Item 5A

# Carson City Opioid Assessment

## FINDINGS & Recommended Implementation Plans

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# Population Analysis – Opioid Use Risk Factors

- Aging Population
- Limited healthcare providers speaking native languages
- Educational attainment
- Population living with disability
- Children in poverty or living in a low-income household

# Population Analysis – Opioid Use Risk Factors

- Poverty
- Housing limitations
- Childcare crisis
- Access to healthcare services for the low-income population

# Population Analysis – Opioid Use Risk Factors

- Special populations
  - Individuals who identify as LGBTQIA+
  - Pregnant women
  - Veterans

# Carson City Health Profile

## Risk Factors for Opioid Misuse

- Mental health
- Experimentation with other drugs
- Adverse Childhood Events (ACEs)
- Special considerations for youth

# Funding

Carson City Direct Allocation (One Nevada Agreement)

- Estimated Allocations FYs 2023-2044: $8,197,099.22
  - Develop opioid budget spending requests based on Goals and Tactics outlined in the Community Needs Assessment.
  - Annual report to State on how City intends to expend or has expended allocations to ensure funds are being used for eligible uses pursuant to SB 390.

State of Nevada Fund for a Resilient Nevada

- Estimated Allocations FYs 2023-2044: $420,293,377.02
  - Allows grants to Local Governments.
  - Community Needs Assessment required to apply for State grant funding.

# Recommended Implementation Plan

- Goal 1: Prevent the Misuse of Opioids and Other Substances
- Goal 2: Enhance Behavioral Health Treatment Resources
- Goal 3: Enhance Prevention and Treatment Efforts in the Criminal Justice System

# Questions

# OPIOID USE AND MISUSE

## COMMUNITY NEEDS ASSESSMENT


CARSON CITY, NEVADA

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# Executive Summary

## Background

The United States opioid epidemic began in 1999 due to an increase in drug overdose deaths from opioid prescription pain relievers. This marked the first wave of the epidemic, which has then been followed by the second wave beginning in 2010 due to a rise in heroin overdose deaths. The nation is currently in its third wave of the opioid epidemic, which started in 2013, and is continuing to worsen dramatically due to synthetic opioid overdose deaths. Out of every four drug overdose deaths in the United States in 2020, three of them involved an opioid. In the single year from 2019 to 2020, the number of drug overdose deaths increased by 30% (Centers for Disease Control and Prevention ["CDC"], 2022). The opioid crisis became a focus of national attention initially in 2015 when it was declared a national emergency by the executive administration of that time (State of Nevada Department of Health and Human Services ["DHHS"], 2022). This helped provide federal funding to help combat the crisis. Currently, the CDC helps to provide upstream support by giving resources to state and local entities, monitoring trends, supporting providers and healthcare systems, and educating the public to make safer choices about opioids (CDC, 2022).

With funding provided at the national level, Nevada implemented the High-Intensity Drug Trafficking Areas ("HIDTA") program under the Drug Enforcement Administration ("DEA") in 2017. HIDTA was enacted to identify high drug trafficking regions within the state that required immediate intervention (DHHS, 2022). Prior to implementation of HIDTA, in 2015 Nevada ranked thirteenth in opioid prescribing and twentieth among opioid-related deaths (CDC, 2022). These outcomes improved four years later; by 2019, Nevada improved to ranking twentieth in opioid prescribing and twenty-eighth in deaths related to opioid overdose nationally (DHHS, 2022). However, Nevada saw a drastic increase in deaths related to overdose of all stimulants from 2015 to 2020 (CDC, 2022).

In 2021, the Nevada Legislature passed Senate Bill ("SB") 390, which was an act relating to behavioral health (2021). This bill helped to provide and establish the suicide prevention and crisis hotline in the State, the Fund for a Resilient Nevada, and guidance for state, local, and tribal government organizations to help address the impact of opioid and substance use disorders across the state (SB 390, 2021). This assessment aims to provide an overview of the impact of opioid use in Carson City, Nevada, risk factors affecting various populations

within the city, areas of intervention identified through CBPR, and strategies to mitigate further negative impacts within the area through available funding.

## Community Overview

### Carson City's Geographical Information

Carson City is located in western Nevada and is both a consolidated municipality and the capital of the state. The county is bordered by Washoe County to the north, Storey County to the northeast, Lyon County to the east, Douglas County to the south and Placer County, CA to the west (U.S. Census Bureau, 2021).

### Carson City's Population

As of 2020 (U.S. Census Bureau), Carson City is the fourth most populous county in the state with 58,639 residents. The county geographically is the smallest in Nevada with 144.53 square miles of land and has an estimated 405.7 population per square mile (U.S. Census Bureau, 2020), the highest population density within the state. Carson City has seen an increase in population growth by 6.1% from 2010 to 2020 (U.S. Census Bureau, 2021). The Nevada State Demographer (2022) estimates that the population of Carson City will grow steadily over the next twenty years ranging from a 0.1%-0.7% increase each year over the next two decades.

Carson City's gender demographics is nearly equal with 51.8% males and 48.2% females. The median age of Carson City residents is 42.1 years, which is older than the overall median age in Nevada of 38.3 years. One in five Carson City residents are over the age of 65 (20.5%), compared to 15.8% within Nevada. Carson City's residents under the age of 18 is 20.0%, compared to 22.2% within Nevada. The percent change of those aged 18 and over has increased by 9.0% since 2010, which will continue to increase as the population ages (U.S. Census Bureau). Carson City's population by age group breakdown in comparison to Nevada and the United States is shown in Figure 1.

Figure 1: Population by Select Age Groups

| | United States | Nevada | Carson City |
|---|---|---|---|
| **Total Population** | 329,725,481 | 3,059,238 | 58,639 |
| **Median Age** | 38.4 | 38.3 | 42.1 |
| **Under 5 years** | 5.9% | 5.9% | 5.2% |
| **5 to 9 years** | 6.1% | 6.2% | 5.6% |
| **10 to 14 years** | 6.6% | 6.7% | 5.8% |
| **15 to 19 years** | 6.6% | 6.1% | 5.5% |
| **20 to 24 years** | 6.5% | 5.9% | 5.9% |
| **25 to 34 years** | 13.8% | 14.5% | 13.0% |
| **35 to 44 years** | 12.9% | 13.5% | 12.1% |
| **45 to 54 years** | 12.6% | 13.0% | 12.1% |
| **55 to 59 years** | 6.7% | 6.5% | 7.4% |
| **60 to 64 years** | 6.3% | 6.0% | 6.9% |
| **65 to 74 years** | 9.6% | 9.9% | 12.0% |
| **75 to 84 years** | 4.5% | 4.5% | 5.6% |
| **85 years and over** | 1.9% | 1.4% | 2.9% |

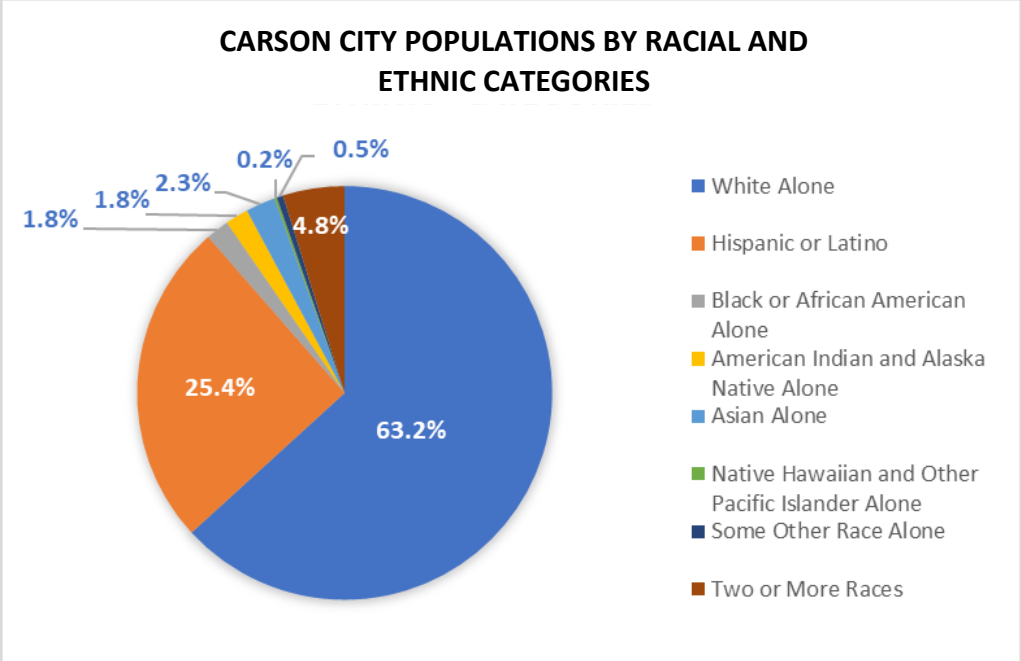
Source: U.S. Census Bureau, American Community Survey, 2022 5-year Estimates Data Profile

## Race and Ethnicity

The race and ethnicity characteristics of Carson City residents have changed considerably over the last decade. In 2010, the majority of Carson City residents were White, Not Hispanic or Latino (70.7%) with the second largest ethnic group being those who identified as Hispanic or Latino (21.3%). These numbers changed considerably by 2020 with the percentage of White, Not Hispanic or Latino residents decreasing slightly to 63.2%, residents who are Hispanic or Latino increasing to 25.4% and the third largest racial or ethnic group becoming individuals

identifying as Two or More Races, not Hispanic or Latino (4.8%) shown in Figure 2 (U.S. Census Bureau, 2020).

Figure 2: Carson City Populations by Racial and Ethnic Categories




Source: U.S. Census Bureau, American Community Survey, 2022 5-year Estimates Data Profile

## Language

For the population 5 years and older, 78% speak English as the primary language at home. The other primary languages spoken at home besides English are: Spanish – 81%, Asian and Pacific Islander – 9%, Other Indo-European – 7%, and other languages – 3%. Of those not speaking English as their primary language and speaking primarily Spanish at home, 31% do not speak English very well. It was reported in the 2022 Quad-County Regional Community Health Needs Assessment ("CHNA") that access to Spanish speaking healthcare providers is limited. From 2010 to 2020, Carson City moved from the 7th most diverse to the 5th most diverse county in the state of Nevada (U.S. Census Bureau, 2020).

## Educational Attainment

In 2022, of the population 25 years and older, 4% had less than a 9th grade education, 7% had an education level between 9th and 12th grade with no diploma or equivalency, 26% have a high school diploma or the equivalency, 28% had some college with no degree, 11% had an Associate degree, 16% had a Bachelor's degree, and 8%

had a Graduate or Professional degree. To summarize, 89% had a high school diploma or equivalency, which is very close to Nevada's percentage of 87%, and 24% had a bachelor's degree or higher, in comparison to Nevada's percentage of 26.5% (U.S. Census Bureau, 2020).

According to the 2023 Nevada Rural and Frontier Data Book, Carson City's 2020 graduation rate was 85.7% compared to 81.3% in Nevada. The percentages of males graduating were 82.4% and the percentage of females were 89.5%.

## Industry and Occupations of Carson City Civilian Residents

Carson City's civilian residents aged 16 years and older are employed in a variety of industries (Figure 3). The top three industries are: educational services, and healthcare and social assistance – 17.7%; arts, entertainment, and recreation, and accommodation and food services – 14.4%; and public administration – 12.2%.

Figure 3: Employment by Industry

| | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|
| **Population Aged 16 +** | 25,998 | 21,579 | 23,278 | 1,500 |
| Agriculture, forestry, fishing and hunting, & mining | 0.7% | 1.7% | 2.3% | 0.6% |
| Construction | 9.1% | 8.4% | 8.2% | 7.6% |
| Manufacturing | 9.4% | 8.5% | 12.7% | 7.5% |
| Wholesale trade | 2.2% | 0.9% | 4.3% | 3.1% |
| Retail trade | 11.8% | 10.1% | 13.9% | 9.0% |
| Transportation & warehousing, & utilities | 3.4% | 4.0% | 7.9% | 5.3% |
| Information | 1.7% | 1.4% | 0.9% | 4.0% |

| | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|
| Finance and insurance, and real estate & rental and leasing | 3.7% | 6.4% | 3.2% | 8.0% |
| Professional, scientific, and management, & administrative and waste management Services | 9.4% | 9.0% | 7.5% | 14.1% |
| Educational services, & healthcare and social assistance | 17.7% | 18.4% | 14.5% | 10.8% |
| Arts, entertainment, and recreation, & accommodation and food services | 14.4% | 15.2% | 11.6% | 17.4% |
| Other services, except public administration | 4.5% | 5.2% | 5.1% | 6.9% |
| Public administration | 12.2% | 10.8% | 7.8% | 5.7% |

Source: U.S. Census Bureau, American Community Survey, 2022 5-year Estimates Data Profile

## Computer and Internet Usage

Of the total households in Carson City, 93.1% have a computer. The households with a broadband internet subscription are 87.6%. (U.S. Census Bureau, 2022)

## Household Income

In 2020, the median household income for Carson City was $67,465, the lowest in comparison to Nevada and the surrounding counties – Nevada - $72,333, Douglas County - $84,262, Lyon County - $70,026, Storey County - $86,932 (Figure 4). Carson City had the highest percentage of households with an income below $25,000 and below $75,000. Storey County had the highest percentage of households with an income of $100,000 or more, and Carson City had the lowest percentage.

Figure 4: Carson City's Annual Household Income Percentages

| ANNUAL HOUSEHOLD INCOME | | | | | |
|---|---|---|---|---|---|
| | **Carson City** | **Douglas County** | **Lyon County** | **Storey County** | **Nevada** |
| Less than $10,000 | 3.9% | 3.3% | 5.5% | 3.0% | 5.6% |
| $10,000 - $14,999 | 3.9% | 2.7% | 3.3% | 4.3% | 3.1% |
| $15,000 - $24,999 | 8.2% | 5.7% | 5.2% | 5.3% | 6.5% |
| $25,000 - $34,999 | 7.3% | 7.2% | 7.7% | 9.7% | 7.4% |
| $35,000 - $49,999 | 11.3% | 9.7% | 12.0% | 10.9% | 11.6% |
| $50,000 - $74,999 | 21.0% | 16.0% | 19.0% | 12.3% | 17.6% |
| $75,000 - $99,999 | 14.0% | 15.3% | 14.4% | 10.2% | 13.6% |
| $100,000 - $149,999 | 17.1% | 19.0% | 20.7% | 25.5% | 17.9% |
| $150,000 - $199,999 | 5.6% | 9.2% | 7.2% | 10.6% | 7.9% |
| $200,000 and above | 7.7% | 12.0% | 5.0% | 8.2% | 8.8% |

Source: U.S. Census Bureau, American Community Survey, 2022 5-year Estimates Data Profile

## Residents Living with a Disability

According to the 2022 CHNA, nearly one in six, (16.5%), Carson City's residents are living with a disability. One in two of these residents (50.3%) residents are ages 75 and over, and slightly more than one in four of these residents (28.0%) are between the ages of 65-74. Older adults are at higher risks of disability and mortality. (Office of Disease Prevention and Health Promotion, n.d.). According to the CDC's Health Equity for People with Disabilities (2021), people with disabilities tend to engage in more risky health behaviors more often, have less access to healthcare, and experience more depression and anxiety. A participant in the 2022 CHNA stated, "We have a large senior population…from the EMS side, our biggest struggle is to and from appointments for people with disabilities and wheelchairs who can't walk more than 10 feet in their walker" (p. 44).

## Poverty

Poverty rates have decreased in many communities since 2010. Carson City's poverty rate in 2020 was 12.5% down from 15.1% in 2010. The poverty rates of the quad counties were Douglas County - 8%, Lyon County - 10.1%, Storey County - 7.8%. Nevada's poverty rate is 12.5%, and the United States' poverty rate is 11.9% (Nevada Rural and Frontier Health Data Book - 11th Edition, 2023). Carson City's poverty rate is higher than the surrounding counties, and the United States. People living in poverty are at high risk for adverse health effects resulting from obesity, smoking, substance use, and chronic stress. (Office of Disease Prevention and Health Promotion, n.d.).

Poverty affects children in multiple ways. Children living in poverty are at high risk for poor development and psychosocial outcomes. This leads to children not graduating from high school, teenage parent being more likely, more likely to be unemployed, and to be incarcerated (American Academy of Pediatrics' Policy Statement, 2016). According to the Nevada Rural and Frontier Health Data Book - 11th edition, Carson City's children, aged 17 and younger, living in poverty was 15.9% in 2020, down from 21.5% in 2010. Nevada's 2020 rate was 16.7% down from 21.3% in 2010. The United States' 2020 rate was 15.7%, down from 21.6% in 2010. The overall child poverty rates of the surrounding counties are Douglas County - 11%, Lyon County - 13.1%, and Storey County - 11.2%. Carson City has the highest child poverty rate in the region and is slightly higher than

the United States' rate. Carson City, and the surrounding counties rates are lower than Nevada's rate (Figure 5).

Figure 5: Poverty Rates

| | United States | Nevada | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|---|---|
| Poverty Rate (2020) | 11.9% | 12.5% | 12.5% | 8.0% | 10.1% | 7.8% |
| Children Living in Poverty (2020) | 15.7% | 16.7% | 15.9% | 11% | 13.1% | 11.2% |

Source: University of Nevada, Reno School of Medicine's Office of Statewide Initiatives, U.S. Census Bureau 2022.

### Public Assistance

Within Carson City, 17.5% of children under the age of 18 are living in a household receiving Supplemental Security Income ("SSI"), cash public assistance income, or food stamps/SNAP within the last 12 months. For comparison, within Nevada the percentage is 25.8%; 14.1% within Douglas County, 23.4% within Lyon County, and 14.6% within Storey County. Carson City does not have the highest percentage when compared to Nevada and Lyon County; however, there are still nearly 1 in 5 children living in a household needing public assistance.

Not every child defined as food insecure receives food stamps/SNAP. Food insecurity is defined by the USDA Economic Research Services as having "limited or uncertain access to adequate food". The food insecurity rate for Carson City residents in 2021 was 15.4% and the childhood insecurity rate was 21.9%. This is a higher percentage when comparing households with children receiving some type of public assistance (Feeding America, Map the Meal Gap).

## Access to Basic Needs

According to the 2022 CHNA, the pandemic had an impact on nearly everyone, especially our vulnerable populations and because of this the effects continue to linger and make it difficult for some residents to

get and stay healthy. "Some of the top community needs identified throughout the primary and secondary research include access to basic needs such as affordable housing, childcare, affordable and accessible prescriptions, and access to healthcare services for low-income individuals" (p. 26).

## Affordable Housing

Housing is an important social determinant of health, as poor-quality housing is associated with negative health outcomes, including chronic disease, injury, and poor mental health" (CHNA, 2023, p. 106). The 2022 median home value in Carson City was $299,900, which was slightly higher in comparison to the State of Nevada - $290,200; Lyon County - $238,600; and Storey County - $264,000, and significantly lower than Douglas County - $416,900. The homeownership rate in Carson City is approximately 61.3%, compared to 60.3% for Nevada. The average median mortgage and median rent is shown in Figure 6.

In 2022, it is estimated that there were 24,132 household units in Carson City. The vacancy rate for Carson City was 5.3%. Douglas and Storey Counties had the highest vacancy rates at 14.2% and 13.5% respectively. Lyon County had a vacancy rate of 8.3%. Of the vacancy rates, the availability of rental units was Carson City - 2.1%, Douglas County - 5.4%, Lyon County - 5.3%, and Storey County - 0.0% (U.S. Census, 2022). To summarize, the rental units' inventory is low.

The inhabitants of the household units are 43% married, 8% co-inhabiting, 21% single male head of household, and 28% single female head of household. Nearly one in two types of households are single heads of household with 43% being male and 57% being female. Of the total single head of household type, 12% have children under the age of 18, and 40% are male head of households and 60% are female head of household. Over 300 households are grandparents responsible for their grandchildren. Slightly above 1 in 3 households are individuals living alone, and 52% of those are over the age of 65 (U.S. Census, 2022).

Figure 6: Median Cost of Housing

| | United States | Nevada | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|---|---|
| Median Mortgage | $1,621 | $1,574 | $1,489 | $1,805 | $1,365 | $1,397 |
| Median Rent | $1,096 | $1,159 | $982 | $1,169 | $1,062 | $704 |

Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-year Estimates

According to the U.S. Department of Housing and Urban Development ("HUD") (2024), the definition of cost burdened is paying more than 30.0% of their income for housing costs. Figure 7 shows the percentage of Carson City households determined to be cost burdened compared to surrounding counties, Nevada and the United States.

Figure 7: Cost Burdened Households (Percentage of Household Income Paying for Housing Costs)

| | United States | Nevada | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|---|---|
| With a Mortgage | 20.6% | 23.0% | 30.9% | 34.6% | 29.2% | 27.7% |
| Without a Mortgage | 10.4% | 8.7% | 10.2% | 12.7% | 11.2% | 11.5% |
| Renter (35.0% or more spent on rent) | 40.0% | 40.8% | 29.6% | 36.9% | 36.2% | 32.9% |

Source: U.S. Census Bureau, 2016-2020 American Community Survey Five-Year Estimates

One in nearly three households with a mortgage are cost burdened which is higher in comparison to Nevada and the United States. One in ten with no mortgage are cost burdened and nearly one in three renters are cost burdened, which is lower than Nevada and the United States.

Fair market rents ("FMR") is defined as the cost to rent a moderately-priced dwelling unit in the local housing market according to HUD. These are the amounts used for housing assistance and are usually a couple of years behind the current market. In 2023, FMRs in Carson City are $921 for an efficiency/studio apartment, $1,066 for a one-

bedroom, $1,359 for a two-bedroom, $1,915 for a three-bedroom, and $2,306 for a four-bedroom. Rent prices have increased approximately 6-8% for the last couple of years. Carson City is the 6th most expensive county in Nevada in terms of FMRs, and the 7th most expensive county for housing behind Clark, Douglas, Elko, Esmeralda, Storey, and Washoe counties (huduser.gov).

A focus group participant of the 2022 CHNA stated, "Rents are in the $2,000 range and most of our clients live on less than $900 a month. We've got motels that have transitioned to a monthly rate and people are paying $900 a month to live in a facility with no kitchen or other amenities'' (p. 26). It should be noted that a Carson City initiative is to work with owners of motels serving as long-term living quarters for individuals to convert to either traditional motels or apartments to provide safe living conditions.

The fair market wage is the wage individuals need to make to afford a two-bedroom rental unit renting for the FMR plus utilities without paying more than 30% of income on housing. The Nevada minimum wage has increased to $10.50 if health insurance is offered; however, the wage has not kept up with inflation. Within Carson City, the fair market wage is $24.48, which equates to $50,918 annually. (National Low Income Housing Coalition, Nevada Factsheet Out of Reach, 2023) For the Fiscal Year 2023, individuals working full-time at minimum wage need 2.33 full-time jobs based on $10.50/hour.

In 2021, Carson City had the highest number of units that were subsidized at 770 within the quad county region. Douglas County had 236, and Lyon County had 164. (U.S. Department of Housing & Urban Development: A Picture of Subsidized Households Housing Insecurity, 2021)

### Housing Instability

According to the 2023 HUD Point in Time Count Report, 316 individuals within Carson City were housing instable. Housing instability takes into account the different issues people face, such as affordability, safety, quality, insecurity, and loss of housing (huduser.gov). It needs to be noted that this number is low as individuals living in motels were not included in the count. The motel data is not required by HUD; however, it has been deemed in Nevada that it is important data to collect since there are individuals who are possibly under-housed or at-risk of becoming homeless. To obtain this number, motel owners or

operators collect the data. The 2022 Point in Time Count had 606 living in motels.

