Governor Brian Sandoval's Prescription Drug Abuse Prevention Summit

Summary of Findings

Introduction and Background

In 2014, Governor Sandoval was selected by the National Governors Association as co-chair of the second round of its Prescription Drug Abuse Prevention Policy Academy for States, as part of the Association's ongoing effort to reduce prescription drug abuse. Nevada was selected as one of seven states to participate in the policy academy on the topic. As part of this academy, the Governor established a Drug Abuse Prevention Task Force which was led by First Lady Kathleen Sandoval. The Task Force organized a statewide meeting that took place over two days in May 2015 and engaged approximately 200 stakeholders and interested individuals. The Task Force recommended policy changes, and with the leadership of Governor Sandoval, was able to introduce and pass Senate Bill 459 which made substantial policy changes regarding prescription drug abuse prevention in Nevada. The Task Force also developed a statewide action plan that relied on the use of data and evidence-based strategies for combating this public health and safety crisis. The State's Substance Abuse Prevention Treatment Agency's (SAPTA) Multidisciplinary Prevention Advisory Committee (MPAC) has been charged with leading implementation of the recommendations in the plan developed by the Governor's Task Force.

On June 21, 2016, Governor Brian Sandoval hosted a comprehensive planning meeting to provide an opportunity for members of the MPAC and other state policy leaders, to hear presentations from state agencies, licensing boards, and other community stakeholders to provide public comment on prescription drug prescribing practices, options for treatment, criminal justice interventions, and challenges and opportunities in the state.

Following that meeting, a two-day summit was held to hear recommendations from stakeholders on how Nevada can best address prescription opioid abuse and its related challenges. Presentation topics included:

- Prescription drug abuse prevention best practices presented by the National Governors Association and the U.S. Department of Veteran Affairs,
- Federal priorities presented by U.S. Department of Agriculture,
- Lessons learned from state implementation presented by Vermont Governor Peter Shumlin,
- Criminal Justice Diversion Strategies presented by Community Oriented Correctional Health Services, and
- The rise of heroin presented by the Centers of Disease Control and Prevention (CDC).

Summit attendees participated in various subject matter tracks to develop recommendations for addressing prescription drug abuse prevention in Nevada.

Nevada's Opioid Problem

As noted in Governor Sandoval's opening remarks at the two-summit held in August 2016, the Centers for Disease Control and Prevention (CDC) recently concluded that deaths from opioid overdoes are reaching levels similar to the human immunodeficiency virus (HIV) epidemic at its peak. Additionally, the National Safety Council concluded that with more than 18,000 deaths from prescription overdose in 2014, the prescription opioid abuse crisis is the most fatal drug crisis on record in United States history. Overdose deaths have soared in recent years; between 2001 and 2014, there was a 200 percent increase in the rate of overdose deaths involving prescription opioids and heroin.[1]

[1] Rose Rudd et al., "Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014," Morbidity and

According to the CDC, more Americans died of drug overdoses in 2014 than in any year on record. Opioids were involved in 61 percent (28,647) of the 47,055 drug overdose deaths that occurred that year in the United States.[2] In addition to the human costs of opioid misuse, the epidemic of prescription drug overdose also imposes a financial toll. Non-medical use of opioid pain relievers—use without a prescription or simply for the feeling or experience the drug causes—costs U.S. insurance companies up to $72.5 billion annually in healthcare expenditures.

The epidemic also imposes substantial costs on state Medicaid programs. A 2009 Government Accountability Office report found that in 2006–2007, roughly 65,000 Medicaid beneficiaries in five states incurred over $60 million in drug costs related to "doctor shopping" for controlled substance prescriptions (i.e., patients obtaining controlled substances from multiple healthcare practitioners without prescribers' knowledge of other prescriptions).[3]

Nevada's overdose death rate for 2010 was 20.7 per 100,000 population, above the national rate of 12.4 per 100,000 population. [4] While, Nevada has seen a decrease in overdose deaths, opiate related hospitalizations have been steadily increasing over the last few years.

