



Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment (Second Edition)

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¹ First edition published in September 2018.

SECTION I. SHORT TITLE.

This Act will be known and may be cited as the “Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment” (the “Act”).

SECTION II. LEGISLATIVE FINDINGS.

- (a) In 2017, 72,000 Americans died of drug overdoses, quadrupling the number of fatal overdoses that occurred in the year 2000, and making today’s opioid epidemic the worst epidemic in one hundred years. [Name of state] is also encountering the worst overdose epidemic in its history.
- (b) First responders, including emergency medical services personnel, firefighters, law enforcement officers, social workers, members of the recovery community, and family members heroically have escalated their lifesaving overdose reversal efforts, all resulting in many more lives saved and many more overdose survivors in our emergency health care systems.
- (c) First responders are reporting that many whose overdoses are reversed are overdosing repeatedly, indicating that most overdose survivors are not being successfully transitioned to treatment and recovery support services, placing themselves at grave risk of death and causing extraordinary strain and suffering to their families and communities, including first responder and health care system services.
- (d) It is urgent that every effort be made to successfully transition overdose survivors to treatment and recovery support services, based on an individualized assessment and application of clinical placement criteria.

SECTION III. PURPOSE.

This Act is designed to:

- (a) ensure that effective practices are used by emergency medical services personnel so that overdose victims are medically stabilized;²
- (b) ensure that effective protocols are used by emergency services personnel and emergency departments so that stabilized overdose survivors are successfully transferred to appropriate treatment and recovery support services, as determined by an individualized treatment plan based on an assessment and clinical placement criteria;
- (c) have responsible state agencies work with all relevant stakeholders to develop a network of Overdose Stabilization & Warm Hand-off Centers where emergency medical service personnel can directly transport most overdose survivors for medical stabilization, detoxification, assessment, referral, and direct placement to individualized treatment and recovery support services;
- (d) have responsible state agencies work with all relevant stakeholders to ensure that the full continuum of addiction treatment and recovery support services are available and coordinated in order to facilitate each overdose survivor's long-term individual process of recovery; and

² The phrase “medically stabilized” covers the variety of ways in which emergency medical service (EMS) personnel could be involved with the medical stabilization and transport of an overdose victim. In most cases, EMS personnel will transport an overdose victim to an emergency department for medical stabilization. However, there are programs throughout the country in which EMS personnel have the option to bypass the emergency department and take an already-stabilized overdose survivor meeting defined criteria directly to assessment and treatment at the appropriate level of care with detoxification or other accompanying withdrawal management services. Emergency medical service providers engaging in this function must be highly structured, physician supervised programs, with rigorous education and competency requirements. For example, effective August 2018, EMS personnel in Orange County (N.C.) may decide to take a survivor directly to a local recovery center after following a strict protocol, including a paramedic’s evaluation, so long as the EMS supervisor agrees with the decision and the survivor consents to the transport. Tammy Grubb, *Will free needles, ambulance rides to rehab help Orange County addicts get clean?*, The Herald Sun (June 22, 2018), <https://www.heraldsun.com/news/local/counties/orange-county/article213578914.html>. Moreover, effective EMS transport of an overdose survivor to an Overdose Stabilization & Warm Hand-off Center created pursuant to this Act, would likely involve reliance upon a similarly strict protocol. Accordingly, under this Act, EMS agencies are provided the legal flexibility to train, certify, and then allow their personnel to transport stabilized overdose survivors to a location other than an emergency department, but there is no requirement to do so. In those instances where states or localities wish to provide EMS agencies with this option, states will need to amend any existing laws/regulations prohibiting EMS from transporting a patient anywhere but to an emergency department.

- (e) ensure that [state] has the necessary treatment and recovery support capacity to address the need for all overdose survivors and others at risk of overdose.

SECTION IV. DEFINITIONS.