### Childcare

The current childcare crisis came to light due to the pandemic. Childcare can be a huge barrier for individuals with children to obtain employment. Barriers include the lack of openings at the existing facilities, the cost, and the hours childcare facilities are open. Carson City has a number of employment opportunities that are either 24/7 operations, shift work, or the hours of operations do not match with the hours of the childcare facilities. During the interviews for the 2022 CNHA, a stakeholder stated, "In general, we need more childcare facilities, there are only five places. They don't take many kids and it's very expensive. Many parents don't work because it only covers gas and childcare. When COVID hit, I had three kids in daycare, and I paid $1,700 every paycheck and I have a 50% discount due to my family owning the facility" (p. 27). The childcare issue had been discussed by the Carson City Behavioral Task Force and it has been noted that older children are not attending school on a regular basis so they can babysit the younger children while the parent goes to work leading to chronic absenteeism. Chronic absenteeism further puts youth at risk for behaviors leading to substance use.

### Affordable and Accessible Prescriptions

According to the 2022 CHNA, access to affordable and accessible prescriptions was ranked the fifth highest need in the community survey and for those younger than 35, the top need for individuals. For those participating in the telephone survey, it was ranked the third highest. One of the biggest challenges is the affordability of the prescriptions.

### Access to Healthcare Services for Low-Income Individuals

According to the Nevada Rural and Frontier Health Data Book (2023), 12.3% of Carson City residents are uninsured. Of those insured, one in four residents are enrolled in Medicaid or 26.1%. According to the 2022 CHNA, 5,336 children under the age of 19 are uninsured. Of those children, approximately 900 or 15.9% were enrolled in Nevada Check Up. According to the 2022 CHNA, one in four adults with employer health insurance plans are estimated to be considered as underinsured and likely struggle to pay for out-of-pocket healthcare costs. In the telephone survey, approximately three in four individuals

said, "within the past two years there has been at least one occasion where they needed medical or mental healthcare but chose not to get it" (p. 29). The reasons given were the inability to pay and long wait times to see providers. The survey respondents ranked access to healthcare services for low-income individuals as the eighth-top need. A participant stated, "We have a lot of seniors, and a lot of people won't take new Medicare patients. A lot of seniors have no access to primary care and when they do, they are struggling because they have no family support here" (p. 44).

## Special Populations

### Individuals Who Identify as LGBTQIA+

As stated in the 2022 CHNA, "the LGBTQIA + community has a significantly higher percent of depressive disorder diagnoses and more days of poor mental health" (p. 213). In Nevada, gay, lesbian, and/or bisexual students were twice as likely to be bullied on school property according to the 2019 Youth Behavioral Risk Factor Surveillance System ("BRFSS"). Research has shown that all forms of bullying are significantly associated with increases in suicidal ideation according to the National Institutes of Health's ("NIH") *Cyberbullying linked with suicidal thoughts and attempts in young adolescents,* 2022. Electronic bullying includes being bullied through texting, Instagram, Facebook, or other social media, during the 12 months before the survey.

According to The Trevor Project's 2021 National Survey on LGBTQ Youth Mental Health, (2021), which collected data between October and December of 2020 and had 34,759 LGBTQ youth respondents, the majority of LGBTQ youth (52%) who were enrolled in middle or high school reported being bullied in the past year, and LGBTQ students who reported being bullied in the past year had three times greater odds of attempting suicide in the past year. However, transgender and nonbinary youth who reported having pronouns respected by all of the people they lived with attempted suicide at half the rate of those who did not have their pronouns respected by anyone with whom they lived. The same study found that 75% of LGBTQ youth reported that they had experienced discrimination based on their sexual orientation or gender identity at least once in their lifetime. The Trevor Project is the world's largest suicide prevention and crisis intervention organization for LGBTQ

young people. (CHNA, 2022) According to Girouard, Michael Paul, "LGBTQ people are also prescribed opioids at higher rates than their sexual and gender majority counterparts, though the cause is not known" (2020, p.1).

### Pregnant Women

Opioids are not safe to take during pregnancy; although, there are some circumstances in which opioids are prescribed. According to Ko et. al (2019), 20,643 responded to questions on the Pregnancy Risk Assessment Monitoring Survey ("PRAMS") about opioid use during pregnancy. Among the respondents, 6.6% reported prescription opioid use. Of the women reporting opioid use, 8.9% reported having a non-healthcare provider source. These included pain relievers left over from an old prescription (5.4%), getting from a friend or family member (1.9%), another way without a prescription (3.0%), and other or undetermined manner (4.3%). Questions were asked about the reason for the opioid use of which 6.3% answered. Reasons for any pain (88.8%), included pain relief from an injury, condition, or surgery prior to pregnancy (22.2%), pain relief from an injury, condition, or surgery during pregnancy (63.8%), and pain relief from an injury, condition, or surgery during an undetermined period of time. The respondents that reported any non-pain reason were 14.4%. The reasons included to relax or relieve tension or stress (7.7%), help with feelings or emotions (3.7%), help to sleep (7.9%), to feel good or get high (1.1%), "hooked" or had to use (2.4%). The conclusion was that an estimated one in five women (21.2%) reported opioid misuse.

According to the CDC, there has been a 131% increase from 2010 to 2017 of opioid-related diagnosis at birth. Opioid use risks during pregnancy include preterm labor and preterm birth, placental abruption, preeclampsia, and miscarriage or stillbirth. Approximately 72 hours after birth, if opioids were used regularly, the baby will go through withdrawals, known as neonatal abstinence syndrome, and may have the following symptoms: tremors, sweating, hyperactive reflexes, vomiting or loose stools, stuffy or runny nose, irritability and crying, sleep problems, poor feeding, and seizures. Symptoms may last about 28 days and are called neonatal withdrawal syndrome.

There are lasting effects on the child as well. There can be developmental issues, such as low birth weight or congenital conditions such as heart structural changes causing functionality problems, glaucoma, a hole near the belly button allowing the

intestines to protrude outside the body, and brain, spinal cord and spine defects. Sudden infant death can also be the result of opioid usage by the pregnant person.

### Veterans

The veteran population in Nevada is decreasing according to the Veterans Health Administration. Carson City's veteran's population has decreased from 5,824 in 2016 to 4,695 in 2022. This has been seen in the surrounding counties as well. In 2022, veterans were 7.5% of the population. In comparison, the veteran's population in Nevada is 5.4%, in Douglas County - 9.1%, in Lyon County - 9.1%, and in Storey County - 8.2%. The average age of veterans is shown in Figure 8.

Figure 8: Average Age of Veterans

| | Carson City | Douglas County | Lyon County | Storey County |
|---|---|---|---|---|
| Under 45 | 772 | 664 | 1,224 | 64 |
| 45 - 64 | 1,171 | 1,023 | 1,653 | 124 |
| 65 - 85 | 2,317 | 2,410 | 2,693 | 221 |
| over 85 | 435 | 361 | 346 | 14 |
| Total | 4,695 | 4,458 | 5,916 | 423 |

Source: University of Nevada, Reno School of Medicine's Office of Statewide Initiatives, Veterans Health Administration. (2022).

According to the American Addiction Centers, "Veterans are more susceptible to opioid addiction as they are more likely to suffer from chronic pain. In addition, many veterans suffer from mental health problems like Post-Traumatic Stress Disorder ("PTSD"), making them more likely to abuse drugs and alcohol in an attempt to self-medicate" (Accessed on 1/14/24 at https://americanaddictioncenters.org/veterans/opioid-addiction).

## Population Analysis for Opioid Use Risk Factors

Carson City's population has a number of risk factors for opioid misuse and abuse. Each risk factor is discussed below.

*Aging population* - The population is aging with one in five (20.5%) being 65 years and older. Older adults are at higher risk for disabilities

and mortality (Office of Disease Presentation and Health Promotion, n.d.).

*Limited healthcare providers speaking native languages* - Carson City has a diverse population with 22% speaking a language other than English at home. The majority (81%) of those that speak another language at home speak Spanish primarily and it was stated in the CHNA that there are a limited number of healthcare providers that speak Spanish. One in three of the 22% do not speak English very well which can lead to not understanding healthcare providers' instructions about opioid use.

*Education attainment* - Eleven percent of the population does not have a high school diploma. This can lead to poverty which puts individuals at a higher risk of opioid abuse.

*Disability* - Nearly one in six (16.5%) of Carson City's residents are living with a disability. Based on age, slightly more than one in four (28.0%) residents between the ages of 65-74 have a disability, and one in two (50.3%) ages 75 and over have a disability. According to the CDC's Health Equity for People with Disabilities webpage (2022), people with disabilities tend to engage in more risky health behaviors more often, have less access to healthcare, and experience more depression and anxiety.

*Children in poverty or living in a low-income household* - Nearly one in five (17.5%) children under the age of 18 are living in a household receiving SSI, cash public assistance income, or food stamps/SNAP. One of the highest within the region. Not every child defined as food insecure receives food stamps/SNAP. Slightly more than one in five (21.9%) children are food insecure meaning they have "limited or uncertain access to adequate food".

*Poverty and low income* - The median household income in Carson City is $67,465, the lowest within the region and Nevada. In addition, Carson City had the highest percentage of households with an income below $25,000 and below $75,000. As a result, Carson City has the highest number of units that are HUD subsidized at 770 within the quad county region.

Carson City's poverty rate is 12.5%, which is higher than the surrounding counties, and the United States. People living in poverty

are at high risk for adverse health effects resulting from obesity, smoking, substance use, and chronic stress; older adults are at higher risks of disability and mortality. (Office of Disease Prevention and Health Promotion, n.d.). Nearly 16% (15.9%) of children under the age of 17 are living in poverty. These children are at high risk for poor development and psychological outcomes putting the individual at risk for not graduating from high school, being a teenage parent, being unemployed, and being incarcerated. One in six (15.4%) residents are food insecure meaning they have "limited or uncertain access to adequate food".

*Housing* - Carson City is the 6th most expensive county in Nevada in terms of FMRs, and the 7th most expensive county for housing. Along with being expensive, the rental vacancy rate is very low at 2.1% for rental units. It takes more than two full time jobs at an hourly wage of $24.48 to afford a two-bedroom unit. Within Carson City, there are one in two (49%) living in a single male or female head of household. Of these, 12% have children under the age of 18. In addition, there are over 300 households in which the grandparents are responsible for their grandchildren.

Being cost burdened means that over 30% of income is spent on housing expenses. One in nearly three (30.9%) households with a mortgage are cost burdened; nearly one in three (29.6%) renters are cost burdened.

According to the 2023 HUD Point in Time County Report, 316 individuals within Carson City are housing instable, this includes the individuals living on the streets.

*Childcare Crisis* - Childcare in Carson City is a need according to the 2022 CHNA. This problem has been discussed at the Carson City Behavioral Health Task Force. The need for childcare could be resulting in absenteeism issues seen within the school district. The lack of childcare options could be resulting in the older children taking care of the younger children so the parent(s) can work. The chronic absenteeism in Carson City is a problem of which the Carson City School District is taking action. Chronic absenteeism further puts youth at risk for behaviors leading to substance use.

*Access to healthcare services for the low-income population* - Over one in eight (12.3%) of Carson City residents are uninsured. Of the

residents insured, slightly over one in four (26.1%) are enrolled in Medicaid. Of those with insurance obtained through their employer, one in four adults are estimated to be considered uninsured and likely struggle to pay for out-of-pocket healthcare costs according to the 2022 CHNA.

### Special Populations

*Individuals who identify as LGBTQIA+* - This population has a significantly higher percentage of depression, experience discrimination, are more likely to be bullied at school and electronically, and at higher risk for attempting suicide. According to Girouard, Michael Paul, "LGBTQ people are also prescribed opioids at higher rates than their sexual and gender majority counterparts, though the cause is not known" (2020, p.1).

*Pregnant Women* - According to a PRAMS study, 6.6% of the respondents reported prescription opioid use, and 8.9% reported obtaining opioids from a non-healthcare provider source. The conclusion of the study was an estimated one in five women (21.2%) reported opioid misuse. These women are at risk for preterm labor and preterm birth, placental abruption, preeclampsia, and miscarriage or stillbirth. The fetuses and newborns are at risk for neonatal abstinence syndrome, neonatal withdrawal syndrome, low birth weight, and/or congenital conditions such as heart issues, glaucoma, hole in the abdominal wall causing intestinal issues, and/or brain, spinal cord and spine defects, and sudden infant death. Lasting effects to the child may include neonatal withdrawal syndrome or NOW. There can be developmental effects as well.

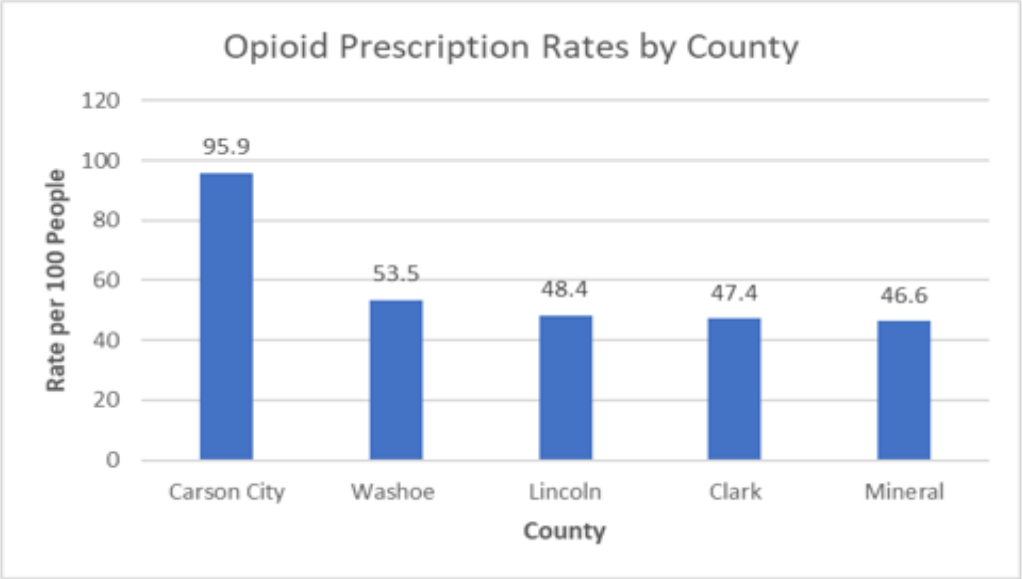
*Veterans* - Carson City's veteran's population is aging. According to the American Addiction Centers, "Veterans are more susceptible to opioid addiction as they are more likely to suffer from chronic pain. In addition, many veterans suffer from mental health problems like PTSD, making them more likely to abuse drugs and alcohol in an attempt to self-medicate" (Accessed on 1/14/24 at https://americanaddictioncenters.org/veterans/opioid-addiction).

## Impacts of Opioid Use/Opioid Use Disorders in Carson City

According to the CDC (2020, 2021, 2022), Carson City saw a decline in opioid prescription rates from 2016 to 2020. However, as of 2020 Carson City has the highest rate of opioid prescriptions, which includes

new orders and refills, in the state at 95.9 per 100 people. Figure 9 displays Carson City in comparison to the other four counties with the highest opioid prescription rates in the state. Washoe, Lincoln, Clark, and Mineral Counties show similar rates from 46.6 to 53.5 prescriptions per 100 people, which is drastically lower than Carson City's prescription rate.

Figure 9: Opioid Prescription Rates by County




Source: CDC, U.S. County Opioid Dispensing Rates 2020. 2022

It is important to note that opioid prescription counts are based off the location of the prescriber rather than the location of the pharmacy, which may suggest that individuals seeking prescriptions may be living in a different county. Some possible contributing factors that impact the rate of opioid prescriptions according to CDC's webpage, Prescribing Practices | Drug Overdose | CDC Injury Center, may include being a smaller city, having a high percentage of white residents, having an aging population, and having many residents that are uninsured, unemployed, or have a chronic condition such as diabetes, arthritis, or a disability. In addition to also having a large proportion of older and white residents, Carson City is at a higher risk of over prescription of opioids with a 57.9% employment rate, 10.5% of residents without health insurance (U.S. Census Bureau, 2021), and 16.5% of residents having a disability (CHNA, 2022). Carson City is also a healthcare hub for surrounding counties.

Opioid use in Carson City is greatly affecting families countywide. The Division of Children and Family Services [DCFS] within the State Office

of Analytics (2022) reported a 14.9% increase in children removed to foster care due to parental drug use from 20% in 2019 to 34.9% in 2021. This measure encompasses parental drug abuse, meth use, and opioid use. This is similar to data regarding children less than 1 year of age where 35.7% of removals to foster care in 2021 were due to parental drug use, a 10.7% increase in comparison to 2020 (DCFS, 2022). Children in foster care can face increased risks of unstable housing or homelessness, limited education, health problems, limited access to health care, delinquency, and overall lack of social connection and support if they are within the foster care system for an extended amount of time during their youth (Youth.gov, n.d.).

Increases in opioid use among Carson City residents puts additional pressure on limited resources providing care for those with opioid use disorders. Although Carson City has both inpatient and outpatient behavioral health services available as resources, there are possibilities of those resources being strained further as the opioid crisis continues. It is also important to consider that neighboring rural county residents may also need to seek care within Carson City due to barriers to care within other jurisdictions.

## Carson City Health Profile

As of 2022 (University of Wisconsin Population Health Institute) the *County Rankings and Roadmaps* ranks Carson City 11 of 16 (Esmeralda County was not surveyed in 2022) counties in the state regarding health outcomes and factors. This is an improvement from its previous ranking of 13 the year prior (University of Wisconsin Population Health Institute, 2021). One out of 5 Carson City residents report having poor or fair health and approximately 1 out of 3 residents are obese (University of Wisconsin Population Health Institute, 2022). Close to 1 out of 5 adults and 1 out of 10 children are uninsured in the county (University of Wisconsin Population Health Institute, 2022). The overall provider shortage is exacerbated further when looking at the ratio of primary care physicians (88.7:100,000) and dentists (79.8:100,000) to the population (University of Nevada, Reno School of Medicine, 2021).

Factors such as those mentioned prior can be risk factors for poor health outcomes. However, risk factors for opioid misuse may not be as linear as something such as obesity leading to diabetes if left unmanaged. Risk factors for opioid misuse are multifaceted and can be

heavily influenced by personal experiences and beliefs. It is crucial to understand where Carson City falls regarding risk factors and to identify high-risk groups as well as areas to intervene to mitigate opioid use and misuse within the community.

## Risk Factors for Opioid Misuse

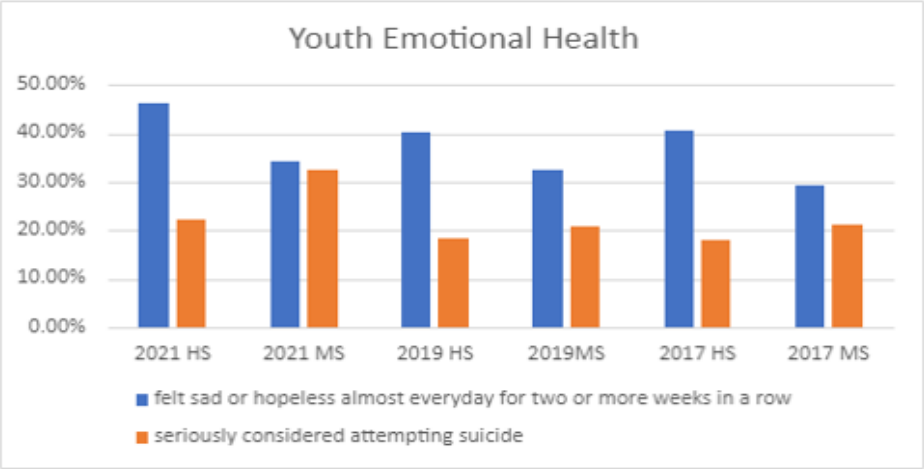
The National Institute on Drug Abuse ("NIDA"), under the NIH, states there is no single factor that is the main determinant of an individual having an addiction but is rather based around the number of risk factors someone has.

(NIDA, 2020). Studies completed to determine the amount that biological factors play in the likelihood of someone having an addiction range from 40 - 60% if they have a family history of addiction (NIDA, 2020). However, there are other risk factors that could put individuals at higher risk of developing an opioid use disorder.

## Mental Health

A risk factor for opioid use in both adult and youth populations is having a mental health disorder or chronic health condition (CDC, 2022; U.S. DOL, n.d.). The Youth Risk Behavior Survey ("YRBS") measures adolescent health behaviors and offers critical data to assist us in understanding the health and welfare of the youth population in Carson City. Data collected on youth emotional health in 2021 (Figure 10), states that almost one in two high school students identify as feeling sad or hopeless almost every day for two or more weeks in a row (Anderson, M., Brandon, K., Zhang, F., Peek, J., Clements-Nolle, K., & Yang, W., 2022).

Figure 10: Youth Emotional Health

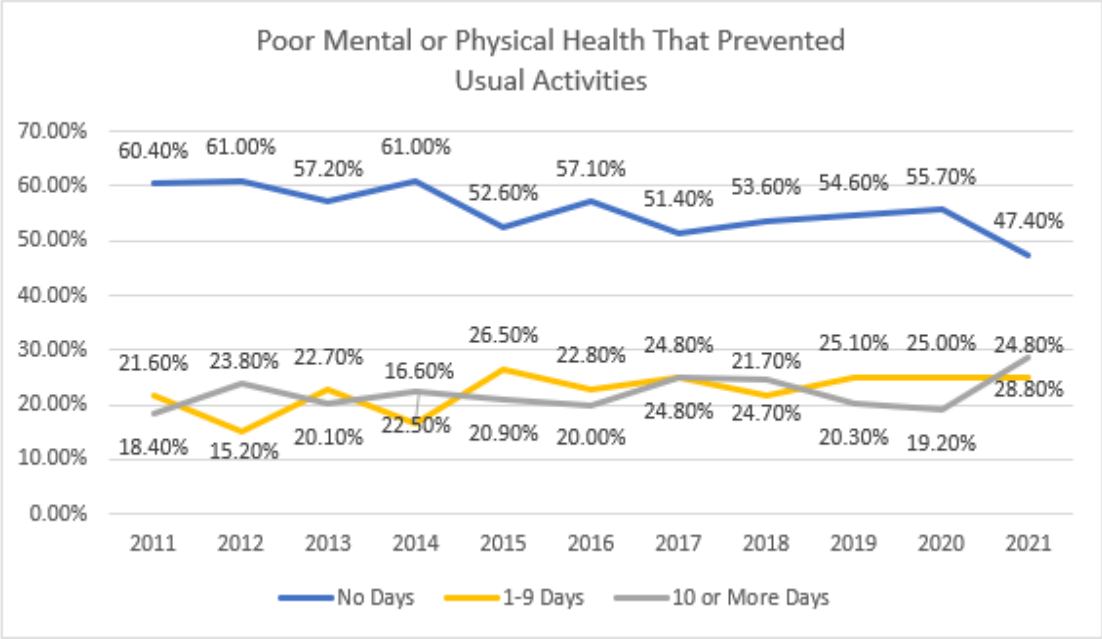



Source: Anderson, Deidrick, Lensch et al., YRBS Reports, 2017-2021

Comparing depression rates among high schoolers between 2019 and 2021, there was a 15% increase over the 2-year period (Anderson, M. et al., 2022). This increase in depression amongst high schoolers correlated with a rise in suicidal ideation by 20% from 2019 to 2021 (Anderson, M. et al., 2022). This increase of depression and suicidal ideation was also found in middle school students, with a slight increase of depression by 6% and a drastic rise in the consideration or attempt of suicide by 57% (one in three middle schoolers) (Anderson, M. et al., 2022).

