NOPE

Naloxone Overdose Prevention Education Working Group

NALOXONE LEGISLATION DRAFTING GUIDE

WHO WE ARE

The Naloxone Overdose Prevention and Education (NOPE) Working Group was formed in 2008 to address issues related to naloxone access in the United States. NOPE currently has over one hundred members, including legal and policy experts, individuals working in naloxone distribution programs, advocates, public health officials, researchers, medical professionals, and others involved in varying aspects of expanding access to naloxone. Members of NOPE have been involved in projects related to naloxone pricing and shortages, advancing policies that include overdose prevention and naloxone, production of advocacy materials like the film *Reach for Me*, maintaining a national database of overdose prevention initiatives, assisting in the implementation of new programs, and advising states on legislative changes related to naloxone, among others. NOPE receives no funding to support its activities.

MODEL NALOXONE LEGISLATION PROVISIONS

DEFINITIONS

1. Health Care Professional

   Sample Language: *"Health care professional" includes, but is not limited to, a physician, a physician assistant, or a nurse practitioner, who is authorized to prescribe an opioid antagonist.*

2. Opioid Antagonist

   Sample Language: *"Opioid antagonist" means any drug that binds to opioid receptors and blocks or disinhibits the effects of opioids acting on those receptors.*

3. Opioid-Related Drug Overdose

   Sample Language: *"Opioid-related drug overdose" means a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid, or another substance with which an opioid was combined, or that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.*

Note that these definitions may be unnecessary. If you choose to include specific definitions in your bill, however, then these definitions are preferred.

THE FOLLOWING PROVISIONS ARE ESSENTIAL TO INCLUDE IN A LAW FOR IT TO BE EFFECTIVE:

1. Third-Party Prescription/Standing Order Distribution

   Sample Language: *Notwithstanding any other law or regulation, a health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe, dispense, and distribute an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.*

This provision authorizes a health care professional to prescribe naloxone for use on a person at risk of opioid overdose, even if the physician has not personally examined that person. It also permits the prescribing practitioner to dispense naloxone to a person other than the person for whom the drug may be used. This practice is not unique; for example, many states explicitly permit such "third party prescription" in the form of expedited partner therapy for sexually transmitted infections. However, state laws often prohibit or discourage it (and prescribers may be unwilling to do it) unless a statute explicitly permits the practice.

The only requirement for receiving a prescription for naloxone that this provision imposes is that the person be "in a position to assist a person at risk of experiencing an opioid-related overdose." It does not impose any educational, training, or certification requirements on either the doctor or the patient. These additional requirements should be avoided if politically possible. *See Provisions That Should Generally Be Avoided, Training/Education Requirements (pg. 8).*

2. Prescriber/Dispenser Civil and Criminal Immunity

Sample Language: *A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.*

This provision provides prescribers assurance of professional, civil, and criminal immunity even if the naloxone prescribed is ultimately used by or for someone else. Because third-party prescription is relatively uncommon, doctors and other health care professionals will likely want to make sure they are protected if they issue a prescription for naloxone to a third-party, even if doing so does not actually pose any special liability risks. While this provision does not provide a *blanket* immunity for health care professionals, it does ensure that prescribers who are acting reasonably will not be punished by their licensing boards, charged with a drug crime, or lose a malpractice civil lawsuit simply because third-party naloxone prescription is an emerging practice.

3. Possession of Naloxone Lawful

Sample Language: Notwithstanding any other law or regulation, any person may lawfully possess an opioid antagonist.

As written, this provision does not tie lawful possession of naloxone to a prescription and/or authorized distribution program. This is ideal. It is important to encourage people who use drugs and their friends and family to share the information and tools they receive with respect to reversing overdose. If a friend gives a person at risk their naloxone kit, for example, that person should still be protected under the law even if they did not receive a prescription for the kit themselves.

4. Civil and Criminal Immunity for Administration of Naloxone

Sample Language: A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioid-related drug overdose shall be immune from criminal prosecution, sanction under any professional licensing statute, and civil liability, for acts or omissions resulting from such act.

This provision ensures that *anyone* (whether specifically authorized to administer naloxone or not) who administers naloxone will be immune from professional, civil, and criminal liability. To our knowledge no person administering naloxone has ever been criminally charged or civilly prosecuted for that act, but this provision may provide peace of mind, particularly in the organizational context.

THE FOLLOWING PROVISIONS ARE HIGHLY DESIRABLE, STRENGTHEN THE EFFECTIVENESS OF THE LAW, AND SHOULD BE INCLUDED IF POLITICALLY FEASIBLE:

1. Permitting EMT-B and EMT-Is to Administer Naloxone

Sample Language: By January 1, 20XX, every Emergency Medical Technician licensed and registered in [the state] shall be authorized and permitted to administer an opioid antagonist as clinically indicated.

In most states, non-Paramedic EMTs are not permitted to administer naloxone. While in many states this can be changed at the regulatory or sub-regulatory levels (particularly if naloxone is available in the intranasal formulation) it is advisable for the statute to mandate this change.

2. Lay Distribution of Naloxone Via Standing Orders

Sample Language: Notwithstanding any other law or regulation, a person or organization acting under a standing order issued by a health care professional who is otherwise authorized to prescribe an opioid antagonist may store an opioid antagonist without being subject to provisions of [the state pharmacy act] except [those provisions regarding storage of drugs], and may dispense an opioid antagonist so long as such activities are undertaken without charge or compensation.

We believe this is the best method by which to distribute naloxone to as many people as possible, particularly those that do not have access to a primary physician or lack medical insurance.

The Overdose Education and Nasal Naloxone Distribution (OEND) programs in Massachusetts provide one example of the standing order model. A recent study of OEND effectiveness concluded that "opioid overdose death rates were reduced in communities where OEND was implemented" compared to communities without OEND implementation. OEND programs trained 2,912 potential bystanders who reported 327 rescues. This study provides observational evidence that by training potential bystanders to prevent, recognize, and respond to opioid overdoses, OEND (though the standing order model) is an effective intervention. *See* Alexander Walley et al., *Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis*, 346 BMJ 1-12 (2013).

3. State Insurance Coverage for Naloxone

Sample Language: *[The single state agency] is directed to ensure that naloxone hydrochloride for outpatient use is covered by the Medicaid prescription drug program on the same basis as other covered drugs.*

This is state specific. Advocates should work with the state Medicaid agency or an attorney familiar with state Medicaid drug law (see contact information below) to determine how best to legislatively provide Medicaid coverage for outpatient naloxone. Not all states have formularies or preferred drug lists, but in those states that do, simply adding naloxone to that list may be sufficient.

4. Funding for Overdose Prevention and Naloxone Distribution

Sample Language: *The [appropriate state agency] shall make grants from funds appropriated pursuant to this section for any of the following purposes:*

> *(a) Drug overdose prevention, recognition, and response, including naloxone administration, education projects;*
>
> *(b) Drug overdose prevention, recognition, and response, including naloxone administration, training for patients receiving opioids and their families and caregivers;*
>
> *(c) Naloxone hydrochloride prescription or distribution projects; or*
>
> *(d) Education and training projects on drug overdose response and treatment, including naloxone administration, for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.*

There is hereby appropriated from the [specify fund – likely General Fund], in the 20XX-XX fiscal year, ($X00,000) for the purpose of funding the grants provided in this section.

Additional funds necessary for the implementation of this section in the 20XX-XX fiscal year and in later fiscal years may be included in the budget appropriation for the [appropriate state agency].

This provision is likely a long shot as appropriating funds necessarily makes legislation more difficult to pass. However, it is certainly worth attempting for funding and removing it if it becomes politically necessary to do so for the bill's passage. Another strategy would be to separate this provision from those that do not require appropriations and submit it as a separate and distinct bill. Given current state budgets, provisions with appropriations have great potential to kill the entire bill.

5. Statewide Surveillance

Sample Language: *The [appropriate state agency] shall ascertain, document, and publish an annual report on the number, trends, patterns, and risk factors related to unintentional drug overdose fatalities occurring within the state each year. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.*

A key obstacle to addressing the opioid overdose epidemic is the paucity of state-wide data on the number, risk factors, and circumstances surrounding opioid overdose fatalities. Surveillance may have associated costs, and, to that extent, may be better off in a separate bill if appropriations are attached to it. Again, appropriations make the bill exponentially more difficult to pass.