In Nevada, physicians write 94 pain killer prescriptions for every 100 residents, with hydrocodone as the most frequently dispensed pain killer. Center for Disease Control reports tell us that only 15% of people who are at most high risk for prescription drug abuse and misuse report getting prescription drugs from a drug dealer, while 27% receive them from a doctor's prescription, 26% get them from friends or relatives, 23% of them buy them from relatives or friends. This data tells us that nationally, prescription drug diversion is a serious issue. We see this to be true in Nevada, when looking at the Nevada Youth Risk Behavior Survey. In 2013 35% of all Nevada high school students reported having taken prescription drugs without a doctor's prescription. While this statistic on its own is alarming, the National Institute on Drug Abuse reviewed data from 2002 to 2012 and found that the incidences of heroin initiation was 19 times higher among those who reported prior non-medical pain reliever use than among those who did not.

Mortality Weekly Report 64 no. 50 (January 1, 2016): 1378–1382, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm (accessed June 13, 2016).

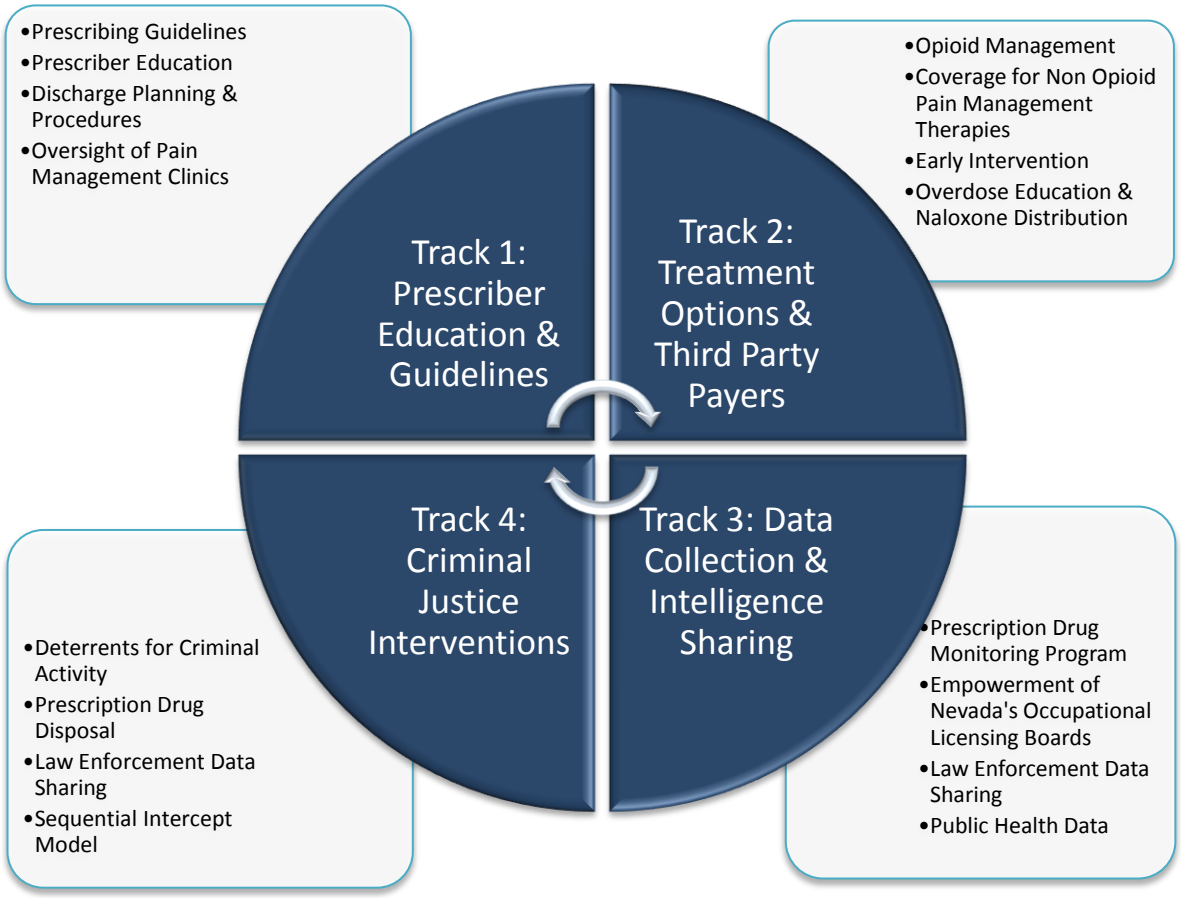
[2] Ibid.