The BRFSS gathers information on health-related risk behaviors among adults. Data presented from DHHS Office of Analytics' 2022 Epidemiologic Profile of the Northern Regions (Figure 11), demonstrates a rise, over a ten-year period, in the number of days where mental or physical health prevented an individual from completing daily activities (DHHS, 2023).

Figure 11: Poor Mental or Physical Health That Prevented Usual Activities




Source: DHHS Office of Analytics Behavioral Health Wellness and Prevention 2022 Epidemiologic Profile, 2023

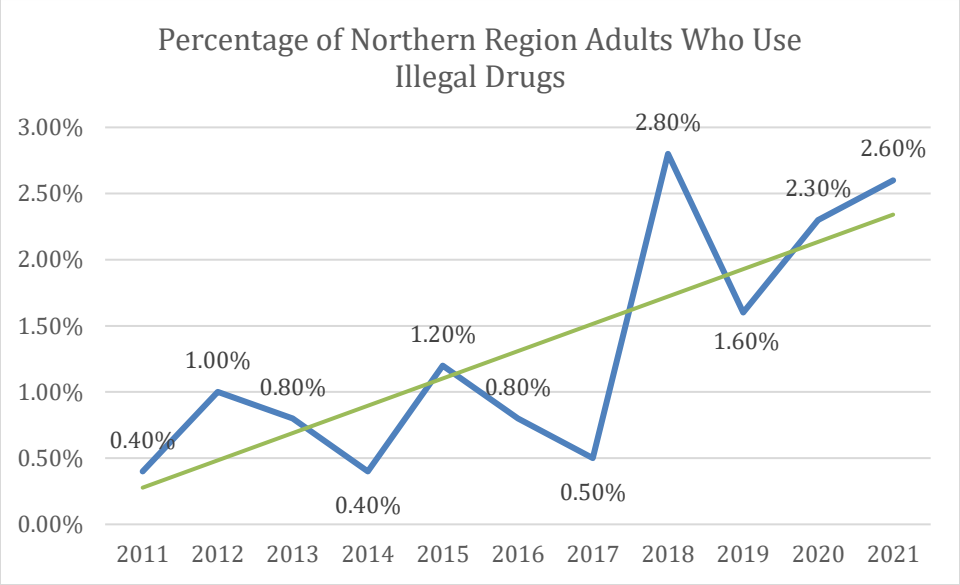
The sharpest decline in "No Days of Poor Mental Health" occurred between 2020 and 2021 with a decline from 55.7% to 47.4% within the year (DHHS, 2023). In 2022, residents of Carson City reported an average of having 4.69 poor mental health days in the last 30 days,

which was similar to the state average during this time of 4.7 days (University of Wisconsin Population Health Institute, 2022).

## Experimentation with other Drugs

An additional risk factor for opioid use in youth and adult populations is the usage or experimentation of illegal drugs (NIDA, 2020; Webster, 2017). The 2022 Epidemiologic profile provides additional information on adults in the Northern Region that utilize illegal drugs. This indicator includes using drugs such as cocaine, methamphetamines, and illegal forms of opioids such as heroin and opioid prescription pain relievers (DHHS, 2023). Figure 12 shows the trends from 2011 to 2021 in adults using illegal drugs in the Northern Region (DHHS, 2022).

Figure 12: Percentage of Northern Regional Adults Who Use Illegal Drugs

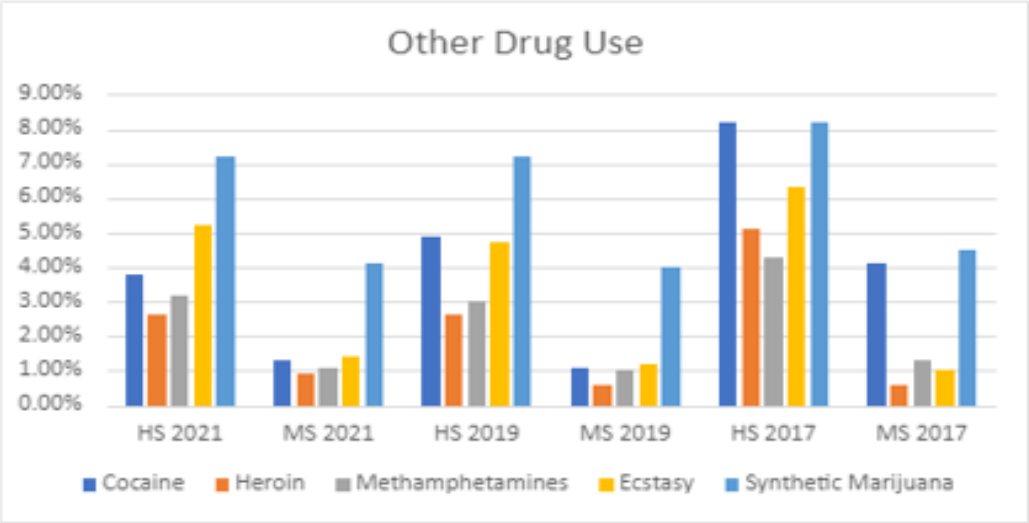



Source: DHHS Office of Analytics Behavioral Health Wellness and Prevention 2022 Epidemiologic Profile 2023

From 2019 to 2021 there has been an increase in adults who use illegal drugs with 2021 levels approaching historic levels of 2018 which was 2.8% (DHHS, 2022).

Figure 13 uses YRBS data to show a consistent trend in drug experimentation, with synthetic marijuana being the most prevalent drug use among middle and high schoolers in Nevada (Anderson et al., 2022; Diedrick et al., 2020; Lensch et al., 2018).

Figure 13: Youth, Other Drug Use




Source: Anderson, Diedrick, Lensch et al., YRBS Reports, 2017-2021

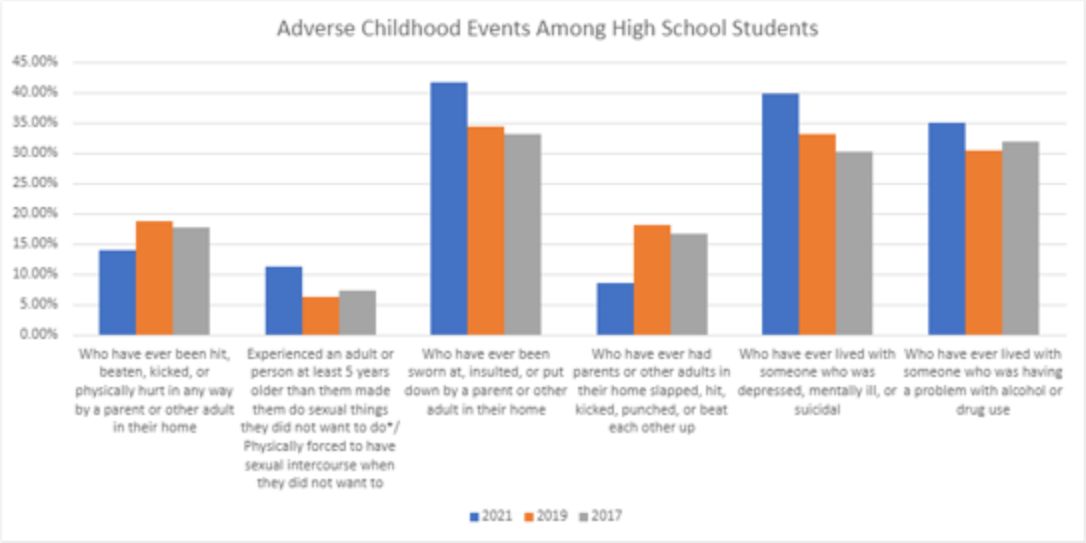
Drug use among high school and middle school students remains consistent between 2019 and 2021 and has decreased from previous rates reported in 2017 (Anderson et al., 2022).

## Adverse Childhood Events ("ACEs")

Adolescent years and experiences are extremely impactful in affecting an individual's transition into adulthood. Stein et al. (2017), found a strong association between ACEs and opioid dependence as an adult. ACEs can include characteristics such as living with a chronic drinker or someone who uses drugs (Stein et al., 2017). The study also found that risk of future opioid use increases dramatically when someone has four or more ACEs (Stein et al., 2017).

According to the YRBS data, since 2017, ACEs appear to be occurring more frequently. Figure 14 shows that nearly 1 in 2 high school students reported experiencing being sworn at, insulted by, or being put down by a parent or other adult in their home (Anderson et al., 2022; Diedrick et al., 2020; Lensch et al., 2018).

Figure 14: Adverse Childhood Events Among High School Students



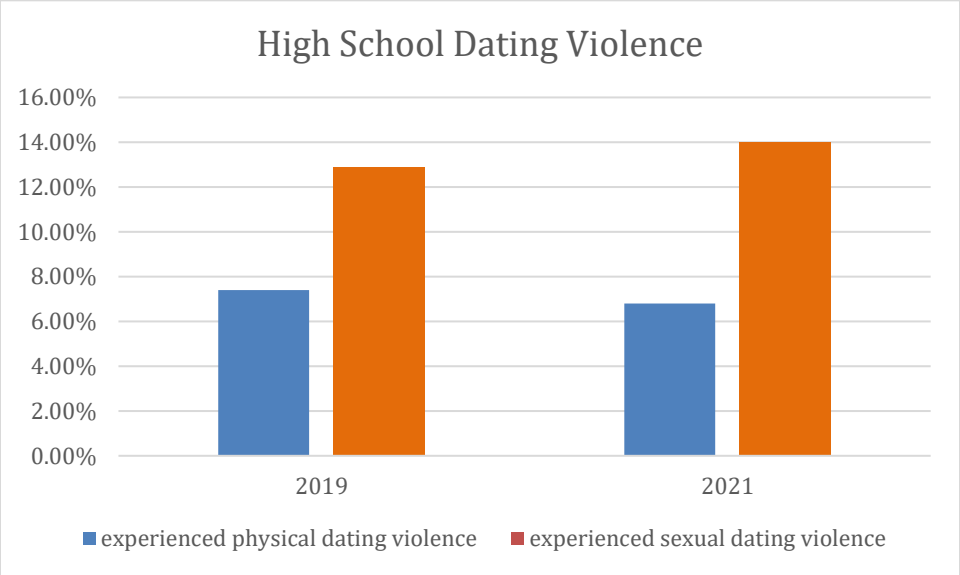

Source: Anderson, Diedrick, Lensch et al., YRBS Reports, 2017-2021

Additionally, 40% of youth identified as living with someone who was depressed, mentally ill, or suicidal. YRBS data reported that nearly 9 out of 10 youths identified having an adult in their household who tried hard to make sure their basic needs were met (Anderson et al., 2022; Diedrick et al., 2020; Lensch et al., 2018).

## Special Considerations for Youth

The youth population is particularly vulnerable to the impacts of opioid use. During formative years, youth are influenced greatly by their relationships with those close to them and the experiences they have. CDC (2022) identifies both peer influence and victimization as risk factors for opioid misuse. YRBS data (Figure 15) between 2015 to 2021 demonstrates a decrease in experienced physical dating violence while percentage of students experiencing sexual dating violence inadvertently increased (Anderson et al., 2022).

Figure 15: High School Dating Violence




Source: Anderson, Diedrick, Lensch et al., YRBS Reports, 2015-2021

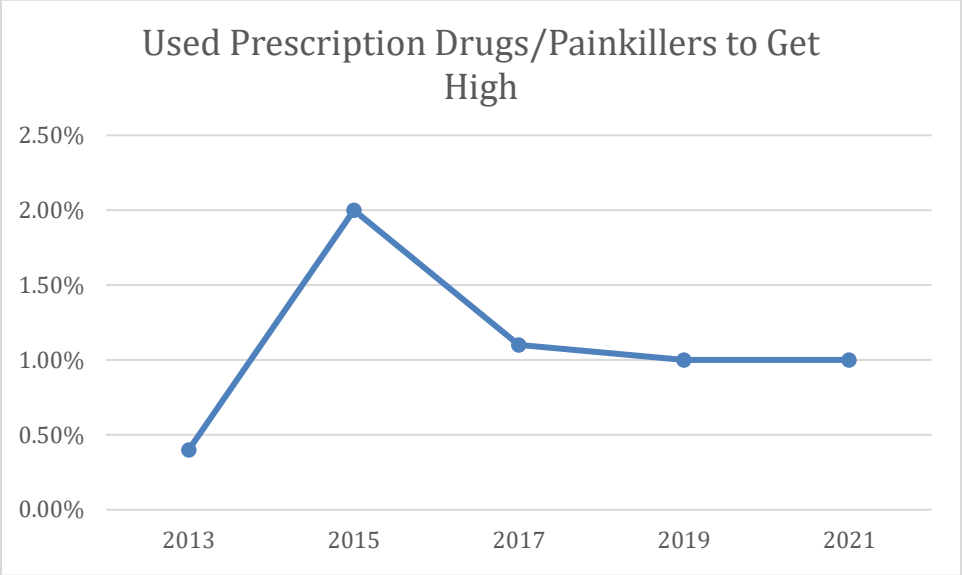
It is important to screen and address risk factors in youth populations, as early intervention can be imperative in preventing lifelong opioid dependency. The CDC states the best methods to reduce opioid use in adolescent populations is by a targeted approach within schools. Interventions such as improving health education, connecting at-risk youth to health services, and making schools a safer and more supportive environment for kids to discuss such matters (CDC, 2022) are some examples of methods to utilize.

## Opioid-Related Outcomes

### Prevalence of Opioid Use

Data regarding the prevalence of opioid use in Carson City is provided by regional and hospital data sets. Figure 16 shows a decrease from 2015 to 2021 among adults using prescription painkillers to get high in the last 30 days among the Northern Nevada region (DHHS, 2022).

Figure 16: Used Prescription Drugs/Pain Killers to Get High

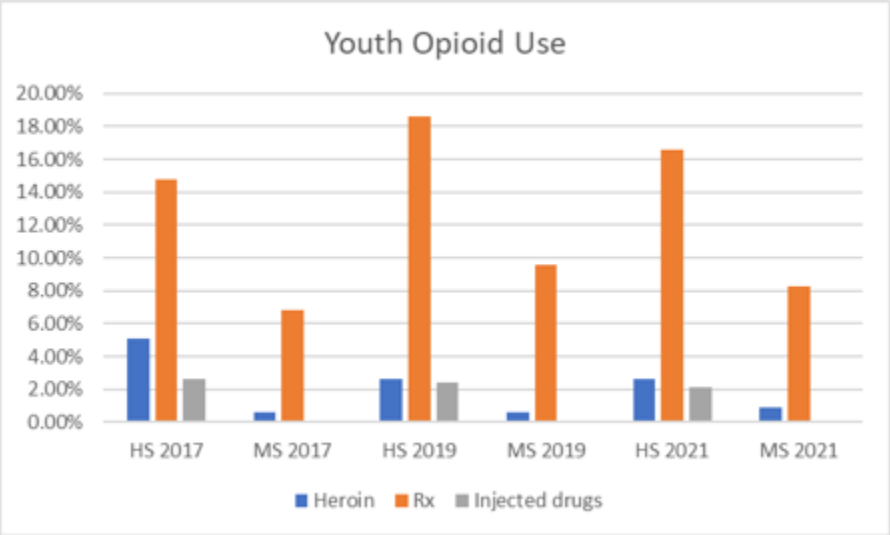



Source: DHHS Office of Analytics Behavioral Health Wellness and Prevention 2022 Epidemiologic Profile: Northern Region, Nevada, 2023 2023

The percentage of adults utilizing prescription drugs and painkillers to get high decreased to an average of 1.0% by 2021 (DHHS, 2022). However, this could suggest that individuals seeking substances could be obtaining them from elsewhere rather than only using prescription opioids to become high.

There is limited data to reflect current use of opioids among the youth population in Carson City, Nevada. YRBS collects data on youth opioid use in Nevada from both middle and high school students. According to 2021 data (Figure 17), nearly 1 in 5 high school respondents and 1 in 10 middle school respondents were using opioids (Anderson et al., 2022).

Figure 17: Youth Opioid Use

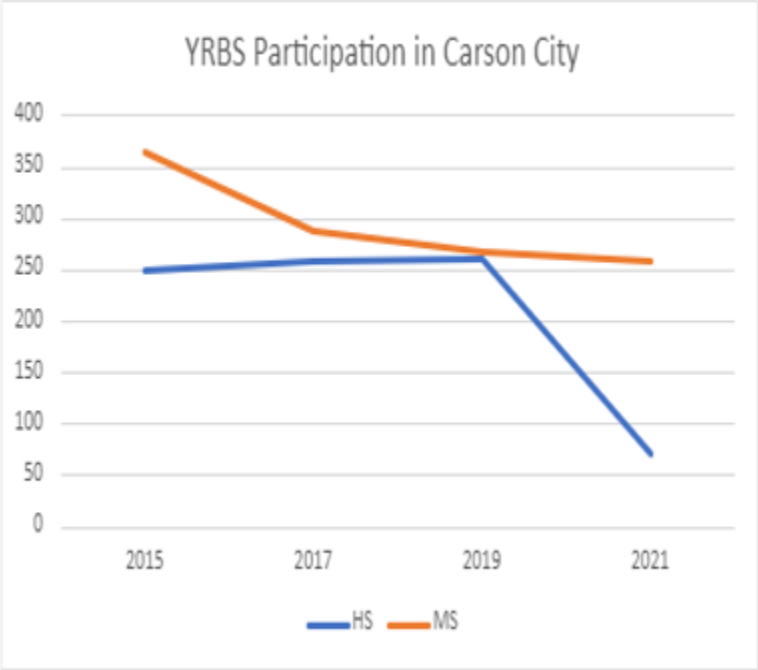



Source: Anderson, Diedrick, Lensch et al., YRBS Reports, 2017-2021

There is a significant use of prescription opioids amongst high school and middle school students compared to other forms of opioids, such as heroin or other injected drugs (Anderson et al., 2022).

However, when comparing youth opioid use rates over the previous year's, the 2021 use rates are suggestive of a downward trend compared to 2019 rates (Anderson et al., 2022). Although this may seem like a positive change in substance use among these populations, the YRBS is done voluntarily by students opting-in, meaning permission is needed from the parent or guardian. In the 2023 Legislative Session, the survey will be administered to all students, except those that opt-out meaning a parent or guardian must request that the student be exempt from participating. Shown in Figure 18, there has been a drastic decline in high school participants since 2019 and a slow decrease in middle school participation beginning in 2015 (Anderson, 2021; Diedrick, 2015; Lensch, 2017).

Figure 18: YRBS Participation in Carson City



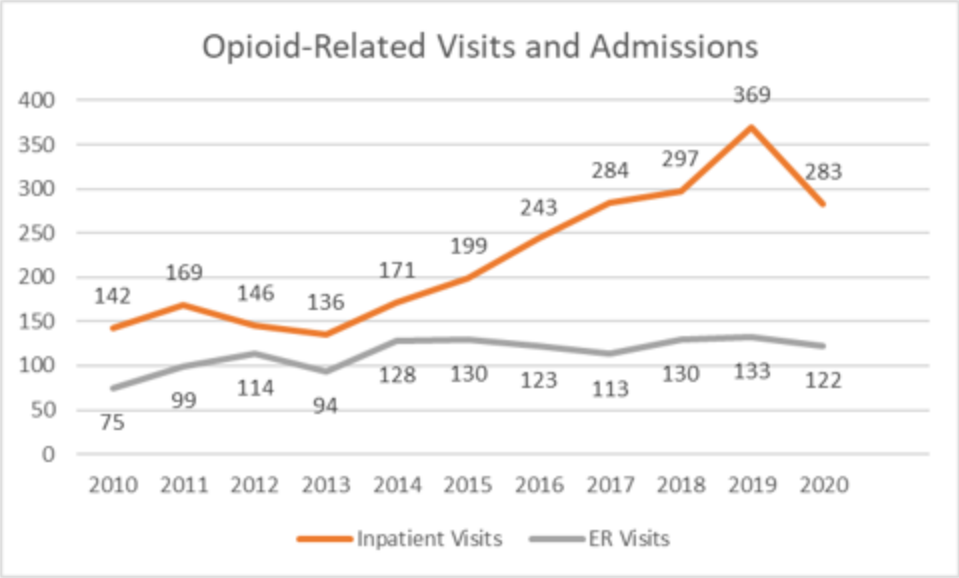

Source: Anderson, Diedrick, Lensch et al., YRBS Reports, 2015-2021

This is important to consider when interpreting data that is beginning to look as though it is improving. The YRBS may not be able to gather information from the students who are most likely to use substances as they may be less willing to participate.

## Hospitalizations and Emergency Room Visits

Inpatient hospital opioid-related admissions have been on the rise in Carson City since 2013 (Figure 19), peaking at 369 admissions in 2019 (DHHS, 2021). However, emergency room visits have been plateauing since 2014 (DHHS, 2021).

Figure 19: Opioid-Related Visits and Admissions



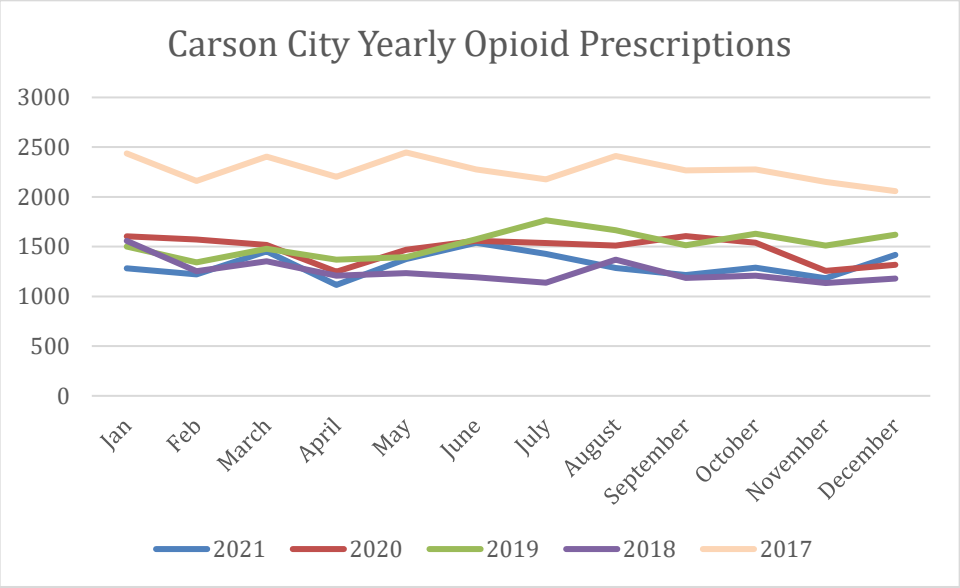

Source: DHHS Office of Analytics, Opioid Surveillance Data Set, 2021

Although a decline in inpatient visits was reported in 2020 (369 to 283), there is limited recent data to compare to. It is a possibility that this decline could be related to strains on hospital systems during the COVID-19 pandemic in which those seeking medical attention due to opioid use may have been referred to other facilities for care or potentially chose to not get treatment due to fear of contracting COVID-19.

## Opioid Prescribing

Opioid prescription data is monitored at the county level by the State of NV Office of Analytics through the Prescription Drug Monitoring Program ("PDMP"). Figure 20 shows that opioid prescription rates have remained steady since 2018 from 1,000-2,000 prescriptions every year (DHHS, 2023).