6. Collaborative Practice Agreements/Pharmacy Dispensing

Sample Language: *None – State Specific.*

State pharmacy provisions generally contain either a collaborative practice agreement provision or state-approved protocols that allow pharmacists to provide certain drugs without a prescription. Collaborative practice agreements permit prescribers to authorize pharmacists to engage in specified activities, including adjusting or initiating drug therapy. In states with state-approved protocols, collaborative practice agreements or similar agreements between physicians and pharmacists are allowed, but modification of existing statutes or regulations may be required to allow pharmacists to dispense prescription drugs without a prescription. It may also be the case that additional legislation is not required in order to implement collaborative practice agreements between physicians and pharmacies for the provision of naloxone. Authorizing legislation may be required, however, in certain states. For example, California specifically authorized collaborative practice agreements for emergency contraceptive pills (*see* California Business and Professions Code sections 4052(8) and 4052.3) and similar legislation would be required for naloxone. For legislative drafting assistance with respect to this provision, please see contacts for "Legal/Legislative Drafting" on pg. 17 below.

THE FOLLOWING PROVISIONS ARE OFTEN SUGGESTED BUT CAN BE DETRIMENTAL TO AN EFFECTIVE LAW:

1. Training and Education Requirements

   Mandatory training and education is an unnecessary barrier to accessing naloxone. Prescribers and dispensers are already required by general practice rules to ensure that patients understand what a particular medication does, when and how to use it, etc. Requiring naloxone-specific education stigmatizes the drug and reduces the chances that already-rushed prescribers will bother prescribing it. A lengthy training program for end users may also reduce the chance that they attempt to get naloxone. Moreover, naloxone is extremely safe and easy to use and accordingly should not require a higher training and education threshold than other prescription medications.

   If it becomes absolutely necessary for the political survival of a naloxone bill to include training and education requirements, they should be as least onerous as possible, and preferably would not use the word "training," but would rather state something like the following: "The person receiving naloxone will be instructed on the proper use of the drug and how to recognize an overdose." Using the phrase "will receive education" or something to that effect leaves it open for interpretation. "Education" could include watching a video, receiving a brochure, or simply a brief discussion with a physician or pharmacist. Ultimately, it is important to avoid state health departments or other agencies mandating stringent and onerous trainings in order to access naloxone. Alternatively, training and education requirements could be mandated through regulations. Though regulations are not easy to change, they can evolve more easily than legislation.

2. Identifying a Single "Home" for Naloxone Distribution Programs

   It is preferable to refrain from identifying a *single* "home," such as the department of health, for naloxone distribution. There should not be a single point of access to naloxone. The goal should be to make distribution possible through many types of agencies (state, NGO, city, etc.). While health departments can be fine settings for overdose programs, they often face unnecessary restrictions, impose onerous training requirements, and can be risk averse.

3. Specifying Naloxone Formulations (i.e., Intranasal)

   Naloxone legislation that specifies intranasal naloxone is unnecessarily limiting. Intranasal naloxone is a non-FDA approved (i.e. non-existent) formulation of naloxone. There is technically no such thing as "intranasal" naloxone, only higher concentration injectable naloxone used off-label intranasally. If something were to happen with the distributor of the luer-lock device or the atomizer (the products that make injectable naloxone intranasal) and either of those products become unavailable and people are unable to acquire "intranasal" naloxone, a law specifying "intranasal" naloxone would essentially be null and void despite the fact that injectable naloxone would be readily available. The higher concentration naloxone used for intranasal administration also tends to be more expensive and would also mean that the state would be supporting one company providing naloxone over another.

4. Data Collection and Reporting

   If there is a way to structure data collection and reporting requirements through existing mechanisms that do not add any additional burden, then it may be okay. However, data collection on programs providing naloxone have the potential to create additional burdens and also to create the impression that naloxone needs a special program just to track it (and devote scarce resources to do the tracking).

A SAMPLE BILL BASED ON THE PROVISIONS ABOVE IS ATTACHED AS EXHIBIT A.

RESPONDING TO CRITICISM

1. Criticism: The Availability of Naloxone Will Encourage Abuse by Drug Users Because They Will be More Likely to Take Larger Doses if They Know Naloxone is Available.

   Response: Naloxone puts opioid users into withdrawal—which is a very unpleasant experience—and takes away from the positive euphoria of opioid use. The following studies have accordingly concluded that the availability of naloxone does not encourage people to use more drugs or to use drugs in riskier ways:

   - Karen H. Seal et al., *Naloxone Distribution and Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study*, 82(2) Journal of Urban Health 303–311 (2005) (Participants trained in overdose prevention and use of naloxone increased their knowledge of heroin overdose management, while heroin use decreased).
   - Temple University of the Commonwealth System of Higher Education, Beasley School of Law, Project on Harm Reduction in the Health Care System, Memorandum, *Legal Analysis of Switching Naloxone from Prescription to Over the Counter*, July 6, 2005 (Two European studies found no serious adverse effects and observed no increase in risky behavior associated with naloxone availability).
   - Scott Burris et al., *Legal Aspects of Providing Naloxone to Heroin Users in the United States*, 12 The International Journal of Drug Policy 237-248 (2001) (One survey of heroin users found that few would use more following administration of naloxone).
   - Sarz Maxwell et al., *Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths*, 25(3) Journal of Addictive Diseases 89-96 (2006) (Participants in naloxone programs reported no interest in increasing dosage or injecting more frequently as a result of naloxone availability).
   - Nancy Worthington et al., Research, *Opiate Users' Knowledge About Overdose Prevention and Naloxone In New York City: A Focus Group Study*, 3(19) Harm Reduction Journal (2006) (Aversion to effects of naloxone administration in study participants refutes concerns of riskier drug-taking activity in opiate users).
   - Karla D. Wagner et al., *Evaluation of an Overdose Prevention and Response Training Program for Injection Drug Users in the Skid Row Area of Los Angeles, CA*, 21(3) International Journal of Drug Policy 186-193 (2010) (Overdose prevention and response training programs may be associated with improved overdose response behavior).

In addition, there may be unanticipated benefits of naloxone distribution: a recent study found that witnesses to overdose who administered naloxone were less likely to share syringes than those who did not administer naloxone.[1] This finding points to "the potential wider, positive effects or behavioral modifications that naloxone distribution may have beyond its ability to reduce overdose risk behaviors or reverse an overdose," such as potentially helping to reduce transmission of hepatitis C and HIV.[2]

2. Criticism: Drug Users and Other Lay People Are Not Medically Trained and Will Be Unable To Administer Naloxone Properly.

   Response: Research studies demonstrate that drug users can effectively recognize an overdose and respond correctly with naloxone:

   - Traci C. Green, *Distinguishing Signs of Opioid Overdose and Indication for Naloxone: An Evaluation of Six Overdose Training and Naloxone Distribution Programs in the United States*, 103 Addiction 979-989 (2008) ("[T]his study reports initial evidence of the effectiveness of overdose training and naloxone distribution programs in opioid overdose recognition and response. People trained through these programs identify opioid overdoses and indications for naloxone as well as medical experts and consistently scored higher in knowledge of overdose and naloxone indication scenarios than their untrained counterparts.").

3. Criticism: Naloxone Will Discourage People From Seeking Drug Treatment.

   Response: On the contrary, studies demonstrate that naloxone program participants may be more likely to access treatment:

   - Karen H. Seal et al., *Naloxone Distribution and Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study*, 82(2) Journal of Urban Health 303–311 (2005) (Drug treatment entry increased after participation in naloxone distribution and overdose prevention and management program).

   Naloxone is a resource that drug users want. By providing it, harm reduction programs can, at the very least, get access to drug users and build relationships with them. This may lead to other health benefits, like HIV testing and treatment, counseling, and drug treatment.

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[1] Phillip Coffin et al., *Drug Overdose, Lay Naloxone and HIV Risk Behaviours Among Persons Who Inject Drugs*, Presented at AIDS Conference 2012, Washington, D.C., *available at* http://pag.aids2012.org/Abstracts.aspx?AID=7909. (last accessed March 10, 2013).

[2] *Opioid Overdose Prevention Training and Community-Based Naloxone Distribution in Ontario*, Ontario Health Promotion E-Bulletin 787, Vol. 2013, No. 787, Feb. 22, 2013, *available at* http://www.ohpe.ca/node/14023 (last accessed March 10, 2013).

4. Criticism: Side Effects From Naloxone Can Be a Threat to the Health and Safety of the Overdose Victim if They Are Not Thereafter Treated by Medical Professionals.