- (a) For the purposes of this Act, unless the context clearly indicates otherwise, the following words and phrases have the meanings given to them in this Section.
- (b) Detoxification facility.— “Detoxification facility” means a facility licensed by the [single state authority on drugs and alcohol] to engage in the process whereby an alcohol-intoxicated, drug-intoxicated, alcohol-dependent or drug-dependent individual is assisted through the period of time to eliminate, by metabolic or other means, the intoxicating alcohol or other drugs, alcohol and other drug dependency factors or alcohol in combination with drugs as determined by a licensed physician, while keeping the physiological risk to the patient at a minimum. Such process includes therapeutic engagement with the individual to motivate the individual to engage in treatment.
- (c) Drug.— “Drug” means: (1) an article recognized in the official United States Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (2) an article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; (3) an article (other than food) intended to affect the structure or any function of the body of man or other animals; and (4) an article intended for use as a component of any article specified in clause (1), (2), or (3). The term does not include devices or their components, parts or accessories.
- (d) Emergency department.— “Emergency department” means a hospital emergency department, a free-standing emergency department, or a health clinic where the clinic carries out emergency department functions.
- (e) Emergency department personnel.— “Emergency department personnel” means physicians, nurses, paramedics, medical assistants, nurses’ aides and other health care professionals working in an emergency department.

- (f) Emergency medical services personnel.— “Emergency medical services personnel” means individuals who possess a current, valid, unrestricted license issued by [state] as an emergency medical technician, advanced emergency medical technician, paramedic, or another [state]-recognized and licensed level with a scope of practice and authority in between emergency medical technician and paramedic who practices under the supervision of a medical director.
- (g) Harm reduction services.— “Harm reduction services” means a range of public health policies designed to lessen the negative social and physical consequences associated with dangerous substance use, while engaging an individual to seek treatment for a substance use disorder.
- (h) Intervention services.— “Intervention services” means services provided by an individual with training and knowledge about the system of substance use disorder treatment options available in the local community and who has specific expertise in interventions with overdose survivors through a process where the substance user is encouraged to accept help.
- (i) Overdose.— “Overdose” means injury to the body that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.³
- (j) Peer specialist.— “Peer specialist” means an individual certified as a peer specialist or as a recovery specialist by a statewide certification body which is a member of a national certification body, or an individual who is certified by another state’s substance use disorder counseling certification board.⁴
- (k) Recovery support services.— “Recovery support services” means case management or other informational, emotional, and intentional support including but not limited to: (1) developing a one-on-one relationship in which a peer specialist encourages, motivates, and supports a peer in recovery; (2) connecting the peer with professional and nonprofessional services and resources available in the community; (3) facilitating or leading recovery-oriented group activities, including support groups and educational

³ This is the CDC definition of overdose, found at <https://www.cdc.gov/drugoverdose/opioids/terms.html>.

⁴ This definition will need to be modified in those states that do not presently engage in the better practice of licensing or certifying peer specialists or recovery specialists.

activities; and (4) helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support.

- (l) Single state authority on drugs and alcohol.— “Single state authority on drugs and alcohol” means the state agency designated by the [state] governor to plan, manage, monitor, coordinate and evaluate substance use disorder treatment and recovery support services in the state, and to administer the federal Substance Abuse Prevention and Treatment Block Grant.
- (m) Substance use disorder treatment provider.— “Substance use disorder treatment provider” means any substance use disorder facility or treatment program that is [licensed], [certified], or [approved] by the state to provide comprehensive substance use disorder treatment and recovery support services, with or without the support of medications, on a hospital, non-hospital residential, or outpatient basis. The term also includes any physician with expertise in providing or coordinating access to comprehensive detoxification or other withdrawal management, medication, counseling and long-term recovery support services.
- (n) Task force.— “Task force” means the Overdose Recovery Task Force established under Section VIII (“Development of Overdose Stabilization and Warm Hand-off Centers”).
- (o) Treatment.— “Treatment” means substance use disorder treatment for alcohol or other drug addiction with a substance use disorder treatment provider in accordance with an individualized assessment and clinical placement criteria.
- (p) Warm hand-off.— “Warm hand-off” means the direct referral and transfer of an overdose survivor immediately after medical stabilization to appropriate substance use disorder treatment. For purposes of this Act, in situations where the direct referral and transfer of an overdose survivor is not possible, “warm hand-off” includes face-to-face or other follow-up contact with recent overdose survivors by first responders and individuals providing intervention services to encourage entry into treatment.⁵

