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Interventions to Combat the Infectious Disease Ramifications of the U.S. Opioid Crisis

Downstream consequences of the U.S. opioid epidemic, including the many lives left in its wake, are a reminder that efforts to combat infectious disease must begin with the search for root causes and potential structural interventions. A syndemics approach facilitates research, policy, and practice that favors the understanding that this current crisis is not a problem associated with a single disease. For people who inject drugs, vulnerability for acquiring HIV (human immunodeficiency virus) and HCV (hepatitis C) are important considerations when crafting policies and implementing programs.[1-3]

Substance use and injection drug use (IDU) is associated with elevated risk of acquiring sexually transmitted infections (STIs) due to increased frequency of sexual risk behaviors, including multiple partnerships and inconsistent condom use in the context of drug use.[4,5] The synergistic overlap between these three conditions (HIV, HCV, STIs) is the result of structural factors which manufacture vulnerability among people who use drugs (PWUD). Thus, effective interventions, including structural interventions to shift law and policy, could leverage these similarities to address overlap where possible. A good example is recent efforts to address HIV and HCV in the context of the U.S. opioid crisis.[6,7]

State Law and Policy Response to the U.S. Opioid Epidemic

The legislative landscape shifted greatly in 2017 when the U.S. Department of Health and Human Services declared the national opioid crisis a public health emergency.[8] The movement to curb the U.S. opioid epidemic has since ramped up. In this policy brief, we explore state-based legislation introduced in 2017 and thereafter in two heavily impacted western states: California and Nevada. The purpose of this brief is to chart the recent proliferation of state-based legislation mapped onto models of response to the current opioid crisis as outlined by federal, state, local, and non-governmental experts. The table below lists California and Nevada legislation passed into law since 2017.

Preventing Substance Use Disorder & Overdose

Opioid Use/Misuse Disorder Prevention		
	California	**Nevada**
Safe storage and disposal	**SB 212** – requires drug makers to build and pay for collection sites to ensure drugs' safe disposal **AB 2859** – requires pharmacies to display safe storage products	No new legislation since 2017

Opioid Use/Misuse Disorder Prevention (Continued)		
	California	**Nevada**
Licensure and continuing education requirements	**SB 1109** – requires opioid addiction risk courses for health care professionals **AB 2487** – authorizes course for health care professionals on opiate-dependent patient management & treatment	**AB 77** – includes training on opioid issues in optometry licensing
Prescription opioid monitoring & regulation	**AB 528** – changes timelines for prescription reporting and patient data review on the Controlled Substance Utilization Review and Evaluation System (CURES) database; authorizes licensed physicians without Drug Enforcement Administration (DEA) registration to register for CURES access **AB 2789** – requires electronic prescriptions in 2022 **AB 2086** – provides prescribers access to CURES database to check for fraudulent prescriptions **AB 1753** – regulates prescription pads	**AB 49** – requires Chief Medical Officer to submit certain drug overdose information to electronic database **AB 239** – tightens prescribing of controlled substances for pain treatment **AB 310** – requires electronic prescriptions beginning 2021 **AB 474** – sets comprehensive prescribing protocols, adds information/drug overdose reporting to electronic Prescription Drug Monitoring Program (PDMP), & sanctions unauthorized prescribers **SB 459** – requires prescribers to review patient utilization report & flags over-prescribers on PDMP database
Pain management and pain clinic oversight	No new legislation since 2017	**SB 430** – re-classifies opioid addiction to allow persons to qualify for medical marijuana
Data collection, access, and sharing	**AB 1751** – permits CURES data sharing across state lines, especially with neighboring states like Nevada	No new legislation since 2017

Addressing Addiction

Treatment Access		
	California	**Nevada**
Medication-assisted treatment (MAT)	**AB 349** – updates reimbursement rates for Medi-Cal drug treatment programs	No new legislation since 2017
Treatment standards for recovery facilities	**SB 823** – requires minimum, evidence-based standards for substance abuse recovery facilities **SB 992** – tightens licensing requirements for recovery facilities	No new legislation since 2017

