-based outcomes to include in SUD treatment provider contracts to support monitoring and oversight. Consideration will be given on how to support providers with the efforts associated with data collection. • **2.2.6.MT-2. Collect additional data via the MMIS**. Utiilze interoperability of MMIS system to streamline value-based reporting.	

Objective 2.3.
Increase number of prevention strategies to prevent opioid and substance use disorders.

Nevada will expand its broad SUD and OUD prevention strategies to include provider training and education; use of technology; data collection and analysis; applying harm reduction principles; and addressing social determinants of health and health disparities.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.3.1. CONTINUE USE OF COMPREHENSIVE PREVENTIVE SERVICES ROOTED IN HARM REDUCTION PRINCIPLES. Leverage harm reduction programs such as Trac-B and Foundations for Recovery to help promote SUD recovery support programs.	• **2.3.1.NT-1. Update First Responder Trainings.** Collaborate with first responder agencies to update their trainings to include content related to the leave behind programs that leave naloxone on site. • **2.3.1.NT-2. Promotion of Harm Reduction Services**. Update Nevada 211 website to allow for user to find Harm Reduction services as service under Addiction. https://www.nevada211.org/addiction-services/ Currently, this information is not easy to locate on the site; adding this information to a main landing page will promote services and provide essential information such as hours of operation, location and availability of services. • **2.3.2.NT-3. Educate providers on Harm Reduction Providers.** There is training information available on harm reduction providers (example: Trac-B PowerPoint). Consider widespread communication to Medicaid providers on the services available from Harm Reduction providers.	• **2.3.1.MT-2. Identify and Recruit Prevention Partners.** Target community members, organizations, volunteers, professionals and other stakeholders to become part of the prevention workforce.	• **2.3.1.LT-1. Explore Medicaid Coverage.** Explore potential Medicaid coverage for recovery services such as Trac-B and Foundations for Recovery. • **2.3.1.LT-2. Prevention Strategies Education.** Enact policy that requires all persons who work with individuals with an SUD diagnosis have a minimum set of hours of prevention strategies and SUD education or training.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.3.2. ADDRESS SOCIAL DETERMINANTS OF HEALTH AND HEALTH DISPARITIES. 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. Social determinants of health, as well as race, ethnicity, sex, sexual orientation, age, and disability impact health outcomes.[13] Nevada recognizes the importance of addressing SDOH needs and will promote the use of a tool to support providers in identifying these factors.[14] [15]	• **2.3.2.NT-1. Assess Health Equity Programs.** Evaluate the work of the Protection Commission and the West Coast Compact on health equity and consider its applicability to Nevada. • **2.3.2.NT-2. Provide Non-Emergency Transport Services.** Enable non-emergency secure behavioral health transport services (a motor vehicle, other than an ambulance or other emergency response vehicle) that is specifically designed, equipped, and staffed by an accredited agent to transport a person alleged to be in a mental health crisis or other behavioral health condition, including those individuals placed on a legal hold. • **2.3.2.NT-3. Generate SDOH Data Reporting.** Request and utilize quarterly SDOH data reporting to engage CASAT and NVPCA as they evaluate SDOH assessment tools such as PRAPARE. • **2.3.2.NT-4. Continue to Collaborate to Implement SDOH Tools.** CASAT and NVPCA will continue collaboration to define the scope, timeline, and goals of	• **2.3.2.MT-1. Examine Tenancy Support.** Identify housing supports for patients in recovery as a prevention strategy to reduce the likelihood of further substance use. • **2.3.2.MT-2. Explore Opportunities with First Responder Groups**. Conduct research with first responder groups to determine the training needed to develop awareness regarding health disparities within the community.	• **2.3.2.LT-1. Make Health Disparities Training Available to First Responders.** Create a training package for first responders including content related to cultural awareness and health disparities among the populations they serve. • **2.3.2.LT-2. Include Use of SDOH Tool in MCO Contracts.** Explore ways to incorporate use of SDOH assessment tool into MCO contracts or a reimbursement mechanism.