[3] Ibid.

[4] Centers for Disease Control and Prevention. Prevention Status Reports 2013: Prescription Drug Overdose— Nevada. Atlanta, GA: US Department of Health and Human Services; 2014.

August 2016 Prescription Drug Abuse Summit

On August 31 and September 1, 2016, Nevada Governor Brian Sandoval hosted the Prescription Drug Abuse Prevention Summit in Las Vegas, Nevada to convene policy makers, health care providers, law enforcement, industry representatives and other interested stakeholders to make recommendations for how Nevada can best address its prescription drug abuse epidemic. More than 450 people from across the state attended. During the two-day summit, breakout sessions were utilized to gather recommendations around four specific subject matter tracks:



This document includes the recommendations that were made to the Governor that were developed during the two-day Summit. These sections are not intended to be exhaustive, rather to highlight the key points that were discussed during each of the breakout sessions.

Summary of Recommendations

Cross Cutting Themes

Through the four subject matter tracks, three key focus areas emerged. These areas included:

Design and implement data driven collaborative systems for decision-making to address the crisis.

- Identify trends, doctor shoppers and high prescribers by using Prescription Drug Monitoring Program (PDMP).
- Work (in a taskforce or fusion center) and partner Federal, State, and Local government on investigations and prosecutions.
    - Expand law enforcement to see the criminal justice system as part of data integration.
- Leverage policies and procedures (like the National Center for Interstate Compacts) for accessing information for the PDMP database.
- Formalize communications through an Executive Order.
- Develop and implement a universal data sharing agreement.
- Create shared definitions and language around comprehensive pain management approaches (Medication-Assisted Treatment/MAT, non-opioid treatment, etc.).

Implement public awareness to educate, inform, and engage the public, prescribers, physicians, and community-based organizations about the crisis.

- Educate the public.
- Create a one-stop resource (website) to report concerns about prescription use.
- Provide information about Naloxone and MAT.
- Ensure there is provider education, training and experience to support non-opioid treatment delivery:
    - Behavioral health providers need to understand the role they could play in pain management services.
    - Physicians need to know what non-opioid pain management services exist and are covered, and how to connect patients to those resources.

Ensure sufficient infrastructure and resources to address the crisis.

- Increase access to MAT.
- Address the healthcare workforce shortage issues (especially in the rural areas) and expand alternative service options such as telemedicine and mobile units.
- Implement patient-centered care to allow the full range of service options to meet their needs.
- Ensure there is a multi-disciplinary approach to public awareness.
- Expand range of non-opioid treatment options, such as:
    - Chiropractic
    - Acupuncture
    - Cognitive Behavioral Therapy
- Expand and promote Screening, Brief Intervention, and Referral to Treatment (SBIRT).

Breakout Session Reports

Track 1: Prescriber Education and Guidelines

Prescribing Guidelines

The development of prescribing guidelines by states has been deemed by the federal government and many national groups as best practice in the fight against prescription drug abuse and misuse. Discussion identified the following recommendations:

- Nevada should examine lessons learned from Washington and other states that have adopted guidelines to determine what limitations and referral practices need to be in place.
- Utilize CDC guidelines and adapt them to meet Nevada's needs.
- Incorporate close monitoring, and ensure that guidelines extend beyond prescribers to pharmacists.
- Guidelines need to be developed/adopted in alignment with provider competency requirements.
- The adoption of prescribing guidelines needs to support – rather than supersede – the clinical management of individual patients.
- Patient needs related to pain management and addiction treatment need to be distinct in the way they are described, defined and treated.
- Medicaid, Managed Care Organizations (MCO) and third party payers need to be actively involved in implementation design.
- Considerations need to be made related to multiple facets of a patient's story – including stage of life, individual history and circumstance, functioning, and whether pain is acute or chronic.
- Prescribers need reimbursement policies that align with guidelines and allow sufficient time for patient counseling and education.
- Adopted guidelines need to undergo regular revision to remain relevant, evidence-based and responsive to the needs of Nevada's culture.
- Prior to adoption, all licensed prescribers should have the opportunity to review and provide feedback.