   Response: Advocates should point to the following empirical studies which indicate that people who refused to be taken to the hospital after receiving naloxone generally did not experience any adverse health effects:

   - G.M. Vilke et al., *Assessment For Deaths in Out-Of-Hospital Heroin Overdose Patients Treated With Naloxone Who Refuse Transport*, 10 Academy of Emergency Medicin 893-6 (2003) (998 patients received naloxone in the field and refused further treatment, and "[w]hen compared by age, time, date, sex, location, and ethnicity, there were no cases in which a patient was treated by paramedics with naloxone within 12 hours of being found dead of an opioid overdose").
   - S.S. Rudolph et al., *Prehospital Treatment of Opioid Overdose in Copenhagen—Is It Safe to Discharge On-Scene?*, 82 Resuscitation 1414-8 (2011) ("We found 4762 cases of acute opioid overdose. In 3245 cases positive identification was obtained. Over this ten year period fourteen patients who were released on-scene after having been treated with naloxone died within 48 h, but only in 3 of these we found a rebound opioid toxicity to be the likely cause of death, corresponding to 0.13% of those 2241 released on scene who were identified.").

INSTITUTIONAL SUPPORTERS OF NALOXONE PROGRAMS AND/OR NALOXONE LEGISLATION

1. National Organizational Support for Peer-Delivered Naloxone Programs

   The following organizations support peer delivered naloxone programs, but not necessarily any particular legislation:

   - American Medical Association

     http://www.ama-assn.org/ama/pub/news/news/2012-06-19-ama-adopts-new-policies.page

   - American Society of Addiction Medicine

     http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/use-of-naloxone-for-the-prevention-of-drug-overdose-deaths

   - Office of National Drug Control Policy

     http://www.whitehouse.gov/ondcp/drugpolicyreform

   - US Conference of Mayors

     http://www.usmayors.org/resolutions/76th_conference/chhs_16.asp

- National Coalition Against Prescription Drug Abuse

  http://leginfo.ca.gov/pub/13-14/bill/asm/ab_0601-0650/ab_635_cfa_20130617_134746_sen_comm.html

- American Public Health Association

  http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1443

- United Nations Office on Drugs and Crime

  http://www.unodc.org/documents/commissions/CND-Res-2011to2019/CND-Res-2012/Resolution_55_7.pdf

- National Alliance of State and Territorial AIDS Directors

  http://www.nastad.org/Docs/014907_NASTAD%20Statement%20of%20Commitment%20Drug%20User%20Health%20August%205%202011.pdf

2. State Examples of Organizational Support for Naloxone Legislation

The following list is provided to give you some ideas of who to approach for support for naloxone legislation in your state, and includes organizational endorsers of state naloxone legislation that were recently helpful in gaining support of legislators. This is not an exhaustive list of supporters, and does not include the many harm reduction organizations, drug policy organizations, AIDS service organizations, and drug user organizations that did most of the lobbying and support, but rather, the endorsers useful in demonstrating mainstream institutional support.

California Endorsers

- California Society of Addiction Medicine
- California Attorneys for Criminal Justice
- California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
- California Opioid Maintenance Providers
- California Public Defenders Association
- Civil Justice Association of California (CJAC)
- City and County of San Francisco
- County Alcohol and Drug Program Administrators Association of California (CADPAAC)
- Medical Board of California

Oregon Endorsers

- County Health Departments
- Oregon Primary Care Association

Colorado Endorsers

- Colorado Medical Society
- Colorado Department of Public Health and Environment
- Colorado Behavioral Healthcare Council
- Colorado Psychiatric Society

North Carolina Endorsers

- North Carolina Sheriff Association
- North Carolina Medical Board
- Injury and Violence Prevention Branch of the state's Division of Public Health
- Drug Control Unit, NC DHHS, Justice Innovations Team (runs state's Prescription Drug Monitoring Program)
- Community Care of North Carolina (Medicaid authority)
- Governors Institute on Substance Abuse
- North Carolina Child Fatality Task Force

New Jersey Endorsers

- New Jersey State Nurses Association
- Lutheran Office of Governmental Ministry
- New Jersey Deputy Fire Chiefs Association
- National Council on Alcoholism and Drug Dependence—New Jersey
- National Association of Social Workers—New Jersey
- New Jersey Hospital Association
- Health Professionals and Allied Employees

New York Endorsers

- Medical Society of the State of New York
- New York Society of Addiction Medicine
- New York State Office of Alcohol and Substance Abuse Services
- New York State Department of Health
- New York City Department of Health and Mental Health
- Nassau County Office of Mental Health
- NYC Department of Homeless Services

Illinois Endorsers

- Chicago Coalition for the Homeless
- Illinois Alcoholism and Drug Dependence Association
- Illinois Public Health Association
- Illinois Nurses Association
- Roosevelt University's Illinois Consortium on Drug Policy

TIPS FOR LEGISLATIVE ADVOCACY[3]

This guide provides you with model legislation for responding to the opioid overdose crisis in your state by increasing access to naloxone. But, obviously, the proposed legislation cannot make an impact until it gets signed into law. Below are some steps for how you can effectively advocate for the model legislation to be introduced and passed in your state.

1. Get to Know Your State's Legislative Process

   Every state has its own process for creating laws, but all states follow this general path:

   First, a member of the legislature must introduce a bill. With the exception of Nebraska, all states have two legislative chambers, known in most states as the house and senate. Any member of either state body can introduce a bill. Very often, bills are introduced by both a member of the house and a member of the senate at the same time.

   Once introduced, the bill is then referred to a legislative committee for further review. Bills with multiple components typically must be considered by multiple committees. For example, drug overdose legislation is often referred to committees dealing with issues of public health, or the judiciary, or both.

   Once referred to committee, the committee chairperson will determine when and if a bill should be considered by that committee. If a committee considers the bill, it will often do so after hearing testimony from experts and members of the public. A bill that is not considered by the committee to which it is assigned is considered to "die in committee," meaning it does not move on to the next step in becoming a law.

   If the bill passes the committee, it will often be referred to another relevant committee to repeat the same process.

   Once the bill passes all relevant committees, the majority leader (e.g., speaker of the house, senate president, or senate president pro tempore) will determine whether it should be voted on by the entire legislative chamber. This is often known as being brought to the floor for a vote.

   Very often bills are amended in committee or on the floor of the legislature, meaning that their original language is changed to effectuate a compromise among the legislators and enhance its likelihood of passing.

   If the bill passes the first chamber, it typically must be reintroduced in the second legislative chamber. For example, if a bill originally was introduced in the senate and passes that chamber, it next must be introduced in the house, and vice versa.

   Once the bill is reintroduced in the second chamber, it then may be referred to committee. Some states have joint committees between both legislative chambers, so the bill only has to go

[3] Adapted from *Legal Interventions to Prevent Opioid Overdose Deaths: Guide to Model Legislation*, Prepared for the Drug Policy Alliance by Northeastern University School of Law, Class of 2015, Legal Skills in Social Context, Social Justice Program.

through one committee related to the issue. For example, Massachusetts has a Joint Committee on Mental Health and Substance Abuse, comprised of members of both the House and the Senate. Other states have separate committees for the house and senate. For example, a bill related to mental health in New York most likely would have to be considered by both the Senate's Mental Health and Developmental Disabilities Committee and the Assembly's Mental Health Committee.

The next step is for the majority leader to determine whether the bill should go up for a vote on the floor of the second legislative chamber. If so, the legislators will vote on the bill.

If the bill passes the floor, its next stop usually is the governor's desk for signing. If the governor signs the bill, it becomes law.

However, in most states, the governor has the power to veto or kill a bill even after it is passed by the legislature. Some states allow governors to veto a single section of the legislation, an action referred to as a line item veto. Often, one or both chambers of the legislature can override this veto with a two-thirds vote.

Usually if the governor does not sign the bill but does not veto it either, the bill will become law by default after a certain period of time has elapsed.

2. Gather Persuasive Information About the Opioid Overdose Crisis in Your State

A key to advocacy is being able to effectively discuss the problem you are trying to solve in a way that is meaningful and relevant to your audience. National statistics about the opioid overdose crisis may be persuasive, but nowhere near as compelling as information you can share about your own state or community. You need to convince the decision makers that this is not only a problem on a national level, but that it directly impacts a significant number of people in your state. How many people die of opioid overdose in your state each year? How does the opioid overdose death rate compare to the rates of other common causes of death in your state, such as car accidents or heart disease?

Statistics specific to your community are even more helpful. Legislators are especially concerned about issues that impact their constituents. If you can show your legislator that opioid overdose is a problem that relates directly to their district, you are more likely to convince them to support meaningful change. While statistics can be powerful, legislators may be more responsive to personal stories or testimonies (see number 6 below).