[13] MMWR, Introduction: CDC Health Disparities and Inequalities Report — United States, 2013. https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a2.htm?s_cid=su6203a2_w
[14] Taking action on the social determinants of health in clinical practice: a framework for health professionals, 2016.
[15] Addressing Social Determinants of Health: The Need for Provider-Community Collaboration, 2018.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
	implementation of the SDOH assessment tools. • **2.3.2.NT-4. On-going communications to Medicaid providers on SDoH resources.** Work with sister agencies to put out a quarterly email blast to providers on SDOH resources. Emails would be short and informational, but also provide links to additional training/resources.		
2.3.3. SUPPORT PROVIDER AND STATE USE OF THE PMP. Continue to foster provider use of the Nevada PMP as part of standard prescribing procedures to reduce rates of potential doctor shoppers, improve overall reduction in opioid prescriptions for pain, and to attempt to reduce stimulant abuse.	• **2.3.3.NT-1. Evaluate Stimulant Use Trends.** Use data to identify opportunities for additional training. Analyze PMP data to identify trends in stimulant prescriptions issued and dispensed, such as potential doctor shoppers and concurrent prescriptions.	• **2.3.3.MT-1. Leverage Successes.** Apply successful practices from opioid prescribing by Nevada providers that can be replicated for prescribing of stimulants.	• **2.3.3.LT-1. Design and Develop PMP Integration with Key Systems.** Design and develop approach for integrations of PMP queries into screening tools and practices. • **2.3.3.LT-2. Implement PMP Integration Workflow.** Develop a workflow and training for providers to integrate PMP queries into screening tools and practices.

Objective 2.4.

Improve care coordination and transitions between levels of care.

Nevada will increase coordination among levels of care.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.4.1. ADVANCE HUB-AND-SPOKE MODEL. A hub-and-spoke model integrates care across primary, acute, and behavioral health settings to improve care coordination. The model creates a network that enables the patient to connect with a range of necessary services within the community. Hub-and-spoke services will be added to the contract with managed care organizations (MCOs). MCOs will be responsible to further the work of the state and advance the hub-and-spoke model in Nevada.	• **2.4.1.NT-1. Market the Hub-and-Spoke Model to Providers.** Drive awareness of the hub-and-spoke model and its participants to large hospital systems.	• **2.4.1.MT-1. Operationalize Hub and Spoke.** Establish and further operationalize the hub-and-spoke model benefit under the managed care program that supports it. • **2.4.1.MT-2. Create Hub-and-Spoke Policy**. Develop policy needed to further operationalize the hub-and-spoke model of care coordination and whole-person treatment effort. • **2.4.1.MT-3. Combine Telehealth Services with Hub-and-Spoke Model.** Incorporate telehealth into a hub-and-spoke model redesign specific to Nevada's needs based on federal regulation or through the use of state plan or a waiver.	• **2.4.1.LT-1. Identify MCO Reporting Requirements**. Determine the specific reporting that is required by MCOs to evaluate expansion of the hub-and-spoke model.

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
2.4.2 IMPLEMENT POLICY FOR PATIENT-CENTERED TREATMENT AND REIMBURSEMENT. Nevada has identified opportunities to provide reimbursement for care coordination services critical to MAT services and services supplied under the hub-and-spoke model.		• **2.4.2.MT-1. Implement the PCOAT Alternative Payment Model (APM).** Improve patient outcomes by payment for a comprehensive set of MAT services that enable providers to deliver successful treatment through implementation of the Patient-Centered Opioid Addiction Treatment (PCOAT) model, an APM.	
2.4.3. EXPAND USE OF REFERRAL MECHANISMS IN NEVADA. Nevada will leverage the Overdose Data to Action (OD2A) grant to increase appropriate utilization and optimization of the OpenBeds referral system. The state will continue to promote this system, as well as provide training and technical assistance for use of the platform.	• **2.4.3.NT-1. Receive Updates.** Receive periodic updates from University of Nevada – Reno, state owner of OpenBeds. • **2.4.3.NT-2. Update Referral Process.** Update the referral process to include use of the eligibility checklist to enable referring providers to confirm Medicaid eligibility and initiate enrollment. • **2.4.3.NT-3. Offer Technical Assistance to Providers.** Continue technical assistance and training for referring and receiving providers to ensure use of the OpenBeds tool is integrated into workflows.	• **2.4.3.MT-1. Create Standardized Referral Form.** Develop a user-friendly standardized form that providers can complete and send with referrals to improve coordination of care. • **2.4.3.MT-2. Coordinate Opioid Treatment Registry Development.** Coordinate with CASAT the development of the opioid treatment registry, an application for providers to explore integration opportunities by listing patients receiving medications, patients in treatment, and facilities providing treatment. • **2.4.3.MT-3. Establish Referral Coordination Policies.** Coordinate MCOs, provider networks, and state agencies to establish policies that facilitate referrals for treatment or recovery service when appropriate.	

