S.A.F.E. Project's "SAFE Takes" on Federal Legislation
Last updated November 28, 2018

Category	National Governors Association (NGA) *(27 recommendations)*	The President's Commission *(56 recommendations)*	Color & Description	S.A.F.E. Take
Public Awareness; Family Outreach & Support	The Administration should develop an evidence-based national campaign to promote prevention and reduce stigma.	*Pres. Comm. #5:* The Administration should fund and collaborate with private sector and non-profit partners to design a wide reaching, multi-platform national campaign addressing the hazards of substance use, the danger of opioids, and stigma.	Green Completed - June 7, 2018 - www.opioids.thetruth.com	PSAs and Awareness Campaigns have mixed results - to be successful, they require also having the resources to address the problem: recovery and treatment options and support for those with substance use disorders. Communities do not have to wait for a national campaign that suits them. In fact, awareness campaigns that are more targeted can be very successful.
Public Awareness; Family Outreach & Support		*Pres. Comm. #49:* The Office of National Drug Control Policy, federal partners, including the Department of Labor, large employers, employee assistance programs, and recovery support organizations should develop best practices on substance use disorders and the workplace.	Yellow Soft Start	Tool kits are starting to emerge, which goes a step further than best practices, as it gives employers a real place to start.
Public Awareness; Family Outreach & Support		*Pres. Comm. #50:* The Office of National Drug Control Policy should work with the Department of Justice, the Department of Labor, the National Alliance for Model State Drug Laws, the National Conference of State Legislatures, and other stakeholders to develop model state legislation/regulation for states to decouple felony convictions and eligibility for business/occupational licenses, where appropriate.	Orange Unknown	This will take time, as most legislatures are currently dealing with prescribing guidelines and treatment. However, this is an important factor in getting communities back on their feet. SAFE considers this an outreach endeavor because it will only work as a destigmatizing function if businesses are on board and increase opportunities for those who are in recovery.
Prescription Medicine		*Pres. Comm. #6:* Various federal agencies should develop model statutes, regulations, and policies with stakeholders that ensure informed patient consent prior to an opioid prescription for chronic pain.	Yellow Moving Forward	H.R. 6 SUPPORT for Patients and Communities Act, requires Medicare Advantage plans and part D prescription drug plans to provide information on risks associated with prolonged opioid use and non-opioid therapy coverage. However, this is just one population receiving opioids. The Pain Management Best Practices Inter-Agency Task Force is well-suited to head this , and is working to identify, review, and determine whether there are gaps or inconsistencies between best practices for pain management, including chronic and acute pain, developed or adopted by federal agencies; propose updates to best practices and recommendations on addressing identified gaps or inconsistencies; provide the public with an opportunity to comment on any proposed updates and recommendations; and develop a strategy for disseminating such proposed updates and recommendations to relevant federal agencies and the general public. However, the review done by this Task Force is only mandated to be presented to Congress. Stakeholders will only see their recommendations and information"if appropriate."
Prescription Medicine		*Pres. Comm. #7:* Health & Human Services (HHS) should coordinate the development of a national curriculum and standard of care for opioid prescribers - to supplement the Centers for Disease Control (CDC) guideline targeted to primary care physicians.	Yellow Moving Forward	H.R. 6 SUPPORT for Patients and Communities Act, instructs FDA to develop evidence-based opioid analgesic prescribing guidelines (where they don't exist), consult stakeholders and other agencies in creating them, and report on how they will be used to protect the public health. This includes a requirement to make a clear statement that the guidelines are intended to inform prescribers and patients in clinical decisions and not restrict, limit, delay, or deny coverage. The existing CDC guidelines are complex and long (52 pages) and have created a lot of controversy over whether or not they hurt patients with unique healthcare needs who depend on opioids for chronic and acute pain. Healthcare providers and their patients must have enough information to help them determine if the benefit of an addictive medication outweighs the risk. CDC is introducing 11 free interactive modules (HYPERLINK 11 free interactive modules with https://www.cdc.gov/drugoverdose/training/online-training.html), in steps, to train healthcare providers on application of the CDC guidelines.
Prescription Medicine		*Pres. Comm. #8:* Federal agencies should collect participation data on prescribing patterns, matched with participation in continuing medical education (CME) data to determine effectiveness and to share with clinicians, stakeholders, and state licensing boards.	Orange Unknown	Some of these organizations are better equipped to handle this than others. While state Prescription Data Management Programs can identify patterns of prescribing, these programs don't always talk to programs in other states or federal systems. States and private entities can already do this, and some healthcare systems have already taken it upon themselves to start tracking patterns and directing educational efforts based on the results. If you would like to learn more about how to implement this kind of change locally, S.A.F.E. can help.
Prescription Medicine		*Pres. Comm. #9:* The Administration should develop a model training program to be disseminated at all levels of medical education on screening for substance use and mental health status to identify at-risk patients.	Green Education Orgs Leading	This effort seems to be moving forward primarily because of groups like the Association of American Medical Colleges (AAMC), the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Council for Continuing Medical Education (ACCME), and the other medical education organizations. This is because they have an inherent interest in it being a successful model. AAMC has a list of efforts and responses on their website. (HYPERLINK their website with https://news.aamc.org/for-the-media/article/medical-schools-address-opioid-epidemic/)
Prescription Medicine		*Pres. Comm. #10:* Congress should amend the Controlled Substances Act to allow the Drug Enforcement Agency (DEA) to require that all prescribers desiring to be relicensed to prescribe opioids show participation in an approved Continuing Medical Education (CME) on opioid prescribing.	Red No Federal Progress	State licensing boards have the ability to provide and require CMEs with this focus. Getting the Controlled Substances Act amended will take time and may not have the desired result.
Prescription Medicine		*Pres. Comm. #11:* Health and Human Services, Department of Justice, Drug Enforcement Agency, Office of National Drug Control Policy, and pharmacy associations should train pharmacists on best practices to evaluate legitimacy of opioid prescriptions and not penalize them for denying inappropriate prescriptions.	Orange Unknown	Some of these organizations are better equipped to handle this than others. The last DEA guide on prescription fraud was published in 2000 and their focus has been more on distribution than individual pharmacists. The variability of licensing and education requirements for pharmacy staff in each state would also be a factor. This is probably best achieved through an inter-agency working group.