Figure 20: Carson City Yearly Opioid Prescriptions



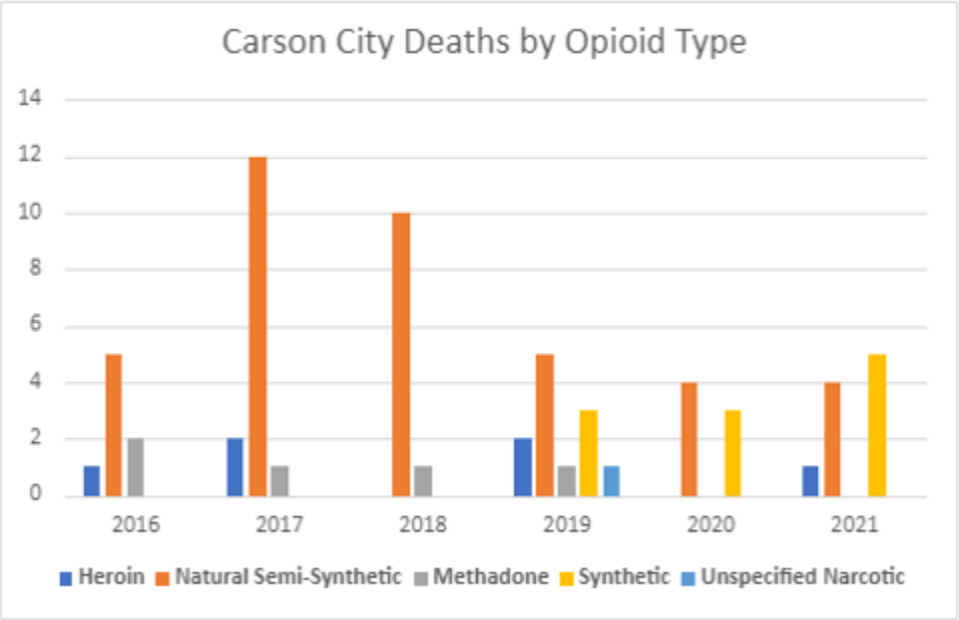

Source: DHHS Office of Analytics, Monitoring the PDMP in Nevada, 2023

In the two most recent months of data, November to December 2021, the largest monthly increase was observed. This increase totaled 233 prescriptions and ended 2021 with a steep increase that would most likely surpass 2019, the second highest prescription number, if the trend is to continue (DHHS, 2023).

## Opioid-Attributable Deaths

Opioid surveillance data reported by DHHS, Office of Analytics (Figure 21) depicts a decrease in deaths related to natural semi-synthetic opioids from 2016 to 2021. (DHHS, 2021). However, deaths due to synthetic opioids have been increasing every year since 2019 (DHHS, 2021).

Figure 21: Carson City Deaths by Opioid Type

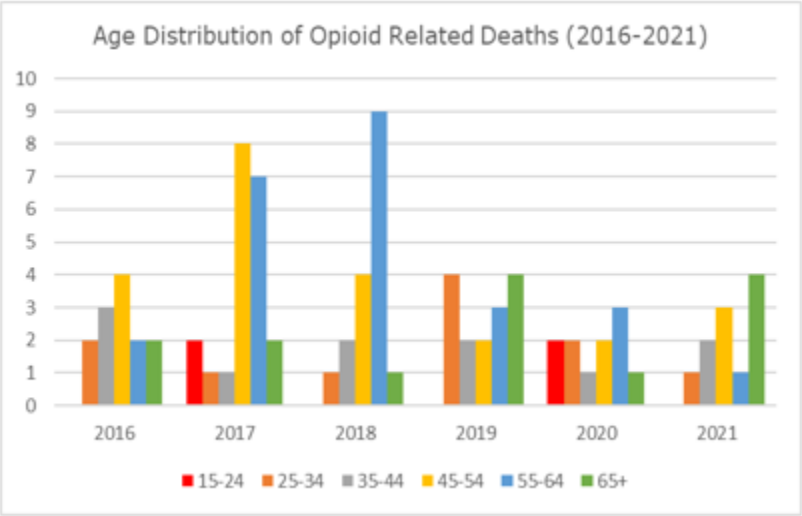



Source: DHHS Office of Analytics, Opioid Surveillance Data Set, 2021

This could suggest a turning point in the opioid environment in Carson City where other synthetic forms of opioids are more available and being sought out by individuals. It is important to note that the 2021 data has not yet been solidified so numbers may potentially be higher than shown below. Opioid-related deaths were highest among White, Caucasian individuals during the time period shown (DHHS, 2021).

Opioid-related deaths affected all age groups from age 15 to over age 65 in Carson City. The age distribution of opioid-related deaths has been changing dramatically since 2018 (Figure 22) when more than half of the deaths were in the 55 to 64 age categories (DHHS, 2021).

Figure 22: Age Distribution of Opioid Related Deaths (2016-2021)

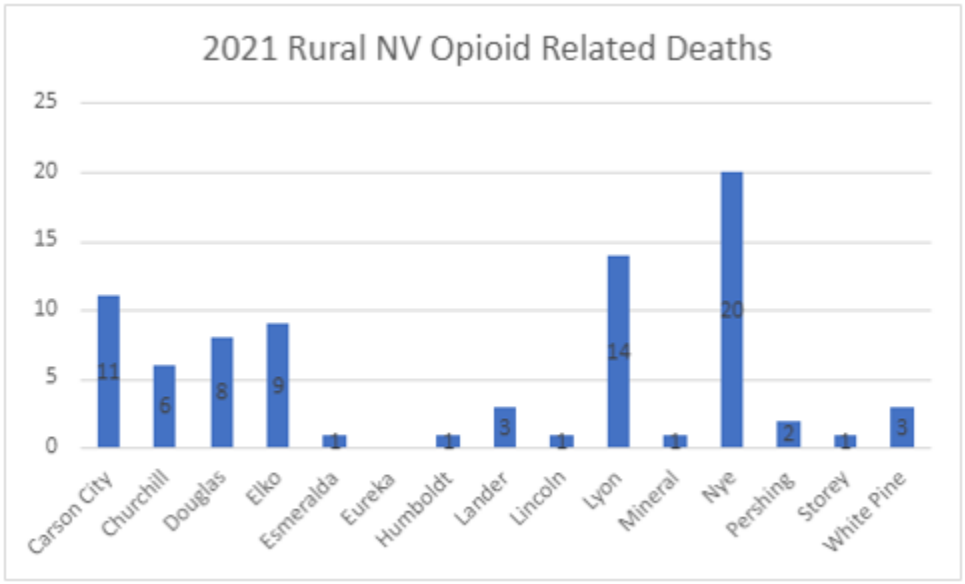



Source: DHHS Office of Analytics, Opioid Surveillance Data Set. 2021

By 2021, the 55 to 64 age category was least affected with only one death in this group and in the 25 to 34 age group (DHHS, 2021). Deaths in the over 65 age group increased as well as in the 35 to 44 and 45 to 54 age groups. This could suggest that individuals within the 45 to 54 age group in the county may be becoming more affected by the opioid crisis than in 2019 and 2020.

The 2021 report from DHHS, Office of Analytics, *Opioid Related Incidence Counts and Rates by County, Nevada Residents, 2021,* shows Carson City (Figure 23) as having the third highest prevalence of deaths from opioids amongst rural counties in the state with 11 deaths (DHHS, 2021).

Figure 23: 2021 Rural Nevada Opioid Related Deaths



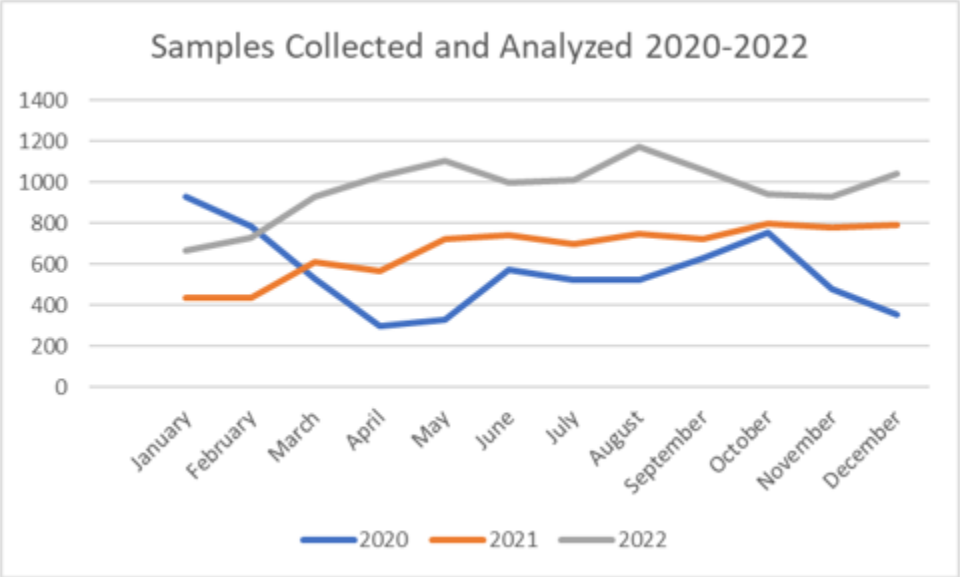

Source: DHHS Office of Analytics, Opioid Surveillance Data Set. 2021

Carson City follows behind Lyon County with 14 deaths and Nye County with 20 deaths in 2021 (DHHS, 2021).

## Opioid-Related Arrests

There is limited data regarding numbers of opioid-related arrests in the Carson City area. However, data through the *2022 End of Year ("EOY") Laboratory Statistics Report* provided by the Carson City Department of Alternative Sentencing (2023), provides a look into testing of substances gathered through law enforcement operations. Figure 24 shows a three-year trend (2020-2022) of substance samples collected and analyzed. Samples collected and analyzed in 2022 greatly exceeded the two preceding years totaling 11,430 specimens.

Figure 24: Samples Collected and Analyzed 2020-2022




Source: Department of Alternative Sentencing, 2022 EOY Laboratory Statistics Report, 2023

There was a large decrease in the number of samples collected and analyzed from January to March 2020. Restrictions on operations during the COVID-19 pandemic may have contributed to this drastic decline. It is difficult to conclude that the 2020 numbers would have been similar to those in 2022; however, January 2020 samples totaled 933 while those in January 2022 totaled 670 (Dept Alt Sentencing, 2023). As the trend at the end of 2022 shows an increasing direction of numbers of samples collected, this could suggest a potential influx of substances into the Carson City area that may be of concern.

## Community-Based Participatory Research ("CBPR")

### Overview

Carson Tahoe Health sponsored the 2022 Quad-County Regional CHNA with collaboration from Carson City Health and Human Services, in addition to other community agencies. The purpose of the CHNA is to identify community health priorities through community, agency, and member participation. This mirrors the overall goal of CBPR, which is to benefit participants and the communities they live in (Nevada Minority Health and Equity Coalition, n.d.). There were several CBPR participants from Carson City including:

| Qualitative Research Participants |
|---|
| Carson City Behavioral Health Taskforce |
| Carson City Fire Department |
| Carson City Health and Human Services |
| Carson City Sheriff's Office |
| Carson Medical Group |
| Carson Tahoe Behavioral Health Assertive Community Treatment |
| Focus Group Discussions (15 groups, 125 participants within the Quad-County Region) |
| Carson City Friends in Service Helping ("FISH") |
| JOIN Inc. |
| National Alliance on Mental Illness ("NAMI") Western Nevada |
| Nevada Association of Counties |
| Nevada Business Group on Health |
| Nevada Urban Indians |
| Northern Regional Behavioral Health Policy Board |
| One-on-one Telephone Interviews (46 within the Quad-County Region) |
| PFLAG - Carson City |
| Ron Wood Family Resource Center |
| Washoe Tribe Health Center |
| Western Nevada College |

Outside of the CHNA, other Carson City agencies and individuals were consulted concerning opioid-related community gaps and needs. These agencies and individuals include:

| Carson City Agencies/Individuals |
|---|
| Nicki Aaker, MSN, MPH, RN; Director of Carson City Health and Human Services |
| Shelly Aldean; Business Owner; and Carson City CIRCLES Co-founder |
| Faith Barber; CCHHS Workforce Case Manager; Alcoholics Anonymous Group Leader within the Carson City Detention Center; Person with Lived Experience |
| Carson City Department of Alternative Sentencing |
| Carson City Department of Juvenile Services ("Juvenile Services") |
| Carson City School District |
| Carson City Sheriff – Ken Furlong |
| Carson City Specialty Courts |

| Carson City Agencies/Individuals Continued |
|---|
| Carson Tahoe Health |
| Christie Contreras; Community Health Worker at Carson City Health and Human Services; Previously employed at Salvation Army |
| Amy Hyne-Sutherland; Public Health Coordinator; Nevada Association of Counties |
| Dr. David Johnson, MD; Carson Tahoe Health Chief of Staff |
| Dr. Lisa Keating, PhD; Psychologist |
| Deacon Craig LaGier; Minister to the Homeless at St. Teresa of Avila Catholic Community; St. Vincent Advisor; Carson City Sheriff Office's Chaplin; Founding Director of the Night Off The Streets ("NOTS") Program |
| Dr. Colleen Lyons; Carson City Public Health Officer |
| Dr. Joe McEllstrem, PhD; Psychologist |
| Kitty McKay; Director of Customer Experience & Foundation Development; Carson Tahoe Health |
| Mary Jane Ostrander; Human Services Division Manager; Carson City Health and Human Services |
| Partnership Carson City |
| Cherlyn Rahr-Wood, MSW; Northern Regional Behavioral Health Coordinator; Secretary of NAMI Western Nevada's Leadership Board |
| Charles Odgers; Carson City Public Defender |
| Stephen Wood; Former Carson City Government Affairs Liaison; Public Information Officer |
| Lisa Yesitis, LSW; Ron Wood Family Resource Center |

## Methodology

The CBPR within the CHNA utilized a qualitative research approach consisting of both one-on-one interviews and focus group discussions with community members, healthcare providers, community organization leaders, and policymakers in the area. The one-on-one interviews were conducted over the telephone and lasted approximately 20 to 30 minutes. These telephone calls included in-depth conversations regarding strengths and challenges to various health topics and possible solutions to those issues. There were 15 total focus group discussions over various platforms including open forums at routine community meetings, hybrid in-person, and Zoom meetings. The format of the focus groups typically began with introductions and concerns and solutions to various issues regarding health topics in the community. Questions for both the one-on-one interviews and focus groups contained questions surrounding health

equity and social determinants of health and their impact on barriers to care in Carson City.

In addition, in order to get a broader view of the problem, gaps, and needs within Carson City, information was obtained from an Opioid Use Working Group and during a meeting of the Carson City Behavioral Health Task Force. These individuals are included within the list of agencies/individuals above.

### Summary of CBPR Findings

Results of the qualitative research provided insight regarding concerns in the Carson City community including, but not limited to:

- Spanish-speaking residents are facing barriers to health care financially, lingually, and sometimes feel fearful when seeking care.
- Older adults are having challenges when seeking care such as lack of transportation, familial support, and barriers from limited providers covering Medicare or Medicaid.
- Carson City is facing a severe healthcare workforce shortage, especially in behavioral health providers.
- Healthcare providers mentioned that recruitment of more individuals to work in the field is a challenge.
- First responders are noticing an increase in calls related to opioid overdoses.
- Opioid use is increasing in the school system among youths.
- School counselors are not trained in substance abuse and how to support students suffering from addiction.
- Many participants noted an increase in substance use in the community overall.
- Providers are noting a lack of services across substance use care overall, including prevention, treatment, and recovery resources.
- Organizations are making efforts to raise awareness and create prevention programs to help act against the increases in substance use.
- Community members noted that patient care facilities have limited capacity and that residents from other counties may seek care in Carson City.
- Stigma is a barrier for some individuals who would like to receive care.
- There is not enough Medication-Assisted Treatment centers and transportation is a barrier to accessing the centers.

- Carson City does not have enough supportive housing options.
- There is not easy access to fentanyl strips, Narcan, and other harm reduction items.
- Youth providers are very hard to find, and it takes months to get an appointment.
- For individuals in a crisis, it is hard to get into someone immediately.
- Limited detox beds in Carson City.

## Assets and Resources

Carson City has several resources that can be utilized to address concerns brought forth by various community stakeholders through the CBPR. These resources include:

### Inpatient Services

- Carson Tahoe Behavioral Health Services
    - Serves individuals 18 years and older
    - Individual and group counseling
    - Medical model detox services
    - Inpatient and outpatient psychiatric services
    - Psychological testing
    - Dialectical Behavioral Therapy ("DBT")
    - Substance abuse treatment, including 14-day addictive disorder rehabilitation
    - Support groups
    - Residential treatment – adults - 52 beds
- Carson Tahoe Health – Mallory Center
    - Serves individuals 18 years and older
    - 24-hour assistance for mental health or substance use emergency
    - 16 beds
- Community Counseling Center ("CCC") – Wellness Program (CCBHC)
    - Serves individuals 18 years and older
    - Residential Treatment for drugs and alcohol (50-bed) (Adult only)
    - Transitional Living - Woman Only
    - Treatment
        - Intensive Outpatient ("IOP")
        - Court Ordered Programs
        - Gambling Addiction

        - Peer support services
        - Case Management
        - SMART Recovery
        - DBT
        - Trauma Informed
        - Cognitive Behavioral Therapy ("CBT")
        - Seeking Safety Program
- Vitality Carson City (CCBHC)
    - Case Management
    - Civil Protective Custody ("CPC")
    - Crisis Management
    - Detox program
    - Medication Management
    - Peer Support
    - Residential treatment (adults)

## Outpatient Services

- Carson City Rural Clinics
    - Case Management
    - Medication Management
    - Therapy
- Carson Tahoe Behavioral Health Services
- Carson Tahoe Behavioral Health Outreach Programs
    - ACT
    - First Episode Psychosis ("FEP")
    - School suicide risk assessment
    - Community education around mental health awareness and suicide
- Carson Tahoe Emergency Services
- Carson Tahoe Medical Group
- CCC – outreach programs (adults, children, and families)
    - Assertive Community Treatment ("ACT")
    - Case management
    - Domestic Violence Counseling
    - Eye Movement Desensitization and Reprocessing ("EMDR")
    - Emergency Crisis Intervention
    - Mental Health Services
    - Therapy (individual, family and couples, child and play, group
    - Trauma treatments

- The Life Change Center of Carson City
- Vitality Carson City
    - Behavioral health screening, assessment and diagnosis
    - Behavioral health risk assessment
    - Counseling
    - IOP
    - Medical-assisted therapy ("MAT")
    - Psychotherapy (family and group)
    - Targeted case management
    - Telehealth

### School Services

- Carson City School-Based Health Center
- Carson City School District
    - School Resource Officers
    - School Social Workers

### Social Support Groups

- Alcoholics Anonymous Meetings
- Narcotics Anonymous Meetings

### Community Resources

- Carson City Health and Human Services
- Carson City C.I.R.C.L.E.S
- FISH
- Nation's Finest
- Night Off The Streets
- Northern Nevada Dream Center
- Partnership Carson City
- Ron Wood Family Resource Center – Children's Therapy
- St. Vincent de Paul
- Salvation Army

### Law Enforcement/Emergency Response

- Carson City Sherriff's Department
- Carson City Mobile Outreach Safety Team [MOST]

### Medication Assisted Treatment

- The Life Change Center of Carson City
- Vitality Carson City

## Carson City Treatment Centers Overview

Carson City has both inpatient and outpatient services for adults seeking care for opioid use disorders. There are two Certified Community Behavioral Health Centers ("CCBHC") within Carson City - CCC and Vitality. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA") (2023), CCBHCs are required to serve anyone requesting services for substance abuse or mental health regardless of their ability to pay, residence, or age. Crisis services are required to be available 24 hours a day, 7 days a week. CCC, Carson Tahoe Behavioral Health and Vitality Integrated Programs provide inpatient and outpatient resources to patients. CCC provides inpatient and outpatient care supporting those facing substance use disorders and their families allowing single parents to obtain the care they need. Carson City also has a 24-hour behavioral health crisis center. The Carson Tahoe Mallory Behavioral Health Crisis Center ("Mallory Center") helps to provide critical care to individuals needing attention for either mental health or substance use emergencies. By providing an option without needing to go through an emergency department, the Mallory Center also helps to alleviate pressure on hospitals in the area. Mallory Center recently expanded to 16 beds.

Although these services in Carson City are available to help support the community, the county is not protected from the ongoing behavioral health provider shortages affecting the state overall. These resources can be further strained as Carson City may be the closest location for residents of neighboring counties seeking care. According to the *2022 County Health Rankings and Roadmaps* (University of Wisconsin Population Health Institute), the ratio of population to mental health providers in Carson City is 330:1. An additional barrier to these resources is that many services in the area are only provided to adults,18 years or older, which is a barrier for youth that may need care.

## Funding

### Carson City's Direct Allocation

The Carson City Board of Supervisors ("Board") has the ultimate authority in determining how funds received directly through the One Nevada Agreement on Allocation of Opioid Recoveries ("Agreement") will be allocated pursuant to the requirements of the Agreement.

According to the Agreement, funds must be used to remediate the harms, impact, and risks caused by the opioid epidemic to the State of Nevada and its residents and are consistent with the uses required by SB 390 of the 2021 Nevada Legislative Session.

The following outlines the eligible uses pursuant to SB 390:

(a) Projects and programs to:

1. Expand access to evidence-based prevention of substance use disorders, early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders;
2. Reduce the incidence and severity of neonatal abstinence syndrome;
3. Prevent incidents of ACEs and increase early intervention for children who have undergone ACEs and the families of such children;
4. Reduce the harm caused by substance use;
5. Prevent and treat infectious diseases in persons with substance use disorders;
6. Provide services for children and other persons in a behavioral health crisis and the families of such persons; and
7. Provide housing for persons who have or are in recovery from substance use disorders;

(b) Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;

(c) Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts;

(d) Evaluation of existing programs relating to substance use and substance use disorders;

(e) Development of the workforce of providers of services relating to substance use and substance use disorders;

(f) The collection and analysis of data relating to substance use and substance use disorders; and

(g) Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling.

The City's proposed projects and programs will be developed in accordance with the Agreement and to achieve the goals identified below.

### Fund for a Resilient Nevada

All money received by the State pursuant to any judgement or settlement of opioid litigation will be deposited in the Fund for a Resilient Nevada. The statewide plan sets out the goals and strategies for the implementation of programs and services potentially funded by the Fund for a Resilient Nevada and other funding sources. According to SB 390, the statewide plan may allocate money to grants to regional, county, local and tribal agencies, and private-sector organizations whose work relates to opioid use disorder and other substance use disorders. Eligible entities can apply for funding through the State of Nevada DHHS. The statewide plan can be found here: Nevada Opioid Needs Assessment and Statewide Plan 2022 (nv.gov)

DHHS will release Notification of Funding Opportunities at various intervals at which time local entities may apply for funding for eligible uses outlined above in accordance with SB 390 that align with state and local goals.

State grants that are awarded to Carson City from the Fund for a Resilient Nevada will be administered in accordance with the grant award and Carson City's Grant Administration Policy.

## Recommended Implementation Goals and Tactics

### Goal 1: Prevent the Misuse of Opioids and Other Substances

Stakeholders in Carson City, recognizing the increase in opioid use over recent years, as previously indicated in this assessment, identified prevention efforts for both youth and adults as a critical need.

Tactic 1: Place safe drug disposal kits for unused prescription drugs in pharmacies throughout the community.

Tactic 2: Provide the Carson City Sheriff's Office with equipment for the disposal of prescription medication and other illicit substances.

Tactic 3: Provide increased access to life-saving overdose prevention medication such as Naloxone and fentanyl testing strips to organizations and agencies that work with at risk populations.