3. Identify a Potential Sponsor in the State Legislature

No legislation can be introduced without a sponsor. If you are an individual or a community-based group, your first step may be to approach the legislators who represent your district. Alternatively, you may wish to identify legislators who may already be leaders on issues related to drug reform, public health, drug treatment, and harm reduction. Visit your state legislature's website and find out the name of the legislative committee or committees that deal with healthcare or public health issues. Review the names of the legislators on that committee. If they have web pages on the legislature's site or their own web pages, visit them. Google them or look them up on your local newspaper's website. Identify which of these legislators

have championed legislation on similar issues in the past or who stressed public health or drug reform issues in their campaigns. It is also worth trying to identify legislators who have been personally affected by overdose. Finally, if no obvious legislators emerge in your search, you also may wish to identify a community in your state which you know has the highest rates of opioid overdose deaths. Contact the legislators from those communities, as this may be a major concern for their district.

4. Identify Local Supporters

   Successful legislative campaigns often have a coalition of supporters behind them. Consider what community groups, social service agencies, and advocacy organizations in your state may have a stake in getting the opioid overdose legislation passed. This may include direct service providers, mental health and medical professional groups, faith-based recovery organizations, academics at local universities, and social change and mutual aid organizations. Encourage these groups to contact their legislators.

5. Anticipate Your Opposition

   It also is critical to identify potential areas of opposition in your state. In some states, physician and nurses groups, trial and consumer attorneys, pharmacy boards, and state departments of alcohol/drugs have been resistant to similar types of legislation depending on the provisions included or not included. It is helpful to predict where you may hit roadblocks so you can have arguments prepared in advance (see "Responding to Criticism" section above).

6. Recognize the Power of Personal Testimony

   Listening to the story of a constituent who lost a child to opioid overdose or a local emergency room nurse who regularly sees patients die from opioid overdose can be exceedingly powerful for a legislator. If you know of such stories, use them.

7. Launch a Strategic Legislative Advocacy Campaign

   Effective strategic legislative advocacy campaigns are based on numerical calculations. First, find out the number of votes you need in each committee for the legislation to pass (once the legislation passes committee, you should do the same for each chamber). Usually, it is 50% of legislators (minus abstentions) plus one. Next, calculate the number of legislators on the committee whom you *know* will support the bill. Then calculate the difference between that number and the number of votes you need (or the number of votes you would like the bill to receive, if you are looking for a number greater than a majority). You may wish to add to that number, to account for possible absences at the time of the vote or changes of heart. The resulting number tells you how many legislators you will need to persuade so that the legislation passes with a majority.

   As you can see, you do not need to convince *every* legislator to vote for your bill to guarantee passage. It is best to identify those legislators who are most apt to vote for the legislation, but have not indicated how they will vote yet. These are persuadable legislators. The best way to identify whether a legislator is apt to support your bill is to look at their past votes on similar issues, particularly as they relate to substance abuse and public health issues. If the legislator

was recently elected and does not have a voting history, consider statements made during the campaign. Votes made while the new legislator served in a previously elected office (e.g. city council) may also be informative.

Target your lobbying to all or most of these persuadable legislators. Identify community supporters in persuadable legislators' districts. Bring these constituents to meet with the persuadable legislators at the State House or in their district offices. Canvas persuadable legislators' districts to obtain constituents' signatures for letter writing and postcard campaigns. Encourage constituents in these districts to call their legislators.

Keep a running tally of all of the legislators on the committee (or chamber, once the legislation passes committee) and how they have indicated they will vote: Are they supporters, persuadables, or opponents? Even after you reach your target number, continue to lobby remaining persuadable legislators, and do not forget to thank those who have committed their support prior to the vote.

TIPS FOR MEDIA ADVOCACY

Please see Exhibit B, drafted by the Drug Policy Alliance.

CONTACTS

Lindsay LaSalle, Attorney
Drug Policy Alliance
(510) 229-5211
llasalle@drugpolicy.org

Corey Davis, Staff Attorney
Network for Public Health Law
(919) 968-6308 x105
cdavis@networkforphl.org

GOOD SAMARITAN LEGISLATION

To the extent you are seeking to introduce a comprehensive overdose prevention bill with both Naloxone and Good Samaritan (i.e., providing immunity from drug arrest/charges when seeking medical assistance in the event of an overdose) provisions, or will be introducing a Good Samaritan bill separately, please contact either Lindsay LaSalle or Corey Davis (above) for Good Samaritan drafting guidance.

EXHIBIT A

DRAFT "OVERDOSE PREVENTION AND EMERGENCY RESPONSE ACT"

The [_____] hereby enacts as follows:

Section 1. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Immunity for persons who prescribe, possess, and/or administer an opioid antagonist during an opioid-related drug overdose.

(a) The following definitions apply throughout this section:

(1) "Health care professional" includes, but is not limited to, a physician, a physician assistant, or a nurse practitioner, who is authorized to prescribe an opioid antagonist.

(2) "Opioid antagonist" means any drug that binds to opioid receptors and blocks or disinhibits the effects of opioids acting on those receptors.

(3) "Opioid-related drug overdose" means a condition including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of an opioid, or another substance with which an opioid was combined, or that a layperson would reasonably believe to be an opioid-related drug overdose that requires medical assistance.

(b) Notwithstanding any other law or regulation, a health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe, dispense, and distribute an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

(c) A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.

(d) Notwithstanding any other law or regulation, any person may lawfully possess an opioid antagonist.

(e) A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioid-related drug overdose shall be immune from criminal prosecution, sanction under any professional licensing statute, and civil liability, for acts or omissions resulting from such act.

Section 2. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Authorizing administration of naloxone hydrochloride by emergency personnel.

(a) By January 1, 20XX, every Emergency Medical Technician licensed and registered in [the state] shall be authorized and permitted to administer an opioid antagonist as clinically indicated.

Section 3. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Medicaid coverage for naloxone hydrochloride.

(a) [The single state agency] is directed to ensure that naloxone hydrochloride for outpatient use is covered by the Medicaid prescription drug program on the same basis as other covered drugs..

Section 4. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Exemption from pharmacy [list requirement here (i.e., permit, license, etc.)] for prescription order for naloxone hydrochloride.

(a) Notwithstanding any other law or regulation, a person or organization acting under a standing order issued by a health care professional who is otherwise authorized to prescribe an opioid antagonist may store an opioid antagonist without being subject to provisions of [the state pharmacy act] except [those provisions regarding storage of drugs], and may dispense an opioid antagonist so long as such activities are undertaken without charge or compensation.

Section 5. The [_____ Code/Act] is amended by adding a section to read:

Section [_____]. Report on unintentional drug overdose.

(a) The [appropriate state agency] shall ascertain, document, and publish an annual report on the number, trends, patterns, and risk factors related to unintentional drug overdose fatalities occurring within the state each year. The report shall also provide information on interventions that would be effective in reducing the rate of fatal or nonfatal drug overdose.

Section [_____]. Grants for drug overdose projects including naloxone hydrochloride.

The [appropriate state agency] shall make grants from funds appropriated pursuant to this section for any of the following purposes:

(a) Drug overdose prevention, recognition, and response, including naloxone administration, education projects;

(b) Drug overdose prevention, recognition, and response, including naloxone administration, training for patients receiving opioids and their families and caregivers;

(c) Naloxone hydrochloride prescription or distribution projects; or

(d) Education and training projects on drug overdose response and treatment, including naloxone administration, for emergency services and law enforcement personnel, including, but not limited to, volunteer fire and emergency services.

There is hereby appropriated from the [specify fund – likely General Fund], in the 20XX-XX fiscal year, ($X00,000) for the purpose of funding the grants provided in this section. Additional funds necessary for the implementation of this section in the 20XX-XX fiscal year and in later fiscal years may be included in the budget appropriation for the [appropriate state agency].

EXHIBIT B

Tip Sheet:
10 Steps to Getting Press

We are the Drug Policy Alliance.

1. **Identify what's "newsworthy."** There is a big difference between an issue and a news story. We can assist the media in covering issues that are important to us by letting them know when a related "story" emerges. What makes something newsworthy? Controversy, anniversaries, civil disobedience, human interest, strange bedfellows, superlatives (first, biggest, etc.) If a topic isn't newsworthy – no matter how important – they probably won't cover it.