Prescription Medicine		*Pres. Comm. #52:* Federal agencies, including Health & Human Services (NIH, CDC, CMS, FDA, and the SAMHSA), Department of Justice, the Department of Defense, the Veterans Administration, and Office of National Drug Control Policy, should engage in a comprehensive review of existing research programs and establish goals for pain management and addiction research (both prevention and treatment). *Pres. Comm. #53:* Congress and the Federal Government should provide additional resources to the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to fund the research areas cited above.	Green Lots of Action	Good news here - National Institute of Health (NIH) has started the HEAL Initiative (Helping to End Addiction Long-Term) with $500 million in federal appropriations for a variety of efforts, including increased research to: Improve Treatments for Opioid Misuse and Addiction Expand therapeutic options for opioid addiction, overdose prevention and reversal Enhance treatments for infants born with Neonatal Abstinence Syndrome (NAS)/Neonatal opioid withdrawal syndrome (NOWs) Optimize effective treatment strategies for opioid addiction Enhance Pain Management Understand the biological underpinnings of chronic pain Accelerate the discovery and pre-clinical development of non-addictive pain treatments Advance new non-addictive pain treatments through the clinical pipeline There is still a lot of shuffling of money and priorities as well as partnerships that may still be awaiting funding. Look forward to more efforts on this front.

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Prescription Medicine		*Pres. Comm. #54:* Center for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), and the United States Preventive Services Task Force (USPSTF) should implement a fast-track review process for any new evidence-based technology supporting substance use disorder (SUD) prevention and treatments (further research of Technology-Assisted Monitoring and Treatment for high-risk patients and SUD patients).	Red Focusing Elsewhere	The process for creating fast-tracking in a way that preserves that accountability could be a distraction from ongoing efforts to address the opioid crisis. Current "fast-tracking" efforts of these federal agencies are focused on growing access to existing evidence-based treatment where there are currently shortages (i.e. Medicaid Innovation Accelerator Program).
Prescription Medicine		*Pres. Comm. #55:* The Commission recommends that commercial insurers and the Center for Medicare & Medicaid Services (CMS) fast-track creation of Healthcare Common Procedure Coding System (HCPCS) codes for FDA - approved technology-based treatments, digital interventions, and biomarker-based interventions. NIH should develop a means to evaluate behavior modification apps for	Orange Unknown	Technological interventions will only be as good as the support system ready to act when technology detects a crisis or an opportunity to intervene. If there is no support available, the person still faces a crisis alone.This is a growing area of research for many healthcare challenges, but progress specific to SUD treatment is unknown. Some of this could come up in the investment and research from recent government funding.
Prescription Medicine		*Pres. Comm. #56:* The Commission recommends that the FDA establish guidelines for post-market surveillance related to diversion, addiction, and other adverse consequences of controlled substances.	Green In Process	Understanding whether or not anti-abuse and deterrent properties of medication are functioning as designed or being overridden, as OxyContin's time release coating has been, is a critical part of medicinal safety. This is evaluated in the pre-market evaluation phase (guidelines are here: https://www.fda.gov/downloads/Drugs/.../Guidances/UCM492172.pdf), and FDA continues to evaluate its process to ensure safety around diversion and abuse (https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm600788.htm). In 2008, the FDA was funded to create Sentinel, another post-market surveillance program which complemented the Adverse Events Reporting System already in place. The President's Commission report does not mention this program in relation to this recommendation so it is unclear if it was considered in this recommendation. The relaunch of the Drug Abuse Warning Network (DAWN) under the Substance Abuse and Mental Health Services Administration in 2019 should also assist with this data in post-market stage.
Prescription Medicine		*Pres. Comm. #42:* The Commission recommends further use of the National Health Service Corps to supply needed health care workers to states and localities with higher than average opioid use and abuse.	Green Steady funding	HRSA's National Health Service Corps (NHSC) received $105 million in Fiscal Year 2018 to expand and improve access to quality opioid and substance use disorder (SUD) treatment in rural and underserved areas nationwide. This funding was appropriated again for 2019.
Prescription Medicine	Provide guidance (HHS) on best practices for care following an overdose to treating hospitals (ex - initiating MAT).	*Pres. Comm. #31:* Health & Human Services (HHS), Center for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), the Veterans Administration (VA), and other federal agencies should incorporate quality measures that address addiction screenings and treatment referrals. HHS should review the scientific evidence on the latest opioid use disorder (OUD) and SUD treatment options and collaborate with the U.S. Preventive Services Task Force (USPSTF) on provider recommendations.	Green Some progress	SAMHSA's Treatment Improvement Protocol (TIP) 63 (HYPERLINK (TIP) 63 with https://store.samhsa.gov/shin/content/SMA18-5063PT2/SMA18-5063PT2.pdf) offers screening, assessment, treatment and referral guidelines for primary care settings. HR 6 Support for Patients and Communities Act includes a demonstration project to increase access to comprehensive, evidence-based outpatient treatment for Medicare beneficiaries with opioid use disorders and includes the development of measures of quality and outcomes for treatment, but does not specifically address measures for screening and referrals.
Prescription Medicine	The Drug Enforcement Agency should remove the requirement for medical residents to apply for federal waiver to prescribe buprenorphine - already practicing under physician supervision.		Red No Known Progress	Currently, doctors, and other healthcare providers made recently eligible under H.R. 6 Support for Patients and Communities Act, must go through training to receive a waiver to prescribe buprenorphine, an opioid agonist, used to treat opioid use disorder. The hurdles to treat an opioid use disorder are much greater than the hurdles to prescribe the opioids that lead to such a disorder. In order to increase access to this important tool in treating OUD, laws have been changed to increase the number of patients that a waivered provider can treat and the types of providers that can use waivers, but the requirement to receive the training and apply for a waiver remains in place.
Prescription Medicine	Congress should extend buprenorphine prescribing privileges (via the Comprehensive Addiction and Recovery Act) to Advanced Practice Registered Nurses (APRNs).		Green Complete	H.R. 6 SUPPORT for Patients and Communities Act provides permanent extension of prescribing authority for physician assistants and nurse practitioners. It also provides authority for clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists for five years.