Tactic 4: Increase the capacity for prevention education for youth and families by hiring juvenile outreach specialists.

Tactic 5: Add an opioid education component to Carson City Health and Human Services' current Tobacco Program that engages students, school faculty and parents.

Tactic 6: Develop campaigns to educate and increase awareness of substance use and substance use disorders.

## Goal 2: Enhance Behavioral Health Treatment Resources

This goal identifies the need for additional behavioral health services and behavioral health personnel within the community. Stakeholders recognized that additional services are needed, especially for at risk and uninsured or underinsured populations, and that these added resources will play a critical role in the prevention and treatment of substance use and opioid misuse within Carson City.

Tactic 1: Support existing and additional residential treatment programs.

Tactic 2: Expand the City's Street Outreach Program to provide services that address opioid and other substance use by the unhoused population.

Tactic 3: Hire a full-time licensed drug and alcohol counselor to provide services for youth involved in the juvenile justice system.

Tactic 4: Provide the Carson City Public Defender's Office with staff to provide case management services for their indigent clients.

## Goal 3: Enhance Prevention and Treatment Efforts in the Criminal Justice System

Stakeholders throughout the community identified the need to support both substance abuse and opioid misuse treatment and prevention efforts throughout Carson City's criminal justice system.

Tactic 1: Remodel and expand the Juvenile Probation facilities to provide more space for classroom instruction, offices for staff and space to support outreach activities and drug and alcohol counseling efforts.

Tactic 2: Identify additional tools and software that can provide real-time access to information and electronic supervision of those enrolled in the court ordered programs of the Department of Alternative Sentencing.

Tactic 3: Provide the necessary equipment and testing supplies to the Department of Alternative Sentencing to allow the Department to keep up with current and future demand for drug testing and other court required services.

Tactic 4: Support the hiring of additional staff in the Department of Alternative Sentencing to provide those enrolled in court ordered programs with the supervision and resources necessary to ensure they meet the requirements of the Courts.

Tactic 5: Provide the necessary training for current and future Carson City staff engaged in prevention and treatment efforts to ensure the application of best practices and prevention strategies.

Tactic 6: Hire a full-time information technology systems technician to provide technology support to the specialty courts.

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*Allocation Summary for Signatories to the One Nevada Agreement - Actual and Estimated (Revised 09-01-2023)*

**State of Nevada - Actual and Estimated Deposits to the Fund for a Resilient Nevada**

*(assumes no default in payments)*

*(CMS Medicaid costs, if any, not deducted)*

*(assumes no administrative fees for court appointed third-party administrators)*

| Settlement Name | Estimated/Actual Allocation Year | Estimated/Actual Allocation Month | Total Annual Allocation | Attorney Fees (Deducted) | Attorney Fees (Through Settlement) | Net Allocation |
|---|---|---|---|---|---|---|
| McKinsey | 2021 | September | $ 28,461,750.49 | $ 5,407,732.59 | $ - | $ 23,054,017.90 |
| Janssen - J&J | 2022 | July | $ 18,612,345.20 | $ 3,536,345.59 | $ - | $ 15,075,999.61 |
| Distributors | 2022 | August | $ 4,340,895.22 | $ 824,770.09 | $ - | $ 3,516,125.13 |
| Distributors | 2022 | September | $ 4,562,069.29 | $ 866,793.17 | $ - | $ 3,695,276.12 |
| American Drug Stores | 2022 | December | $ 657,900.01 | $ 131,580.00 | $ - | $ 526,320.01 |
| Mallinckrodt (BK) | 2022 | December | $ 811,293.19 | $ 162,258.64 | $ - | $ 649,034.55 |
| Janssen - J&J (Fee Fund) | 2023 | July | $ - | $ (4,603,844.83) | $ - | $ 4,603,844.83 |
| Distributors | 2023 | July | $ 4,562,069.29 | $ 866,793.17 | $ - | $ 3,695,276.12 |
| Allergan | 2023 | July | $ 1,660,972.77 | $ 123,850.76 | $ 1,458,406.49 | $ 1,537,122.01 |
| CVS | 2023 | August | $ 6,877,247.99 | $ - | $ 5,731,040.01 | $ 6,877,247.99 |
| Distributors (Fee Fund) | 2023 | August | $ - | $ (15,432,662.80) | $ - | $ 15,432,662.80 |
| Mallinckrodt (BK) | 2023 | September | $ - | $ (162,258.64) | $ - | $ 162,258.64 |
| Walmart | 2023 | September | $ 14,136,532.91 | $ - | $ 1,511,506.58 | $ 14,136,532.91 |
| Walgreens | 2023 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Janssen - J&J (Fee Fund) | 2024 | July | $ - | $ (302,274.46) | $ - | $ 302,274.46 |
| Distributors (Fee Fund) | 2024 | July | $ - | $ (735,956.63) | $ - | $ 735,956.63 |
| Distributors | 2024 | July | $ 5,710,075.94 | $ 1,084,914.43 | $ - | $ 4,625,161.51 |
| Allergan | 2024 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2024 | July | $ 3,137,299.63 | $ - | $ - | $ 3,137,299.63 |
| CVS | 2024 | August | $ 6,877,247.99 | $ - | $ 5,731,040.01 | $ 6,877,247.99 |
| Purdue (BK) | 2024 | July | $ 24,561,600.00 | $ 5,280,744.00 | $ - | $ 19,280,856.00 |
| Walgreens | 2024 | December | $ 6,541,719.00 | $ - | $ 6,718,803.74 | $ 6,541,719.00 |
| Janssen - J&J | 2025 | April | $ 1,173,447.81 | $ 222,955.08 | $ - | $ 950,492.73 |
| Distributors | 2025 | July | $ 5,710,075.94 | $ 1,084,914.43 | $ - | $ 4,625,161.51 |
| Allergan | 2025 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2025 | July | $ 3,137,299.63 | $ - | $ - | $ 3,137,299.63 |
| CVS | 2025 | August | $ 6,877,247.99 | $ - | $ 5,731,040.01 | $ 6,877,247.99 |
| Walgreens | 2025 | December | $ 6,541,719.00 | $ - | $ 6,718,803.74 | $ 6,541,719.00 |
| Distributors | 2026 | July | $ 5,710,075.94 | $ 1,084,914.43 | $ - | $ 4,625,161.51 |
| Allergan | 2026 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2026 | July | $ 3,137,299.63 | $ - | $ - | $ 3,137,299.63 |
| CVS | 2026 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2026 | December | $ 6,541,719.00 | $ - | $ 6,718,803.74 | $ 6,541,719.00 |
| Distributors | 2027 | July | $ 5,710,075.94 | $ 1,084,914.43 | $ - | $ 4,625,161.51 |
| Allergan | 2027 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2027 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2027 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2027 | December | $ 6,541,719.00 | $ - | $ 6,718,803.75 | $ 6,541,719.00 |
| Distributors | 2028 | July | $ 6,715,737.27 | $ 1,275,990.08 | $ - | $ 5,439,747.19 |
| Allergan | 2028 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2028 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2028 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2028 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Distributors | 2029 | July | $ 6,715,737.27 | $ 1,275,990.08 | $ - | $ 5,439,747.19 |
| Allergan | 2029 | July | $ 1,660,972.77 | $ 123,850.76 | $ - | $ 1,537,122.01 |
| Teva | 2029 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2029 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2029 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Distributors | 2030 | July | $ 6,715,737.27 | $ 1,275,990.08 | $ - | $ 5,439,747.19 |
| Teva | 2030 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2030 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2030 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Distributors | 2031 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2031 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2031 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2031 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Distributors | 2032 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2032 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| CVS | 2032 | August | $ 6,877,248.00 | $ - | $ - | $ 6,877,248.00 |
| Walgreens | 2032 | December | $ 6,541,719.00 | $ - | $ - | $ 6,541,719.00 |
| Distributors | 2033 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2033 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| Walgreens | 2033 | December | $ 6,541,718.99 | $ - | $ - | $ 6,541,718.99 |
| Distributors | 2034 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2034 | July | $ 670,038.92 | $ - | $ 2,239,601.25 | $ 670,038.92 |
| Walgreens | 2034 | December | $ 6,541,718.99 | $ - | $ - | $ 6,541,718.99 |
| Distributors | 2035 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2035 | July | $ 3,137,299.64 | $ - | $ - | $ 3,137,299.64 |
| Walgreens | 2035 | December | $ 6,541,718.99 | $ - | $ - | $ 6,541,718.99 |
| Distributors | 2036 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2036 | July | $ 3,137,299.64 | $ - | $ - | $ 3,137,299.64 |
| Walgreens | 2036 | December | $ 6,541,718.99 | $ - | $ - | $ 6,541,718.99 |
| Distributors | 2037 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2037 | July | $ 4,033,670.95 | $ - | $ - | $ 4,033,670.95 |
| Walgreens | 2037 | December | $ 6,541,718.99 | $ - | $ - | $ 6,541,718.99 |
| Distributors | 2038 | July | $ 5,645,254.94 | $ 1,072,598.44 | $ - | $ 4,572,656.50 |
| Teva | 2038 | July | $ 4,033,670.95 | $ - | $ - | $ 4,033,670.95 |
| Teva | 2039 | July | $ 4,033,670.95 | $ - | $ - | $ 4,033,670.95 |
| Teva | 2040 | July | $ 4,033,670.95 | $ - | $ - | $ 4,033,670.95 |
| Teva | 2041 | July | $ 4,033,670.95 | $ - | $ - | $ 4,033,670.95 |
| Teva | 2041 | July | $ 12,101,012.85 | $ - | $ - | $ 12,101,012.85 |
| Teva | 2042 | July | $ 12,101,012.85 | $ - | $ - | $ 12,101,012.85 |
| | | TOTAL | $ 433,971,722.79 | $ 13,678,345.77 | $ 64,955,058.06 | $ 420,293,377.02 |

OPIOID BUDGET SPENDING REQUESTS
CARSON CITY DIRECT ALLOCATIONS

| DESCRIPTION | GOAL / TACTIC | FY 25 | FY 26 | FY 27 | FY 28 | FY 29 |
|---|---|---|---|---|---|---|
| Beginning Balance | | 1,240,517 | 1,204,544 | 916,231 | 686,335 | 415,216 |
| Estimated FY Allocations | | 845,648 | 394,620 | 474,732 | 456,292 | 476,146 |
| | | | | | | |
| Courts | | | | | | |
| RePath App - Electronic Supervision | G3 / T2 | 72,000 | 72,000 | 72,000 | 72,000 | 72,000 |
| Global Satellite Positioning (GPS) Units | G3 / T2 | 6,125 | 6,125 | 6,125 | 6,125 | 6,125 |
| Residential Treatment Programs - Specialty Courts | G2 / T1 | 30,000 | 30,000 | 30,000 | 30,000 | 30,000 |
| | | $ 108,125 | $ 108,125 | $ 108,125 | $ 108,125 | $ 108,125 |
| Sheriff's Office | | | | | | |
| Drug Incinerator | G1 / T2 | $ 65,000 | - | - | - | - |
| Health & Human Services | | | | | | |
| Street Outreach Team | G2 / T2 | 13,000 | 13,000 | 13,000 | 13,000 | 13,000 |
| Life-Saving Overdose Medicine | G1 / T3 | 5,000 | 5,000 | 5,000 | 5,000 | 5,000 |
| Testing Strips | G1 / T3 | 200 | 200 | 200 | 200 | 200 |
| Prescription Drug Disposal (At-Home Kits) | G1 / T1 | 7,000 | 7,000 | 7,000 | 7,000 | 7,000 |
| Public Education Campaigns for Drug Programs | G1 / T6 | 10,000 | 10,000 | 10,000 | 10,000 | 10,000 |
| | | $ 35,200 | $ 35,200 | $ 35,200 | $ 35,200 | $ 35,200 |
| Department of Alternative Sentencing | | | | | | |
| Drug Testing Equipment Upgrades & Lab Improvements: | | | | | | |
| Lockers for Drug Sample Storage | G3 / T3 | 13,110 | - | - | - | - |
| Drug Test Analyzer | G3 / T3 | 65,000 | - | - | - | - |
| Drug Laboratory Freezers | G3 / T3 | 28,388 | - | - | - | - |
| Drug Laboratory Refrigerators | G3 / T3 | 11,854 | - | - | - | - |
| Drug Test Kits and Supplies | G3 / T3 | 45,000 | 45,000 | 45,000 | 45,000 | 45,000 |
| Training | G3 / T5 | 5,000 | 5,000 | 5,000 | 5,000 | 5,000 |
| Drug Testing Technician (2 - Hourly) | G3 / T4 | 34,674 | 34,674 | 34,674 | 34,674 | 34,674 |
| Alternative Sentencing Specialist | G3 / T4 | 72,379 | 75,998 | 79,798 | 83,788 | 87,977 |
| Alternative Sentencing Lab Technician | G3 / T4 | 74,000 | 77,700 | 81,585 | 85,664 | 89,947 |
| | | $ 349,405 | $ 238,372 | $ 246,057 | $ 254,126 | $ 262,599 |
| Juvenile Detention and Probation | | | | | | |
| Licensed Drug and Alcohol Counselor | G2 / T3 | 110,566 | 116,095 | 121,899 | 127,994 | 134,394 |
| Juvenile Services Outreach Specialist Position (1) | G1 / T4 | 78,162 | 82,070 | 86,174 | 90,482 | 95,006 |
| Training for Staff & Materials for Education & Outreach | G3 / T5 | 21,000 | 21,000 | 21,000 | 21,000 | 21,000 |
| Parent Project Training | G3 / T5 | 36,000 | | | | |
| | | $ 245,728 | $ 219,165 | $ 229,073 | $ 239,477 | $ 250,401 |
| Carson City Public Defender | | | | | | |
| Case Manager | G2 / T4 | $ 78,162 | $ 82,070 | $ 86,174 | $ 90,482 | $ 95,006 |
| GRAND TOTAL | | $ 881,621 | $ 682,932 | $ 704,629 | $ 727,410 | $ 751,331 |
| Ending Balance | | $ 1,204,544 | $ 916,231 | $ 686,335 | $ 415,216 | $ 140,032 |

| OPIOID SPENDING REQUESTS<br>STATE GRANTS (Fund for a Resilient Nevada) | | | | | | |
|---|---|---|---|---|---|---|
| DESCRIPTION | | FY 25 | FY 26 | FY 27 | FY 28 | FY 29 |
| Courts | | | | | | |
| Court IT Systems Technician | G3 / T6 | 85,968 | 90,266 | 94,780 | 99,519 | 104,495 |
| Health & Human Services | | | | | | |
| Public Health Program Specialist (50%) Opioid Ed | G1 / T5 | 42,938 | 45,085 | 47,339 | 49,706 | 52,191 |
| Community Health Worker (50%) Opioid Ed | G1 / T5 | 36,146 | 37,953 | 39,851 | 41,844 | 43,936 |
| | | 79,084 | 83,038 | 87,190 | 91,550 | 96,127 |
| Department of Alternative Sentencing | | | | | | |
| Alternative Sentencing Officer | G3 / T4 | 108,907 | 114,353 | 120,070 | 126,074 | 132,377 |
| Alternative Sentencing Technician (1 - Hourly) | G3 / T4 | 17,337 | 17,337 | 17,337 | 17,337 | 17,337 |
| | | 126,244 | 131,690 | 137,407 | 143,411 | 149,715 |
| Juvenile Detention and Probation | | | | | | |
| Expansion of Juvenile Probation Building | G3 / T1 | - | - | 5,120,000 | - | - |
| Juvenile Services Outreach Specialist Position (1) | G1 / T4 | 78,162 | 82,070 | 86,174 | 90,482 | 95,006 |
| | | 78,162 | 82,070 | 5,206,174 | 90,482 | 95,006 |
| GRAND TOTAL | | $ 369,458 | $ 387,064 | $ 5,525,551 | $ 424,961 | $ 445,343 |

*Allocation Summary for Signatories to the One Nevada Agreement - Actual and Estimated (Revised 09-01-2023)*

**Carson City - Actual and Estimated Allocations**

*(assumes no default in payments)*

*(CMS Medicaid costs, if any, not deducted)*

*(assumes no administrative fees for court appointed third-party administrators)*

| Settlement Name | Estimated/Actual Allocation Year | Estimated/Actual Allocation Month | Total Annual Allocation | Attorney Fees (Deducted) | Attorney Fees (Through Settlement) | Net Allocation |
|---|---|---|---|---|---|---|
| Janssen - J&J | 2022 | July | $ 432,300.73 | $ 64,845.11 | $ - | $ 367,455.62 |
| Distributors | 2022 | August | $ 100,824.06 | $ 15,123.61 | $ - | $ 85,700.45 |
| Distributors | 2022 | September | $ 105,961.17 | $ 15,894.18 | $ - | $ 90,066.99 |
| American Drug Stores | 2022 | December | $ 15,280.75 | $ 3,820.19 | $ - | $ 11,460.56 |
| Mallinckrodt (BK) | 2022 | December | $ 18,843.55 | $ 4,710.89 | $ - | $ 14,132.66 |
| Distributors | 2023 | July | $ 105,961.17 | $ 15,894.18 | $ - | $ 90,066.99 |
| Allergan | 2023 | July | $ 38,578.68 | $ 4,805.56 | $ 33,873.76 | $ 33,773.12 |
| CVS | 2023 | August | $ 124,105.30 | $ - | $ 166,390.42 | $ 124,105.30 |
| Mallinckrodt (BK) | 2023 | September | $ - | $ (4,710.89) | $ - | $ 4,710.89 |
| Walmart | 2023 | September | $ 328,343.01 | $ - | $ 43,883.87 | $ 328,343.01 |
| Walgreens | 2023 | December | $ 90,700.91 | $ - | $ - | $ 90,700.91 |
| Distributors | 2024 | July | $ 132,625.41 | $ 19,893.81 | $ - | $ 112,731.60 |
| Allergan | 2024 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2024 | July | $ 33,308.92 | $ - | $ - | $ 33,308.92 |
| CVS | 2024 | August | $ 124,105.30 | $ - | $ 166,390.42 | $ 124,105.30 |
| Purdue (BK) | 2024 | July | $ 570,481.44 | $ 142,620.36 | $ - | $ 427,861.08 |
| Walgreens | 2024 | December | $ 90,700.91 | $ - | $ 181,458.94 | $ 90,700.91 |
| Janssen - J&J | 2025 | April | $ 27,255.15 | $ 4,088.27 | $ - | $ 23,166.88 |
| Distributors | 2025 | July | $ 132,625.41 | $ 19,893.81 | $ - | $ 112,731.60 |
| Allergan | 2025 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2025 | July | $ 33,308.92 | $ - | $ - | $ 33,308.92 |
| CVS | 2025 | August | $ 124,105.30 | $ - | $ 166,390.42 | $ 124,105.30 |
| Walgreens | 2025 | December | $ 90,700.91 | $ - | $ 181,458.94 | $ 90,700.91 |
| Distributors | 2026 | July | $ 132,625.41 | $ 19,893.81 | $ - | $ 112,731.60 |
| Allergan | 2026 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2026 | July | $ 33,308.92 | $ - | $ - | $ 33,308.92 |
| CVS | 2026 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2026 | December | $ 145,167.15 | $ - | $ 181,458.94 | $ 145,167.15 |
| Distributors | 2027 | July | $ 132,625.41 | $ 19,893.81 | $ - | $ 112,731.60 |
| Allergan | 2027 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2027 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2027 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2027 | December | $ 145,167.15 | $ - | $ 181,458.94 | $ 145,167.15 |
| Distributors | 2028 | July | $ 155,983.47 | $ 23,397.52 | $ - | $ 132,585.95 |
| Allergan | 2028 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2028 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2028 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2028 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2029 | July | $ 155,983.47 | $ 23,397.52 | $ - | $ 132,585.95 |
| Allergan | 2029 | July | $ 38,578.68 | $ 4,805.56 | $ - | $ 33,773.12 |
| Teva | 2029 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2029 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2029 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2030 | July | $ 155,983.47 | $ 23,397.52 | $ - | $ 132,585.95 |
| Teva | 2030 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2030 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2030 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2031 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2031 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2031 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2031 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2032 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2032 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| CVS | 2032 | August | $ 149,751.38 | $ - | $ - | $ 149,751.38 |
| Walgreens | 2032 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2033 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2033 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| Walgreens | 2033 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2034 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2034 | July | $ 14,868.82 | $ - | $ 60,486.31 | $ 14,868.82 |
| Walgreens | 2034 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2035 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2035 | July | $ 69,619.75 | $ - | $ - | $ 69,619.75 |
| Walgreens | 2035 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2036 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2036 | July | $ 69,619.75 | $ - | $ - | $ 69,619.75 |
| Walgreens | 2036 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2037 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2037 | July | $ 89,511.11 | $ - | $ - | $ 89,511.11 |
| Walgreens | 2037 | December | $ 145,167.15 | $ - | $ - | $ 145,167.15 |
| Distributors | 2038 | July | $ 131,119.84 | $ 19,667.98 | $ - | $ 111,451.86 |
| Teva | 2038 | July | $ 89,511.11 | $ - | $ - | $ 89,511.11 |
| Teva | 2039 | July | $ 89,511.11 | $ - | $ - | $ 89,511.11 |
| Teva | 2040 | July | $ 89,511.11 | $ - | $ - | $ 89,511.11 |
| Teva | 2041 | July | $ 89,511.11 | $ - | $ - | $ 89,511.11 |
| Teva | 2041 | July | $ 268,533.33 | $ - | $ - | $ 268,533.33 |
| Teva | 2042 | July | $ 268,533.33 | $ - | $ - | $ 268,533.33 |
| | | TOTAL | $ 8,800,135.68 | $ 603,036.46 | $ 1,786,655.16 | $ 8,197,099.22 |

| | MALLINCKRODT | | | Purdue (BK) | | | ALLERGAN | | | AMERICAN DRUG STORES | | | WALMART | | | CVS | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount |
| FY 2023 | 12/1/2022 | 12/28/2022 | 14,132.66 | | | | | | | 12/1/2022 | 12/28/2022 | 11,460.56 | | | | | | |
| FY 2024 | 9/1/2023 | 12/27/2023 | 4,710.89 | | | | 7/1/2023 | 10/16/2023 | 33,773.12 | | | | 7/1/2023 | | 328,343.01 | 8/1/2023 | 10/16/2023 | 124,105.30 |
| FY 2025 | | | | 7/1/2024 | | 427,861.08 | 7/1/2024 | | 33,773.12 | | | | | | | 8/1/2024 | | 124,105.30 |
| FY 2026 | | | | | | | 7/1/2025 | | 33,773.12 | | | | | | | 8/1/2025 | | 124,105.30 |
| FY 2027 | | | | | | | 7/1/2026 | | 33,773.12 | | | | | | | 8/1/2026 | | 149,751.38 |
| FY 2028 | | | | | | | 7/1/2027 | | 33,773.12 | | | | | | | 8/1/2027 | | 149,751.38 |
| FY 2029 | | | | | | | 7/1/2028 | | 33,773.12 | | | | | | | 8/1/2028 | | 149,751.38 |
| FY 2030 | | | | | | | 7/1/2029 | | 33,773.12 | | | | | | | 8/1/2029 | | 149,751.38 |
| FY 2031 | | | | | | | | | | | | | | | | 8/1/2030 | | 149,751.38 |
| FY 2032 | | | | | | | | | | | | | | | | 8/1/2031 | | 149,751.38 |
| FY 2033 | | | | | | | | | | | | | | | | 8/1/2032 | | 149,751.38 |
| FY 2034 | | | | | | | | | | | | | | | | | | |
| FY 2035 | | | | | | | | | | | | | | | | | | |
| FY 2036 | | | | | | | | | | | | | | | | | | |
| FY 2037 | | | | | | | | | | | | | | | | | | |
| FY 2038 | | | | | | | | | | | | | | | | | | |
| FY 2039 | | | | | | | | | | | | | | | | | | |
| FY 2040 | | | | | | | | | | | | | | | | | | |
| FY 2041 | | | | | | | | | | | | | | | | | | |
| FY 2042 | | | | | | | | | | | | | | | | | | |
| FY 2043 | | | | | | | | | | | | | | | | | | |
| FY 2044 | | | | | | | | | | | | | | | | | | |
| | | | $ 18,843.55 | | | $ 427,861.08 | | | $ 236,411.84 | | | $ 11,460.56 | | | $ 328,343.01 | | | $ 1,420,575.56 |