Prescriber Education

Many prescribers do not receive in-depth training on opioid prescribing and addiction during their schooling. Discussion of recommendations for clinician training curriculum and continuing education requirements identified the following:

- Multi-disciplinary approach necessary where various disciplines help in determining the role that pain plays for a patient, and design the most responsive treatment.
- Beyond provider/prescriber education resources, communication about available resources is needed – evaluate feasibility of a website listing education availability that all Nevada providers can access, to facilitate connection to where education is happening and how to get it.
- Nevada's physician shortage impacts the approach to prescriber education significantly: the shortage of primary care results in patients finding care in acute care settings where provider-patient relationships do not exist.
- More MAT providers are needed.
- Prescriber should provide patient coaching in a supportive environment so patients can feel like they are not alone in dealing with sometimes difficult and complex problems.

Discharge Planning and Procedures

Discussion around the development of appropriate discharge planning procedures for those individuals who present in an emergency room with a potential opioid overdose identified the following:

- Adopt a multidisciplinary approach to discharge planning that includes social workers, RNs, and referral providers.
- Provide overdose death and hospital data back to the prescribing clinician (link PDMP to hospital and death data).
- Ensure that information needed for successful transitions in care is provided, including Naloxone administration and response, and collateral information from involved by-standers.
- Maintain an electronic bed capacity inventory for referral and/or transfer to substance use disorder/ behavioral health treatment.
- Initiate MAT prior to discharge, as appropriate.
- Define the role of pharmacists in discharge plan, following 2015 guidelines of the College of Psychiatric and Neurologic Pharmacists.
- Ensure that behavioral health issues are assessed and addressed in discharge plan.
- Ensure that ER providers and staff have up-to-date resource information for warm hand-offs to supportive services.
- Implement overdose response teams that work in partnership with recovery communities.
- Use PDMP to flag patients who have been treated for overdose.
- Consider negotiating with manufacturers to obtain a competitive pricing agreement for naloxone procurement.

Oversight of Pain Management Clinics

Discussion around how Nevada should provide oversight to pain management clinicians and physicians.

There is not consensus on how pain management clinics are, and should be, defined, so determining oversight mechanisms is difficult. There is consensus on the following recommendations:

- Involve medical board, pharmacy board, and other prescriber licensing boards in process of determining how pain clinics should be defined.
- The majority of pain prescriptions in Nevada are given by primary care providers. Tie oversight to non-punitive education on guidelines for all prescribers and staff.
- Oversight needs to incorporate review of how pain management specialists classify themselves in terms of board certification.

Track 2: Treatment Options and Third Party Payers

Opioid Management

Unprecedented access to prescription drugs has led to an increased need for medication assisted treatment through opioid treatment programs. Recommendations for this track included:

- There was widespread agreement amongst session attendees that Nevada should adopt guidelines for comprehensive opioid treatment management across all payers.
- Guidelines should be developed by reviewing what other states/systems have already developed around this issue and creating a customized version for Nevada.
- Guidelines should be established by a multidisciplinary team.

Medicaid Barriers

- Billing for MAT is sometimes problematic as there are not clearly understood billing codes.
- Develop Medicaid approved provider options in rural parts of the state.
- Reduce payment and administrative barriers to Medicaid.

Access Barriers

- There is more access needed to MAT within the criminal justice field (institutions, parole, and after-care settings), including providing support to those that are homeless.
- Utilize existing policies (i.e., suboxone waiver) to expand access to MAT – this will require outreach to qualified providers and revised payment structure.
- Eliminate access barriers such as fail first.
- Address workforce shortage issues (especially in the rural areas) and expand alternative service options such as telemedicine and mobile units.
- Ensure patient-centered care which allows the full range of service options to meet each patient's needs.
- Incentivize care coordination through appropriate payment structure.