Prescription Medicine	Health & Human Services and the Drug Enforcement Agency, via exceptions under the public health emergency declaration, should issue policy guidance on providing Medication Assisted Treatment (MAT) via telehealth and encourage providers to use it. Congress should provide a permanent fix to ensure rural populations can access MAT after the public health emergency declaration expires - (currently prohibited by Ryan Haight Online Pharmacy Consumer Protection Act).	*Pres. Comm. #41:* The Commission recommends that federal agencies revise regulations and reimbursement policies to allow for substance use disorder treatment via telemedicine.	Yellow Highly Desired, but Slow Going	Rural populations are particularly difficult to incorporate into many of the measures combating the opioid crisis. Telehealth might be one way to assist, but there must also be measures to address populations without access to broadband and devices equipped for telehealth which often still require a "physical examination," performed via video and other computer facilitated equipment. H.R. 6 SUPPORT for Patients and Communities Act requires the Centers for Medicare & Medicaid Services to issue guidelines to states for providing services via telehealth for treatment of substance use disorder (SUD) that are federally reimbursed. It also expands the use of telehealth services by eliminating certain statutory originating site requirements for telehealth services furnished to Medicare beneficiaries for the treatment of SUDs and co-occurring mental health disorders, beginning July 1, 2019.
Prescription Medicine		*Pres. Comm. #44:* The Commission recommends HHS implement naloxone co-prescribing pilot programs to confirm initial research and identify best practices. ONDCP should, in coordination with HHS, disseminate a summary of existing research on co-prescribing to stakeholders.	Yellow Needs More Effort	H.R. 6 SUPPORT for Patients and Communities Act includes a provision supporting co-prescribing of naloxone in emergency rooms for patients brought in with an overdose, but doesn't address co-prescribing in conjunction with opioids for patients in primary care or other specialty settings. The Indian Health Service's website has guidance on co-prescribing of naloxone (https://www.ihs.gov/odm/overdose-prevention-treatment/naloxone-prescribing/). The Surgeon General has made it clear that having a high portion of the population carrying naloxone is a priority, and that co-prescribing is an integral part of saving lives from this epidemic. This information should be provided more widely.
Prescription Medicine	The Office of the National Coordinator for Health Information Technology within Health & Human Services should require that electronic health record (EHR) vendors make their systems interoperable with all state prescription drug monitoring programs (PDMPs).		Orange Heavy Lift	It's unclear how big the differences might be between PDMP systems, but as states begin to require doctors to check a PDMP before prescribing highly controlled medications, integration between PDMPs and EHRs becomes more critical. Currently, most systems are separate, requiring a provider to log into both, adding more time constraints with a patient. A system that allows for customization and wide interoperability is required.
Prescription Medicine	The Drug Enforcement Agency should create new requirements that health care providers register with their state PDMP and complete training to prescribe opioids (similar to what is required to prescribe medication assisted treatment (MAT)) - using Center for Disease Control's (CDC) prescribing guideline in training.		Orange Uncertain	The DEA's focus is law enforcement, not the quality of medical training. Currently, there are more bureaucratic hurdles for prescribing MAT than there are for prescribing the opioids themselves. This is at least one factor in a low number of providers prescribing medication for treating opioid use disorder. Education should be the focus here and that change has been initiated within the medical education community.
Prescription Medicine	Health & Human Services should invest in additional research and evaluation of non-pharmacological therapies for pain and guidance to assist states in making appropriate coverage decisions in Medicaid and other state administered health programs.		Yellow Signs of Progress	This is an important goal. Between the Pain Management Best Practices Inter-Agency Task Force, the National Institutes of Health HEAL Initiative, and the numerous new grants coming out of federal agencies, including the passage of H.R. 6 SUPPORT for Patients and Communities Act, research and evaluation will expand, but it will likely not happen quickly.

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Prescription Medicine		*Pres. Comm. #12:* The Administration should support the Prescription Drug Monitoring Program (PDMP) Act and mandate that states receiving grant funds comply with PDMP requirements, including data sharing.	Red Low Legislative Likelihood	Mandates from the federal government that are not accompanied with funding to implement these mandates tend to be problematic. In this case, states could end up shifting money to this effort at the cost of more critical priorities, resulting in a growth of unresolved challenges. All but one state (Missouri) have a statewide PDMP, and many make its use mandatory.
Prescription Medicine		*Pres. Comm. #13:* Federal agencies should mandate PDMP checks and consider amending requirements under the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals to screen and stabilize patients in an emergency department, regardless of insurance status or ability to pay.	Red Low Viability	Like Recommendation 12 - this requirement would not come with direct funding (EMTALA is an unfunded mandate) which means states have to shift money to a requirement like this. States should be making full use of their PDMPs and many, but not all, have mandates to check the PDMP. New grant money for the crisis could help states achieve this, mandate or not. HR 6 SUPPORT for Patients and Communities Act does provide some resources for hospitals and other entities to develop protocols to address the provision of an overdose reversal medication, such as naloxone, upon discharge, connection with peer-support specialists, and referral to treatment and other services that best fit the patient's needs.
Prescription Medicine		*Pres. Comm. #14:* PDMP data integration with electronic health records, overdose episodes, and substance use disorder-related decision support tools for providers is necessary to increase effectiveness.	Orange Non-specific/non-trackable	This recommendation is non-agency specific and more of a statement of principle. CMS has issued new guidance with information to help states leverage federal funding into approaches for PDMP and EHR integration and innovation in Health IT. Innovation in both the public and private sector here is a reason to be hopeful.
Prescription Medicine		*Pres. Comm. #15:* The Office of National Drug Control Policy and the Drug Enforcement Agency (DEA) should increase electronic prescribing to prevent diversion and forgery. The DEA should revise regulations regarding electronic prescribing for controlled substances.	Yellow Mixed Results Possible	Electronic prescribing is considered a vital tool in regaining control over prescription opioids. There are already some states that require it, and there is legislation that could incentivize it, federally. Although there are areas in rural America that don't even have consistent broadband internet access. Requiring new technology without funding the requirement, and without appropriate waivers erects barriers to appropriate care even when well intended.
Prescription Medicine		*Pres. Comm. #16:* The Federal Government should work with states to remove legal barriers and ensure Prescription Drug Management Programs (PDMP) incorporate available overdose/naloxone deployment data, including the Department of Transportation's (DOT) Emergency Medical Technician (EMT) overdose database. It is necessary to have overdose data/naloxone deployment data in the PDMP to allow users of the PDMP to assist patients.	Yellow Long Way to Go	A PDMP is only as helpful as the quality and timeliness of the inputs. When information is excluded or delayed, there are missed opportunities to counsel, assist, and protect patients from the risks associated with the use of any prescription medicine. Naloxone prescriptions should be included in that. There is some progress in municipalities that have elected to engage in their own mapping.