| | DISTRIBUTORS (AmerisourceBergen/ Card Health/ McKesson) | | | Janssen/Johnson & Johnson | | | TEVA | | | WALGREENS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fiscal Year | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount | Date Due | Date Received | Amount | TOTAL |
| | 8/1/2022 | 8/22/2022 | 85,700.45 | | | | | | | | | | |
| FY 2023 | 9/1/2022 | 9/30/2022 | 90,066.99 | 7/15/2022 | 8/22/2022 | 367,455.62 | | | | | | | 568,816.28 |
| FY 2024 | 7/1/2023 | 11/15/2023 | 90,066.99 | | | | | | | 12/31/2023 | 2/6/2024 | 90,700.91 | 671,700.22 |
| FY 2025 | 7/1/2024 | | 112,731.60 | 4/15/2025 | | 23,166.88 | 7/15/2024 | | 33,308.92 | 12/31/2024 | | 90,700.91 | 845,647.81 |
| FY 2026 | 7/1/2025 | | 112,731.60 | | | | 7/15/2025 | | 33,308.92 | 12/31/2025 | | 90,700.91 | 394,619.85 |
| FY 2027 | 7/1/2026 | | 112,731.60 | | | | 7/15/2026 | | 33,308.92 | 12/31/2026 | | 145,167.15 | 474,732.17 |
| FY 2028 | 7/1/2027 | | 112,731.60 | | | | 7/15/2027 | | 14,868.82 | 12/31/2027 | | 145,167.15 | 456,292.07 |
| FY 2029 | 7/1/2028 | | 132,585.95 | | | | 7/15/2028 | | 14,868.82 | 12/31/2028 | | 145,167.15 | 476,146.42 |
| FY 2030 | 7/1/2029 | | 132,585.95 | | | | 7/15/2029 | | 14,868.82 | 12/31/2029 | | 145,167.15 | 476,146.42 |
| FY 2031 | 7/1/2030 | | 132,585.95 | | | | 7/15/2030 | | 14,868.82 | 12/31/2030 | | 145,167.15 | 442,373.30 |
| FY 2032 | 7/1/2031 | | 111,451.86 | | | | 7/15/2031 | | 14,868.82 | 12/31/2031 | | 145,167.15 | 421,239.21 |
| FY 2033 | 7/1/2032 | | 111,451.86 | | | | 7/15/2032 | | 14,868.82 | 12/31/2032 | | 145,167.15 | 421,239.21 |
| FY 2034 | 7/1/2033 | | 111,451.86 | | | | 7/15/2033 | | 14,868.82 | 12/31/2033 | | 145,167.15 | 271,487.83 |
| FY 2035 | 7/1/2034 | | 111,451.86 | | | | 7/15/2034 | | 14,868.82 | 12/31/2034 | | 145,167.15 | 271,487.83 |
| FY 2036 | 7/1/2035 | | 111,451.86 | | | | 7/15/2035 | | 69,619.75 | 12/31/2035 | | 145,167.15 | 326,238.76 |
| FY 2037 | 7/1/2036 | | 111,451.86 | | | | 7/15/2036 | | 69,619.75 | 12/31/2036 | | 145,167.15 | 326,238.76 |
| FY 2038 | 7/1/2037 | | 111,451.86 | | | | 7/15/2037 | | 89,511.11 | 12/31/2037 | | 145,167.15 | 346,130.12 |
| FY 2039 | 7/1/2038 | | 111,451.86 | | | | 7/15/2038 | | 89,511.11 | | | | 200,962.97 |
| FY 2040 | | | | | | | 7/15/2039 | | 89,511.11 | | | | 89,511.11 |
| FY 2041 | | | | | | | 7/15/2040 | | 89,511.11 | | | | 89,511.11 |
| FY 2042 | | | | | | | 7/15/2041 | | 89,511.11 | | | | 89,511.11 |
| FY 2043 | | | | | | | 7/15/2042 | | 268,533.33 | | | | 268,533.33 |
| FY 2044 | | | | | | | 7/15/2043 | | 268,533.33 | | | | 268,533.33 |
| | | | $ 2,006,133.56 | | | $ 390,622.50 | | | $ 1,342,739.03 | | | $ 2,014,108.53 | $ 8,197,099.22 |

Senate Bill No. 390–Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to behavioral health; providing for the establishment of a suicide prevention and behavioral health crisis hotline; exempting a telecommunications provider from certain damages relating to the hotline; requiring the imposition of a surcharge on certain communications services to support the hotline; creating the Fund for a Resilient Nevada; requiring the Attorney General to deposit the proceeds of certain litigation into the Fund; authorizing the Department of Health and Human Services to use the money in the Fund for certain statewide projects and to award grants to various public and private entities to address the impact of opioid use disorder and other substance use disorders; prescribing certain procedures relating to the awarding of those grants; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing federal law establishes the National Suicide Prevention Lifeline program, including the establishment of a national suicide prevention and mental health crisis hotline that may be accessed by dialing the digits 9-8-8. (42 U.S.C. §§ 290bb-36c) **Section 2** of this bill defines the term "National Suicide Prevention Lifeline program" to refer to that program. **Section 3** of this bill requires the Division of Public and Behavioral Health of the Department of Health and Human Services to perform certain activities to support the implementation of a hotline for persons who are considering suicide or otherwise in a behavioral health crisis that may be accessed by dialing the digits 9-8-8. Specifically, **section 3** requires the Division to: (1) establish at least one support center to answer calls to the hotline and coordinate the response to those calls; (2) encourage the establishment of or establish mobile crisis teams to respond to calls; and (3) perform certain other duties related to the hotline. **Section 3** exempts telecommunications providers from certain damages relating to the hotline. **Section 4** of this bill establishes operational requirements and duties for a support center. Those duties include coordinating and deploying necessary services for persons who access the hotline and providing follow-up services for such persons. **Section 6** of this bill requires the Division to annually submit to the Legislature, the Commission on Behavioral Health and each regional behavioral health policy board a report concerning the usage of the hotline and the services provided to persons who access the hotline.

Existing federal law authorizes a state to impose a fee or charge on a commercial mobile communication service or an IP-enabled voice service to fund the operations of a suicide prevention and mental health crisis hotline established pursuant to the National Suicide Prevention Lifeline program. (47 U.S.C. § 251a) **Section 5** of this bill requires the State Board of Health to adopt regulations to impose a surcharge on mobile communication services, IP-enabled voice services and landline telephone services. **Section 5** requires the Division to deposit the proceeds from the surcharge into an account and use that money to support the operation of the hotline and the services provided to persons who access the

hotline. **Section 5** additionally authorizes the Division to accept gifts, grants and donations to support those activities. **Section 6** of this bill requires the Division to annually submit to the Legislature a report concerning the revenue generated by the surcharge and deposits and expenditures from the account.

Existing law: (1) creates the Fund for a Healthy Nevada; (2) requires the State Treasurer to deposit in the Fund the proceeds of litigation by the State against manufacturers of tobacco products; and (3) requires the Department of Health and Human Services, with the authorization of the Legislature, to allocate the money in the Fund for certain purposes to address the health needs of residents of this State. (NRS 439.620, 439.630) **Sections 7-9.9** of this bill similarly: (1) create the Fund for a Resilient Nevada Fund to hold the proceeds of certain litigation by the State concerning the manufacture, distribution, sale and marketing of opioids; and (2) provide for the use of that money for statewide projects and distribution as grants to regional, local and tribal governments and private sector organizations for projects that address the impacts of opioid use disorder and other substance use disorders. **Sections 7-7.6** of this bill define certain relevant terms. **Section 7.7** of this bill creates the Advisory Committee for a Resilient Nevada, which is made up of persons who are affected by or otherwise interested in issues relating to substance use disorder. **Section 7.8** of this bill prescribes procedural requirements governing the operation of the Advisory Committee. **Section 7.9** of this bill requires the Advisory Committee to submit to the Director of the Department a biennial report of recommendations concerning the allocation and distribution of money from the Fund. **Section 8** of this bill creates the Fund and requires the Director to administer the Fund. **Section 8** also prescribes certain requirements relating to the expenditure of money from the Fund, including requiring such expenditures to comply with the State Budget Act and other requirements concerning the expenditure of state money. **Section 10** of this bill authorizes the Interim Finance Committee to perform duties relating to the authorization of administrative expenses from the Fund during a regular session of the Legislature. **Section 9** of this bill requires the Department to: (1) conduct a statewide needs assessment to determine the priorities for allocating money from the Fund; and (2) based on that needs assessment, develop a statewide plan for allocating the money in the Fund. **Sections 9.5 and 9.6** of this bill prescribe specific requirements concerning the statewide needs assessment conducted pursuant to **section 9** and the statewide plan developed pursuant to that section, respectively. Specifically, **section 9.6** authorizes the statewide plan to provide for the allocation of money from the Fund to: (1) fund certain statewide projects to address the impact of opioid use disorder and other substance use disorders; and (2) provide grants to regional, local or tribal governments and private sector organizations whose work relates to opioid use disorder or other substance use disorders. **Section 10.3** of this bill exempts the statewide plan from the requirements of the Nevada Administrative Procedure Act. **Section 9.7** of this bill requires each regional, local or tribal governmental entity that wishes to apply for a grant of money from the Fund to conduct a needs assessment and develop a plan for the expenditure of the money, and **sections 9.8 and 9.9** of this bill prescribe requirements governing such a needs assessment and plan, respectively. **Section 9.7** also requires any regional, local or tribal governmental entity or private sector organization that receives a grant to annually submit to the Department a report concerning the use of that money. Additionally, if a regional, local or tribal governmental entity that receives a grant later receives its own recovery resulting from litigation relating to the manufacture, distribution, sale or marketing of opioids, **section 9.7** authorizes the Department to recover all or a portion of the grant money, not to exceed the amount of the recovery.

**Section 11** of this bill requires any state agency that has previously received proceeds of litigation by the State concerning the manufacture, distribution, sale and marketing of opioids to transfer any uncommitted portion of those proceeds to the Director of the Department for deposit in the Fund.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

**Section 1.** Chapter 433 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9.9, inclusive, of this act.

**Sec. 2.** ***As used in sections 2 to 6, inclusive, of this act, unless the context otherwise requires, "National Suicide Prevention Lifeline program" means the National Suicide Prevention Lifeline program established by 42 U.S.C. § 290bb-36c.***

**Sec. 3.** ***1. The Division shall support the implementation of a hotline for persons who are considering suicide or otherwise in a behavioral health crisis that may be accessed by dialing the digits 9-8-8 by:***

***(a) Establishing at least one support center that meets the requirements of section 4 of this act to answer calls to the hotline and coordinate the response to persons who access the hotline;***

***(b) Encouraging the establishment of and, to the extent that money is available, establishing mobile crisis teams to provide community-based intervention, including, without limitation, de-escalation and stabilization, for persons who are considering suicide or otherwise in a behavioral health crisis and access the hotline;***

***(c) Participating in any collection of information by the Federal Government concerning the National Suicide Prevention Lifeline program;***

***(d) Collaborating with the National Suicide Prevention Lifeline program and the Veterans Crisis Line program established pursuant to 38 U.S.C. § 1720F(h) to ensure consistent messaging to the public about the hotline; and***

***(e) Adopting any regulations necessary to carry out the provisions of sections 2 to 6, inclusive, of this act, including, without limitation:***

***(1) Regulations establishing the qualifications of providers of services who are involved in responding to persons who are considering suicide or are otherwise in a behavioral health crisis and access the hotline;***

*(2) Any regulations necessary to allow for communication and sharing of information between persons and entities involved in responding to crises and emergencies in this State to facilitate the coordination of care for persons who are considering suicide or are otherwise in a behavioral health crisis and access the hotline; and*

*(3) Regulations defining the term "person professionally qualified in the field of behavioral health" for the purposes of this section.*

*2. A mobile crisis team established pursuant to paragraph (b) of subsection 1 must be:*

*(a) A team based in the jurisdiction that it serves which includes persons professionally qualified in the field of behavioral health and providers of peer recovery support services;*

*(b) A team established by a provider of emergency medical services that includes persons professionally qualified in the field of behavioral health and providers of peer recovery support services; or*

*(c) A team established by a law enforcement agency that includes law enforcement officers, persons professionally qualified in the field of psychiatric mental health and providers of peer recovery support services.*

*3. A telecommunications provider and its employees, agents, subcontractors and suppliers are not liable for damages that directly or indirectly result from the installation, maintenance or provision of service in relation to the hotline implemented pursuant to this section, including, without limitation, the total or partial failure of any transmission to a support center, unless willful conduct or gross negligence is proven.*

*4. As used in this section, "peer recovery support services" means nonclinical supportive services that use lived experience in recovery from a substance use disorder or other behavioral health disorder to promote recovery in another person with a substance use disorder or other behavioral health disorder by advocating, mentoring, educating, offering hope and providing assistance in navigating systems.*

**Sec. 4.** *1. Any support center established pursuant to section 3 of this act must:*

*(a) Meet the requirements established for participation in the National Suicide Prevention Lifeline program including, without limitation, requirements established by the National Suicide Prevention Lifeline Program for serving lesbian, gay, bisexual, transgender and questioning persons, persons with substance use*

***disorders or persons with co-occurring disorders, Native Americans and other high-risk and specialized populations identified by the Substance Abuse and Mental Health Services Administration of the United States Health and Human Services. Such requirements include, without limitation, requirements for training staff to respond to callers who are members of specialized populations and transferring such callers to an appropriate specialized center or subnetwork.***

***(b) Use technology that is interoperable between systems for responding for crises and emergencies across this State, including, without limitation:***

***(1) Systems used to provide emergency 911 service;***

***(2) Systems used by providers of emergency medical services; and***

***(3) Registries of beds available for persons who require inpatient psychiatric treatment.***

***2. A support center shall:***

***(a) Enter into an agreement with the National Suicide Prevention Lifeline program to participate in the network of local crisis support centers established by that program;***

***(b) Implement the operational and clinical standards and best practices prescribed by the National Suicide Prevention Lifeline program for a local crisis support center;***

***(c) Share information with other persons and entities in this State responsible for providing services to persons in a behavioral health crisis to facilitate performance of the duties described in paragraph (d);***

***(d) Coordinate and deploy necessary services, including, without limitation, crisis stabilization services and mobile crisis teams, for persons who are considering suicide or otherwise in a behavioral health crisis and access the hotline established pursuant to section 3 of this act; and***

***(e) Provide follow-up services for persons who are considering suicide or otherwise in a behavioral health crisis and access the hotline established pursuant to section 3 of this act.***

***3. As used in this section, "crisis stabilization services" has the meaning ascribed to it in NRS 449.0915.***

**Sec. 5.** ***1. The State Board of Health shall adopt regulations to impose a surcharge on each access line of each customer of a company that provides commercial mobile communication services or IP-enabled voice services in this State in accordance with 47 U.S.C. § 251a and each access line or trunk line of each customer to the local exchange of any***

***telecommunications provider providing those lines in this State. Those companies and providers shall collect the surcharge from their customers and transfer the money collected to the Division pursuant to regulations adopted by the State Board of Health. The amount of the surcharge must be sufficient to support the uses set forth in subsection 2, except that the amount of the surcharge must not exceed 35 cents for each access line or trunk line.***

***2. The Crisis Response Account is hereby created in the State General Fund. Any money collected from the surcharge imposed pursuant to subsection 1 must be deposited in the State Treasury for credit to the Account. The Division shall administer the Account. The money in the Account:***

***(a) Must be used by the Division to carry out the provisions of sections 2 to 6, inclusive, of this act, to the extent authorized by 47 U.S.C. § 251a; and***

***(b) Must not be used to supplant existing methods of funding that are available for those purposes.***

***3. The interest and income earned on the money in the Account, after deducting any applicable charges, must be credited to the Account.***

***4. Any money remaining in the Account at the end of each fiscal year does not revert to the State General Fund but must be carried over into the next fiscal year.***

***5. The Division may accept gifts, grants and donations for the purpose of carrying out the provisions of sections 2 to 6, inclusive, of this act.***

**Sec. 6.** ***On or before December 31 of each year, the Division shall compile:***

***1. A report concerning the usage of the hotline established pursuant to section 3 of this act and the services provided to persons who are considering suicide or otherwise in a behavioral health crisis and access the hotline and submit the report to:***

***(a) The Commission on Behavioral Health;***

***(b) Each regional behavioral health policy board created by NRS 433.429; and***

***(c) The Director of the Legislative Counsel Bureau for transmittal to:***

***(1) In odd-numbered years, the Legislative Committee on Health Care created by NRS 439B.200 and the Legislative Committee on Senior Citizens, Veterans and Adults With Special Needs created by NRS 218E.750; and***

***(2) In even-numbered years, the next regular session of the Legislature.***

*2. A report concerning the revenue generated by the surcharge imposed pursuant to section 5 of this act and deposits and expenditures from the Account created by that section and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:*

*(a) In odd-numbered years, the Interim Finance Committee; and*

*(b) In even-numbered years, the next regular session of the Legislature.*

**Sec. 7.** *As used in sections 7 to 9.9, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 7.1 to 7.6, inclusive, of this act have the meanings ascribed to them in those sections.*

**Sec. 7.1.** *"Advisory Committee" means the Advisory Committee for a Resilient Nevada created by section 7.7 of this act.*

**Sec. 7.2.** *"Agency which provides child welfare services" has the meaning ascribed to it in NRS 432B.030.*

**Sec. 7.3.** *"Fund" means the Fund for a Resilient Nevada created by section 8 of this act.*

**Sec. 7.4.** *"Office" means the Office of Minority Health and Equity of the Department created by NRS 232.474.*

**Sec. 7.5.** *"Special population" means a population uniquely affected by substance use or substance use disorder. The term includes, without limitation:*

*1. Veterans;*

*2. Persons who are pregnant;*

*3. Parents of dependent children;*

*4. Youth;*

*5. Persons who are lesbian, gay, bisexual, transgender and questioning; and*

*6. Persons and families involved in the criminal justice system, juvenile justice system and child welfare system.*

**Sec. 7.6.** *"Substance use disorder prevention coalition" means a coalition of persons and entities who possess knowledge and experience related to the prevention of substance use and substance use disorders in a region of this State.*

**Sec. 7.7.** *1. The Advisory Committee for a Resilient Nevada is hereby created within the Department.*

*2. The Attorney General shall appoint to the Advisory Committee:*

*(a) One member who possesses knowledge, skills and experience working with youth in the juvenile justice system;*

***(b) One member who possesses knowledge, skills and experience working with persons in the criminal justice system;***

***(c) One member who possesses knowledge, skills and experience in the surveillance of overdoses; and***

***(d) One member who:***

***(1) Resides in a county other than Clark or Washoe County; and***

***(2) Has experience having a substance use disorder or having a family member who has a substance use disorder.***

***3. The Office shall appoint to the Advisory Committee:***

***(a) One member who:***

***(1) Resides in Clark County; and***

***(2) Has experience having a substance use disorder or having a family member who has a substance use disorder;***

***(b) One member who possesses knowledge, skills and experience in public health;***

***(c) One member who is the director of an agency which provides child welfare services or his or her designee;***

***(d) One member who represents a program that specializes in the prevention of substance use by youth;***

***(e) One member who represents a faith-based organization that specializes in recovery from substance use disorder; and***

***(f) One member who represents a program for substance use disorders that is operated by a nonprofit organization and certified pursuant to NRS 458.025.***

***4. The Director shall appoint to the Advisory Committee:***

***(a) One member who:***

***(1) Resides in Washoe County; and***

***(2) Has experience having a substance use disorder or having a family member who has a substance use disorder;***

***(b) One member who is a physician certified in the field of addiction medicine by the American Board of Addiction Medicine or its successor organization;***

***(c) One member who represents a nonprofit, community-oriented organization that specializes in peer-led recovery from substance use disorder;***

***(d) One member who has survived an opioid overdose;***

***(e) One member who represents a program to prevent overdoses or otherwise reduce the harm caused by the use of substances;***

***(f) One member who represents an organization that specializes in housing; and***

*(g) One member who possesses knowledge, skills and experience with the education of pupils in kindergarten through 12th grade.*

*5. In appointing the members of the Advisory Committee pursuant to subsections 2, 3 and 4, the appointing authorities shall coordinate the appointments when practicable so that the members of the Advisory Committee represent the diversity of:*

*(a) This State; and*

*(b) The communities within this State that are disproportionately affected by opioid use disorder and disparities in access to care and health outcomes.*

*6. The term of each member of the Advisory Committee is 2 years. A member may be reappointed for an additional term of 2 years in the same manner as the original appointment. A vacancy occurring in the membership of the Advisory Committee must be filled in the same manner as the original appointment.*

*7. To the extent that money is available for these purposes:*

*(a) Each member of the Advisory Committee who is not an officer or employee of this State is entitled to receive a salary of not more than $80, as fixed by the Department, for each day or portion of a day spent on the business of the Advisory Committee.*

*(b) Each member of the Advisory Committee is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally while engaged in the business of the Advisory Committee.*

*8. A member of the Advisory Committee who is an officer or employee of this State or a political subdivision of this State must be relieved from his or her duties without loss of regular compensation to prepare for and attend meetings of the Advisory Committee and perform any work necessary to carry out the duties of the Advisory Committee in the most timely manner practicable. A state agency or political subdivision of this State shall not require an officer or employee who is a member of the Advisory Committee to:*

*(a) Make up the time he or she is absent from work to carry out his or her duties as a member of the Advisory Committee; or*

*(b) Take annual leave or compensatory time for the absence.*

**Sec. 7.8.** *1. At the first meeting of each calendar year, the Advisory Committee shall elect from its members a Chair.*

*2. The Advisory Committee shall meet at least twice annually at the call of the Chair or a majority of its members.*

*3. A majority of the members of the Advisory Committee constitutes a quorum for the transaction of business, and a*

***majority of a quorum present at any meeting is sufficient for any official action taken by the Advisory Committee.***

***4. The Department shall provide staff assistance to the Advisory Committee.***

**Sec. 7.9.** ***1. On or before June 30 of each even-numbered year, the Advisory Committee shall submit to the Director of the Department a report of recommendations concerning:***

***(a) The statewide needs assessment conducted pursuant to paragraph (a) of subsection 1 of section 9 of this act, including, without limitation, the establishment of priorities pursuant to paragraph (e) of subsection 1 of section 9.5 of this act; and***

***(b) The statewide plan to allocate money from the Fund developed pursuant to paragraph (b) of subsection 1 of section 9 of this act.***

***2. When developing recommendations to be included in the report pursuant to subsection 1, the Advisory Committee shall consider:***

***(a) Health equity and identifying relevant disparities among racial and ethnic populations, geographic regions and special populations in this State; and***

***(b) The need to prevent overdoses, address disparities in access to health care and prevent substance use among youth.***