GOAL 3:

Facilitate Data-Driven Decision-Making

Improve Nevada's data collection, integrity, and reporting infrastructure and capabilities to enable data-driven insights and decision-making.

OBJECTIVES OVERVIEW

Objective 3.1.	Objective 3.2.	Objective 3.3.
Improve data infrastructure to accurately monitor provider capacity.	Improve ability to generate accurate, timely, and reliable SUD and OUD provider capacity data reports.	Increase access to near real-time SUD and OUD provider capacity and related data.

Objective 3.1.

Improve data infrastructure to accurately monitor provider capacity.

Nevada will identify solutions to better collect, analyze, and report relevant SUD and OUD provider capacity and related data.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.1.1. ESTABLISH NEVADA ALL-PAYERS CLAIM DATABASE (APCD). The Nevada APCD will be used to aggregate medical, pharmacy and dental claims from all insurance payers to inform cost containment and quality improvement efforts, in addition to transparency provisions.	• **3.1.1.NT-1. Apply for grant funding to support implementation of APCD**. Application for grant funding is due in September 2021. • **3.1.1.NT-2. Develop APCD**. Form workgroup to determine infrastructure of APCD including if there will be a mechanism to develop blended funding model within this sytem.	• **3.1.1.MT-1. Development of APCD.** State will begin planning for and designing of APCD.	**3.1.1.LT-1. Implementation of the APCD. State will implement the Nevada APCD.**

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.1.2. ESTABLISH MECHANISM USING CLAIMS DATA TO ACCURATELY IDENTIFY PROVIDER CAPACITY AT AN INDIVIDUAL LEVEL. Establish mechanism to accurately identify and count addiction specialists.	• **3.1.2.NT-1. Use Data Best Practices.** Apply data collection methods and analysis to identify and count individual addiction specialists and treatment providers who are not individually enrolled.	• **3.1.2.MT-1. Eliminate Manual Data Collection and Program MMIS to Provide Data.** Use the MMIS portal to automate request to providers to identify individual addiction specialist's service providers and the capacity of each. • **3.1.2.MT-2. Aggregate Data from Individual Addiction Specialists and Treatment Providers for Capacity Analysis.** Regularly generate aggregate data summary reports to determine levels of capacity and impacts from policy and infrastructure changes. • **3.1.2.MT-3. Develop a Business Case.** Draft a business case, which outlines the need for enrollment of individual SUD and OUD treatment providers to accurately assess the number of providers and their capacity.	
3.1.3. DEVELOP ABILITY TO COLLECT AND ANALYZE DATA TO DISTINGUISH PROVIDERS WHO ARE ELIGIBLE TO SUBMIT CLAIMS FOR SUD SERVICES AND MAT. Implement technical capabilities to access historical individual provider capacity reports (SAMSHA, SAPTA, and Provider Enrollment), including a reliable consistent method to identify SUD and MAT Medicaid providers.	• **3.1.3.NT-1. Apply a Universal Indicator.** Create indicators on the provider enrollment record that signifies eligibility to provide SUD and MAT services.	• **3.1.3.MT-1. Update the Universal Indicator.** Update indicators so that a provider's eligibility to bill for SUD or MAT services is an integral and current element of their record.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.1.4. ACCURATELY IDENTIFY CAPACITY OF SUD AND OUD TREATMENT PROVIDERS. Identify data variances among reports about SUD and OUD providers and services by comparing CMS-64, T-MSIS and CMS quarterly progress report data.	• **3.1.4.NT-1. Coordinate Ongoing Data Reports.** Schedule ongoing meetings among the QPR, T-MSIS, and CMS-64 reporting teams to identify data variances and data correlation, and to ensure consistent data reporting. • **3.1.4.NT-2. Conduct Inventory of Baseline Data.** Continue current activities to gather behavioral health data from state, federal, tribal, and local resources. • **3.1.4.NT-3. Inter-Department Data Workgroup.** Establish a workgroup comprised of DHCFP, DPBH, and other state agency stakeholders to regularly share and analyze SUD and other related data, as well as make system change recommendations as needed. • **3.1.4.NT-4. Establish SUD Databook and Dashboards.** Establish Nevada SUD databook and reporting dashboards to improve data visualization and communication. Create dashboard reporting regarding process and outcome data, indicators, benchmarks, and specific measures.	• **3.1.4.MT-1. Maintain and Enhance SUD Databook and Dashboards.** Continue to monitor and identify enhancements to the Nevada SUD databook and reporting dashboards to improve data visualization and communication. • **3.1.4.MT-2. Culturally Relevant Data and Metrics.** Determine culturally relevant, specific tribal behavioral health metrics.	