Prescription Medicine		*Pres. Comm. #17:* Communities should utilize Take Back Day to inform the public about drug screening and treatment services. Hospitals/clinics and retail pharmacies should become year-round authorized collectors and explore the use of drug deactivation bags.	Green Steady Progress	Take Back Days are an important tool in reducing the supply of prescription medicines to those who may misuse them. In addition to the two national Take Back Days (in April and October) sponsored by the Department of Justice and the DEA, many pharmacies have become year-round collectors. Communities should also, to the extent possible, consider deactivation bags where collection is less feasible. DEA public disposal locator: https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1, National Board of Pharmacy Drug Disposal Locator: https://nabp.pharmacy/initiatives/awarxe/drug-disposal-locator/
National Coordination		*Pres. Comm. #1:* Congress and the Administration should increase block grant funding for opioid-related and substance use disorder (SUD)-related activities in the states.	Green Good, but Not Enough	Increased funding to states and communities is a great first step, but should be paired with a national strategy focusing on bold ideas, promising practices, and evidence-based youth prevention efforts.
National Coordination	Congress and the Administration should increase federal funding to states for SUD related activities, streamline the grant process (extend duration), and increase flexibility in grants/funding.	*Pres. Comm. #2:* The Office of National Drug Control Policy (ONDCP), through support from Health & Human Services and the Department of Justice, should establish a coordinated system for tracking all federally-funded initiatives.	Yellow Warning, Caution Ahead	Tracking the effectiveness of grants made by the Federal Government is an important accountability measure. An increase in grants should go along with an effort to make grants more flexible. States and individual recipients still struggle to meet overburdensome reporting requirements, while new actors in the field struggle to understand the grant-making process. There is an influx of money, but efficacy, coordination and tracking are to be determined.
National Coordination	Increase coordination and communication between agencies - via inter-agency task force or executive agency.	*Pres. Comm. #3:* Congress should fund implementation of ONDCP review for every federal program and mandate federal and state cooperation.	Yellow Some Coordination	Inter-agency task forces are a great way to accelerate progress on initiatives important to the Administration, but must be paired with the resources and accountability to drive action. ONDCP is a natural office to lead an inter-agency task force and should receive the resources and legitimacy to facilitate a review process. While ONDCP does coordinate federal agency actions, it does not have the funding and resources to do reviews at the suggested level. Reviews of federal programs should be based on measures appropriate to the program area; prevention and treatment programs must be evaluated by different criteria.
Full-Spectrum Prevention	Continue to coordinate with existing prevention programs in schools and avoid increasing stigma and fear around punitive approaches for those who need access to treatment. Expand federal support for new and additional resources to support training officers in schools, community engagements, and other educational activities.		Yellow Limited Infrastructure	This recommendation will largely be helped by implementing universal screening programs for students, in addition to supportive environments and activities to keep students out of triggering situations for return to use. Funding without the infrastructure to support long-term prevention and support for those in recovery will reap few benefits. Our SAFE Campuses program will work to support and provide opportunities for those in recovery in higher education.
Full-Spectrum Prevention		*Pres. Comm. #18:* The Center for Medicare & Medicaid Services (CMS) should remove pain survey questions entirely on patient satisfaction surveys so that providers are never incentivized for offering opioids to raise their survey score. The Office of National Drug Control Policy (ONDCP) and Health & Human Services should establish a policy to prevent hospital administrators from using patient ratings from CMS surveys improperly.	Yellow Slow Progress	There is no agreement on what the right measures are for patient satisfaction and health outcomes, especially as they relate to propensity for opioid misuse. (INSERT citations: https://jamanetwork.com/journals/jama/fullarticle/2626561, https://www.sciencedirect.com/science/article/pii/S2352344118300335). Research in these areas is key; ensuring that patients have access to the right treatment, rather than the easiest and cheapest treatment, which matters to the long term wellness of the patient. NGA has a long history of working with states to tackle complex issues, including opioids. Their leadership helps states develop public policy options, and helps identify what is working in other states. Analysis of which states have policies that correspond to removing pain survey questions, as well as an analysis of what is working or not working would be helpful. The states then adopt their own state policy and regulations to align state systems with federal regulations. The bureaucracy around changing state policy, internal systems, and effective implementation of those changes will slow down this
Full-Spectrum Prevention		*Pres. Comm. #19:* CMS should review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.	Yellow Time & Labor Intensive	There are few provisions for alternative pain treatments across federal and private insurers. Some states are convening "Payors" councils to examine service definitions and establish payment mechanisms. CMS included in its 2018, Roadmap to Address the Opioid Crisis (HYPERLINK https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf), a plan to "disseminate best practices for state Medicaid agencies and other payers on alternative pain management strategies and other tactics to address the opioid crisis." Although, reimbursement rates for alternative treatments remain an under addressed barrier to reducing opioid dependence.
Treatment & Recovery		*Pres. Comm. #4:* The Department of Education should collaborate with states (Dept. of Ed) on student assessment programs, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) - to identify at-risk youth who may need treatment.	Red Little Federal Progress	There are two sides to this - data sharing can save lives. However, without strong privacy protection, it can adversely affect one's livelihood in and after recovery. Proceed with caution. We wrote about this (HYPERLINK wrote about this with https://www.safeproject.us/article/healthcare-coordination-for-substance-use-disorder-patients-saving-lives-or-invasion-of-privacy/) as legislation was being introduced, however, it did not make it into the final version of H.R. 6, SUPPORT for Patients and Communities Act.

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Treatment & Recovery	Congress should align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA) to bring substance use disorder (SUD) info with other types of health data.		Yellow Little Movement	Schools are leary of doing any assessments on kids. They don't want to be held responsible for knowing something about a child and not addressing it. Assessment in schools by school staff is rare. However, school districts do not need to wait for the Department of Education to implement SBIRT - there is a free tool available (CRAFFT Screening Tool - http://www.ceasar-boston.org/CRAFFT/index.php).
Treatment & Recovery	The Administration should expedite approval of Medicaid Institute for Mental Diseases (IMD) waivers. Congress should enact legislation creating an exception to IMD exclusion for those receiving SUD treatment.		Green Steady Progress	Waivers can currently be requested for opioid use disorder but not for broader substance use disorder. As part of the Department of Health and Human Services effort to combat the ongoing opioid crisis, on November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) issued guidance (HYPERLINK issued guidance with https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf) describing additional flexibilities to help states improve access to, and quality of, SUD treatment through Medicaid section 1115 demonstrations. The Medicaid Innovation Accelerator Program (IAP) is available to support Medicaid agencies interested in strategic design support to develop their section 1115 SUD demonstration proposals and implementation plans. For more information, visit IAP SUD Individualized Technical Support Opportunities (HYPERLINK IAP SUD Individualized Technical Support Opportunities with https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/individualized-technical-support-opportunities/index.html). H.R. 6, SUPPORT for Patients and Communities Act provides the option to cover care in IMDs, which may otherwise not be reimbursed, for treatment of SUD for patients aged 21-64 during fiscal years 2019-2023. However, this is still not a permanent solution.