⁵ An example of an initiative involving face-to-face follow-up contact with overdose survivors is the Quick Response Team (“QRT”) that originated in Colerain Township, Ohio, and later expanded to over 40 Ohio counties and areas outside of the state. WCPO Staff, *Colerain Township first responders receive award for overdose response*, WCPO Cincinnati (June 11, 2018), <https://www.wcpo.com/news/local-news/hamilton-county/colerain->

- (q) Warm Hand-off Centers.— “Warm Hand-off Centers” means the Overdose Stabilization and Warm Hand-off Centers established under Section VIII (“Development of Overdose Stabilization and Warm Hand-off Centers”).

SECTION V. COMPREHENSIVE STATE WARM HAND-OFF INITIATIVE.

- (a) In general.— The single state authority on drugs and alcohol will lead and collaborate with the [state] Department of Health and other appropriate state and local agencies to develop a comprehensive state warm hand-off initiative to ensure that all reasonable measures are taken to have overdose survivors medically stabilized and then directly transferred to appropriate substance use disorder treatment, which may be provided by: (1) a licensed detoxification facility or other medical facility for detoxification and assessment services, followed by substance use disorder treatment by a licensed provider, matched to the individual’s clinical needs, based on the biopsychosocial assessment and application of clinical placement criteria, and coordinated with ongoing recovery support services; or (2) a physician or other substance use disorder treatment provider with expertise in providing or coordinating medication-assisted treatment.⁶
- (b) Harm reduction.— Where an overdose survivor persistently refuses referral and transfer to appropriate substance use disorder services, as set forth in subsection (a), harm

township/colerain-township-first-responders-to-receive-award-for-overdose-response. Generally speaking, the QRT consists of a three-member team (law enforcement officer, a firefighter medic, and a licensed addiction counselor) who make follow-up visits to the homes of overdose survivors within a few days of the overdose to encourage the survivor to enter treatment. Todd Dykes, *Quick response seen as key to battling Hamilton County’s heroin crisis*, WLWT5 (January 4, 2017), <http://www.wlwt.com/article/quick-response-seen-as-key-to-battling-hamilton-countys-heroin-crisis/8298936>.

⁶ As explained in Section III, the medical stabilization may occur: (1) at an emergency department or Warm Hand-off Center, after transportation there by emergency medical service personnel; or (2) where proper training, certification, and physician supervision are present, by emergency medical services personnel themselves, prior to transporting the survivor directly to a detoxification facility or substance use disorder treatment provider. The Act does not require option (2), but is broad enough to allow it if a state/locality chooses to implement such an option in those overdose situations where there are no medical complications and direct transport to a detoxification facility or substance use disorder treatment provider is therefore medically appropriate.

reduction services, as designated by the single state authority on drugs and alcohol, shall be provided.⁷

(c) Program elements.— The comprehensive state program will include, but not be limited to, the following, which will be implemented within twelve (12) months of the effective date of this Act:

(1) Establishing warm hand-off partnerships between the single state authority on drugs and alcohol, local/regional administrators, and emergency departments as follows.—

(A) The single state authority on drugs and alcohol will direct its [local/regional administrators] to establish partnerships with all emergency departments in their respective [localities/regions] and to assist those emergency departments to implement warm hand-off procedures for overdose survivors. Such assistance may include but not be limited to working with emergency departments to ensure that intervention services are available in a timely fashion.

(B) Owners/operators of emergency departments will take reasonable steps to train and credential any individuals providing intervention services, using the facility’s established credentialing process for staff and vendors providing care, in order to facilitate unhindered communication between the person providing intervention services and the overdose survivor.⁸

(C) The [local/regional administrators] shall regularly assess the network of available detoxification facilities, medical facilities providing detoxification services, substance use treatment providers, recovery support services, and harm reduction services, and communicate the findings of each assessment to all individuals providing intervention services for overdose survivors, so that a

⁷ The Act purposely leaves it for each state to determine what to include within “harm reduction services.”