Opioid Overdose Prevention		
	California	**Nevada**
Naloxone access	**AB 714** – clarifies AB 2760 & conditions for co-prescribing naloxone **AB 2256** – expands access to specially trained law enforcement officers **AB 2760** – allows physicians' offices to offer patients naloxone	No new legislation since 2017
911 Good Samaritan laws	No new legislation since 2017	**SB 459** – provides immunity from civil and criminal liability and professional discipline for certain health care professionals to prescribe and dispense an opioid antagonist and for persons who seek medical assistance for a person who is experiencing a drug or alcohol overdose under certain circumstances

Brief descriptions of the above laws and policy strategies are provided in the Appendix.

Pursuing New Evidence-Based Interventions

Supervised injection sites	**AB 362** – seeks to establish a 6-year pilot program in the City and County of San Francisco to implement overdose prevention programs that provide a hygienic space, staffed by health care professionals, where PWUD can consume pre-obtained drugs, use provided sterile consumption supplies, and access referrals to substance use disorder treatment
Contingency Management	**SB 888** – seeks to expand the state Medicaid program's substance use disorder services to include contingency management services, an evidence-based practice used to treat substance use

The recent proliferation of legislation supporting efforts to address the opioid epidemic has been comprehensive. There continue to be areas of opportunity, however, in developing law and policy interventions to address addiction and decreasing barriers to treatment. In California, two new bills pending before its legislature seek to facilitate greater treatment engagement through the implementation of innovative strategies.

Evidence suggests that supervised injection sites save lives and decrease risks associated with substance use.[9] A single supervised injection site in San Francisco could prevent 3.3 new HIV transmissions per year and would save the State of California roughly $3.5 million per year in expenses related to health care, emergency services, and crime.[10] Contingency management services seek to utilize positive reinforcement in the form of rewards to promote healthy behaviors, such as attending treatment and abstaining from substance use.[11,12] Incentives may include cash or cash-equivalent vouchers, vouchers for goods and services, or tickets for random draws from a pool of prizes.[13] These evidence-based interventions are promising new directions aimed at improving harm reduction services for PWUD in California.

Eliminating Continued Barriers to Substance Use Treatment

In addition to expanding the use of new strategies to address the opioid epidemic, another set of law and policy interventions to consider are targeted efforts to eliminate continued barriers to effective treatment such as medication-assisted treatment (MAT). Patients treated with MAT have better outcomes, including a reduction in opioid use, fewer opioid-related overdoses, less involvement with the criminal justice system, and less exposure to infectious disease transmission.[14] Additionally, patients receiving MAT have better retention in treatment.[14] Because so much substance use treatment has focused on abstinence models and self-help, leveraging the broad spectrum of evidence-based treatment for substance use is key.

Despite its proven effectiveness, MAT uptake faces specific implementation challenges in both California and Nevada, including the following identified barriers:

- Treatment programs incorporating buprenorphine or naltrexone, two key medications used for MAT, are limited[15,16]
- The majority of privately-funded substance use treatment programs did not offer treatment with medication, and only one third of patients treated for opioid dependence in programs offering MAT were actually enrolled in such treatment[17]
- Despite a significant number of physicians prescribing buprenorphine, it remains unclear to what degree these physicians are adhering to recommended practices, including the provision of behavioral counseling[18]
- Cost continues to be a concern, as less than half of all substance use treatment facilities in California accept Medicaid[19]
- MAT coverage, including access to different medication options, and restrictions such as prior authorization requirements established by private insurers remain a barrier.[20-22]

In California, pending Senate Bill 854 seeks to remove some of the identified treatment barriers by prohibiting insurers from requiring prior authorization before coverage for FDA-approved prescriptions, such as MAT, and would additionally require that FDA-approved medications for treatment of substance use disorders be available on the lowest cost-sharing tier.[23]