2. **Develop written materials**. The first thing a reporter is likely to ask when you call them to pitch a story is: "Do you have anything in writing?" Help make their job as easy as possible by developing brief, easy-to-read materials. Especially important is a 1-2 page media advisory or press release with details of an event or news story. The style and content should resemble a simple newspaper story, with strong headlines, facts and quotes. Other background materials can be helpful, including fact sheets, spokespeople bios or report summaries.

3. **Develop a targeted media list**. It is important to think about which reporters will be interested in your story. Are they reporters who cover health? Politics? Entertainment? Is it a local or a national story? Is it a story that's good for newspaper, radio and/or television? From there, develop a list of reporters' names and numbers to call.

4. **Keep an eye on your email**. To quickly send your materials to a reporter, it's important to keep an eye on your email when making pitch calls. If a reporter wants to see something right away, it won't help to send them something several hours later.

5. **Identify strategic spokespeople.** The messenger is often just as important as the message when it comes to the media. It is also crucial that spokespeople are articulate and knowledgeable on the issue, and easily reach-able by reporters on deadline. (Not having a cell phone can sometimes mean not being included in a story!!) Remember – reporters are not your friends. Be careful and strategic when doing interviews.

6. **Practice your telephone pitch**. Reporters get hundreds of calls a day. What's likely to make a reporter not hang up on you, or immediately delete your message, is if you develop a well focused, 30-second pitch that highlights the essence of your news story. Once you hook them, you can describe in more detail why you are calling and how you can get them more information. Practice leaving messages on your own voicemail. Don't forget to leave your phone number if you leave a message.

7. **Never lie or exaggerate.** It is important that reporters feel they can trust the information you give them. If they find out you are lying or exaggerating, it will greatly hurt your chances of being able to pitch them a story again.

8. **Don't take no for an answer.** Pitching is not dating. If a reporter says no, try another reporter, or call them again when you have a different story. If you get one out of ten reporters to write about your story, that is a huge success!

9. **Use the media to get more media.** If a good article comes out on your issue, send it to other reporters who might also be interested. Oftentimes newspapers will be more interested in op-ed pieces if the topic has been in the recent news. Articles and op-eds can also lead to radio interviews, and local stories can lead to national stories, if they're seen by the right editors/producers.

10. **Say thank you**. Developing friendly relationships with reporters is helpful when trying to pitch news stories. They appreciate thanks, and will be more likely to return your phone call the next time around.

Duchek, Michael

From: Malcore, Jennifer
Sent: Friday, September 27, 2013 4:07 PM
To: Duchek, Michael
Subject: FW: AODA/HIV prevention programs at ARCW and Narcan/Naloxone distribution mechanism for ARCW staff

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Bill Keeton [mailto:Bill.Keeton@arcw.org]
Sent: Friday, September 20, 2013 12:50 PM
To: Malcore, Jennifer
Cc: Ramie Zelenkova; Ignatowski, Alex - DHS
Subject: Re: AODA/HIV prevention programs at ARCW and Narcan/Naloxone distribution mechanism for ARCW staff

Hello Jennifer -

As a follow-up to your email from earlier this week, I have continued to look for model legislation or language that could help in the drafting process. In the interest of getting the bill passed without undue attention or concern - especially given that our needle exchange and HIV prevention activities could draw attention away from the the issue the legislation will address - I am attaching a document produced by a harm-reduction based organization regarding naloxone availability, distribution, possession and prescribing practices.

The incorporation of the below suggested language, which comes from the attached document, may help reduce apprehension or concern related to our needle exchange activities. Its inclusion also would help protect both ARCW staff who operate the training and distribution programs, as well as the individuals who we train.

I offer them as a suggestion and would be happy to discuss at your convenience.

Thanks,
Bill

Third-Party Prescription/Standing Order Distribution Sample Language:
Notwithstanding any other law or regulation, a health care professional otherwise authorized to prescribe an opioid antagonist may, directly or by standing order, prescribe, dispense, and distribute an opioid antagonist to a person at risk of experiencing an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. Any such prescription shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

Prescriber/Dispenser Civil and Criminal Immunity Sample Language:
A health care professional who, acting in good faith and with reasonable care, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action for (1) such prescribing or dispensing; and (2) any outcomes resulting from the eventual administration of the opioid antagonist.

Possession of Naloxone Lawful Sample Language:
Notwithstanding any other law or regulation, any person may lawfully possess an opioid antagonist.

Civil and Criminal Immunity for Administration of Naloxone Sample Language:
A person who, acting in good faith and with reasonable care, administers an opioid antagonist to another person whom the person believes to be suffering an opioidrelated drug overdose shall be immune from criminal prosecution, sanction under any professional licensing statute, and civil liability, for acts or omissions resulting from such act.

Lay Distribution of Naloxone Via Standing Orders Sample Language:
Notwithstanding any other law or regulation, a person or organization acting under a standing order issued by a health care professional who is otherwise authorized to prescribe an opioid antagonist may store an opioid antagonist without being subject to provisions of [the state pharmacy act] except [those provisions regarding storage of drugs], and may dispense an opioid antagonist so long as such activities are undertaken without charge or compensation.

Bill Keeton
Vice President for Government and Public Relations
ARCW.org
414-225-1572 (o)
414-313-2036 (c)

On Sep 17, 2013, at 4:28 PM, "Malcore, Jennifer" <Jennifer.Malcore@legis.wisconsin.gov> wrote:

> Bill,
>
> Thank you for the response. I will be sure to go over the material with DHS and the Representative and get back to you with any questions.
>
> Have a good night.
>
> ***Jennifer Malcore***
> Office of State Representative John Nygren
> Co-Chair , Joint Committee on Finance
> 89th Assembly District
> 309 East, State Capitol
> 608.266.2344
>
> ---
>
> **From:** Bill Keeton [mailto:Bill.Keeton@arcw.org]
> **Sent:** Tuesday, September 17, 2013 4:24 PM
> **To:** Malcore, Jennifer
> **Cc:** Ramie Zelenkova; Ignatowski, Alex - DHS; 'jbauknecht@hwz-gov.com'
> **Subject:** AODA/HIV prevention programs at ARCW and Narcan/Naloxone distribution mechanism for ARCW staff
>
> Hello Jennifer –
>
> My apologies for not getting this information to you sooner, and for this being a relatively long email.
>
> Below are answers to questions you and Representative Nygren raised during our conversation last week. If you have any additional questions or would like more clarification or detail, please don't hesitate to contact me.

Q. How many slots do we have for our harm reduction AODA treatment program at any given time?

A. Our day treatment and intensive outpatient groups typically have between 8-10 individuals enrolled in them. Additionally, we have an estimated 20 individual counseling sessions open weekly. Treatment is available for alcohol and other substance abuse issues, including for individuals confronting heroin/opiate addiction.

Q. What is the total number of people we have had go through our AODA program?

A. Between 2002-2012, ARCW has served 564 individuals through our AODA treatment program in Milwaukee. In Green Bay (where the program started one year and two months ago) we have served 106 individuals. So far in 2013, 171 individuals have been served through our AODA program (combined in Green Bay and Milwaukee).

Q. What is the success rate for our AODA program?

A. To date in 2013, we have a 39% success rate (as defined by the State of Wisconsin). ARCW works with the State of Wisconsin through what is called the STAR-SI Program. We were chosen to participate in this select group of AODA treatment providers who engage annually in various initiatives to rigorously enhance the quality of programming.

According to research, success rates for AODA treatment programs across the United States are low, with averages between 0-40% and most programs falling in the very low portion of this range.

Q. How many referrals to AODA treatment does our Lifepoint clean syringe exchange and opiate overdose prevention program make on an annual basis?

A. Approximately 225 referrals to treatment services, including to the ARCW AODA program, annually. Annually, our Lifepoint program reaches approximately 17,000 injection drug users.

Q. What is the total number of people we have trained on narcan/Naloxone?

A. ARCW has trained 2,491 people in how to safely administer narcan/naloxone since starting our opiate overdose prevention program in 2008.

Q. What is the total number of reported peer reversals in the history of the program?

A. 2,134 individuals trained by ARCW have returned to ARCW to report a peer reversal since 2008.

You had also asked for a legislative mechanism to carve-in our HIV/opiate overdose prevention staff with the paramedics and police for the possession and use of narcan/naloxone.

This can be accomplished by utilizing the already existing definition of an AIDS service organization in chapter 252 of the Statutes by stating that the individual possessing narcan must be either an employee of a state designated ASO or be an individual trained by such. You could make this pool even smaller by saying that the ASO hosting/training individuals in the use of narcan must receive funding from the state

from the appropriation account 20.435 (1) (md) to do HIV prevention work. We would also be willing to have our staff go through training by DHS should that be an option Representative Nygren or the legislature would want to include.