⁸ “Credentialing” is the process of evaluating the qualifications and practice history of a provider within a medical facility. Upon receiving credentials, the provider is granted the authority: (1) to perform the agreed upon service(s) in the medical facility; and (2) to exchange information about patient care within the framework of an interdepartmental system of care in a hospital without violating applicable privacy and confidentiality laws and regulations.

backlog of referrals does not occur and survivors can obtain treatment, including specialized programs, and other support services, where necessary.⁹

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- (D) The [local/regional administrators] shall also regularly assess the network of services that address the needs of the families of overdose survivors, and shall work with emergency departments to ensure that appropriate mechanisms are in place to connect those families to needed services.

(2) Prioritizing overdose survivors for substance use disorder treatment.—

- (A) Treatment funded by Medicaid and federal Substance Abuse Prevention and Treatment Block Grant.— The single state authority on drugs and alcohol will direct its [local/regional] administrators to include overdose survivors as one of its prioritized populations for Medicaid and federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding, in accordance with individualized assessments and clinical placement criteria.
- (B) Data collection.— The single state authority on drugs and alcohol shall work with its [local/regional] administrators and with the [state EMS agency] to gather the following data, which it will publish and annually update on its publicly accessible website:
 - (i) the number of individuals treated by emergency medical service personnel for overdoses;
 - (ii) levels of care and lengths of stay of overdose survivors in Medicaid facilities and federal SAPTBG-funded treatment provider facilities;

⁹ An example of this assessment and transmittal of near real-time information about treatment resources is the Delaware Treatment and Referral Network, in which “social workers, health care providers and others use the digital system to pinpoint where state treatment resources are available and reserve a space for a specific patient.” Mark Eichmann, *Delaware online reservations for substance abuse treatment finds success*, WHYY (April 19, 2019), <https://whyy.org/articles/delaware-online-reservations-for-substance-abuse-treatment-finds-success/>.

¹⁰ An example of a specialized program would be treatment programs in which parents with dependent children can have their children with them in the residential treatment facility. See NAMSDDL’s “Model Family Preservation Act”.

- (iii) the number of Medicaid-funded and federal SAPTBG-funded overdose survivors in treatment who received a lower level of care or shorter length of stay than determined necessary by the physician or the treatment provider using the above-referenced placement criteria;
- (iv) of those individuals identified in clause (iii), the number who received a lower level of care or shorter length of stay in treatment than determined necessary due to each of the following: lack of funding, patients leaving against medical advice, and any other reasons identified by the single state authority on drugs and alcohol; and
- (v) any other trends or observations deemed significant by the single state authority on drugs and alcohol or its [local/regional administrators], emergency medical services personnel, substance use disorder treatment providers or the recovery support services community, which may include possible correlation in variations of the level of care and lengths of stay in treatment, with geographic region, behavioral health managed care organization, treatment program, or other factors.

(3) Emergency medical services personnel – training in effective warm hand-off protocols.—

- (A) Training curriculum.— The [state] Department of Health [or other state department/agency/independent board that oversees EMS personnel licensure], in collaboration with the single state authority on drugs and alcohol and individuals from the recovery support services community, will develop a warm hand-off training curriculum for emergency medical services personnel addressing the most effective protocols to successfully transport overdose survivors for medical stabilization to emergency departments or, where available, to Warm Hand-off Centers as created in this Act and approved by the local EMS Medical Director.
- (B) Elements of curriculum.— The training curriculum will address:
 - (i) The elements of addiction, stigma, treatment referral, recommended safety procedures to limit first responder exposure to the drug(s)

involved, resilience training and effective strategies for immediate and expeditious transport of the overdose survivor after administration of an opioid overdose reversal drug, in order to maximize the likelihood of successful transports of patients.¹¹

- (ii) Where emergency medical services is authorized, the necessary skills to determine when it is appropriate to directly transfer an overdose survivor to a Warm Hand-off Center or other appropriate substance use disorder treatment, and when it is appropriate instead to transfer the overdose survivor to an emergency department.
 - (iii) Effective protocols and skills for participating in face-to-face or other follow-up contact to engage recent overdose survivors to encourage and facilitate entry into treatment, including alliances with recovery support services for follow-up contacts.
- (C) Continuing education requirement.— The curriculum must be in compliance with the standards of the Commission on Accreditation for Prehospital Continuing Education and be approved by the [state] Department of Health [or other state department/agency that oversees EMS personnel licensure], local EMS Medical Director and the single state authority on drugs and alcohol. These trainings will be mandatory for all emergency medical service personnel, and, in accordance with the standards set forth by the [state] Department of Health [or other state department/agency that oversees EMS personnel licensure] in consultation with the single state authority on drugs and alcohol, will require competency assurance of the necessary cognitive, psychomotor and affective skills upon completion of the program of instruction, as a condition of licensure renewal.

