

# Federal and Model State Warm Hand-Off Legislation

How NAMSDL's model warm hand-off act complements and strengthens the "SUPPORT for Patients and Communities Act" (Pub. L. 115-271)

## Warm Hand-Off Provisions in the "SUPPORT for Patients and Communities Act" (Sections 7081 and 7121)



Directs the Secretary of Health and Human Services to facilitate the development of best practices for:

- emergency treatment of known or suspected drug overdoses
- using recovery coaches to encourage overdose survivors to seek treatment for substance use disorders
- coordinating and continuing care and treatment after a drug overdose



Establishes a grant program to support implementation of voluntary programs for care and treatment of individuals after a drug overdose that includes:

- withdrawal and detoxification services
- using recovery coaches to help support recovery
- establishing policies and procedures to support long-term treatment, prevent relapse and reduce recidivism and future overdose
- establishing integrated models of care



Establishes a grant program to enable operation of comprehensive opioid recovery centers that will provide, among other things:

- intake, evaluation and periodic patient assessments meeting individualized clinical needs
- the full continuum of treatment services
- patient assessments to support sustained and clinically-significant recovery
- onsite access to medication and toxicology services
- family support service offerings to stabilize affected families

## NAMSDL's Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment:

*Directs the single state authority on drugs and alcohol to collaborate with state/local agencies to ensure that emergency services personnel and emergency departments are trained on and follow the most effective practices for successfully transferring stabilized overdose survivors to appropriate treatment and recovery support services. These practices include the use of intervention services (which can include recovery coaches) to encourage survivors to accept treatment.*

*Directs the single state authority on drugs and alcohol to aggressively pursue federal funding opportunities to support a state grant program covering warm hand-off initiatives, including the development of Overdose Stabilization and Warm Hand-Off Centers ("OSWHCs"), based on proven integrated care models established by WestCare Foundation in Nevada.*

*Creates a task force to develop and implement state OSWHCs, which are staffed locations that:*

- can medically oversee the stabilization of overdose survivors;
- begin detoxification;
- engage survivors with intervention specialists;
- complete full addiction assessment;
- connect and refer survivors to all modalities and levels of treatment, including MAT; and
- address the needs of survivors' families and children, including using them in the engagement and treatment of the survivor.



# Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment

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# Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment

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## **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) These 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;<sup>1</sup>
- (b) ensure that effective practices 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; and
- (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.

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<sup>1</sup> 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 a detoxification facility. 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.

#### SECTION IV. DEFINITIONS.

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.

- (a) “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.
- (b) “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.
- (c) “Emergency department” means a hospital emergency department, a free-standing emergency department, or a rural health clinic where the clinic carries out emergency department functions.
- (d) “Emergency department personnel” means physicians, nurses, paramedics, medical assistants, nurses’ aides and other health care professionals working in an emergency department.
- (e) “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.

- (f) “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.
- (g) “Overdose” means injury to the body that happens when a drug is taken in excessive amounts. An overdose can be fatal or nonfatal.<sup>2</sup>
- (h) “Recovery support services” social support includes informational, emotional, and intentional support including but not limited to: (i) developing a one-on-one relationship in which a peer leader with recovery experience encourages, motivates, and supports a peer in recovery, (ii) connecting the peer with professional and nonprofessional services and resources available in the community, (iii) facilitating or leading recovery-oriented group activities, including support groups and educational activities, and (iv) helping peers make new friends and build healthy social networks through emotional, instrumental, informational, and affiliation types of peer support.
- (i) “Single state authority on drugs and alcohol” in [state] means the state agency designated by the [state] governor to plan, manage, monitor, and evaluate substance use disorder treatment and recovery support services in the state.<sup>3</sup>
- (j) “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 alcohol or other drug addiction treatment and recovery support services, with or without the support of addiction 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, medication, treatment and long-term recovery support services.
- (k) “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.

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<sup>2</sup> This is the CDC definition of overdose, found at <https://www.cdc.gov/drugoverdose/opioids/terms.html>.

<sup>3</sup> As defined in Section 201(e) of the Second Chance Act of 2007, Pub.L. 110-199.

- (1) “Warm hand-off” means the direct referral and transfer of an overdose survivor immediately after medical stabilization: (1) to a licensed detoxification facility or other medical facility for detoxification, and then (2) to a substance use disorder treatment provider, with treatment matched to the individual’s clinical needs, based on a biopsychosocial assessment and application of clinical placement criteria, and coordinated with recovery support services. For purposes of this Act, in situations where the direct referral and transfer of an overdose survivor is not practicable, “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.<sup>4</sup> Also, for purposes of this Act, “warm hand-off” is deemed to include the provision of harm reduction services to overdose survivors who persistently refuse referral and transfer to detoxification and treatment.<sup>5</sup>

## SECTION V. COMPREHENSIVE STATE WARM HAND-OFF INITIATIVE.

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 a detoxification facility or other medical facility for detoxification, and to a substance use disorder treatment provider and recovery support services, for a course of treatment and recovery support, in accordance with an

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<sup>4</sup> 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-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>.

<sup>5</sup> The Act purposely allows each state to determine what to include within “harm reduction services.”

individualized assessment and application of clinical placement criteria.<sup>6</sup> 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:

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

- (1) 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 in every reasonable way to implement robust warm hand-off procedures for overdose survivors. Such support may include but not be limited to working with emergency departments to ensure that intervention services are available in a timely fashion.
- (2) The 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.<sup>7</sup>
- (3) The [local/regional administrators] shall regularly assess the network of available detoxification facilities, medical facilities providing detoxification services, substance use treatment providers, and recovery support services, and communicate this up-to-date information to all individuals providing intervention services for overdose survivors, so that a backlog of referrals does not occur.