By way of background, here is the language I am referencing from Ch. 252:

252.12 HIV and related infections, including hepatitis C virus infections; services and prevention.

252.12(1) (1) Definitions. In this section:

- 252.12(1)(b) (b) "AIDS service organizations" means nonprofit corporations or public agencies that provide, or arrange for the provision of, comprehensive services to prevent HIV infection and comprehensive health and social services for persons who have HIV infection, and that are designated as such by the department under sub. (4).
- 252.12(1)(c) (c) "Nonprofit corporation" means a nonstock corporation organized under ch. 181 that is a nonprofit corporation, as defined in s. 181.0103 (17).
- 252.12(1)(d) (d) "Organization" means a nonprofit corporation or a public agency which proposes to provide services to individuals with acquired immunodeficiency syndrome.
- 252.12(1)(e) (e) "Public agency" means a county, city, village, town or school district or an agency of this state or of a county, city, village, town or school district.

Bill Keeton
Vice President of Government and Public Relations
AIDS Resource Center of Wisconsin
414.225.1572 (o)
414.313.2036 (c)
<image001.jpg>

Duchek, Michael

From: Malcore, Jennifer
Sent: Friday, September 27, 2013 4:07 PM
To: Duchek, Michael
Subject: RE: Naloxone

Mike,

I understand what you are saying with the police and fire, they would need a prescription. With adding them, I was under the assumption that each department would have to find a Dr that would prescribe them the naloxone. I am eager to hear what you find on that.

OK, the Aids resource center, my understanding is that they want their resource staff that is trained in administering narcan/naloxone to be on the list of those that by statute can give out naloxone with clean needles and administer naloxone without fear of being arrested for giving out a controlled substance. There is a Dr. at the UW that gives our prescriptions for naloxone to the Aids resource center. Does that help? I am also going to send you some more information from them.

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Duchek, Michael
Sent: Friday, September 27, 2013 3:59 PM
To: Malcore, Jennifer
Subject: Naloxone

Jennifer,

I've done a bit of educating myself on this topic and after some back and forth I got in touch with Eric (we emailed back and forth a bit) and the EMS people at DHS and will see if they weigh in for how best to allow basic EMTs to administer Narcan. I also asked about police and firefighters. It's my understanding that a prescription or order is required for naloxone because it's a prescription drug, so I don't think police can simply get it even if we add language to somehow authorize it so a bit more may be needed. I will see if they have any response on that.

As far as the AIDS resource center – can you clarify again what you want to do for them? I understand how to identify them in the statutes, but is it something they can't do that you want them to be able to do or is more about immunity for them for administering naloxone?

Anyway, I think I will try to get in touch with you early next week, hopefully after I hear back from some of them further at DHS.

-Mike

Duchek, Michael

From: Wendorff, Eric J - DHS <Eric.Wendorff@dhs.wisconsin.gov>
Sent: Friday, September 27, 2013 2:45 PM
To: Duchek, Michael; Oppor, Louis L - DHS
Cc: Ignatowski, Alex - DHS; McKeown, Karen D - DHS; Litza, Brian D - DHS; Charles Cady MD (cecady@mcw.edu)
Subject: RE: Nalaxone legislation

Mike,

I don't have any specific language. You will want to provide that this is an exception to the requirement of§ 256.15 (6n). I think you should consult with Brian Litza and Dr. Cady for any concerns they may have about the need for training and potential logistical problems with implementation. I would appreciate the opportunity to review your draft with the EMS program.

Thanks.

Eric

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: Friday, September 27, 2013 1:19 PM
To: Wendorff, Eric J - DHS; Oppor, Louis L - DHS
Cc: Ignatowski, Alex - DHS; McKeown, Karen D - DHS
Subject: RE: Nalaxone legislation

Eric,

Rep. Nygren is seeking to draft legislation that would allow EMT basics to administer Narcan as well. Basically I think the idea would be to override the scope of practice and allow EMT basics to do it even if not in an approved pilot program. Jennifer Malcore in his office suggested you might have some suggested language in order to do this, so while I could try to come up with something myself, I thought I would start with you.

They'd also like to give police officers and firefighters the same authority.

-Mike

From: Wendorff, Eric J - DHS [mailto:Eric.Wendorff@dhs.wisconsin.gov]
Sent: Friday, September 27, 2013 1:14 PM
To: Oppor, Louis L - DHS
Cc: Duchek, Michael; Ignatowski, Alex - DHS; McKeown, Karen D - DHS
Subject: RE: Nalaxone legislation

I don't know. The EMS medical director, Dr. Charles Cady, or the EMS unit supervisor, Brian Litza, would be the persons to ask.

From: Oppor, Louis L - DHS
Sent: Friday, September 27, 2013 1:12 PM
To: Wendorff, Eric J - DHS
Cc: Duchek, Michael - LEGIS; Ignatowski, Alex - DHS; McKeown, Karen D - DHS
Subject: Re: Nalaxone legislation

I am wondering if it makes a difference if it injection or nasal spray?

Lou Oppor
Div of Mental Health and Substance
608 266 9485

Sent from my iPhone

On Sep 27, 2013, at 12:00 PM, "Wendorff, Eric J - DHS" <Eric.Wendorff@dhs.wisconsin.gov> wrote:

> Mike,
>
> Scopes of practice authorize what different levels of EMTs may do. The scopes are available on the DHS-EMS web site. Administration of Narcan is within the scope of practice for the EMT Intermediate Technician, EMT Intermediate, and paramedic levels. EMT basics may administer Narcan **if but only if** they have an approved pilot program.
>
> Here's a link to the scopes of practice.
>
> http://www.dhs.wisconsin.gov/ems/License_certification/scope_of_practice.htm
>
> ---
>
> **From:** Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
> **Sent:** Friday, September 27, 2013 11:09 AM
> **To:** Ignatowski, Alex - DHS; Oppor, Louis L - DHS
> **Cc:** Wendorff, Eric J - DHS; McKeown, Karen D - DHS
> **Subject:** RE: Nalaxone legislation
>
> Thanks Alex, Lou just called me and suggested they may be the right people. And Jennifer mentioned an Eric, so maybe that is who I should have been talking to.
>
> ---
>
> **From:** Ignatowski, Alex - DHS [mailto:Alex.Ignatowski@dhs.wisconsin.gov]
> **Sent:** Friday, September 27, 2013 11:03 AM
> **To:** Duchek, Michael; Oppor, Louis L - DHS
> **Cc:** Wendorff, Eric J - DHS; McKeown, Karen D - DHS
> **Subject:** RE: Nalaxone legislation
>
> Hi Mike – I thought it would be helpful to bring a few more people into the loop right away. I didn't realize that Naloxone was the same as Narcan. I have cc'd Eric Wendorff (Legal Council) and Karen McKeown (Public Health Administrator).
>
> Thanks!
>
> ---
>
> **Alex Ignatowski**
> Legislative Advisor
> Department of Health Services
> Office: 608-266-3262
> Mobile: 608-301-6149
> alex.ignatowski@wisconsin.gov

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: Friday, September 27, 2013 10:53 AM
To: Oppor, Louis L - DHS
Cc: Ignatowski, Alex - DHS
Subject: RE: Nalaxone legislation

Lou,

Jennifer in Rep. Nygren's office would like to, as I understand it, allow all EMTs to be able to administer naloxone. It's my understanding that this is currently prohibited by way of the Scopes of Practice, which is not in the statutes or rules, but do determine what EMTs can/cannot do. So I'm assuming the idea would be to override this Scope of Practice. Jennifer suggested you or someone at DHS would have suggested language.

I'm also hoping you can help me understand a little bit more about naloxone. I understand it's not a controlled substance (961.16 (2) (a)) but that a prescription may otherwise be required to get it. Is that correct? If so, can you explain to me how EMTs currently obtain naloxone without a prescription? Jennifer would also like police and fire to be able to administer it similarly. Feel free to call.

Mike Duchek
Legislative Attorney
Wisconsin Legislative Reference Bureau
(608) 266-0130

From: Ignatowski, Alex - DHS [mailto:Alex.Ignatowski@dhs.wisconsin.gov]
Sent: Friday, September 27, 2013 10:39 AM
To: Duchek, Michael
Cc: Oppor, Louis L - DHS
Subject: RE: Nalaxone legislation

Hi Mike,

Lou is the best contact in the Department and he will be able to bring in anyone else that may be able to help as well. He is cc'd on this email. Please keep me in the loop. Let me know if you need anything else.