Number of Medication-Assisted Treatment Providers & Facilities		
(As of June 5, 2020)	**California**	**Nevada**
Buprenorphine Practitioners	4,973	381
Substance Use Facilities[1]	1,426	79
Facilities Providing Substance Use Treatment[2]	1,406	78
Buprenorphine Use in Treatment	583	28
Naltrexone Use in Treatment	492	23
Methadone Use in Treatment	135	14

Sources: SAMHSA Behavioral Health Treatment Services Locator Map

[1] Substance use facilities provide different types of care, such as substance use treatment, detoxification, transitional or halfway housing or a sober home.
[2] Excludes detoxification or transitional facilities.

State Law and Policy Response to Intersecting Epidemics

Law and policy response to the opioid epidemic must leverage existing HIV law and policy. Conversely, existing responses to the HIV epidemic must expand to consider HCV and STI-related outcomes implicated by the opioid crisis. Potential strategies, some of which have already been addressed above, include:

- Increasing syringe and needle exchange programs (SEPs)
- Establishing safe injection (SIS) or supervised consumption (SCS) sites
- Considering prescription heroin as an alternative treatment
- Eliminating insurance barriers to MAT prescription
- Offering MAT in criminal justice settings and upon release from incarceration
- Supporting Emergency Department initiation of buprenorphine treatment
- Implementing HIV, HCV, STI outbreak planning and response
- Coordinating prevention and treatment of substance use, HIV, HCV, and STIs.[24-26]

Structural interventions developed in response to the HIV/AIDS epidemic may serve as a blueprint for the U.S. opioid response. Ending HIV transmission is achievable, and while eradication of HCV is an ambitious goal, it is not an impossible one. California and Nevada have led dynamic efforts to shift their respective law and policy in response to the U.S. opioid crisis. More law and policy interventions will be required to continue to shift the needle and tackle syndemic factors that contribute to HIV, HCV and STI vulnerability among PWUD.

Appendix

Preventing Substance Use Disorder & Overdose

Prescription opioid monitoring & regulation: In response to the over-prescribing of opioids in the 1990s,[27] states have regulated prescribing practices to allow only for necessary amounts minimizing risk.[20] A common state-level intervention, prescription drug monitoring programs (PDMPs), require licensed prescribers and pharmacists to register with a database and report controlled substance prescriptions. These laws require prescribers to review patients' prescription histories to decide medically appropriate care and alert them to potential drug misuse, abuse/use disorder, or diversion by patients. Related laws involve prescription limits, tamper-resistant prescriptions, patient ID requirements, and restrictions on multiple prescribers.[28] California's earliest PDMP dates to the 1930s,[29] and its current online database, the Controlled Substance Utilization Review and Evaluation System (CURES 2.0), was rolled out in 2015.[30] Nevada's Prescription Monitoring Program (NV PMP) is integrating prescription data into the state's electronic health records and pharmacy management systems.[31]

Pain management and pain clinic oversight: State medical boards set practice standards for health care professionals, including guidelines for treating patients in pain/with chronic pain. Law and policy strategies include enforcement of existing laws related to pain management. For example, recently, Nevada has targeted "pill mills" to complement its prescription opioid monitoring.[21]

Syringe services programs: Current laws permit legal access to clean needles and syringes through physicians and exchange programs and non-prescription sale in pharmacies. They shield public entities from prosecution for distributing such paraphernalia if done for disease, drug injury, and overdose prevention. They commonly provide additional access points at other community-based health and social services agencies. California has had syringe exchange programs since the late 1980s.[32] Pending California legislation proposes to lift the sunset provision of the current law on syringe access and will allow pharmacists the discretion to offer sterile syringes as part of the state's comprehensive approach to preventing the spread of HIV, hepatitis B, and hepatitis C. The bill would also allow adults to possess syringes solely for personal use.[33] The Nevada legislature repealed the barrier to such programs in 2013, but they were limited until federal legislation in 2016 allowed the use of federal funds for this purpose.[34,35] In 2017, Nevada pioneered the country's first vending machines that dispense syringes and safe sex kits.[36]