¹¹ EMS personnel who begin transporting the overdose victim *immediately* after administering naloxone, rather than waiting until the victim fully regains consciousness, report much greater success in avoiding the dangerous situation of the victim fleeing the overdose scene. Without successful transport and follow-up stabilization, a post-reversal victim remains vulnerable to falling back into an overdose condition and dying.

(4) Emergency department personnel—training in substance use disorders, intervention, and referral to treatment.—

(A) Training curriculum.— The [state] Department of Health [or other state department/agency that oversees continuing medical education training and credits for emergency department personnel], in collaboration with the single state authority on drugs and alcohol and representatives of the recovery support services community, will promulgate a training curriculum in the effective warm hand-off to treatment of drug overdose survivors. The curriculum will address the basic elements of addiction, stigma, referral to treatment, recovery support services, the recovery community, resilience training and effective strategies for interacting with the recently reversed overdose survivor to maximize the likelihood that there will be a successful and immediate warm hand-off to treatment. The curriculum will address the needs of those who decline treatment, including harm reduction services and follow-up therapeutic engagement with the individual to motivate the individual to engage in treatment.

(B) Continuing education requirement.— The curriculum must be in compliance with [the national accrediting body (or bodies) for the continuing education of emergency department personnel] and be approved by the [state] Department of Health [or other state department/agency that oversees continuing medical education training and credits for emergency department personnel] and the single state authority on drugs and alcohol. These trainings will be mandatory for all emergency department personnel and, in accordance with the standards set forth by the [state] Department of Health [or other state department/agency/independent board that oversees continuing medical education training and credits for emergency department personnel] in consultation with the single state authority on drugs and alcohol, will require competency assurance of the necessary cognitive, psychomotor and affective skills upon completion of the program of instruction as a condition of licensure renewal. Such training may satisfy the emergency department personnel’s

patient safety continuing medical education requirements. The providers of the training shall include qualified individuals who also are in recovery.

(d) State grant for warm hand-off initiatives.—

(1) Program established.— There is established in the office of the [single state authority on drugs and alcohol] a Warm Hand-off Initiative Grant Program for the purpose of incentivizing the development of successful warm hand-off programs and operations established pursuant to this Act.

(2) Budget allocation.—An amount of [\$] for fiscal years [20__ - 20__] shall be appropriated to the [single state authority on drugs and alcohol] to fund the Warm Hand-off Initiative Grant Program.

(3) Activities.¹²— The [single state authority on drugs and alcohol] may award grants from the Warm Hand-off Initiative Grant Program for the following:

(A) To emergency departments, for one or more of the following:

- (i) Implementing warm hand-off procedures for overdose survivors, as described under paragraph (c)(1).
- (ii) Training and credentialing individuals providing intervention services, as described under paragraph (c)(1).
- (iii) Training emergency department personnel in substance use disorders, intervention and referral to treatment, as described under paragraph (c)(4).

(B) To emergency medical services, for the purpose of training emergency medical service personnel in effective warm hand-off protocols, as described under paragraph (c)(3).

(C) To [local/regional administrators], for the purposes described in subparagraph (c)(1)(C), the (i) assisting in the ongoing assessment of the network of available capacity in detoxification facilities, medical facilities providing

¹² In addition to specifying activities for which grants may be awarded, state legislators enacting this model Act may wish to include additional state-specific grant information in the bill, such as customary grant limitations, the grant application process, and identification of which applicants or activities may be given highest priority for awards.

detoxification services, treatment providers and recovery support services and (ii) communicating the findings of the assessment to all individuals providing intervention services for overdose survivors.

(D) Increasing the capacity of the network of substance use disorder providers, in order to address the treatment needs of overdose survivors with substance use disorders.