Thanks,

Alex

Alex Ignatowski
Legislative Advisor
Department of Health Services
Office: 608-266-3262
Mobile: 608-301-6149
alex.ignatowski@wisconsin.gov

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: Friday, September 27, 2013 10:21 AM
To: Ignatowski, Alex - DHS
Subject: Nalaxone legislation

Alex,

I've been asked to get in touch with someone at DHS regarding naloxone legislation. Jennifer in Nygren's office said you'd know who I should contact. Let me know.

Mike Duchek
Legislative Attorney
Wisconsin Legislative Reference Bureau
(608) 266-0130

Duchek, Michael

From: Malcore, Jennifer
Sent: Friday, September 27, 2013 10:38 AM
To: Duchek, Michael
Subject: FW: AODA/HIV prevention programs at ARCW and Narcan/Naloxone distribution mechanism for ARCW staff

Here you go!!

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Bill Keeton [mailto:Bill.Keeton@arcw.org]
Sent: Tuesday, September 17, 2013 4:24 PM
To: Malcore, Jennifer
Cc: Ramie Zelenkova; Ignatowski, Alex - DHS; 'jbauknecht@hwz-gov.com'
Subject: AODA/HIV prevention programs at ARCW and Narcan/Naloxone distribution mechanism for ARCW staff

Hello Jennifer –

My apologies for not getting this information to you sooner, and for this being a relatively long email.

Below are answers to questions you and Representative Nygren raised during our conversation last week. If you have any additional questions or would like more clarification or detail, please don't hesitate to contact me.

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A. Our day treatment and intensive outpatient groups typically have between 8-10 individuals enrolled in them. Additionally, we have an estimated 20 individual counseling sessions open weekly. Treatment is available for alcohol and other substance abuse issues, including for individuals confronting heroin/opiate addiction.

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A. Approximately 225 referrals to treatment services, including to the ARCW AODA program, annually. Annually, our Lifepoint program reaches approximately 17,000 injection drug users.

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You had also asked for a legislative mechanism to carve-in our HIV/opiate overdose prevention staff with the paramedics and police for the possession and use of narcan/naloxone.

This can be accomplished by utilizing the already existing definition of an AIDS service organization in chapter 252 of the Statutes by stating that the individual possessing narcan must be either an employee of a state designated ASO or be an individual trained by such. You could make this pool even smaller by saying that the ASO hosting/training individuals in the use of narcan must receive funding from the state from the appropriation account 20.435 (1) (md) to do HIV prevention work. We would also be willing to have our staff go through training by DHS should that be an option Representative Nygren or the legislature would want to include.

By way of background, here is the language I am referencing from Ch. 252:

252.12 HIV and related infections, including hepatitis C virus infections; services and prevention.

252.12(1) (1) Definitions. In this section:

- 252.12(1)(b) (b) "AIDS service organizations" means nonprofit corporations or public agencies that provide, or arrange for the provision of, comprehensive services to prevent HIV infection and comprehensive health and social services for persons who have HIV infection, and that are designated as such by the department under sub. (4).
- 252.12(1)(c) (c) "Nonprofit corporation" means a nonstock corporation organized under ch. 181 that is a nonprofit corporation, as defined in s. 181.0103 (17).
- 252.12(1)(d) (d) "Organization" means a nonprofit corporation or a public agency which proposes to provide services to individuals with acquired immunodeficiency syndrome.
- 252.12(1)(e) (e) "Public agency" means a county, city, village, town or school district or an agency of this state or of a county, city, village, town or school district.

Bill Keeton
Vice President of Government and Public Relations
AIDS Resource Center of Wisconsin
414.225.1572 (o)
414.313.2036 (c)


ARCW
AIDS Resource Center of Wisconsin
Excellence in HIV Health Care

Duchek, Michael

From: Dodge, Tamara
Sent: Friday, September 27, 2013 8:23 AM
To: Duchek, Michael
Subject: RE: EMTs

Go right ahead. I think in some departments the firefighters are also EMTs so the issue may be police.

Tamara J. Dodge
Attorney
Wisconsin Legislative Reference Bureau
P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Duchek, Michael
Sent: Friday, September 27, 2013 8:07 AM
To: Dodge, Tamara
Subject: FW: EMTs

I will take this if you have no objection as I discussed this with her last month (chapter 256). Apparently last October a pilot program was begun to allow EMT basics to administer narcan/naloxone, but I am not sure what the results have been and what the status of it is. I'm a little unsure about having police/firefighters administering drugs. That's something else I'll have to look into. I'll try to look into it more and call her today.

From: Malcore, Jennifer
Sent: Thursday, September 26, 2013 5:01 PM
To: Duchek, Michael
Subject: RE: EMTs

Mike,

I would like to put in drafting a bill that authorizes all EMT's including basic to administer Nalaxone (narcan), in the language I would also like to include police and fire but make it so they have the choice, we don't want to mandate it.

Please call me tomorrow to talk this over.

Thank you,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Duchek, Michael
Sent: Thursday, August 15, 2013 10:13 AM
To: Malcore, Jennifer
Subject: EMTs

Jenny,

What I found is that this seems like it's likely controlled by chapter DHS 110 of the Administrative Code (see specifically s. DHS 110.12 and see the note that follows it and http://www.dhs.wisconsin.gov/ems/License_certification/scope_of_practice.htm).

In the statutes, the authority originates with s. 256.15, but as I said, the details about which drugs can be prescribed appear to be found in those scopes of practice on the web site.

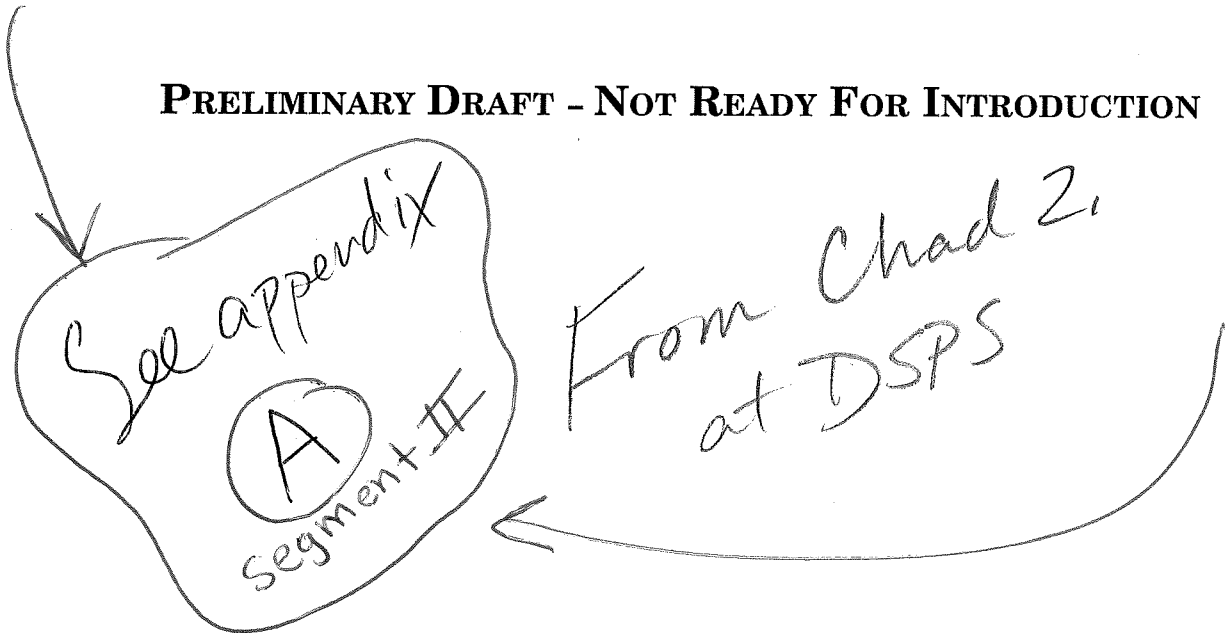
See if this helps answer your questions. Someone at DHS might be able to tell you more about the process for establishing those scopes of practice and what drugs are put on it, etc.