Safe storage and disposal: Syringe and needle exchange programs often include educating individuals in safe disposal and storage of these materials. Other laws require pharmacies and drug manufacturers to provide necessary equipment and facilities for these purposes, as in a recent California law mandating drug makers to build and fund collection sites.

Licensure and continuing education requirements: These laws require providers to seek, as a condition for licensing, continuing medical education (CME) in non-opioid pain management and the risks of opioid use disorders, and to register for access to PDMPs.[28] In California, most physicians and surgeons are required to complete 12 CME hours on either pain management and treatment of terminally ill and dying patients or the treatment and management of

opiate-dependent patients.[37] In Nevada, two hours of training on pain management or addiction care are required for each licensure period. For physicians or physician assistants registered to dispense controlled substances, two hours of CME on the misuse and abuse of controlled substances, prescribing opioids, or addiction are required.[38]

Data collection, access, and sharing: California's efforts aim at enhancing access to and use of CURES, its interoperability with electronic health records (EHR) and inter-state data sharing, and using data to educate and address fraud, diversion, and enforcement.[39] Likewise, Nevada emphasizes data sharing between public health and law enforcement officials to promote community-based diversion opportunities for people living with behavioral health issues, overdose prevention and community preparedness, and data collection by public health analysts to study overdose, crime, morbidity/mortality data .[40,41]

Public education & awareness: California has tailored its public awareness efforts about the risk of addiction and dangers of opioid misuse toward rural adults, seniors, and pregnant women.[42] Nevada has sought to educate the public, prescribers, and community-based organizations, particularly through two recent television and radio campaigns promoting stigma reduction around opioid use disorder and awareness of naloxone treatment.[43]

Addressing Addiction

Naloxone access: The distribution of naloxone, the chief antidote to opioid overdose and not itself a controlled substance, was restricted early on. State laws prohibited third-party prescriptions where prescribers would provide a person in a position to assist someone at risk of an opioid overdose a prescription of naloxone. State laws also limited prescriptions made by prescribers that did not have an existing patient-prescriber relationship with the patient. Since 2015, both Nevada and California have passed numerous laws that expand access by offering civil, criminal, and disciplinary immunity for prescribers, dispensers, and lay administrators of naloxone. Both allow third-party prescription and prescriptions issued with standing orders to healthcare and community workers seeking to assist individuals at risk of experiencing or witnessing an overdose. Additionally, both states have taken large steps to allow pharmacists to dispense naloxone without a prescription, enabling consumers to purchase naloxone over the counter.[44-46]

911 Good Samaritan laws: These laws provide civil and criminal immunity from liability or sanction for witnesses of overdose who are under the influence of or possessing controlled substances for personal use, if they call 911 or render emergency aid to overdose victims. California's Good Samaritan law dates to 2012 and Nevada's to 2015.[47,48]

Medication-assisted treatment (MAT): Medication-Assisted Treatment (MAT) for opioid use includes treatment with methadone, buprenorphine (Suboxone®, Subutex®, Probuphine®, SublocadeTM), and naltrexone (Vivitrol®). The "whole patient" approach, which incorporates MAT and behavioral counseling, is considered the most effective approach for treatment.[14,49]

Treatment standards for recovery facilities: Greater attention has been paid to the regulation of recovery facilities, including the implementation of minimal standards that are based in evidence. Many of these regulations are seeking to address a historical lack of standards and oversight of this particular industry.