Coverage for Non-Opioid Pain Management Therapies

Non-opioid pain management therapies have been identified as viable strategies for the management of chronic pain. Discussion of related issues identified the following:

- Nevada should support non-opioid pain management therapies.
- Non-opioid therapy options identified include:
    - Cognitive Behavioral Therapy
    - Chiropractic
    - Yoga
    - Supervised Exercise
    - Acupuncture
    - Interdisciplinary Rehab
    - Physical Therapy and Occupational Therapy
    - Spinal Manipulation
    - Massage/Rolfing
    - Hypnotherapy
    - Marijuana
    - Steroid Injections
    - Pallet Rich Plasma
    - Stem Cell Therapy
    - Magnetic EEG/EKG Guided Therapy
- A wide range of non-opioid treatment options should be made available to meet the unique needs of each patient. If forced to prioritize therapies, options which should be offered include:

    - Chiropractic
    - Acupuncture
    - Cognitive Behavioral Health

    Each of these therapies should be clearly defined to communicate what kinds of care within each therapy are covered.

- Therapies offered should be supported by evidence-based results of success.

Availability of Workforce

- Make licensing and certification process less cumbersome.
- Non-traditional providers need to have a mechanism to be Medicaid eligible for service reimbursement. Identify certification standards. Look at other state solutions to learn about how to do this.
- Incentivize professional internship or practice in rural areas.

Access to Care

- Expand telemedicine options.
- Address transportation barriers.
- Case coordination needs to be provided as a component of comprehensive care. Peer leadership models also promote access to care.
- Partner with existing providers (trusted community resources – like schools) to act as an access point.
- Partner with universities and colleges to secure resources and implement mobile services in rural areas.
- Examine Rural Veteran's Programs in Oregon and Washington as potential models for increasing access to care in rural areas.
- Use of community health workers as a component of care.

Providers don't always understand how to support their clients with non-opioid pain management

- Increase education, training and experience among Behavioral Health workforce.
- Educate providers on how to support MAT and non-medication therapies, to understand how and why to get people connected to the care they need.
- Increase educational component to training/licensing about the variety of therapy options to support pain management.

Medicaid Billing is Cumbersome

- Simplify billing process.
- Conduct additional Medicaid billing outreach to educate providers on how to bill.
- Conduct public outreach to enhance public's understanding of opioid risks and alternative care options which may be offered by physicians.
- Create shared definitions/language around comprehensive pain management approaches (MAT, non-opioid treatment, etc.).
- Ensure that the entire continuum of care is part of a Medicaid benefit package
- Enhance provider education, training and experience which would support non-opioid treatment delivery.
- Address the disincentives associated with physicians "prescribing" non-opioid treatment options. (disposition of clientele, client dissatisfaction, time associated with treatment option which is not adequately reimbursed).
- Increase educational component to training/licensing about the variety of therapy options available which support pain management.
- Develop a multidisciplinary team to support Medicaid and solution implementation.
- Address compounding treatment/recovery factors such as housing and transportation.

Early Intervention

This session discussed early intervention strategies and identified the following:

- Enhance primary care physicians' knowledge and/or comfort in addressing the behavioral health component of comprehensive care.
- Increase primary care physicians' knowledge in available community resources.
- Facilitate connection between a physician providing a referral and being able to get status on such referral.
- Increase provider capacity in both primary care and behavioral healthcare.
- Lower the threshold for adolescent entry into drug court.
- Educate patients and providers about acceptable levels of pain and how pain should be managed.
- Increase reimbursement rates for SBIRT activities to incentivize service provision.
- Integrate behavioral healthcare into primary care settings (either through co-location or onsite telehealth options).
- Utilize mid-level professionals or behavioral health care workers to provide SBIRT activities within primary care settings.
- Expand pre-op drug screening and connection to treatment when issue is identified.
- Look at IMPACT: Improving Mood—Promoting Access to Collaborative Treatment model out of University of Washington and customize an approach for Nevada.
- Distribute information about best practice tools to use for screening.
- Conduct a public education campaign aimed at the earliest form of intervention – prevention. **ABCD** Campaign:
    - A: (Use) **A**s Directed
    - B: **B**e Aware, Don't Share
    - C: **C**ontrol your Meds
    - D: **D**ispose Appropriately
- Expand use of SBIRT amongst providers and with complimentary professionals:
    - Encourage/require physicians issue screenings.
    - Embed screenings into electronic health records and provide training to support utilization.
    - Pharmacist directed SBIRT.
    - Require SBIRT training (being utilized in New York state).
- Develop a resource directory geared towards health professionals about community resources available to patients (Healthiernv.org).
- Establish a statewide forum for sharing best practice information on SBIRT and integrated care.
- Gather a diverse group of stakeholders to problem solve telehealth issues to expand access.
- Use behavioral health telemedicine within primary care settings/clinics who can conduct SBIRT and other behavioral health services.