Objective 3.2.

Improve ability to generate accurate, timely, and reliable SUD and OUD provider capacity data reporting.

Nevada's SUD data is accurate, well-coordinated, synchronized, and automated; reusable SUD reporting is available with sets of common reports, thus significantly reducing or eliminating monitoring and reporting cost and burden.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.2.1 UPDATE SUD AND OUD DATA REPORTING STANDARDS IN MEDICAID AND AND INCREASE COORDINATION BETWEEN REPORTING TEAMS. Further development of reporting standards will reduce the effort required to produce reports and reduce reporting inconsistencies.	• **3.2.1.NT-1. Apply Data Governance Processes to Develop and Enhance Applicable Standards.** Create Inter-Departmental Data Workgroup to develop SUD and OUD reporting standards to improve Quarterly Progress Report (QPR), T-MSIS, and CMS 64 reporting.	• **3.2.1.MT-1. Apply Reporting Standards.** Ensure reporting standards are being met through monitoring metrics that correlate SUD and OUD data. • **3.2.1.MT-2. Assign Reporting Responsibilities.** Identify position(s) responsible for monitoring and reporting the process and outcome measures to DHCFP, DPBH, and other appropriate state agencies. • **3.2.1.MT-3. Generate Annual SUD and OUD Report.** Develop and publish annual SUD and OUD report with specific identified data points and indicators. • **3.2.1.MT-4. Provider Capacity Data and Needs Assessment Reporting.** Combine SUD and OUD provider capacity data reporting with needs assessments data to continuously identify and address gaps in prevention, treatment and recovery services for special, historically underserved, and vulnerable populations.	

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.2.2 UTILIZE DATA GOVERNANCE PROCESSES TO INCREASE COORDINATION BETWEEN REPORTING TEAMS. Data governance concept best practices ensure that Nevada's multiple agencies are defining data consistently. This significantly reduces the need for interpretation of reports and possible misunderstanding of results.	• **3.2.2.NT-1. Continue to Apply Data Governance Practices.** Continue to apply data governance best practices to clarify roles in decision-making and accountability, particularly for data elements that are used by multiple reports.	• **3.2.2.MT-1. Support Data Governance Inter-Departmental Data Workgroup.** Assure that the data governance working group will regularly address data integrity, reporting needs, use of standards, and changes in SUD and OUD provider capacity-related data elements.	

Objective 3.3.
Increase access to near real-time SUD and OUD provider capacity and related data.

Increase Nevada's access to real-time SUD and OUD data to generate timely insights regarding the impact of policies and infrastructure changes on expansion of provider capacity and resulting beneficiary health outcomes.

STRATEGIES AND TACTICS

Strategies	Near-Term Tactics (30 Days up to 1 Year)	Mid-Term Tactics (1 – 3 Years)	Long-Term Tactics (3 – 5 Years)
3.3.1. INCREASE ACCESS TO REAL-TIME SUD AND OUD DATA AND USE OF INNOVATIVE ANALYTIC TOOLS. Currently the State does not have access to sufficient real-time SUD and OUD data. Access to real-time data allows Nevada to prepare relevant reports and quickly identify and address areas of concern.	• **3.3.1.NT-1. Explore Use of Statewide Registries.** Examine statewide registries including electronic lab results, birth registries, medication management, PMP, OpenBeds, and other registries to define interoperability-based use cases related to data analysis and reporting. • **3.3.1.NT-2. Leverage other non-claims data sources (birth records, grievance reports).** Use non-claims data sources to support the identification of barriers to SUD treatment services and provider capacity. Identify need for other non-claims data reporting like provider and recipient grievances.	• **3.3.1.MT-1. Create Interoperability Between Statewide Registries.** Establish interoperable connections between Medicaid and statewide registries including electronic lab results, medication management, PMP, OpenBeds, and other registries for data analysis and reporting. • **3.3.1.MT-2. Design and Develop Interoperable Systems With Access to Real-Time SUD and OUD Data.** Conduct research regarding interoperability of HIE-based data (based on provider EHR submitted data) or similar data sources. Utilize HIE clinical data to produce timely information, such as service utilization.	• **3.3.1.LT-1. Continue to Build Interoperable Systems to Access Real-Time SUD and OUD Data.** Continue research and develop implementation strategies to enable electronic sharing of data from provider EHRs or similar HIE data sources and generate dashboard reporting.