References

1. Vickerman P, Martin NK, Roya A, et al. Is the HCV-HIV co-infection prevalence amongst injecting drug users a marker for the level of sexual and injection related HIV transmission? Drug Alcohol Depend. 2013;132(1-2):172-181. doi: 10.1016/j.drugalcdep.2013.01.020. Accessed April 10, 2020.
2. Alter MJ. Epidemiology of viral hepatitis and HIV co-infection. Jnl of Hepatology. 2006;44(Supplement 1):S6-S9. doi: 10.1016/j.jhep.2005.11.004. Accessed April 10, 2020.
3. Platt L, Easterbrook P, Gower E, et al. Prevalence and burden of HCV co-infection in people living with HIV: a global systematic review and meta-analysis. Lancet Infect Dis. 2016;16(7):797-808. doi: 10.1016/S1473-3099(15)00485-5. Accessed April 10, 2020.
4. Injection drug use and HIV risk. Centers for Disease Control and Prevention Website. https://www.cdc.gov/hiv/risk/idu.html. Accessed April 10, 2020.
5. HIV and people who inject drugs. Centers for Disease Control and Prevention Website. https://www.cdc.gov/hiv/risk/idu.html. Accessed April 10, 2020.
6. National Academies of Sciences, Engineering, and Medicine. Integrating Responses at the Intersection of Opioid Use Disorder and Infectious Disease Epidemics: Proceedings of a Workshop. Washington, DC: The National Academies Press; 2018. doi: https://doi.org/10.17226/25153.
7. National Center for HIV/AIDS, Viral Hepatitis, and TB Prevention. Strategic plan through 2020: updated December 2015. Centers for Disease Control and Prevention Website. https://www.cdc.gov/nchhstp/strategicpriorities/docs/nchhstp-strategic-plan-through-2020-508.pdf. Updated August 23, 2018. Accessed February 25, 2020.
8. HHS acting secretary declares public health emergency to address national opioid crisis. U.S. Department of Health & Human Services Website. https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html. Published October 26, 2017. Accessed April 9, 2020.
9. Miyashita A, Gamboa R, Leibowitz A, Holloway I. HIV and safer drug consumption programs in California. California HIV/AIDS Research Program Website. http://www.californiaaidsresearch.org/files/Safe-Consumption-Sites-Report_3.20.18.pdf. Published March 2018. Accessed April 9, 2020.
10. Amos I, Jozaghi E, Bluthenthal RN, Kral AH. A cost-benefit analysis of a potential supervised injection facility in San Francisco, California, USA. Jnl of Drug Issues. 2017;47(2):164-184. doi: 10.1177/0022042616679829. Published December 13, 2016. Accessed April 9, 2020.
11. Prendergast M, Podus D, Finney J, Greenwell L, Roll J. Contingency management for treatment of substance-use disorders: a meta-analysis. Addiction. 2006;101(11):1546-1560. doi: 10.1111/j.1360-0443.2006.01581.x. Accessed April 9, 2020.
12. Fitzsimons H, Tuten M, Borsuk C, Lookatch S, Hanks L. Clinician-delivered contingency management increases engagement and attendance in drug and alcohol treatment. Drug Alcohol Depend. 2015;152:62-67. doi:10.1016/j.drugalcdep.2015.04.021. Accessed June 18, 2020.
13. Petry NM, Bohn MJ. Fishbowls and candy bars: using low-cost incentives to increase treatment retention. Sci. Pract. Perspect. 2003;2(1):55-61. doi: 10.1151/spp032155. Accessed April 9, 2020.
14. Medication and counseling treatment. Substance Abuse and Mental Health Services Administration Website. https://www.samhsa.gov/medication-assisted-treatment/treatment. Updated April 9, 2020. Accessed April 9, 2020.
15. Mojtabai R, Mauro C, Wall MW, Barry CL, Olfson M. Medication treatment for opioid use disorders in substance use treatment facilities. Health Aff (Millwood). 2019;38(1):14-23. doi: 10.1377/hlthaff.2018.05162. Accessed April 17, 2020.
16. 2018 National survey of substance abuse treatment services (N-SSATS) state profiles. Substance Abuse and Mental Health Services Administration Website. https://wwwdasis.samhsa.gov/dasis2/nssats/n2018_st_profiles.pdf. Accessed April 17, 2020.
17. Knudsen HK, Abraham AJ, Roman PM. Adoption and implementation of medications in addiction treatment programs. Jnl Addict Med. 2011;5(1):21-27. doi: 10.1097/ADM.0b013e3181d41ddb. Accessed April 17, 2020.
18. Cunningham CO, Sohler NL, McCoy K, Kunins HV. Attending physicians' and residents' attitudes and beliefs about prescribing buprenorphine at an urban teaching hospital. Fam Med. 2006;38(5):336-340. Published May 2006.
19. Behavioral health treatment services locator. Substance Abuse and Mental Health Services Administration Website. https://findtreatment.samhsa.gov/locator. Accessed April 17, 2020.
20. Parker AM, Strunk D, Fiellin DA. State responses to the opioid crisis. J Law Med Ethics. 2018;46(2):367-381. doi: 10.1177/1073110518782946. Accessed March 31, 2020.
21. Wickramatilake S, Zur J, Mulvaney-Day N, Klimo MC, Selmi E, Harwood H. How states are tackling the opioid crisis. Public Health Rep. 2017;132(2):171-179. doi: 10.1177/0033354916688206. Accessed March 31, 2020.
22. Reif S, Creedon TB, Horgan CM, Stewart MT, Garnick DW. Commercial health plan coverage of selected treatments for opioid use disorders from 2003 to 2014. J Psychoactive Drugs. 2017;49(2):102-110. doi: 10.1080/02791072.2017.1300360. Accessed April 17, 2020.
23. California Senate Bill 854 (2019-2020).
24. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Evidence-based