- Address federal regulations that limit communication efforts between behavioral health and primary health care professionals.

Overdose Education & Naloxone Distribution

This session included discussion of recommendations specific to education and Naloxone distribution.

- Priority groups for overdose education and naloxone distribution include:
    - Physicians
    - Pharmacists
    - Patients and families
    - School personnel (teachers, nurses, coaches, athletic directors)
    - First responders (Law enforcement, firefighters, EMT's)
    - Substance abuse and treatment facility staff
    - Judges
    - Treatment groups and associations (AA, NA, etc.)

Prescriber and Patient

- Implement automated risk warning upon initial prescription of opioids.
- Implement PDMP warnings about opioid use.

Patient

- Implement pharmacist warning provided to patient and family regarding opioid use and danger of misuse.

Professionals

- Provide education to professionals utilizing existing Continuing Education Unit (CEU) structure.

At-risk Population

- Integrate messaging into mandatory training component of the Substance Abuse and Mental Health Services Administration (SAMHSA) services.

General Population

- Implement a public education campaign utilizing TV advertisements, internet presence and social media push advertising.
- Pharmacists need to dispense Naloxone and educate patients who have been prescribed an opioid (with consideration given to appropriate reimbursement).
- Expand access to Naloxone:
    - Make multiple Naloxone doses available to individuals who have been prescribed Naloxone so that multiple family members have it available.
    - Enable over the counter access to anyone wanting Naloxone.
    - Ensure that treatment providers have access to Naloxone (homeless/substance abuse programs).
- Ensure training and education is available to everyone who may administer Naloxone.

Track 3: Data Collection and Intelligence Sharing

Prescription Drug Monitoring Program (PDMP)

Historically, the Nevada PDMP has been used to identify patients who may be "doctor shopping." Not until recently has the PDMP been used as a data source to understand prescribing patterns. Discussion of this topic identified the following:

- Implement systems to push data from the PDMP to providers.
- Provide data by zip code to allow for geomapping.
- Implement a time limit for prescribing (such as between 7-21 days on acute pain and then certification for renewals).
- Enforce illegality of samples and auto refills.
- Implement a report card linked to consequences.
- Ensure Health Insurance Portability and Accountability Act (HIPAA) compliance between data systems.
- Ensure a mechanism for state boards to report back to PDMP.
- Facilitate access to lock in health plans.
- Mandate providers receiving state dollars sign up to submit data in PDMP and make this a requirement of licensing.
- Evaluate requiring a second signature for prescription/pain specialists/behaviorists.

Empowerment of Nevada's Occupational Licensing Boards

In addition to licensing physicians, Nevada's occupational licensing boards regulate the practice of medicine in the state. This session discussed the following key points:

- Boards all agree they need to do more and have been working more collaboratively. They are crafting language for a bill draft and need Legislative support to:
    - Shorten the time frame to obtain records and lengthen check in to a 60-day dispensing license.
- Facilitate access to medical records for investigations.
- Address the issue of phantom prescribers, who are licensees not on the books.