(4) Receipt of funding.— The [single state authority on drugs and alcohol] may receive such gifts, grants, and endowments from public or private sources as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of the Warm Hand-off Initiative Grant Program and expand the same or any income derived from it according to the term of the gifts, grants, or endowments. In addition, the [single state authority on drugs and alcohol, and other state agencies] shall aggressively pursue all federal funding, matching funds, and foundation funding for the Warm Hand-off Initiative Grant Program.

(e) Emergency department implementation of effective warm hand-off procedures for overdose survivors.—

(1) Reporting requirement.— Within six months of the effective date of this Act, the [state] Department of Health [or other state department/agency that licenses hospitals or other owners/operators of emergency departments] will require, as a condition of licensure for the owner/operation of each emergency department, a written report from each entity that meets established standards, which will include but not be limited to:

(A) a description of the emergency department’s warm hand-off procedures;

(B) certification from the [local/regional administrator for the single state authority on drugs and alcohol] of the emergency department’s partnership with the [single state authority on drugs and alcohol’s regional/local administrator] to attain the most effective possible warm hand-off outcomes;

(C) the number of overdose patients:

- (i) treated in the emergency department¹³;
 - (ii) screened to be in need of treatment;
 - (iii) successfully transferred to treatment;
 - (iv) refusing treatment and the reasons given for why; and
 - (v) who return to the emergency department on subsequent occasion(s);
- (D) the emergency department’s action plan to continue to improve warm hand-off outcomes; and
- (E) results of monitoring staff sensitivity, antistigma and antidiscrimination efforts within the emergency department, including an action plan to address staff training and sensitivity needs.
- (2) Reporting intervals.— The reporting under this subsection will be required annually for five years following the effective date of this Act, as promulgated in rules by the single state authority on drugs and alcohol and the [state] Department of Health [or other state department/agency that licenses hospitals or other owners/operators of emergency departments] and biannually thereafter.
- (3) Warm hand-off protocol and reporting requirements.— The [state] Department of Health [or other state department/agency that licenses hospitals or other owners/operators of emergency departments] and the single state authority on drugs and alcohol will develop and publish minimum warm hand-off protocol and reporting requirements for emergency departments.
- (f) Medicaid; eligibility to be a provider and coverage for the warm hand-off initiative.—
- (1) In general.— The [state Medicaid agency] will require emergency medical services with patient transport capability, emergency departments, and personnel working within each of these entities, to demonstrate compliance with the requirements of subsections (c)(3), (c)(4) and (e) of the Act in order to be eligible to [be in the Medicaid network].

¹³ The number of overdoses treated in emergency departments should be greater than the number transported to emergency departments by EMS personnel. The data reported by emergency departments would include individuals brought in directly by family, friends, and bystanders.

- (2) Reimbursement rates.— The [state Medicaid agency] will establish and provide reasonable and fair reimbursement rates, approved by the single state authority on drugs and alcohol for the services provided for in this Act. These rates will include but not be limited to full and fair reimbursement for:
- (A) emergency medical services successfully transporting overdose victims for medical stabilization at an emergency department or a Warm Hand-off Center;
 - (B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility, substance use disorder treatment provider or Warm Hand-off Center;
 - (C) follow-up contact with recent overdose survivors by emergency medical services personnel or others engaging in intervention services to encourage and facilitate entry into treatment;
 - (D) intervention services and warm hand-off services; and
 - (E) case management providing support, guidance, and navigation of the treatment and recovery systems.

(3) Provider costs incorporated.— The reimbursement rates will take into account the providers' costs in meeting the training, data reporting and other requirements of this Act.¹⁴

(g) Private health insurance coverage for the warm hand-off initiative.—

(1) Reimbursement rates.— The [state department/agency that regulates private health insurance], in consultation with the single state authority on drugs and alcohol, will require all health insurers providing coverage in [the state] to establish and provide reasonable and fair reimbursement rates. These rates will include but not be limited to full and fair reimbursement for:

- (A) emergency medical services successfully transporting overdose victims for medical stabilization at an emergency department or a Warm Hand-off Center;

¹⁴ Ideally, reimbursement rates should be designed to incentivize and reward positive outcomes for successful medical stabilization of overdose victims and successful assessment, referral and direct placement to individualized care for their substance use disorders.