strategies for preventing opioid overdose: what's working in the United States. Centers for Disease Control and Prevention Website. https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf. Published 2018. Accessed March 31, 2020.

25. Kilmer B, Taylor J, Caulkins JP, et al. Considering heroin-assisted treatment and supervised drug consumption sites in the United States. Santa Monica, CA: RAND Corporation; 2018. https://doi.org/10.7249/RR2693. Accessed March 31, 2020.
26. Ramachandran S, Thai H, Forbi JC. A large HCV transmission network enabled a fast-growing HIV outbreak in rural Indiana, 2015. EBioMedicine. 2018;37(Nov):374-381. doi: 10.1016/j.ebiom.2018.10.007. Accessed April 17, 2020.
27. Jones MR, Novitch MB, Sarrafpour S, et al. Government legislation in response to the opioid epidemic. Curr Pain Headache Rep. 2019;23(40). doi:10.1007/s11916-019-0781-1. Accessed March 31, 2020.
28. Soelberg CD, Brown RE J, Du Vivier D, Meyer JE, Ramachandran BK. The US opioid crisis: current federal and state legal issues. Anes Analg. 2017;125(5):1675-1681. doi: 10.1213/ANE.0000000000002403
29. Office of the Attorney General California Department of Justice. Prescription drug monitoring program. Office of the Attorney General Website. https://oag.ca.gov/sites/all/files/agweb/pdfs/pdmp/brochure.pdf. Accessed April 20, 2020.
30. Lauer G. CURES controversy rekindled. California Healthline Website. https://californiahealthline.org/news/cures-controversy-rekindled/. Published August 13, 2015. Accessed April 20, 2020.
31. Prescription monitoring program. Nevada State Board of Pharmacy Website. http://bop.nv.gov/links/PMP/. Accessed March 31, 2020.
32. Syringe exchange programs in California: an overview. California Department of Public Health Website. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/Overview%20SEPs%20in%20CA_2017.pdf. Updated April 2018. Accessed April 20, 2020.
33. California Assembly Bill 2077 (2019-2020).
34. U.S. Department of Health and Human Services. Implementation guidance to support certain components of syringe services programs, 2016. Department of Health and Human Services HIV Website. https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf. Published March 29, 2016. Accessed April 9, 2020.
35. Nevada Department of Health and Human Services. Syringe services program report July 2018. Nevada Division of Public and Behavioral Health Website. http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/Hepatitis/dta/Publications/Syringe%20Services%20Program%20Report-July%202018%20update%20FINAL.pdf. Accessed March 31, 2020.
36. Apgar B. Nation's first public needle vending machine for drug users debuts in Las Vegas. Las Vegas Review-Journal Website. https://www.reviewjournal.com/life/health/nations-first-public-needle-vending-machine-for-drug-users-debuts-in-las-vegas/. Published April 12, 2017. Accessed March 31, 2020.
37. Medical Board of California. Continuing medical education. Medical Board of California Website. https://www.mbc.ca.gov/Licensees/Continuing_Education/. Accessed March 31, 2020.