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<sup>6</sup> As explained in Section III, the medical stabilization may occur: (1) at an emergency department or Overdose Stabilization & 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. 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 is therefore medically appropriate.

<sup>7</sup> "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. [Add information about places in U.S. where this occurs.]

(4) 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.

(b) **Prioritizing overdose survivors for substance use disorder treatment.**

(1) **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.

(2) **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 website:

- (A) the number of individuals treated by emergency medical service personnel for overdoses;
- (B) levels of care and lengths of stay of overdose survivors in Medicaid facilities and federal SAPTBG-funded treatment provider facilities;
- (C) 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;
- (D) of those individuals identified in subparagraph (2)(C), 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
- (E) any other trends or observations deemed significant by the single state authority on drugs and alcohol or its [local/regional] administrators, 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.

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

(1) **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, will develop a warm hand-off training curriculum for emergency medical services personnel.

(2) **Elements of curriculum.**

(A) Required elements of the warm hand-off training curriculum for emergency services personnel include the most effective protocols to successfully transport overdose survivors for medical stabilization to emergency departments or, where available, to Overdose Stabilization & Warm Hand-Off Centers, as created in this Act and approved by the local EMS Medical Director. In addition, the required curricula will address the elements of addiction, stigma, treatment referral, recommended safety procedures to limit first responder exposure to the drug(s) involved, 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.<sup>8</sup>

(B) Where an [appropriate state or local agency] (1) authorizes emergency medical services personnel to medically stabilize certain overdose survivors without transportation to an emergency department, or (2) engages emergency medical services personnel to participate in face-to-face or other follow-up contact with recent overdose survivors to encourage entry into treatment, the warm hand-off

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<sup>8</sup> 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.

training curriculum for emergency medical services personnel will also contain effective protocols, including alliance with recovery support services for the follow-up contacts, for successfully performing these activities.

(3) **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.

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

(1) **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, 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, 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 also include harm reduction strategies for those who decline treatment.

(2) **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.

**(e) State grant for warm hand-off initiatives.**

(1) 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. 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.

(2) 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.

**(f) 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: (1) treated in the emergency department<sup>9</sup>; (2) screened to be in need of treatment; (3) successfully transferred to treatment; (4) refusing treatment and the reasons given for why; and (5) who return to the emergency department on subsequent occasion(s); and
- (D) the emergency department’s action plan to continue to improve warm hand-off outcomes.

(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.

(g) **Medicaid; eligibility to be a provider and coverage for the warm hand-off initiative.**

(1) The [state Medicaid agency] will require emergency medical services with patient transport capability, emergency departments, and personnel working within each of

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<sup>9</sup> The number of overdoses treated in emergency departments should be different from (and 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.

these entities, to demonstrate compliance with the requirements of subsections (c), (d), and (f) of the Act in order to be eligible to [be in the Medicaid network].

- (2) 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 an Overdose Stabilization and Warm Hand-Off Center;
  - (B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility or Overdose Stabilization and 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) 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 and transferred of these overdose victims to clinically appropriate detoxification and treatment programs.

**(h) Private health insurance coverage for the warm hand-off initiative.**

- (1) 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 an Overdose Stabilization and Warm Hand-Off Center;
  - (B) emergency medical services successfully medically stabilizing an overdose survivor and successfully transporting the individual to a detoxification facility or Overdose Stabilization and 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) 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 and transfer of these overdose victims to clinically appropriate detoxification and treatment programs.
- (3) 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) The attending physician in an emergency department, or a physician's designee, will make reasonable efforts to obtain a signed patient consent to disclose information about the patient's drug overdose to family members or others involved in the patient's health care.
- (b) 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 in compliance with applicable privacy and confidentiality laws and regulations.<sup>10</sup> 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) 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) 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 and directly transferred to clinically appropriate detoxification facilities, to treatment or to recovery support services

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<sup>10</sup> 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) There is hereby created an Overdose Recovery Task Force (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; and
  - (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].
- (b) The initial purpose of the Task Force will be to develop and implement Overdose Stabilization & Warm Hand-Off Centers. Such Centers will be staffed locations that can medically oversee the stabilization of overdose survivors, begin detoxification, 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. The Centers also will address the needs of the survivors' families and children, and utilize them in the engagement and treatment of the survivor, as appropriate.

- (c) 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 Overdose Stabilization & Warm Hand-Off Centers, in addition to their current functions.
- (d) The development and implementation of Overdose Stabilization & Warm Hand-Off Centers undertaken by the Task Force will include:
  - (1) identifying areas that will benefit most from placement of the Centers, through an analysis of population density and number of overdose deaths;
  - (2) creating the design, staffing structure, operation, and operational protocols of the 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 Overdose Stabilization & Warm Hand-Off Centers;
  - (4) identifying funding source(s) for the Centers; and
  - (5) establishing a new licensing category to cover the Centers.
- (e) The operations of each Overdose Stabilization & 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 survivors<sup>11</sup>;
  - (2) ability to identify overdose survivors whose medical situations are sufficiently complex to require immediate transportation to an emergency department, based upon developed protocols;
  - (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;

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<sup>11</sup> 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.

- (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 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 Center to treatment programs.
- (f) The Task Force will periodically evaluate the performance and effectiveness of the Centers, and will gather and make recommendations for continuous quality improvement.
- (g) The provisions of Sections VI and VII(b) of this Act apply to Overdose Stabilization & 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.**

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; and (2) its estimated impact on the percentage and numbers of overdose survivors successfully being transferred to and engaged in treatment. This annual report will also be published on the websites of the single state authority on drugs and the other involved department(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.]