Joint Session: Law Enforcement Data Sharing

This joint session discussed development of collaborative information sharing efforts between state public health agencies and law enforcement. It identified the following:

- Use the Fusion Center to model reports using de-identified data on trends (Look at New Hampshire model for their partnership with public health, law enforcement, etc.).
- Create a centralized data center with the technical expertise and resources for analyzing and extracting information specific to the partners/communities needs. Ensure data is complete, accurate, and useful and adheres to HIPAA and other privacy standards. Look at Wisconsin and other models for opportunities to leverage.
- Use data to drive policy and resource decisions; and help direct investigations. Data includes:
    - Addiction analysis data
    - Prescriber/payer data
    - Coroner data re: overdose deaths

- Examine what the Drug Enforcement Administration (DEA) is doing in Clark County and expand it statewide.
- Utilize coroners, PDMP, and Public Health as a starting place to establish an agreement for data sharing.
- Improve timeliness and distribution of data (e.g., death records, hospital overdoses, Emergency Medical Services/Fire data re: overdoses and naloxone distribution, etc.).
- Add local health departments into the information sharing partnerships.

Public Health Data

This session discussed recommendations regarding data collection, and identified the following:

- Evaluate feasibility of implementing a dashboard (in development through DPBH).
- There is a need for both identified and de-identified data and agreements about how data is collected and reported.
- Work with coroners to ensure that overdose death data is standardized.
- Collect data from Prescription Drug Monitoring Program and the Division of Public Health including local health districts and workforce data.
- Use predictive analytics for best practice identification and public education.
- Promote use of the Health Insurance Exchange (HIE) to obtain more/better data with greater participation.
- Work toward integrated data system consistent reporting, so data sets ask the same question across multiples systems.
- Use memorandums of understanding (MOU) to put formal data sharing agreements into place.
- Utilize shared resources across state systems to strengthen data collection and sharing.
- Allow access for research and evaluation.
- Legislation should promote data sharing if needed within the guidelines of HIPAA.

Track 4: Criminal Justice Interventions:

Deterrents for Criminal Activity

This session discussed Nevada's policies and thresholds for the prosecution of criminal activity related to illegal distribution of opiates.

There is general agreement that Nevada should lower the state's thresholds for the prosecution of criminal activity related to illegal distribution of opiates. Suggested actions, policies and statutes to lower Nevada's thresholds for the prosecution of criminal activity related to illegal distribution of opiates:

- Amend Nevada Statute to mimic federal thresholds for trafficking Schedule 1 substances.
- Lower thresholds for determining felony classes (suggested levels: 4 to less than 12 grams – C felony, 12- 28 grams – B felony, 28 grams or more – A felony).
- In addition to changes in weights, determine number of pills and lowered pill quantity.
- Expand penalties – conspiracy is a C felony and considered too low.
- Enhance penalties for medical/other professional provider convicted of crime [related to opioids].
- Allow aggregation in order to demonstrate/prosecute conspiracy; expand penalties for conspiracy.

Suggested approaches to expand law enforcement partnerships and data access to better target over-prescribers, traffickers/criminal include:

- Develop policies and procedures for using PDMP database to send alerts and help investigate overprescribing. Could use National Crime Information Center (NCIC) policies/procedures as example.
- Add state and local partners to participate on the DEA task force to connect cross state trafficking.
- Educate the community about the true scope of the opioid trafficking and use epidemic.
- Build on and formalize partnerships between agencies, provide a single point of contact for each agency. Use the High Intensity Drug Trafficking Area program (HIDTA) framework. Formalize how executive supervisors communicate.

Prescription Drug Disposal

Nevada has a robust year-round prescription drug take back program that is run through the State's many prevention coalitions. Nevada has struggled to find a sustainable solution for prescription drug disposal.

There was agreement that Nevada should adopt a statewide strategy for sustainable, effective drug disposal.

The disposal options that should be considered in the Nevada strategy included:

- Conduct a cost-benefit analysis of an in-state incinerator, noting the expense of shipping to California for disposal. Where feasible, purchase small incinerators.
- Continue use of lock box/collection receptacles.
- Examine the partnership between Fallon Sheriff's Office and local hospital (Banner Churchill Community Hospital) for incinerating drugs.
- For ultimate end users (e.g., households), use "shake and bake" methods to render drugs unusable and seal in pouches for leach-proof landfill disposal. Replicate innovative Coalition strategies for providing these pouches to funeral homes and hospices to dispose of prescription drugs collected there.
- Research systems and current laws for mail back programs; work with partners (Walgreens, etc.) to address concerns and adapt to Nevada.