Treatment & Recovery	Health & Human Services (HHS) should strengthen federal oversight and ensure the Mental Health Parity and Addiction Equity Act (MHPAEA)/parity violations do not limit access to substance use disorder (SUD) treatment.	*Pres. Comm. #33:* HHS, The Centers for Medicare and Medicaid Services (CMS), the Indian Health Service (IHS), Tricare, the Drug Enforcement Agency (DEA), and the Veterans Administration (VA) should remove reimbursement and policy barriers to SUD treatment, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use, and provide treatment within 24 to 48 hours, directly or through referral. *Pres. Comm. #35:* Because the Department of Labor (DOL) regulates health care coverage provided by many large employers, the Commission recommends that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations. *Pres. Comm. #36:* Federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity. HHS, in consultation with DOL and	Yellow Uncoordinated	There is a lot of confusing messaging from the government about parity rules and enforcement, healthcare insurance coverage for inpatient treatment, and substance use. Congress has been making progress on some areas, but overall, government action on this front shows a lack of coordinated effort.
Treatment & Recovery	Expand access to evidence-based SUD and mental health services for justice-involved populations. Specifically, medicaid coverage for medicaid-eligible individuals who are incarcerated pending disposition or nearing release. CMS should grant states (under 1115 authority) partial waivers of inmate exclusion otherwise barring states form receiving federal Medicaid funding in these circumstances.	*Pres. Comm. #37:* The Commission recommends the National Institute on Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national, state, local, and tribal stakeholders use medication-assisted treatment (MAT) with pre-trial detainees and continuing treatment upon release.	Red Needs Funding, Culture and Attitude Change	The most lethal time for any opioid user is the two weeks after release from jail or prison. Social and environmental factors as well as a decreased tolerance both increase vulnerability for return to use and overdose. The move to allow for Medication Assisted Treatment (MAT), also known as pharmacotherapy, for incarcerated individuals has been very slow, mostly due to funding, concerns over diversion of prescription medicine for illicit use within the facilities, and a general misunderstanding of the role of these medications and their effectiveness for longer term treatment of SUD. Even if inmates have access to MAT/pharmacotherapy, those with felony charges are not eligible for medicaid coverage upon release until their probation is complete, creating a dangerous gray area. Public-Public and Public-Private partnerships must be formed in most cases so the correctional facility can make a warm handoff of medical services to the local managed care organization (MCO/Medicaid provider) or county health department. In 2016 Rhode Island launched a first of its kind program (HYPERLINK first of its kind program to https://www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594) in the country to provide medically assisted substance abuse treatment for incarcerated individuals, as well as transition programs to connect with treatment providers upon release. Rhode Island is currently the only state that mandates the use of all three evidenced-based opioid withdrawal medications (Vivitrol, Suboxone, and Methadone). All of these systems mentioned are working on incorporating MAT/pharmacotherapy into their programs and making it available to current incarcerated offenders. H.R. 6, Support for Patients and Communities Act requires Health and Human Services to convene a stakeholder group to report on best practices for states on this topic. This is an important, but tiny step in an area critical to impacting this crisis.
Treatment & Recovery	Health and Human Services should revise Medicare coverage requirements to cover methadone at community outpatient treatment programs.		Green Complete	H.R. 6, SUPPORT for Patients and Communities Act expands Medicare coverage to Opioid Treatment Providers and does not limit the coverage to methadone only. This is a big win for senior citizens using Medicare who struggle with opioid use disorder. However, there are still many barriers for Medicaid clients, who have to pay out of pocket for treatment in these programs.
Treatment & Recovery	The Health Resources and Services Administration (HRSA) should expand definition of approved sites where primary care providers can be reimbursed for providing medication assisted treatment (MAT) and other behavioral health interventions to include substance use disorder (SUD) treatment facilities.	*Pres. Comm. #34:* Health and Human Services (HHS) review and modify rate-setting (including policies that indirectly impact reimbursement) to better cover the true costs of providing SUD treatment, including inpatient psychiatric facility rates and outpatient provider rates.	Yellow Needs More Work	H.R. 6, SUPPORT for Patients and Communities Act works to increase the number of providers who can treat SUD with MAT. However, reimbursement rates will impact how many qualified providers actually provide the treatment, and it doesn't seem to address that. Once improved reimbursement demonstrates positive impact in the field then the rate will be justified. SAMSHA-HRSA promotes the use of integrated care for treatment of substance use disorder with tools and resources. HYPERLINK tools and resources with: https://www.integration.samhsa.gov/clinical-practice/substance_use)

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Treatment & Recovery		*Pres. Comm. #32:* Adopt process, outcome, and prognostic measures of treatment services as presented by the National Outcome Measurement and the American Society of Addiction Medicine (ASAM).	Yellow Slow Progress	Yes! We need more money for research of evidence based practices and recovery supports that work. Policies for outcome measurements have to be adopted by insurers, providers, healthcare systems, and government to enable real change in treatment models.
Treatment & Recovery		*Pres. Comm. #39:* The federal government should partner with appropriate hospital and recovery organizations to expand the use of recovery coaches, especially in hard-hit areas. Insurance companies, federal health systems, and state payers should expand programs for hospital and primary case-based SUD treatment and referral services.	Green Progress at State Level	Great recommendation - doable and affordable. The model can save lives and money. Rhode Island - RI-CARES - was one of the first states to use recovery coaches in the emergency room (ER). They are collecting data about their work and now other states are adopting this practice. This model can be utilized in any ER.
Treatment & Recovery		*Pres. Comm. #40:* The Commission recommends the HRSA prioritize addiction treatment knowledge across all health disciplines.	Yellow Slow Pogress	Psychiatric/medical academic programs have an average of 8 hours of total education for students about substance use disorders. Information in this area should be much more available and more intensive for health care providers. Medical schools, boards, and healthcare systems can all help make this a reality today.