***3. When developing recommendations concerning the establishment of priorities pursuant to paragraph (e) of subsection 1 of section 9.5 of this act, the Advisory Committee shall use an objective method to define the potential positive and negative impacts of a priority on the health of the affected communities with an emphasis on disproportionate impacts to any population targeted by the priority.***

***4. Before finalizing a report of recommendations pursuant to subsection 1, the Advisory Committee must hold at least one public meeting to solicit comments from the public concerning the recommendations and make any revisions to the recommendations determined, as a result of the public comment received, to be necessary.***

**Sec. 8.** ***1. The Fund for a Resilient Nevada is hereby created in the State Treasury. Unless otherwise required by the applicable judgment or settlement, the Attorney General shall, after deducting any fees and costs imposed pursuant to an applicable contingent fee contract as described in NRS 228.111, deposit in the Fund all money received by this State pursuant to any judgment received or settlement entered into by the State of Nevada as a result of litigation concerning the manufacture,***

***distribution, sale or marketing of opioids conducted in accordance with the declaration of findings issued by the Governor and the Attorney General pursuant to paragraph (a) of subsection 1 of NRS 228.1111 on January 24, 2019.***

***2. The Director of the Department shall administer the Fund.***

***3. The interest and income earned on the money in the Fund must, after deducting any applicable charges, be credited to the Fund. All claims against the Fund must be paid as other claims against the State are paid.***

***4. To the extent authorized by the terms of any judgment or settlement described in subsection 1, the Director of the Department may submit to the Interim Finance Committee a request for an allocation for administrative expenses from the Fund pursuant to this section. Except as otherwise limited by this subsection, the Interim Finance Committee may allocate all or part of the money so requested. The annual allocation for administrative expenses from the Fund must not exceed 8 percent of the money deposited into the Fund. For the purposes of this subsection, expenses directly related to conducting a statewide needs assessment pursuant to paragraph (a) of subsection 1 of section 9 of this act, developing the statewide plan to allocate money from the Fund pursuant to paragraph (b) of subsection 1 of section 9 of this act and allocating money from the Fund in accordance with that statewide plan do not constitute administrative expenses.***

***5. The money in the Fund remains in the Fund and does not revert to the State General Fund at the end of any fiscal year.***

***6. Except as otherwise provided in subsection 4, all money that is deposited or paid into the Fund is hereby appropriated to the Department to be used, subject to the provisions of chapter 353 of NRS, to carry out the provisions of sections 9 to 9.7, inclusive, of this act.***

***7. Money expended from the Fund must not be used to supplant existing methods of funding that are available to state, regional, local or tribal agencies.***

***8. The Department may accept and deposit into the Fund gifts, grants, donations and appropriations to support the activities described in sections 9 to 9.7, inclusive, of this act.***

**Sec. 9.** ***1. At least once every 4 years, the Department, in consultation with the Office, shall:***

***(a) Conduct a statewide needs assessment in accordance with section 9.5 of this act; and***

***(b) Based on the statewide needs assessment, develop or revise, as applicable, a statewide plan to allocate the money in the Fund in accordance with section 9.6 of this act.***

***2. When performing the duties described in subsection 1, the Department and the Office shall consider:***

***(a) The recommendations provided by the Advisory Committee in the report submitted pursuant to section 7.9 of this act; and***

***(b) The recommendations of state, regional, local and tribal governmental entities in this State whose work relates to opioid use disorders and other substance use disorders.***

***3. On or before January 31 of each year, the Department shall transmit a report concerning all findings and recommendations made and money expended pursuant to sections 9 to 9.7, inclusive, of this act to:***

***(a) The Governor;***

***(b) The Director of the Legislative Counsel Bureau for transmittal to:***

***(1) In odd-numbered years, the next regular session of the Legislature; and***

***(2) In even-numbered years, the Legislative Committee on Health Care and the Interim Finance Committee;***

***(c) The Commission;***

***(d) Each regional behavioral health policy board created by NRS 433.429;***

***(e) The Office of the Attorney General; and***

***(f) Any other committees or commissions the Director of the Department deems appropriate.***

***4. The Department may adopt any regulations or take such other actions as are necessary to carry out its duties pursuant to sections 7 to 9.9, inclusive, of this act.***

**Sec. 9.5.** ***1. A statewide needs assessment conducted by the Department, in consultation with the Office, pursuant to paragraph (a) of subsection 1 of section 9 of this act must:***

***(a) Be evidence-based and use information from damages reports created by experts as part of the litigation described in subsection 1 of section 8 of this act.***

***(b) Include an analysis of the impacts of opioid use and opioid use disorder on this State that uses quantitative and qualitative data concerning this State and the regions, counties and Native American tribes in this State to determine the risk factors that contribute to opioid use, the use of substances and the rates of opioid use disorder, other substance use disorders and co-occurring disorders among residents of this State.***

***(c) Focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions and special populations in this State.***

***(d) Take into account the resources of state, regional, local and tribal agencies and nonprofit organizations, including, without limitation, any money recovered or anticipated to be recovered by county, local or tribal governmental agencies through judgments or settlements resulting from litigation concerning the manufacture, distribution, sale or marketing of opioids, and the programs currently existing in each geographic region of this State to address opioid use disorder and other substance use disorders.***

***(e) Based on the information and analyses described in paragraphs (a) to (d), inclusive, establish priorities for the use of the funds described in subsection 1 of section 8 of this act. Such priorities must include, without limitation, priorities related to the prevention of overdoses, addressing disparities in access to health care and the prevention of substance use among youth.***

***2. When conducting a needs assessment, the Department, in consultation with the Office, shall:***

***(a) Use community-based participatory research methods or similar methods to conduct outreach to groups impacted by the use of opioids, opioid use disorder and other substance use disorders, including, without limitation:***

***(1) Persons and families impacted by the use of opioids and other substances;***

***(2) Providers of treatment for opioid use disorder and other substance use disorders;***

***(3) Substance use disorder prevention coalitions;***

***(4) Communities of persons in recovery from opioid use disorder and other substance use disorders;***

***(5) Providers of services to reduce the harms caused by opioid use disorder and other substance use disorders;***

***(6) Persons involved in the child welfare system;***

***(7) Providers of social services;***

***(8) Faith-based organizations;***

***(9) Providers of health care and entities that provide health care services; and***

***(10) Members of diverse communities disproportionately impacted by opioid use and opioid use disorder; and***

***(b) Conduct outreach to governmental agencies who interact with persons or groups impacted by the use of opioids, opioid use***

***disorder and other substance use disorders, including, without limitation:***

***(1) The Office of the Attorney General, the Department of Public Safety, the Department of Corrections, courts, juvenile justice agencies and other governmental agencies involved in law enforcement or criminal justice;***

***(2) Agencies which provide child welfare services and other governmental agencies involved in the child welfare system; and***

***(3) Public health agencies.***

**Sec. 9.6.** ***1. The statewide plan to allocate money from the Fund established by the Department, in consultation with the Office, pursuant to paragraph (b) of subsection 1 of section 9 of this act must:***

***(a) Establish policies and procedures for the administration and distribution of money from the Fund;***

***(b) Allocate the money in the Fund for the purposes described in subsection 2; and***

***(c) Establish requirements governing the use of money allocated from the Fund.***

***2. The statewide plan may allocate money to:***

***(a) Statewide projects, which may include, without limitation:***

***(1) Expanding access to evidence-based prevention of substance use disorders, early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders;***

***(2) Programs to reduce the incidence and severity of neonatal abstinence syndrome;***

***(3) Prevention of adverse childhood experiences and early intervention for children who have undergone adverse childhood experiences and the families of such children;***

***(4) Services to reduce the harm caused by substance use;***

***(5) Prevention and treatment of infectious diseases in persons with substance use disorders;***

***(6) Services for children and other persons in a behavioral health crisis and the families of such persons;***

***(7) Housing for persons who have or are in recovery from substance use disorders;***

***(8) Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;***

***(9) Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts;***

*(10) The evaluation of existing programs relating to substance use and substance use disorders;*

*(11) Development of the workforce of providers of services relating to substance use and substance use disorders;*

*(12) The collection and analysis of data relating to substance use and substance use disorders;*

*(13) Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling; and*

*(14) Implementing the hotline for persons who are considering suicide or otherwise in a behavioral health crisis and providing services to persons who access that hotline in accordance with the provisions of sections 2 to 6, inclusive, of this act.*

*(b) Grants to regional, county, local and tribal agencies and private-sector organizations whose work relates to opioid use disorder and other substance use disorders.*

*3. The projects described in paragraph (a) of subsection 2 many include, without limitation, projects to maximize expenditures through federal, local and private matching contributions.*

*4. The Department, in consultation with the Office, may revise the statewide plan to allocate money from the Fund as necessary without conducting a statewide needs assessment pursuant to paragraph (a) of subsection 1 of section 9 of this act so long as a needs assessment is conducted at the intervals required by that subsection.*

**Sec. 9.7.** *1. If the Department awards grants pursuant to paragraph (b) of subsection 2 of section 9.6 of this act, the Department, in consultation with the Office, must:*

*(a) Develop, solicit and accept applications for those grants. An application submitted by a regional, local or tribal governmental entity must include, without limitation:*

*(1) The results of a needs assessment that meets the requirements of section 9.8 of this act; and*

*(2) A plan for the use of the grant that meets the requirements of section 9.9 of this act.*

*(b) Coordinate with and provide support to regional, local and tribal governmental entities in conducting needs assessments and developing plans pursuant to paragraph (a).*

*(c) Consider any money recovered or anticipated to be recovered by county, local or tribal governmental agencies through judgments received or settlements entered into as a result*

***of litigation concerning the manufacture, distribution, sale or marketing of opioids.***

***(d) Conduct annual evaluations of programs to which grants have been awarded.***

***2. To the extent authorized by the terms of any judgment or settlement described in subsection 1 of section 8 of this act, the recipient of a grant pursuant to paragraph (b) of subsection 2 of section 9.6 of this act may use not more than 8 percent of the grant for administrative expenses related to the grant or the projects supported by the grant.***

***3. The recipient of a grant pursuant to paragraph (b) of subsection 2 of section 9.6 of this act shall annually submit to the Department a report concerning the expenditure of the money that was received and the outcomes of the projects on which that money was spent.***

***4. If a regional, local or tribal governmental entity that receives a grant pursuant to paragraph (b) of subsection 2 of section 9.6 of this act later recovers money through a judgment or a settlement resulting from litigation concerning the manufacture, distribution, sale or marketing of opioids:***

***(a) The regional, local or tribal governmental entity must immediately notify the Department; and***

***(b) The Department may recover from the governmental entity an amount not to exceed the amount of the grant or the amount of the recovery, whichever is less.***

***5. A regional, local or tribal governmental entity that receives a grant pursuant to paragraph (b) of subsection 2 of section 9.6 of this act shall conduct a new needs assessment and update its plan for the use of the grant at intervals prescribed by regulation of the Department, which must be not less than every 4 years.***

**Sec. 9.8.** ***1. A needs assessment conducted pursuant to subparagraph (1) of paragraph (a) of subsection 1 of section 9.7 of this act by a regional, local or tribal governmental entity applying for a grant must:***

***(a) Be evidence-based.***

***(b) Include an analysis of the impacts of opioid use and opioid use disorder on the area under the jurisdiction of the applicant that uses quantitative and qualitative data to determine the risk factors that contribute to opioid use, the use of substances and the rates of opioid use disorder, other substance use disorders and co-occurring disorders among residents of the area.***

***(c) Focus on health equity and identifying disparities across all racial and ethnic populations, geographic regions and special populations in the area under the jurisdiction of the applicant.***

***(d) Take into account the resources of the applicant and the programs currently existing in the area under the jurisdiction of the applicant to address opioid use disorder and other substance use disorders.***

***(e) Based on the information and analyses described in paragraphs (a) to (d), inclusive, establish priorities for the use of the funds for which the applicant is applying.***

***2. When conducting a needs assessment, a regional, local or tribal governmental entity applying for a grant shall:***

***(a) Use community-based participatory research methods or similar methods to conduct outreach to groups impacted by the use of opioids, opioid use disorder and other substance use disorders, including, without limitation:***

***(1) Persons and families impacted by the use of opioids and other substances;***

***(2) Providers of treatment for opioid use disorder and other substance use disorders;***

***(3) Substance use disorder prevention coalitions;***

***(4) Communities of persons in recovery from opioid use disorder and other substance use disorders;***

***(5) Providers of services to reduce the harms caused by opioid use disorder and other substance use disorders;***

***(6) Persons involved in the child welfare system;***

***(7) Providers of social services;***

***(8) Faith-based organizations;***

***(9) Providers of health care and entities that provide health care services; and***

***(10) Members of diverse communities disproportionately impacted by opioid use and opioid use disorder; and***

***(b) Conduct outreach to governmental agencies that interact with persons or groups impacted by the use of opioids, opioid use disorder and other substance use disorders, including, without limitation:***

***(1) Courts, juvenile justice agencies and other governmental agencies involved in law enforcement or criminal justice;***

***(2) Agencies which provide child welfare services and other governmental agencies involved in the child welfare system; and***

***(3) Public health agencies.***

**Sec. 9.9.** *1. A plan for the use of grant money by a state, local or tribal governmental entity developed pursuant to subparagraph (2) of paragraph (a) of subsection 1 of section 9.7 of this act must:*

*(a) Establish policies and procedures for the administration and distribution of the grant money for which the governmental entity is applying;*

*(b) Describe the projects to which the governmental entity is proposing to allocate grant money; and*

*(c) Establish requirements governing the use of the grant money.*

*2. A plan for the use of grant money by a state, local or tribal governmental entity may allocate money pursuant to paragraph (b) of subsection 1 to:*

*(a) Projects and programs to:*

*(1) Expand access to evidence-based prevention of substance use disorders, early intervention for persons at risk of a substance use disorder, treatment for substance use disorders and support for persons in recovery from substance use disorders;*

*(2) Reduce the incidence and severity of neonatal abstinence syndrome;*

*(3) Prevent incidents of adverse childhood experiences and increase early intervention for children who have undergone adverse childhood experiences and the families of such children;*

*(4) Reduce the harm caused by substance use;*

*(5) Prevent and treat infectious diseases in persons with substance use disorders;*

*(6) Provide services for children and other persons in a behavioral health crisis and the families of such persons; and*

*(7) Provide housing for persons who have or are in recovery from substance use disorders;*

*(b) Campaigns to educate and increase awareness of the public concerning substance use and substance use disorders;*

*(c) Programs for persons involved in the criminal justice or juvenile justice system and the families of such persons, including, without limitation, programs that are administered by courts;*

*(d) Evaluation of existing programs relating to substance use and substance use disorders;*

*(e) Development of the workforce of providers of services relating to substance use and substance use disorders;*

*(f) The collection and analysis of data relating to substance use and substance use disorders; and*

***(g) Capital projects relating to substance use and substance use disorders, including, without limitation, construction, purchasing and remodeling.***

***3. The projects described in subsection 2 may include, without limitation, projects to maximize expenditures through federal, local and private matching contributions.***

**Sec. 10.** NRS 218E.405 is hereby amended to read as follows:

218E.405 1. Except as otherwise provided in subsection 2, the Interim Finance Committee may exercise the powers conferred upon it by law only when the Legislature is not in a regular or special session.

2. During a regular or special session, the Interim Finance Committee may also perform the duties imposed on it by NRS 228.1111, subsection 5 of NRS 284.115, NRS 285.070, subsection 2 of NRS 321.335, NRS 322.007, subsection 2 of NRS 323.020, NRS 323.050, subsection 1 of NRS 323.100, subsection 3 of NRS 341.126, NRS 341.142, paragraph (f) of subsection 1 of NRS 341.145, NRS 353.220, 353.224, 353.2705 to 353.2771, inclusive, 353.288, 353.335, 353C.224, 353C.226, paragraph (b) of subsection 4 of NRS 407.0762, NRS 428.375, 439.4905, 439.620, 439.630, 445B.830, subsection 1 of NRS 445C.320 and NRS 538.650 ~~[.]~~ ***and section 8 of this act.*** In performing those duties, the Senate Standing Committee on Finance and the Assembly Standing Committee on Ways and Means may meet separately and transmit the results of their respective votes to the Chair of the Interim Finance Committee to determine the action of the Interim Finance Committee as a whole.

3. The Chair of the Interim Finance Committee may appoint a subcommittee consisting of six members of the Committee to review and make recommendations to the Committee on matters of the State Public Works Division of the Department of Administration that require prior approval of the Interim Finance Committee pursuant to subsection 3 of NRS 341.126, NRS 341.142 and paragraph (f) of subsection 1 of NRS 341.145. If the Chair appoints such a subcommittee:

(a) The Chair shall designate one of the members of the subcommittee to serve as the chair of the subcommittee;

(b) The subcommittee shall meet throughout the year at the times and places specified by the call of the chair of the subcommittee; and

(c) The Director or the Director’s designee shall act as the nonvoting recording secretary of the subcommittee.

**Sec. 10.3.** NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

➥ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~[or]~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~[.]~~ ***; or***

***(i) The adoption, amendment or repeal of the statewide plan to allocate money from the Fund for a Resilient Nevada created by section 8 of this act established by the Department of Health and Human Services pursuant to paragraph (b) of subsection 1 of section 9 of this act.***

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

**Sec. 10.6.** 1. As soon as practicable after the effective date of this section:

(a) The Attorney General shall appoint to the Advisory Committee:

(1) The members described in paragraphs (a) and (b) of subsection 2 of section 7.7 of this act to initial terms that expire on July 1, 2022.

(2) The members described in paragraphs (c) and (d) of subsection 2 of section 7.7 of this act to initial terms that expire on July 1, 2023.

(b) The Office of Minority Health and Equity of the Department shall appoint to the Advisory Committee:

(1) The members described in paragraphs (a), (b) and (c) of subsection 3 of section 7.7 of this act to initial terms that expire on July 1, 2022.

(2) The members described in paragraphs (d), (e) and (f) of subsection 3 of section 7.7 of this act to initial terms that expire on July 1, 2023.

(c) The Director of the Department shall appoint to the Advisory Committee:

(1) The members described in paragraphs (a), (b) and (c) of subsection 4 of section 7.7 of this act to initial terms that expire on July 1, 2022.

(2) The members described in paragraphs (d) to (g), inclusive, of subsection 4 of section 7.7 of this act to initial terms that expire on July 1, 2023.

2. As used in this section:

(a) "Advisory Committee" means the Advisory Committee for a Resilient Nevada created by section 7.7 of this act.

(b) "Department" means the Department of Health and Human Services.

**Sec. 11.** Any state agency that has received money from a settlement or judgment as a result of the litigation described in subsection 1 of section 8 of this act before January 1, 2022, shall, to the extent authorized by the settlement or judgment, transfer to the Director of the Department of Health and Human Services any portion of such money that remains uncommitted for deposit in the Fund for A Resilient Nevada pursuant to section 8 of this act.

**Sec. 11.5.** 1. During the 2022-2023 interim, the Department of Health and Human Services, in consultation with the Office of

Minority Health and Equity of the Department, may, without further legislative authorization, use money in the Fund For A Resilient Nevada created by section 8 of this act to conduct an initial statewide needs assessment and develop an initial statewide plan to spend the money in the Fund pursuant to section 9 of this act.

2. The Department, in consultation with the Office, shall:

(a) Develop a proposed budget to carry out the provisions of the initial statewide plan developed pursuant to subsection 1 for the remainder of the 2022-2023 interim; and

(b) Obtain the approval of the Interim Finance Committee for that budget before money from the Fund is used for the purposes described in the plan. Notwithstanding the provisions of section 8 of this act, such approval is sufficient to authorize the use of money from the Fund as prescribed in the budget for the remainder of the 2022-2023 interim.

**Sec. 12.** The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

**Sec. 13.** Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

**Sec. 14.** 1. This section and sections 7 to 13, inclusive, of this act become effective upon passage and approval.

2. Sections 1 to 6, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2022, for all other purposes.

**20** ~~~~~ **21**

# ONE NEVADA AGREEMENT ON ALLOCATION OF OPIOID RECOVERIES

**WHEREAS**, the people of the State of Nevada and its communities have been harmed by the misfeasance, nonfeasance, and malfeasance of certain individuals and entities, including licit and illicit opioid distribution, that has created an opioid epidemic both nationally and within the State of Nevada;

**WHEREAS**, on January 24, 2019, the Honorable Steve Sisolak, Governor of the State of Nevada, in consultation with the Honorable Aaron D. Ford, Attorney General of the State of Nevada, entered a Declaration of Findings Pursuant to NRS 228.1111(1)(a), declaring that the State of Nevada is combating the opioid epidemic;

**WHEREAS**, the State of Nevada though its elected representatives and counsel, including the Honorable Aaron D. Ford, Attorney General of the State of Nevada, and certain Local Governments, through their elected representatives and counsel, are separately engaged in opioid-related litigation seeking to hold various entities and individuals accountable for the opioid epidemic in the State of Nevada based on their misconduct relating to the unlawful manufacture, marketing, promotion, distribution, and/or dispensing of prescription opioids;

**WHEREAS**, the State of Nevada and its Local Governments share a common desire to remediate and alleviate the impacts of the opioid epidemic throughout the State of Nevada;

**THEREFORE**, the State of Nevada and its Local Governments, desire, subject to formal approval effectuating this One Nevada Agreement on Allocation of Opioid Recoveries ("Agreement") relating to the resolution or partial resolution of opioid-related litigation and the allocation and use of the proceeds of any Recoveries as described; and

**NOW THEREFORE**, the Parties agree and desire to be bound as follows:

## A. Definitions

As used in this Agreement:

1. The "State" or "State of Nevada" shall mean the State of Nevada acting through its Attorney General.
2. “Local Governments” shall mean the Local Governments listed in **Exhibit A**, attached.
3. "Litigating Counties" shall mean the following Nevada Counties: Carson City, Churchill, Clark, Douglas, Esmeralda, Humboldt, Lincoln, Lyon, Mineral, Nye, Washoe, and White Pine;
4. "Non-Litigating Counties" shall mean the following Nevada Counties: Elko, Eureka, Lander, Pershing, and Storey;
5. “Litigating Cities and Districts” shall mean the Cities and Districts listed in **Exhibit B**, attached;
6. “Counsel” shall mean the contingency fee retained attorneys to the State of Nevada and each of the Litigating Counties and Litigating Cities and Districts for their respective opioid-related litigation.
7. "The Parties" shall mean the State of Nevada and the Local Governments.
8. "Defendant" or "Defendants" shall mean one or more entities and/or individuals responsible for the opioid epidemic in the State of Nevada based upon various theories and causes of action asserted in pending opioid-related litigation by the State of Nevada, the Litigating Counties, and the Litigating Cities and Districts as listed in **Exhibit C**, attached.
9. "Lead Litigator Costs" shall mean the costs incurred to date for opioid-related litigation by the State of Nevada, the Litigating Counties, and the Litigating Cities

and Districts against the Defendants of at the time of any Recovery. Costs do not include attorney fees or contingency fees for Counsel.

10. "Federal Government CMS Medicaid Costs" shall mean 22.52% of any Recovery after deduction of the Lead Litigator Costs that may be asserted, and only if determined to be recoverable, against the State of Nevada's Federal Government Centers for Medicaid Services costs for claims, otherwise commonly known as the federal share of Medicaid claims payments.

11. "Negotiating Committee" shall mean Counsel for the State of Nevada, the Nevada Attorney General or his designees as required by NRS chapter 228.1113, et seq., and Counsel for the Litigating Counties, and the Litigating Cities and Districts (collectively, "Members") in their respective opioid-related litigation.