38. Nevada State Board of Medical Examiners. CME requirements summary. Nevada State Board of Medical Examiners Website. http://medboard.nv.gov/uploadedFiles/mednvgov/content/Licensees/CME_Requirements_MDs_PAs.pdf. Accessed March 31, 2020.
39. California Department of Public Health. Statewide opioid safety (SOS) workgroup policy framework categories and topics. California Department of Public Health Website. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Opioids/OpioidPolicyFramework_June2018.pdf. Accessed March 31, 2020.
40. Nevada Division of Public and Behavioral Health. Opioid response summit 2019, final report of Nevada's summit proceedings. Nevada Division of Public and Behavioral Health Website. http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/2019-Opioid-Summit-Report-ADA.pdf. Published August 2019. Accessed March 31, 2020.
41. Woodard, S. Nevada's comprehensive approach to addressing the opioid crisis. Nevada Department of Health and Human Services End HIV Website. http://endhivnevada.org/wp-content/uploads/2019/02/Addressing-the-Opioid-Epidemic-in-Nevada_Woodard.pdf. Accessed March 31, 2020.
42. California Department of Public Health. Education and information. California Department of Public Health Website. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/CaliforniasPublicEducationCampaigns.aspx. Updated February 19, 2020. Accessed March 31, 2020.
43. Nevada Department of Health and Human Services. State targeted response summary. Nevada State Opioid Response Website. https://www.nvopioidresponse.org/state-initiatives/. Published May 1, 2018. Accessed March 23, 2020.
44. Wuest JD, Long Y. Nevada naloxone regulations. Nevada Division of Public and Behavioral Health Website. http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/Docs/Nevada%20Naloxone%20Regulations.pdf. Accessed April 21, 2020.
45. California Department of Public Health. Naloxone statewide standing order frequently asked questions (FAQs). California Department of Public Health Website. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Naloxone/Naloxone%20FAQs%20062118.pdf. Updated June 18, 2018. Accessed April 21,

2020.
46. National Conference of State Legislatures. Drug overdose immunity and good Samaritan laws. National Conference of State Legislatures Website. https://www.ncsl.org/research/civil-and-criminal-justice/drug-overdose-immunity-good-samaritan-laws.aspx#Calling%20911. Published June 5, 2017. Accessed March 23, 2020.
47. California Legislative Information. Assembly bill no. 472; 2011-2012. California Legislative Information Website. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB472. Accessed April 21, 2020.
48. Nevada Electronic Legislative Information System. Chapter 453c - good Samaritan drug overdose act. Nevada Electronic Legislative Information System Website. https://www.leg.state.nv.us/NRS/NRS-453C.html. Accessed April 21, 2020.
49. National Institute on Drug Abuse. Effective treatments for opioid addiction. National Institute on Drug Abuse Website. https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction. Updated November 2016. Accessed April 17, 2020.