Treatment & Recovery		*Pres. Comm. #46:* The Commission recommends that HHS implement guidelines and reimbursement policies for Recovery Support Services, including peer to peer programs, jobs and life skills training, supportive housing, and recovery housing.	Green On the Right Track	These recovery support services were included in the first piece of legislation called CARA (Comprehensive Addiction Recovery Act), however, they were not funded. Some states have added recovery coaches to their formulary but it is hit and miss. When someone successfully stops misusing, but can't find employment, or housing, or a community of support, they are more likely to re-engage in misuse. Recovery Support Services are part of treatment. H.R. 6, SUPPORT for Patients and Communities Act requires HHS to issue best practices for recovery housing, and to identify common indicators in fraudulent recovery housing operators. The Building Communities of Recovery program was reauthorized and modified by the law to include peer support networks and funding for community organizations focused on long-term recovery support services. H.R. 6 also requires HHS to establish a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support to facilitate expansion of comprehensive recovery support programs in communities, as well as provide a program to support transition to independent living and return to the workforce.
Treatment & Recovery	Health & Human Services (HHS) should issue guidance encouraging universal screening of pregnant women as part of comprehensive obstetric care. HHS should also issue comprehensive standards for treating neonatal abstinence syndrome.	*Pres. Comm. #47:* HHS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Administration on Children, Youth and Families (ACYF) should disseminate best practices for states regarding interventions and strategies to keep families together, when it can be done safely (e.g., using a relative for kinship care). These practices should include utilizing comprehensive family centered approaches and should ensure families have access to drug screening, substance use treatment, and parental support. Further, federal agencies should research promising models for pregnant and postpartum women with substance use disorders (SUDs) and their newborns, including screenings, treatment interventions, supportive housing, non-pharmacologic interventions for children born with neonatal abstinence syndrome, medication-assisted treatment (MAT) and other recovery supports.	Green Moving Forward	When screening laws lead to separation of families with a charge of "neglect and abuse," the safety and health risk increases for mothers and children. The opioid crisis has caused a dramatic increase in the number of children in foster care. Communities and states must ask (if children can be kept safe with their parents); does investment in finding ways to keep families together and healthy make more fiscal and emotional sense than foster care? H.R. 6, SUPPORT for Patients and Communities Act has several provisions to improve care for infants with neonatal abstinence syndrome and their mothers - an important step in reducing the impact of this crisis to next generations. The law includes a study to identify gaps in Medicaid coverage for pregnant and postpartum mothers, clarification for states on provision of Medicaid to infants with NAS, and provision of support for their mothers. It also provides funding for HHS to test a "recovery coach" program for parents with children in foster care, along with an increase of funding to increase capacity for family-focused residential treatment.
Treatment & Recovery		*Pres. Comm. #48:* ONDCP, the Substance Abuse and Mental health Services Administration (SAMHSA), and the Department of Education (DOE) identify successful college recovery programs, including "sober housing" on college campuses, and provide support and technical assistance to increase the number and capacity of high-quality programs to help students in recovery.	Red Needs Funding	Great idea but there has been no money for this. Technical assistance and services for Collegiate Recovery Programs has not previously been funded by the federal government and there is no current legislation to support it.
Treatment & Recovery		*Pres. Comm. #51:* ONDCP, federal agencies, the National Alliance for Recovery Residences (NARR), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and housing stakeholders should work collaboratively to develop quality standards and best practices for recovery residences, including model state and local policies. These partners should identify barriers (such as zoning restrictions and discrimination against MAT patients) and develop strategies to address these issues.	Green Consistent Progress	NARR has done a great job to move this initiative forward with support from many partners. Standards have been developed and housing all over the country is implementing better quality according to these standards. Continued work must be done but work to date must be applauded and recognized. In May 2018, the National Council for Behavioral Health and NARR partnered in creating a Recovery Housing Toolkit (HYPERLINK: https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf) to help state policy makers move forward.
Law Enforcement & Medical Response	The Administration should issue guidance to facilitate more open data sharing. Congress should provide the Department of Justice (DOJ) with increased federal funding for trainings and technical assistance that support state law enforcement and public health data and information sharing initiatives.		Green New Funding Available	New federal funding through the 21st Century Cures Act and DOJ Comprehensive Opioid Abuse Program (COAP) is available to states. These programs can and should be used to help states better integrate public health and public safety data sharing initiatives. response.
Law Enforcement & Medical Response	Congress should increase Justice Assistance Grant Program (JAG) funding for state and local narcotic interdiction efforts and officer safety programs, increase funding and emphasize the role of preparing for and connecting individuals to community-based treatment programs, and increase funding (for the National Institute of Corrections, SAMHSA, and the Office of Justice Programs) to develop and provide MAT for justice-involved populations		Red Not Moving Fast Enough	This is one of the most important recommendations in the NGA report. There are some great state and county models for providing Medical-Assisted Treatment (MAT) to justice-involved populations, but they need to be scaled and universally adopted. Additionally the transition from incarceration back into society is the most deadly time for any substance users. Incarcerated individuals with substance use disorder are 130 times more likely to die of an overdose than the general population within the first two weeks following release.
Law Enforcement & Medical Response	The federal government should offer more assistance to accelerate state crime lab testing and share real-time drug data. Increase federal coordination and funding for state medical examiner offices to increase understanding and provide a more targeted public safety and public health response by states.		Yellow Needs Standardization	States need federal assistance to respond to rapid increases in overdose cases and toxicology reports. Medical examiners must continue to work to identify ways of unify the language and coding used to identify and report cause of death and associated substances found in post mortem drug screens. States should also participate in mapping projects such as ODMAP {HYPERLINK with http://www.hidta.org/odmap/) and the Opioid Mapping Initiative (HYPERLINK Opioid Mapping Initiative) with http://opioidmappinginitiative-opioidepidemic.opendata.arcgis.com/) to track overdose deaths and overdose reversals.

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Law Enforcement & Medical Response	Increase federal efforts to strengthen electronic customs relation and to develop better chemical screen devices.		Yellow Essential, But Difficult	The STOP ACT addresses these concerns, but is still proposed legislation. The effectiveness of these efforts, however, depends on cooperation by international partners, namely China. The majority of fentanyl and opioid analogues are being manufactured in China and shipped through the international mail system. Fentanyl is the primary driver in the dramatic spike in opioid deaths over the last 4 years.