- (B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility, substance use disorder treatment provider or a Warm Hand-off Center;
 - (C) follow-up contact with recent overdose survivors by emergency medical services personnel or intervention specialists to encourage and facilitate entry into treatment;
 - (D) intervention and warm hand-off services; and
 - (E) case management providing support, guidance, and navigation of the treatment and recovery systems.
- (2) Provider costs incorporated.— The reimbursement rates will take into account the providers’ costs in meeting the training, data reporting and other requirements of this Act, and will be designed to incentivize and reward positive outcomes for successful medical stabilization of overdose victims and successful assessment, referral and direct placement to individualized care for their substance use disorders.
- (3) No pre-authorization.— The [state department/agency that regulates private health insurance] will require all health insurers providing coverage in the state to eliminate pre-authorization requirements for treatment in instances where an overdose survivor is transported to treatment pursuant to this Act.

SECTION VI. CONSENTS.

- (a) In general.— The attending physician in an emergency department, or a physician’s designee, will make reasonable efforts to obtain the patient’s signed consent to disclose information about the patient’s drug overdose to family members or others involved in the patient’s health care.
- (b) Exception.— If consent cannot practicably be provided because of the patient’s incapacity or a serious and imminent threat to a patient’s health or safety, the physician, or physician’s designee, may disclose information about a patient’s opioid-related

overdose, so long as such disclosure is compliant with applicable privacy and confidentiality laws and regulations.¹⁵ Such laws shall include:

- (1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191 (Aug. 21, 1996);
- (2) 45 C.F.R. parts 160 and 164 (HIPAA Privacy and Security Rules);
- (3) federal confidentiality law and regulations, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2;
- (4) any relevant state law related to the privacy, confidentiality, and disclosure of protected health information; and
- (5) any policies or regulations of the single state authority on drugs and alcohol governing the care of protection of client information.

SECTION VII. IMMUNITY.

- (a) Emergency medical services.— Absent evidence of a malicious intent to cause harm, no emergency medical services agency or emergency medical service personnel may be held liable for medically stabilizing, or attempting to medically stabilize an overdose victim, or for transporting or attempting to transport an overdose victim for medical stabilization.
- (b) Emergency department.— Absent evidence of a malicious intent to cause harm, no health care unit, emergency department personnel, or person providing intervention services or recovery support services may be held liable for their efforts to have overdose survivors properly assessed, referred and directly placed in individualized care for their substance use disorders.

¹⁵ See <https://www.hhs.gov/sites/default/files/hipaa-opioid-crisis.pdf>, describing how Health Insurance Portability and Accountability Act of 1996 regulations allow health professionals to share health information to certain individuals in emergency or dangerous situations.

SECTION VIII. DEVELOPMENT OF OVERDOSE STABILIZATION & WARM HAND-OFF CENTERS.

- (a) Establishment.— There is hereby created an Overdose Recovery Task Force, consisting of _____ members as specified below:
- (1) the [Director/Secretary] of the single state authority on drugs and alcohol or the [Director's/Secretary's] designee;
 - (2) the [Director/Secretary] of the [state] Department of Health or the [Secretary/Director's] designee;
 - (3) the [Director/Secretary] of the [state department/agency that oversees EMS personnel] or the [Director/Secretary's] designee [if different than (2)];
 - (4) the [Director/Secretary] of the [state department/agency that oversees emergency department personnel] or the [Director/Secretary's] designee [if different than (2)];
 - (5) the [Director/Secretary] of the [state child welfare agency] or the [Director/Secretary's] designee;
 - (6) representatives designated by each of the critical stakeholder groups, including, but not limited to, a representative from [the associations of emergency physicians, emergency medical service personnel, emergency medical service agencies, law enforcement agencies, hospitals, treatment programs, and a statewide recovery organization]; and
 - (7) an individual in recovery who is an overdose survivor.
- (b) Purpose.—
- (1) In general.— The initial purpose of the Task Force will be to develop and implement Overdose Stabilization & Warm Hand-off Centers. Such Warm Hand-off Centers will be staffed locations that can medically oversee the stabilization of overdose survivors, begin detoxification where necessary, engage survivors with intervention specialists, complete full addiction assessment and referral, and connect and refer survivors to all modalities and levels of treatment, depending on the survivors' individual clinical needs.