Suggested policies and practices:

- Implement the Extended Producers/Manufacturers Responsibility Model (Alameda, San Francisco, other California counties; Kings County, WA) where pharmaceutical companies pay for/contribute funding for take backs and disposal.
- Include doctors at the table(s) during take back events to illustrate how much prescription drugs are turned in; help educate public turning in pills.
- Continue public and practitioner education to increase understanding of how and where to safely dispose.
- Reduce number of days for initial pain prescriptions and ask patients to come back and see provider for a refill.

Sequential Intercept Model

The sequential intercept model emphasizes the implementation of interventions to divert individuals from the criminal justice system by linking them to treatment and support services. Discussion included:

- Ensure a Sequential Intercept Model (SIM) is working for the individual.
- Ensure utilization is appropriate.
- Suspend Medicaid rather than terminate once a person is jailed.
- Connect information systems.
- Ensure people are placed in the right programs.
- Promote insurance payments for individuals attending counseling.
- Engage others/shared case management (police, parole, caseworkers, providers, etc.) to develop with solutions.

Promote successful implementation of Sequential Intercept Model:

- Help connect individuals with a warm body, to assist with completing forms. Implement a shared, validated risk assessment tool.
- Encourage providers to be actively involved with specialty courts, and provide wraparound services. Continue work on a re-entry task force, with the purpose of identifying who should be eligible for services. Establish a single point of contact onsite.
- Develop offsite services, which can be funded through Medicaid.
- Implement a collective impact model, designed to expedite change. Promote Nevada Department of Corrections' pilot for medication treatment program. Train staff on motivational interviewing with prisoners.
- Promote collaboration across agencies, and to share resources. Focus on high risk offenders. Provide training to officers to be more engaged. Support transitional housing.
- Integrate SBIRT into the criminal justice setting.
- Assess resources in the community.
- Set up co-response teams.
- Conduct assessments (housing, community supports, finances) to link to resources.
- Promote peer supports for defendants, those in treatment, or who are early in model.
- Leverage Medicaid funding to supplement grants in Nevada, increase sustainability.
- Utilize targeted case management (TCM) more fully.
- Implement Medicaid enrollment as part of Parole and Probation roles (Medicaid reimbursable at 50%).
- Promote utilization of MAT.
- Create a one-stop shop for the inmates with focus on evidence based practices, and community supervision.
- Conduct ongoing program and outcomes evaluation – evidence based practice for corrections.
- Target a population, and create services for the population. Leverage Medicaid services to meet needs.
- Implement Crisis Intervention Team (CIT) and pair a social worker with an officer. Embrace the community to include others that are in recovery.
- Evaluate Nevada becoming a [Medicaid] suspension State rather than a termination State.
- Use presumptive Medicaid eligibility – considered a best practice (see Connecticut).
- Implement a statewide valid risk assessment tool and work with local municipalities to launch the tool.
- Leverage Certified Community Behavioral Health Clinics (CCBHC).
- Leverage eligibility opportunities for enrollment and TCM.
- Increase certified peer mentors/navigators.
- Remove eligibility requirements/prohibitions MAT.
- Leverage the School of Social Work's Intercept 1 Model.
- Formalize MOST (Mobile Outreach Street Team) model statewide.

Model for Change: Collective Impact Model

The Summit was facilitated using the lenses of the Collective Impact Model. Collective Impact is a framework to tackle deeply entrenched and complex social problems, like opioid abuse. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.

John Kania and Mark Kramer first wrote about collective impact in the **Stanford Social Innovation Review** in 2011 and identified five key elements. Collective Impact research reinforces that complex social problems can't be solved with singular, simple or siloed interventions.

The five essential elements of Collective Impact are:

1. **Common agenda**. All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
2. **Shared measurement**. Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
3. **Mutually reinforcing activities.** Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
4. **Continuous communication**. Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation.
5. **Backbone support.** Creating and managing collective impact requires a separate organization with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations.

Going forward, this framework should be used by State agency leaders, policy makers, industry and community leaders to implement systems changes and affect prescription drug abuse and over does death rates in Nevada.

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