Law Enforcement & Medical Response	The Office of National Drug Control Policy (ONDCP) should continue to engage and convene additional federal and non-federal agencies to better understand the priorities of both public health and public safety entities at all levels of government.		Red ONDCP Leadership Vacuum	Ever since early rumors that the Trump Administration planned to eliminate ONDCP the agency has been largely absent from the policy debate. The two primary offices run by ONCDP, High Intensity Drug Trafficking Areas and Drug Free Communities, are critical and independent voices that lead and augment the work of the Department of Justice and Department of Health and Human Services. ONDCP must re-exert leadership as the chief convening power that focused on aligning the public safety and public health drug policy priorities for the country. Too often we're addressing public health issues with public safety solutions.
Law Enforcement & Medical Response	ONDCP should continue and/or increase federal support for regional High Intensity Drug Trafficking Areas (HIDTAs) and state law enforcement efforts, and scale up and replicate innovative partnerships at state and local level - nationwide. Increase federal grant dollars for state fusion centers and other state law enforcement entities requiring more personnel and analysts. Increase flexibility in grant funding to meet dynamic challenges, such as direct investments in state and local narcotic interdiction initiatives. Expand the role of HIDTAs to allow more robust assistance to state and local law enforcement led prevention		Yellow More Funding Needed	HIDTAs play a critical role in augmenting state and local drug interdiction efforts. HIDTA funding should have been drastically increased as the crisis unfolded. This did not occur and additional federal funding is required. However, H.R. 6, Support for Patients and Communities Act includes a reauthorization for ONDCP, the Drug Free Communities program and the HIDTA program with multiple provisions to improve coordination, strategy, and progress. In September, ONDCP named 10 new areas as HIDTAs and this month President Trump announced $34 million in additional funding for the HIDTA program.
Law Enforcement & Medical Response	The federal government should ensure concerns and key issues from state law enforcement are incorporated into larger federal supply reduction efforts. Future Drug Enforcement Agency (DEA) and the Organized Crime Drug Enforcement Task Forces (OCDETF) Program priorities and strategies should incorporate state law enforcement concerns about illicit opioid distribution, targeting transnational criminal organizations and violent gangs, emerging and existing markets, and reinforce DEA's ability to regulate distributors suspected of misconduct.		Orange Unknown	While it is absolutely true that DEA and OCDETF should be incorporating the recommendations of states and local jurisdictions, it's hard to know whether or not they are. More specific information about the recommendations state and local agencies are making to federal agencies.
Law Enforcement & Medical Response	The federal government should support research, development, and court admissibility of a simple, accurate and cost-effective roadside testing method for drugged driving (including marijuana) to reduce risk to the motoring public.		Orange Unknown	The President's Budget request from the Office of National Drug Policy (ONDCP) for fiscal year 2018 (Oct 1 2017-Sep 30 2018) asked for $2.72 million in the Department of Transportation, National Highway Transportation Safety Administration to do this kind of research. However, in early 2018, there was speculation that the White House was prepared to eliminate almost all of ONDCP's funding. It's unclear from further budget requests if this is included for fiscal year 2019, which is now underway.
Law Enforcement & Medical Response	The federal government should increase support for National Guard Counterdrug Program to allow greater program capacity, providing states with funds to partner with local agencies and community groups and augment state use of this program to cut illicit drug supply.		Green Partnerships Growing	This is an achievable goal - strong federal/state cooperative opportunity. Congress and the President approved $217,178,000 for the National Guard counter-drug program; and $25,276,000 for the National Guard counter-drug schools program in the fiscal year 2019 appropriations bill.
Law Enforcement & Medical Response		*Pres. Comm. #20:* The Federal Government should strengthen data collection activities enabling real-time surveillance of the opioid crisis at the national, state, local, and tribal levels.	Yellow Needs Improvement	This needs increased funding for federal and state data sharing of law enforcement and health data to address the crisis in real time. A lot of innovation is happening in this area, but it is largely funded by philanthropy and state governments. The Centers for Medicare & Medicaid Services (CMS) has a map that shows Medicare prescription rates for opioids, but the newest data is from 2016.
Law Enforcement & Medical Response		*Pres. Comm. #21:* The Federal Government should work with the states to develop and implement standardized rigorous drug testing procedures, forensic methods, and use of appropriate toxicology instrumentation in the investigation of drug-related deaths.	Yellow Slow Movement	The Department of Justice and the Department of Health and Human Services have established the Medicolegal Death Investigation (MDI) Federal Interagency working group (MDI-WG) which started work in March 2018. The MDI-WG is developing short and long term goals for activities including: Developing technologies/systems to facilitate information/data sharing between ME/C offices; toxicology laboratories; and Federal, State, and local entities, with specific focus on combating the opioid crisis. States like West Virginia have already begun using data on drug-related deaths to help in prevention efforts. Delayed coordination with states is a missed opportunity to reverse the trajectory of injuries and deaths in the shorter term.
Law Enforcement & Medical Response		*Pres. Comm. #22:* Reinstituting the Arrestee Drug Abuse Monitoring (ADAM) program and the Drug Abuse Warning Network (DAWN) to improve data collection and provide resources for other promising surveillance systems.	Yellow Slow Progress	Substance Abuse and Mental Health Services Administration (SAMHSA) is reinstating the Drug Abuse Warning Network in mid-2019 (footnote: https://www.samhsa.gov/data/data-we-collect/dawn-drug-abuse-warning-network). According to SAMHSA, "Important improvements to new DAWN include improved timeliness of data, data available at more frequent intervals, and data for a wider range of geographic area types, including urban, suburban, and rural areas. Having data available more quickly means that DAWN can serve as a true "early warning" system and inform public health response efforts in local areas." It does not appear there are any plans to reinstate ADAM.