- (2) Families.— Warm Hand-off Centers will address the needs of the survivors’ families and children, and utilize them in the engagement and treatment of the survivor, as appropriate.
- (c) Expansion of services.— The Task Force may also explore mechanisms to expand, where feasible, the function of currently existing crisis healthcare facilities so that they can serve as Warm Hand-off Centers, in addition to their current functions.
- (d) Development.— The development and implementation of Warm Hand-off Centers undertaken by the Task Force will include:
- (1) identifying areas that will benefit most from placement of the Warm Hand-off Centers, through an analysis of population density and number of overdose deaths;
 - (2) creating the design, staffing structure, operation, and operational protocols of the Warm Hand-off Centers, which may include consideration of existing detoxification facilities with expanded capacity and functions;
 - (3) expanding the functions of currently existing crisis healthcare facilities so they also serve as Warm Hand-off Centers;
 - (4) identifying funding source(s) for the Warm Hand-off Centers; and
 - (5) establishing a new licensing category to cover the Warm Hand-off Centers.
- (e) Requirements.— The operations of each Warm Hand-off Center will include at least the following:
- (1) capacity to safely medically stabilize and manage the chronic non-life threatening medical needs of overdose survivors¹⁶;
 - (2) ability to identify overdose survivors whose medical situations are sufficiently complex to require immediate transportation to an emergency department, based upon developed protocols;

¹⁶ In this section, “chronic non-life threatening medical needs” includes, but is not limited to medical conditions such as diabetes, HIV/AIDS and hepatitis C and psychiatric conditions such as depression, schizophrenia and bipolar affective disorder.

- (3) state-licensure as a medical, non-hospital residential or hospital detoxification facility;
 - (4) intervention services conducted by staff with specific expertise in therapeutically engaging those who have just survived an overdose;
 - (5) treatment assessments with physicians or other clinicians with certified expertise in undertaking drug and alcohol assessments and applying appropriate clinical placement criteria;
 - (6) working relationships with treatment programs of all modalities, including those that provide family preservation services, in the reasonable vicinity of the Warm Hand-off Center;
 - (7) development of protocols and referral agreements to govern the transfer of patients to and from emergency departments and treatment programs; and
 - (8) access to direct transportation from the Warm Hand-off Center to treatment programs.
- (f) Evaluation.— The Task Force will periodically evaluate the performance and effectiveness of the Warm Hand-off Centers, and will gather and make recommendations for continuous quality improvement.
- (g) Application.— The provisions of Sections VI and VII(b) of this Act apply to Warm Hand-off Centers.

SECTION IX. RULES AND REGULATIONS.

State agencies and officials will promulgate rules and regulations on an [expedited or emergency] basis necessary to implement their responsibilities under this Act.

SECTION X. ANNUAL REPORT TO THE LEGISLATURE.

- (a) In general.— The single state authority on drugs and alcohol and the [state] Department of Health [or other state department(s)/agency(ies)/independent board(s) that oversees EMS personnel licensure and/or continuing medical education and credits for emergency department personnel] jointly will provide a brief, written, annual report to the members of the [appropriate legislative committees], documenting:

- (1) compliance with the requirements of this Act;
- (2) The number of overdose survivors successfully being transferred to and engaged in treatment;
- (3) The number of Warm Hand-off Centers in operation;
- (4) The total number of overdose victims each Warm Hand-off Center has received; and
- (5) The total amount of funds awarded from the Warm Hand-off Initiative Grant Program in the previous year and the amount each grantee received.

(b) Publication.— This annual report will also be published on the publicly accessible websites of the single state authority on drugs and the other involved partment(s)/agency(ies)/independent board(s).

SECTION XI. SEVERABILITY.

If any provision of this Act or application thereof to any individual or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are severable.

SECTION XII. EFFECTIVE DATE.

This Act will be effective on [specific date or reference to normal state method of determination of the effect.]