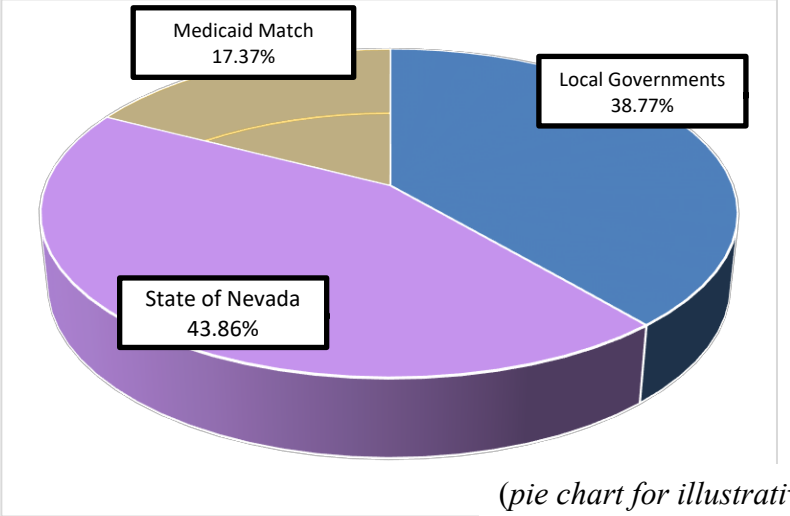
12. "Recovery" or "Recoveries" shall mean monetary amounts obtained through the negotiated resolution of legal or equitable claims against any Defendant in any opioid-related litigation listed in **Exhibit C**, and shall include any Recoveries against any Defendant through bankruptcy proceedings related to the opioid-related litigation in **Exhibit C** to the extent the bankruptcy court allows for use of this Agreement to allocate Recoveries.

13. "Approved Purposes" shall mean only uses to remediate the harms, impact, and risks caused by the opioid epidemic to the State of Nevada and its residents, and are consistent with those uses required by Senate Bill 390 (SB 390) as enrolled by the 81st (2021) Nevada Legislative Session and signed into law by the Nevada Governor, or uses that are listed as an approved use for abatement purposes in any plan approved by a bankruptcy court that are not otherwise inconsistent with SB 390.

**B. Allocation of Recoveries**

1. With the exception of up to 8% for administrative costs, or unless otherwise limited by Court Order, all Recoveries must be used for Approved Purposes.

2. Any Recovery, after deduction of Lead Litigator Costs, unless otherwise limited by Court Order, and the Federal Government CMS Medicaid Costs, if and only if applicable, shall be divided into percentages and allocated within these percentages as follows:




(*pie chart for illustrative purposes*)

**1) "State of Nevada Allocation":** 43.86% to the State of Nevada;

**2) "Local Governments Allocation":** 38.77% to the Local Governments to be allocated by percentage of claims data for the Local Governments as outlined in **Exhibit D**, attached; and

**3) "Medicaid Match Allocation":** 17.37% representing what is referred to as the Medicaid Match which amount shall be allocated among the Counties as follows: **a)** 65% to Clark County, **b)** 14% to Washoe County, and **c)** 21% to the remaining Litigating and Non-Litigating Counties by population, as outlined in **Exhibit E**, attached.

3. Unless otherwise directed by court order, the State of Nevada shall receive and divide and allocate any Recoveries described in Paragraph 2.

4. The State of Nevada and Local Governments shall exercise due diligence to complete a release against any Defendant, if necessary, as a result of a Recovery pursuant to this Agreement.

5. The State of Nevada and Local Governments shall make every reasonable effort to coordinate any related press releases and/or press interaction concerning any settlement or other disposition under this Agreement.

6. The State of Nevada and Local Governments are, after deduction of Lead Litigator Costs unless otherwise limited by Court Order, and the Federal Government CMS Medicaid Costs, if and only if applicable, from any Recovery, each responsible for any remaining costs of that Party's litigation from that Party's share of the Recovery after allocation.

7. The State of Nevada and Local Governments are each responsible, unless otherwise directed by court order, for payment of any attorney fees for the use of their Counsel in maintaining their respective opioid-related litigation from their share of the Recoveries after allocation pursuant to the terms of their respective contingency fee agreements. However, in the event Counsel is eligible to apply for attorney fees or costs from a national fund created by one or more Defendants in connection with a Recovery, Counsel will refund any amount recovered from said national fund proportionate to the amount of attorney fees paid under each respective contingency fee agreement.

8. Additionally, a fee adjustment of 25% shall be deducted from the share of each of the allocation amounts to the Non-Litigating Counties described in Paragraph 2 of

this Agreement. The total amount of the fee adjustment deducted pursuant to this paragraph shall then be allocated to the Litigating Counties by total percentage of claims data for those Litigating Counties as outlined in **Exhibit F**, attached.

9. In the event a Local Government merges, dissolves, ceases to exist, opioid-related litigation is dismissed with prejudice including the exhaustion of any and all appeals related to the Court's order of dismissal, or is excluded from a specific recovery for any reason, the allocation percentage for that Local Government shall be reallocated as follows:

   a. If a Local Government excluded under this paragraph is a Litigating City or District, then that Litigating City or District's allocated share shall be added to the share of the County in which the Litigating City or District is located in addition to the County's allocated share.

   b. If a Local Government excluded under this paragraph is a County, then that County's allocated share shall be added to the State's share minus the allocated shares of any Litigating City or District located within the excluded County that would otherwise be entitled to receive their shares.

10. Funds received by the State of Nevada or Local Governments, which are obtained from entities or individuals not listed on **Exhibit C**, or from sources unrelated to a Recovery, i.e., via grant, bequest, gift or the like, are excluded from this Agreement.

11. The State of Nevada's share of Recoveries, after deduction of any remaining costs and attorney fees, shall be deposited in the Fund for Resilient Nevada through Senate Bill 390 (2021).

12. Nothing in this Agreement alters or intends to alter or change the right of the State of Nevada or any Local Governments to pursue its own claims against any Defendant through that Parties' separate opioid-related litigation. Rather, the intent of this Agreement is to join all Parties to seek and negotiate binding global settlement or settlements and to obtain Recoveries with one or more Defendants in the State of Nevada or Local Governments opioid-related litigation for the benefit of all Parties to this Agreement.

**C. Waiver of Conflict of Interest.** Consistent with the intent of this Agreement, the Parties agree that there is no conflict of interest in Counsel representing the Parties to this Agreement, but to the extent Counsel's representation may constitute a conflict of interest, the Parties waive any potential conflict of interest.

**D. Reporting.** Accountability - Prior to July 1st of each year, or as otherwise required by any Court Order, each of the Local Governments shall provide information to the State, to the attention of Mark J. Krueger, Chief Deputy Attorney General at mkrueger@ag.nv.gov, about how they intend to expend, and how they did expend, their allocated shares of any Recovery/Recoveries to ensure such Recoveries are being used for Approved Purposes only. Local Governments shall respond and provide documents to any reasonable requests from the State for data or information about the use of the Recoveries, including Local Government or third-party programs, services, or infrastructure receiving the Recoveries.

**E. Miscellaneous**

1. **Construction.** With regard to each and every term and condition of this Agreement, the Parties understand and agree that the same have or has been mutually negotiated, prepared and drafted, and if at any time the Parties are required to interpret or construe any such term or condition, no consideration shall

be given to the issue of which Party actually prepared, drafted or requested any term or condition thereof.

2. **Severability Clause.** In the event any provision or part of this Agreement is found to be invalid or unenforceable, only that particular provision or part so found, and not the entire Agreement, will be inoperative.

3. **Entire Agreement.** This Agreement, contains the entire agreement between the Parties and supersedes and cancels all previous negotiations and agreements, if any.

4. **Governing Law.** This Agreement shall be governed by and construed in accordance with the law of the State of Nevada.

5. **Amendments.** Any and all amendments to this Agreement must be in writing which must be signed by all Parties and must be approved by their respective Commissions, Councils, or Boards.

6. **Signature in Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be an original and all of which shall together constitute one and the same instrument. This Agreement and any amendments thereto, to the extent signed and delivered by means of a facsimile machine or electronic scan (including in the form of an Adobe Acrobat PDF file format), shall be treated in all manner and respects as an original agreement and shall be considered to have the same binding legal effect as if it were the original signed version thereof.

7. **Legal Advice.** The Parties acknowledge that they have been advised to have this Agreement reviewed by their respective Deputy Attorney Generals, District Attorneys, and City Attorneys (collectively "Government Attorneys") and the

Government Attorneys have had the opportunity to participate in the negotiation of this Agreement.

**F. Acknowledgment of Agreement and Binding Authority**

This Agreement has been collaboratively drafted to maintain all individual claims and causes of action in each Parties' opioid-related litigations while allowing the State and its Local Governments to cooperate in exploring all possible means of obtaining a Recovery/Recoveries against the Defendants. This Agreement is jointly entered into by the State of Nevada and Local Governments, is approved by the Parties' respective Commissions, Councils, and Boards, and provides binding authority from each Party to the Agreement regarding the resolution through the Negotiating Committee and allocation of any Recovery. However, other than those settlements or other disposition in this Agreement, nothing in this Agreement binds any party to any specific outcome of each Parties' opioid-related litigation.

We, the undersigned, hereby agree to be bound by this Agreement, which shall have an effective date of August 9, 2021.

Executed this _____ day of_____, 2021.

STATE OF NEVADA

By: _____ Dated:_____
NEVADA ATTORNEY GENERAL

Signed and approved by each signatory. Signature on file.

CHURCHILL COUNTY

By: _____ Dated:_____
REPRESENTATIVE FOR THE LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CLARK COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

DOUGLAS COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

ELKO COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

ESMERALDA COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

EUREKA COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

HUMBOLDT COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

LANDER COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

LINCOLN COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

LYON COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

MINERAL COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

PERSHING COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

STOREY COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

WASHOE COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

WHITE PINE COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

BOULDER CITY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

NYE COUNTY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CARSON CITY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF HENDERSON

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF LAS VEGAS

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF MESQUITE

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF NORTH LAS VEGAS

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF RENO

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF WEST WENDOVER

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF FERNLEY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF ELY

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CITY OF SPARKS

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

NORTHERN LYON COUNTY FIRE
PROTECTION DISTRICT

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

CENTRAL LYON COUNTY FIRE
PROTECTION DISTRICT

By: _____ Dated:_____

REPRESENTATIVE FOR THE
LOCAL GOVERNMENT

Signed and approved by each signatory. Signature on file.

# EXHIBIT A

| LOCAL GOVERNMENT | COURT | CASE NO. |
|---|---|---|
| Carson City | 1st Judicial District Court | 20TRT00471B |
| Clark County | 8th Judicial District Court | A-17-765828-C<br>*Transferred to MDL* |
| Churchill County | 10th Judicial District Court | 20-10DC-0805 |
| Douglas County | 9th Judicial District Court | 2020CV00139 |
| Elko County | | |
| Esmeralda County | 5th Judicial District Court | CV20-5117 |
| Eureka County | | |
| Humboldt County | 6th Judicial District Court | CV0022306 |
| Lander County | | |
| Lincoln County | 7th Judicial District Court | CV0702620 |
| Lyon County | 3rd Judicial District Court | 20-CV-00795 |
| Nye County | MDL | 1:18-op-46238-DAP |
| Northern Lyon County Fire Protection District | 3rd Judicial District Court | 20-CV-00795 |
| Central Lyon County Fire Protection District | 3rd Judicial District Court | 20-CV-00795 |
| Mineral County | 11th Judicial District Court | 21CV-TT12-2020-0104 |
| Pershing County | | |
| Storey County | | |
| Washoe County | 2nd Judicial District Court | CV20-01142 |
| White Pine County | 7th Judicial District Court | CV-2007076 |
| City of West Wendover | 4th Judicial District Court | DC-CV-20-70 |

# EXHIBIT A

| | | |
|---|---|---|
| City of Fernley | 3rd Judicial District Court | 20-CV-00796 |
| City of Sparks | 2nd Judicial District Court | CV20-01152 |
| City of Ely | 7th Judicial District Court | CV-2007077 |
| City of Las Vegas | 8th Judicial District Court | A-19-800697-B |
| City of North Las Vegas | 8th Judicial District Court | A-19-800699-B |
| City of Henderson | 8th Judicial District Court | A-19-800695-B |
| City of Reno | 2nd Judicial District Court | CV18-01895 |
| City of Mesquite | U.S District Court, District of Nevada | 2:19-cv-01058<br>*Transferred to MDL* |
| Boulder City | U.S District Court, District of Nevada | 2:19-cv-01057<br>*Transferred to MDL* |

# EXHIBIT B

| LITIGATING CITIES AND DISTRICTS | COURT | CASE NO. |
|---|---|---|
| City of West Wendover | 4th Judicial District Court | DC-CV-20-70 |
| City of Fernley | 3rd Judicial District Court | 20-CV-00796 |
| City of Sparks | 2nd Judicial District Court | CV20-01152 |
| City of Ely | 7th Judicial District Court | CV-2007077 |
| City of Las Vegas | 8th Judicial District Court | A-19-800697-B |
| City of North Las Vegas | 8th Judicial District Court | A-19-800699-B |
| City of Henderson | 8th Judicial District Court | A-19-800695-B |
| City of Reno | 2nd Judicial District Court | CV18-01895 |
| City of Mesquite | U.S District Court, District of Nevada | 2:19-cv-01058 *Transferred to MDL* |
| Boulder City | U.S District Court, District of Nevada | 2:19-cv-01057 *Transferred to MDL* |
| Northern Lyon County Fire Protection District | 3rd Judicial District Court | 20-CV-00795 |
| Central Lyon County Fire Protection District | 3rd Judicial District Court | 20-CV-00795 |

# EXHIBIT C

| DEFENDANTS |
| --- |
| A&H KATSCHKE LTD dba MEADOW VALLEY PHARMACY |
| ACTAVIS INC f/k/a WATSON PHARMACEUTICALS INC |
| ACTAVIS PHARMA, INC. f/k/a WATSON PHARMA, INC |
| ACTAVIS PHARMA, INC. |
| ACTAVIS, LLC |
| ADAM KATSCHKE |
| AIDA B MAXAM |
| ALEC BURLAKOFF |
| ALEJANDRO JIMINEZ INCERA |
| ALLERGAN FINANCE, LLC (fka ACTAVIS, INC. fka WATSON PHARMACEUTICALS, INC.) |
| ALLERGAN INC |
| ALLERGAN PLC f/k/a ACTAVIS PLC |
| ALLERGAN USA INC |
| AMERICAN DRUG STORES |
| AMERISOURCEBERGEN DRUG CORPORATION |
| ANDA PHARMACEUTICALS, INC. |
| ANDA, INC |
| BAILY STORES LLC dba PROFESSIONAL PHARMACY |
| BEACON COMPANY |
| BEVERLY SACKLER |
| BOB TUCKER, INC. dba BOB TUCKER'S UNITED DRUG |
| C&R PHARMACY d/b/a KEN'S PHARMACY f/k/a LAM'S PHARMACY |
| CARDINAL HEALTH 105, INC. |
| CARDINAL HEALTH 108 LLC D/B/A METRO MEDICAL SUPPLY |
| CARDINAL HEALTH 108, LLC |
| CARDINAL HEALTH 110, LLC |
| CARDINAL HEALTH 200, LLC |
| CARDINAL HEALTH 414, LLC |
| CARDINAL HEALTH 6 INC |
| CARDINAL HEALTH INC. |
| CARDINAL HEALTH PHARMACY SERVICES, LLC |
| CARDINAL HEALTH TECHNOLOGIES |
| CARDIOLOGY PC |
| CEPHALON, INC. |
| CVS HEALTH CORP. |
| CVS INDIANA |
| CVS PHARMACY, INC. |

# EXHIBIT C

| |
|---|
| CVS RX SERVICES INC |
| CVS TN DISTRIBUTION LLC |
| DAVID A. SACKLER |
| DEPOMED, INC |
| DEREK BRADDIX, APRN |
| DEVENDRA I. PATEL |
| DEVENDRA I. PATEL |
| ECONOMY DRUG |
| ECONOMY DRUG INC |
| ENDO HEALTH SOLUTIONS INC. |
| ENDO INTERNATIONAL PLC |
| ENDO PHARMACEUTICALS, INC. |
| GARY C RIDENOUR A PROFESSIONAL CORPORATION dba HIGH DESERT CLINIC |
| GARY C RIDENOUR dba HIGH DESERT CLINIC |
| GARY C. RIDENOUR MD |
| HOLPER OUT-PATIENTS MEDICAL CENTER, LTD |
| HORACE PAUL GUERRA IV |
| ILENE SACKLER LEFCOURT |
| INCERA LLC |
| INCERA-IUVENTUS MEDICAL GROUP PC |
| INSYS THERAPEUTICS, INC. |
| JANSSEN PHARMACEUTICA INC. n/k/a JANSSEN PHARMACEUTICALS, INC. |
| JANSSEN PHARMACEUTICALS, INC. |
| JOHN KAPOOR |
| JOHNSON & JOHNSON |
| JOLLY'S DRUG STORE LLC dba JOLLY'S DRUG STORE |
| JONATHAN D. SACKLER |
| JOSEPH A ROWAN |
| KATHE A. SACKLER |
| KROGER LIMITED PARTNERSHIP II D/B/A PEYTON'S NORTHERN |
| LONGS DRUG STORE CALIFORNIA LLC |
| MALLINCKRODT BRAND PHARMACEUTICALS INC |
| MALLINCKRODT LLC |
| MALLINCKRODT PLC |
| MALLINCKRODT US HOLDINGS, INC. |
| MASTERS PHARMACEUTICAL, LLC. f/k/a MASTERS PHARMACEUTICAL INC |
| MCKESSON CORPORATION |
| MICHAEL BABICH |

# EXHIBIT C

| |
|---|
| MORTIMER D.A. SACKLER |
| NORAMCO, INC. |
| OMNICARE DISTRIBUTION CENTER LLC |
| ORTHOMCNEIL-JANSSEN PHARMACEUTICALS, INC. n/k/a JANSSEN PHARMACEUTICALS, INC |
| P.F. LABORATORIES, INC. |
| PAR PHARMACEUTICAL COMPANIES. |
| PAR PHARMACEUTICAL, INC. |
| PATEL NORTH EASTERN NEVADA |
| PATEL NORTHEASTERN NEVADA CARDIOLOGY PC |
| PLP ASSOCIATES HOLDINGS L.P. |
| PURDUE HOLDINGS, L.P. |
| PURDUE PHARMA L.P. |
| PURDUE PHARMA, INC. |
| PURDUE PHARMACEUTICALS LP |
| RAND FAMILY CARE LLC |
| REX DRUG CO. dba REX DRUG |
| RICHARD M SIMON |
| RICHARD S. SACKLER |
| RITE AID CORPORATION |
| RITE AID OF MARYLAND, INC. D/B/A RITE AID MID-ATLANTIC CUSTOMER SUPPORT CENTER, INC. |
| ROBERT D. HARVEY |
| ROBERT GENE RAND |
| ROSEBAY MEDICAL COMPANY L.P. |
| SAFEWAY INC. dba SAFEWAY PHARMACY #2255 |
| SCOLARI'S FOOD & DRUG COMPANY aka SCOLARI'S PHARMACY #23 |
| SCOLARI'S WAREHOUSE MARKETS, INC. |
| SHOUPING LI |
| SMITH'S FOOD & DRUG CENTERS, INC. D/B/A PEYTON'S PHOENIX |
| SPECGX LLC |
| STEVEN A HOLPER MD PROFESSIONAL CORPORATION; |
| STEVEN A. HOLPER |
| SUNRISE LEE |
| TEVA PHARMACEUTICAL INDUSTRIES, LTD. |
| TEVA PHARMACEUTICALS USA. |
| THE KROGER CO |
| THE PILL BOX LLC dba THE PILL BOX |

# EXHIBIT C

| |
|---|
| THE PURDUE FREDERICK COMPANY, INC. d/b/a THE PURDUE FREDERICK COMPANY INC. |
| THE PURDUE FREDERICK COMPANY, INC. |
| THERESA SACKLER |
| THRIFTY PAYLESS, INC |
| WALGREEN CO. |
| WALGREEN EASTERN CO., INC |
| WALGREENS BOOTS ALLIANCE, INC.; |
| WALMART INC. |
| WATSON LABORATORIES, INC. |
| WATSON PHARMACEUTICALS, INC. n/k/a ACTAVIS, INC. |

# EXHIBIT D

| LOCAL GOVERNMENTS ALLOCATION (38.77%) | |
|---|---|
| **Government Entity** | **Percentage** |
| CARSON CITY | 1.075935% |
| CHURCHILL COUNTY | 0.326145% |
| CLARK COUNTY | 66.975937% |
| DOUGLAS COUNTY | 1.045568% |
| ELKO COUNTY | 0.637853% |
| ESMERALDA COUNTY | 0.047413% |
| EUREKA COUNTY | 0.143721% |
| HUMBOLDT COUNTY | 1.000680% |
| LANDER COUNTY | 0.548128% |
| LINCOLN COUNTY | 0.198633% |
| LYON COUNTY | 0.685710% |
| MINERAL COUNTY | 0.734928% |
| NYE COUNTY | 1.026687% |
| PERSHING COUNTY | 0.514733% |
| STOREY COUNTY | 0.130572% |
| WASHOE COUNTY | 6.841995% |
| WHITE PINE COUNTY | 1.235851% |
| BOULDER CITY | 0.214114% |
| ELY CITY | 0.009582% |
| FERNLEY CITY | 0.020925% |
| HENDERSON CITY | 3.333451% |
| LAS VEGAS CITY | 6.835696% |
| MESQUITE CITY | 0.212146% |
| NORTH LAS VEGAS CITY | 3.512749% |
| RENO CITY | 1.963939% |
| SPARKS CITY | 0.615879% |
| WEST WENDOVER CITY | 0.081671% |
| CENTRAL LYON FIRE PROTECTION DISTRICT | 0.021854% |
| NORTH LYON FIRE PROTECTION DISTRICT | 0.007505% |

# EXHIBIT E

| MEDICAID MATCH ALLOCATION (17.37%) (65:14:21 - Population) | |
|---|---|
| **Government Entity** | **Percentage** |
| CARSON CITY | 3.434222% |
| CHURCHILL COUNTY | 1.529849% |
| CLARK COUNTY | 65% |
| DOUGLAS COUNTY | 3.003624% |
| ELKO COUNTY | 3.241494% |
| ESMERALDA COUNTY | 0.053617% |
| EUREKA COUNTY | 0.124616% |
| HUMBOLDT COUNTY | 1.033718% |
| LANDER COUNTY | 0.339762% |
| LINCOLN COUNTY | 0.318327% |
| LYON COUNTY | 3.532121% |
| MINERAL COUNTY | 0.276686% |
| NYE COUNTY | 2.857327% |
| PERSHING COUNTY | 0.413033% |
| STOREY COUNTY | 0.253224% |
| WASHOE COUNTY | 14% |
| WHITE PINE COUNTY | 0.588380% |

# EXHIBIT F

| LITIGATING COUNTIES ALLOCATION | |
|---|---|
| **Government Entity** | **Percentage** |
| CARSON CITY | 1.325117% |
| CHURCHILL COUNTY | 0.401679% |
| CLARK COUNTY | 82.487271% |
| DOUGLAS COUNTY | 1.287717% |
| ESMERALDA COUNTY | 0.058394% |
| HUMBOLDT COUNTY | 1.232434% |
| LINCOLN COUNTY | 0.244635% |
| LYON COUNTY | 0.844517% |
| MINERAL COUNTY | 0.905134% |
| NYE COUNTY | 1.264463% |
| WASHOE COUNTY | 8.426571% |
| WHITE PINE COUNTY | 1.522068% |