Appendix A: Acronyms

Acronym	Term
AHRQ	AGENCY FOR HEALTH CARE RESEARCH AND QUALITY
APM	ALTERNATIVE PAYMENT MODEL
APRN	ADVANCED PRACTICE REGISTERED NURSES
ASAM	AMERICAN SOCIETY OF ADDICTION MEDICINE
CARA	COMPREHENSIVE ADDICTION AND RECOVERY ACT
CASAT	CENTER FOR THE APPLICATION OF SUBSTANCE ABUSE TECHNOLOGIES
CCBHC	CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS
CLAS	CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES
CMS-64	CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS-64 IS A SPECIFIC REPORT)
CHIP	CHILDREN'S HEALTH INSURANCE PROGRAM
CMS	CENTERS FOR MEDICARE & MEDICAID SERVICES
DPBH	DEPARTMENT OF PUBLIC AND BEHAVIORAL HEALTH
DHCFP	DIVISION OF HEALTH CARE FINANCING AND POLICY
DHHS	DEPARTMENT OF HEALTH AND HUMAN SERVICES
ECHO	EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES
ED	EMERGENCY DEPARTMENT
EHR	ELECTRONIC HEALTH RECORD
FQHC	FEDERALLY QUALIFIED HEALTH CENTER
GME	GRADUATE MEDICAL EDUCATION
HIE	HEALTH INFORMATION EXCHANGE
HIV	HUMAN IMMUNODEFICIENCY VIRUS
IAR	INFRASTRUCTURE ASSESSMENT REPORT
IMD	INSTITUTIONS FOR MENTAL DISEASE
IOTRC	INTEGRATED OPIOID TREATMENT AND RECOVERY CENTER
MAT	MEDICATION-ASSISTED TREATMENT
MCO	MANAGED CARE ORGANIZATION
MHPAEA	MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT
MMIS	MEDICAID MANAGEMENT INFORMATION SYSTEM
MSM	MEDICAID SERVICES MANUAL
NAS	NEONATAL ABSTINENCE SYNDROME
NVHC	NEVADA HEALTHCARE
NVPCA	NEVADA PRIMARY CARE ASSOCIATION
OBOT	OFFICE BASED OPIOID TREATMENT
OCR	OFFICE FOR CIVIL RIGHTS

Acronym	Term
OTP	OPIOID TREATMENT PROGRAMS
OUD	OPIOID USE DISORDER
PAMA	PROTECTING ACCESS TO MEDICARE ACT
PCOAT	PATIENT CENTERED OPIOID ADDICTION TREATMENT
PMP	PRESCRIPTION DRUG MONITORING PROGRAM
PMP	NEVADA PRESCRIPTION MONITORING PROGRAM
PRAPARE	PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS, AND EXPERIENCES
QMHP	QUALIFIED MENTAL HEALTH PROFESSIONAL
QPR	QUARTERLY PROGRESS REPORT
RHC	RURAL HEALTH CENTER
SAMHSA	SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SAPTA	SUBSTANCE ABUSE PREVENTION AND TREATMENT AGENCY
SBIRT	SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT
SDOH	SOCIAL DETERMINANTS OF HEALTH
SEI	SOCIAL ENTERPRENEURS INC.
SOR	STATE OPIOID RESPONSE
SPA	STATE PLAN AMENDMENT
SUD	SUBSTANCE USE DISORDER
SWOT	STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS
TMSIS	TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM

Appendix B: Acknowledgements

The Nevada SUPPORT Act Planning Grant Strategic Plan was written in collaboration with DPBH and support from contractors. DHCFP would like to thank the below mentioned stakeholders, along with all the community and partners and individuals who gave significant and essential input and feedback into this process via survey, interviews, public workshop and planning sessions.

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