Law Enforcement & Medical Response		*Pres. Comm. #23:* Enhance federal sentencing penalties for the trafficking of fentanyl and fentanyl analogues.	Green In Motion	The United States Sentencing Commission voted to approve an amendment in April 2018 to alter guidelines on synthetic drugs. It included a multipart change to address synthetic cathinones (bath salts), synthetic cannabinoids, fentanyl, and fentanyl analogues. The amendment creates a new guideline definition for "fentanyl analogue" and raises penalties with a four-level sentencing enhancement (Footnote https://www.ussc.gov/about/news/press-releases/april-12-2018). According to the USSC, "In setting the new drug ratios, the Commission considered among other factors, the severity of the medical harms to the user, the current ratios applied in similar cases, known trafficking behaviors, and concerns for public safety. In recognition that potencies vary, the Commission also adopted departure language for drugs in a class that are more or less potent." Fentanyl is the leading cause of opioid related deaths (Footnote: https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates)"
Law Enforcement & Medical Response		*Pres. Comm. #24:* Federal law enforcement should target Drug Trafficking Organizations and other individuals who produce and sell counterfeit pills, including including those sold via the internet.	Green DEA Targeting Pill Presses & Dark Web	SAMHSA estimates that less than 1% of the misused pain relievers are sourced from the internet (surface and Dark Web). In the last few years the Drug Enforcement Agency (DEA) has increased its efforts to track key components of pill presses that have been ordered separately and assembled illegally. More information is needed on the source of counterfeit and diverted medications. The Federal Government has looked to technology giants like Google and Facebook to assist in their crackdown. (HYPERLINK assist in their crackdown with https://www.cnbc.com/2018/06/27/facebook-google-others-to-meet-with-fda-about-online-opioid-sales.html)
Law Enforcement & Medical Response		*Pres. Comm. #25:* Congress should amend the law to give the DEA the authority to regulate the use of pill presses/ tableting machines with requirements for the maintenance of records, inspections for verifying location and stated use, and security provisions.	Orange Need Funding and Authority	The DEA is already responsible for the purchase of pill presses, but they are often illegally assembled from ordering unregulated replacement parts. The DEA does need the ability to regulate key parts and ongoing operations. Pill presses and key components should be tracked by serial number and tracked for regular inspection.

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Law Enforcement & Medical Response		*Pres. Comm. #26:* The U.S. Customs and Border Protection and the U.S. Postal Service should use additional technologies and drug detection canines to expand efforts to intercept fentanyl (and other synthetic opioids) in envelopes and packages at international mail processing distribution centers.	Yellow Logistical Challenge	The STOP Act of 2018 (H.R. 5788) includes critical tools to reduce international tracking through the mail. It passed the House in the early summer and was included in the Senate version of H.R. 6, SUPPORT for Patients and Communities Act. It should be noted that the rise of fentanyl coming through the international mail system coincided with the explosion of e-commerce. U.S. Customs and Border Protection is already dealing with a 300% increase in international packages. Efficiently finding a needle in a cardboard stack is exceedingly difficult.
Law Enforcement & Medical Response		*Pres. Comm. #27:* Congress and the Federal Government should use advanced electronic data on international shipments from high-risk areas to identify international suppliers and their U.S.-based distributors.	Yellow Doesn't Ensure Compliance	Provisions supporting this recommendation from the STOP Act of 2018 (H.R. 5788) were also included in H.R. 6, SUPPORT for Patients and Communities Act (Section 8003). While encouraging international governments to utilize Advanced Electronic Data (AED) on all packages is important, ensuring compliance is more critical. It will cost China billions of dollars to modernize their postal system and there is very little discussion about how to incentivize them to do so.
Law Enforcement & Medical Response		*Pres. Comm. #28:* Congress should support the Synthetics Trafficking and Overdose Prevention (STOP) Act and the Federal Government should work with the international community to implement the STOP Act in accordance with international laws and treaties.	Yellow Good First Step	The STOP Act of 2018 (H.R. 5788) was passed by the House in mid-2018 and included in the final version of H.R. 6, SUPPORT for Patients and Communities Act signed into law by President Trump. The President has also requested and secured global support from 130 member nations of the United Nations (U.N.) in what he called a "Global Call to Action on the World Drug Problem." (Footnote: https://www.cbsnews.com/news/trump-delivers-remarks-united-nations-counter-narcotics-drugs-live-stream-2018-09-24/)
Law Enforcement & Medical Response		*Pres. Comm. #29:* Coordinate federal and Drug Enforcement Agency's (DEA) effort to prevent, monitor, and detect the diversion of prescription opioids for illicit distribution or usage.	Green Significant Progress	This coordination is happening. Both the DEA and States believe they have made significant progress in the last 2-3 years.
Law Enforcement & Medical Response		*Pres. Comm. #30:* The White House should develop a national outreach plan for the Fentanyl Safety Recommendations for First Responders. The Federal Government should partner with Governors and state fusion centers to develop and standardize data collection, analytics, and information-sharing related to first responder opioid-intoxication incidents.	Green Solutions on Hand	Fentanyl and other powerful opioid analogues present a real danger to law enforcement, but too much emphasis on the danger and too little on the mitigation techniques is counter productive. For example, many local law enforcement agencies have stopped all field testing of substances for fear of fentanyl exposure. Fentanyl exposure is a real danger, but one that is also easily mitigated. The Department of Justice recently released new materials including a video (HYPERLINK https://www.dea.gov/press-releases/2018/08/30/justice-department-announces-release-new-fentanyl-safety-video-first) to ensure law enforcement agencies are protecting their officers (Footnote: https://www.dea.gov/press-releases/2018/08/30/justice-department-announces-release-new-fentanyl-safety-video-first). The key to success will be in coordination, which has already proven challenging (HYPERLINK https://www.nbcbayarea.com/multimedia/Opioid-Overdose-Map-App-494281381.html).
Law Enforcement & Medical Response		*Pres. Comm. #38:* The Department of Justice (DOJ) should broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with a substance use disorder (SUD) who violate probation terms with substance use should be diverted into drug court, rather than prison.	Yellow Need More Growth	Every criminal court in the United States should have diversion programs in place. Every judge should have the opportunity and procedure to afford the appropriate plaintiffs the opportunity to complete a treatment program. Additional funds are required for federal grants for the state and local drug courts.
Law Enforcement & Medical Response		*Pres. Comm. #43:* The National Highway Traffic Safety Administration (NHTSA) should review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of fentanyl overdoses.	Green States Have Answered	First responders' inability to provide naloxone, from a regulatory standpoint, has not been as big of a problem as access and cost for communities to stock naloxone, in large part because states have provided temporary authorities in the midst of the crisis. However, no first responder should be threatened with the loss of their license or certification as a result of administering naloxone.
Law Enforcement & Medical Response		*Pres. Comm. #45:* The Department of Health and Human Services (HHS) should develop new guidance for Emergency Medical Treatment and Labor Act (EMTALA) compliance with regard to treating and stabilizing substance use disorder (SUD) patients and provide resources to incentivize hospitals to hire appropriate staff for their emergency rooms.	Red Treatment Shortage	Treating and stabilizing acute patients is what emergency rooms do. It is what happens after the initial assessment and triage has taken place that is so important. A warm handoff to medical treatment and therapy is key. A shortage of treatment centers is at the crux of this problem. Funding will be required to bridge the gap for hospitals that have a shortage of staff, high demand for assistance, and few options for nearby treatment. The practice of discharging patients SUD patients from emergency departments is complex and a matter of capacity that requires funding and professionals.