Mike Duchek
Legislative Attorney
Wisconsin Legislative Reference Bureau
(608) 266-0130

State of Wisconsin
2013 – 2014 LEGISLATURE

LRB–3360/P2
MED:wlj:jm

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION



AN ACT ***to renumber and amend*** 441.07 (1) (d) and 448.015 (4) (bm); ***to amend*** 450.10 (1) (a) (intro.), 450.11 (1), 450.11 (3), 450.11 (4) (a) 5. a., 450.11 (7) (h) and 895.48 (1); and ***to create*** 441.07 (1) (d) 2., 441.18, 448.015 (4) (bm) 2., 448.037, 450.01 (1) (d), 450.11 (1i) and 450.11 (4) (a) 5. c. of the statutes; **relating to:** prescription, possession, dispensing, delivery, and administration of the drug naloxone and immunity for certain individuals who prescribe, dispense, deliver, or administer naloxone.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 441.07 (1) (d) of the statutes is renumbered 441.07 (1) (d) (intro.) and amended to read:

441.07 **(1)** (d) (intro.) Misconduct or unprofessional conduct. In this paragraph, "misconduct" and "unprofessional conduct" do not include ~~providing~~ any of the following:

1. Providing expedited partner therapy as described in s. 448.035.

SECTION 2. 441.07 (1) (d) 2. of the statutes is created to read:

441.07 **(1)** (d) 2. Prescribing, delivering, or dispensing the drug naloxone in accordance with s. 441.18 (2).

SECTION 3. 441.18 of the statutes is created to read:

441.18 Prescription for and delivery of naloxone. (1) In this section:

(a) "Administer" has the meaning given in s. 450.01 (1) (d).

(b) "Deliver" has the meaning given in s. 450.01 (5).

(c) "Dispense" has the meaning given in s. 450.01 (7).

(d) "Opioid–related drug overdose" has the meaning given in s. 448.037 (1) (d).

(2) (a) An advanced practice nurse certified to issue prescription orders under s. 441.16 may, directly or by the use of a standing order, prescribe the drug naloxone to a person in a position to assist an individual at risk of experiencing an opioid–related drug overdose and may deliver or dispense the drug to that person. A prescription order under this paragraph need not specify the name and address of the individual to whom the naloxone will be administered, but shall instead specify the name of the person to whom the drug will be delivered or dispensed.

(b) An advanced practice nurse who prescribes, delivers, or dispenses the drug naloxone under par. (a) shall ensure that the person to whom the drug will be delivered or dispensed has the knowledge and training necessary to safely administer the drug to an individual experiencing an opioid–related overdose and

that the person will ensure that any individual to whom the person further delivers or dispenses the drug has or receives that knowledge and training.

(3) An advanced practice nurse who, acting in good faith, prescribes, delivers, or dispenses the drug naloxone in accordance with sub. (2) may not be subject to any criminal or civil liability and may not be subject to professional discipline under s. 441.07 for any outcomes resulting from prescribing, delivering, or dispensing that drug.

SECTION 4. 448.015 (4) (bm) of the statutes is renumbered 448.015 (4) (bm) (intro.) and amended to read:

448.015 **(4)** (bm) (intro.) "Unprofessional conduct" does not include ~~providing~~ any of the following:

1. Providing expedited partner therapy as described in s. 448.035.

SECTION 5. 448.015 (4) (bm) 2. of the statutes is created to read:

448.015 **(4)** (bm) 2. Prescribing, delivering, or dispensing the drug naloxone in accordance with s. 448.037 (2).

SECTION 6. 448.037 of the statutes is created to read:

448.037 Prescription for and delivery of naloxone. (1) In this section:

(a) "Administer" has the meaning given in s. 450.01 (1) (d).

(b) "Deliver" has the meaning given in s. 450.01 (5).

(c) "Dispense" has the meaning given in s. 450.01 (7).

(d) "Opioid–related drug overdose" means a condition including extreme physical illness, decreased level of consciousness, respiratory depression, coma, or the ceasing of respiratory or circulatory function resulting from the consumption or use of an opioid, or another substance with which an opioid was combined.

(2) (a) A physician or physician assistant may, directly or by the use of a standing order, prescribe the drug naloxone to a person in a position to assist an individual at risk of experiencing an opioid–related drug overdose and may deliver or dispense the drug to that person. A prescription order under this paragraph need not specify the name and address of the individual to whom the naloxone will be administered, but shall instead specify the name of the person to whom the drug will be delivered or dispensed.

(b) A physician or physician assistant who prescribes, delivers, or dispenses the drug naloxone under par. (a) shall ensure that the person to whom the drug will be delivered or dispensed has the knowledge and training necessary to safely administer the drug to an individual experiencing an opioid–related overdose and that the person will ensure that any individual to whom the person further delivers or dispenses the drug has or receives that knowledge and training.

(3) A physician or physician assistant who, acting in good faith, prescribes, delivers, or dispenses the drug naloxone in accordance with sub. (2) may not be subject to any criminal or civil liability and may not be subject to professional discipline under s. 448.02 for any outcomes resulting from prescribing, delivering, or dispensing that drug.

SECTION 7. 450.01 (1) (d) of the statutes is created to read:

450.01 **(1)** (d) In the case of the drug naloxone, any person.

SECTION 8. 450.10 (1) (a) (intro.) of the statutes is amended to read:

450.10 **(1)** (a) (intro.) In this subsection, "unprofessional conduct" includes any of the following, but does not include the dispensing of an antimicrobial drug for expedited partner therapy as described in s. 450.11 (1g) or the delivery or dispensing of naloxone as described in s. 450.11 (1i):

SECTION 9. 450.11 (1) of the statutes is amended to read:

450.11 **(1)** DISPENSING. ~~No~~ Except as provided in sub. (1i) (b) 2., no person may dispense any prescribed drug or device except upon the prescription order of a practitioner. All prescription orders shall specify the date of issue, the name and address of the practitioner, the name and quantity of the drug product or device prescribed, directions for the use of the drug product or device, the symptom or purpose for which the drug is being prescribed if required under sub. (4) (a) 8., and, if the order is written by the practitioner, the signature of the practitioner. Except as provided in ~~s.~~ ss. 441.18 (2), 448.035 (2), and 448.037 (2), all prescription orders shall also specify the name and address of the patient. Any oral prescription order shall be immediately reduced to writing by the pharmacist and filed according to sub. (2).

SECTION 10. 450.11 (1i) of the statutes is created to read:

450.11 **(1i)** NALOXONE. (a) *Prescription and liability.* 1. A pharmacist may, upon the prescription order of an advanced practice nurse prescriber under s. 441.18 (2), or a physician or physician assistant under s. 448.037 (2), that complies with the requirements of sub. (1), deliver or dispense the drug naloxone to the person specified in the prescription order. The pharmacist shall provide a consultation in accordance with rules promulgated by the board for the delivery or dispensing of a prescription to the person to whom the drug is delivered or dispensed.

2. A pharmacist who, acting in good faith, delivers or dispenses the drug naloxone in accordance with subd. 1. may not be subject to any criminal or civil liability and may not be subject to professional discipline under s. 450.10 for any outcomes resulting from delivering or dispensing that drug.

(b) *Possession, dispensing, and delivery.* 1. Any person may possess the drug naloxone.

2. Any person who is not a pharmacist, physician, physician assistant, or advanced practice nurse prescriber may deliver or dispense the drug naloxone to another person.

(c) *Immunity.* 1. In this paragraph, "opioid–related drug overdose" has the meaning given in s. 448.037 (1) (d).

2. a. Except as provided in subd. 2. b. to d., any person who delivers or dispenses the drug naloxone to another person shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing that drug.

b. An advanced practice nurse prescriber who delivers or dispenses the drug naloxone in accordance with s. 441.18 (2) shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing that drug if the advanced practice nurse prescriber complies with s. 441.18 (3).

c. A physician or physician assistant who delivers or dispenses the drug naloxone in accordance with s. 448.037 (2) shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing that drug if the physician or physician assistant complies with s. 448.037 (3).

d. A pharmacist who delivers or dispenses the drug naloxone in accordance with par. (a) 1. shall be immune from civil or criminal liability for any outcomes resulting from delivering or dispensing that drug if the pharmacist complies with par. (a) 2.

3. Except as provided in s. 895.48 (1g), any person who, reasonably believing another person to be experiencing an opioid–related drug overdose, administers the

drug naloxone to that person shall be immune from civil or criminal liability for any outcomes resulting from the administration of the drug to that person.

SECTION 11. 450.11 (3) of the statutes is amended to read:

450.11 **(3)** PREPARATION OF PRESCRIPTION DRUGS. ~~No~~ Except as provided in sub. (1i) (b), no person other than a pharmacist or practitioner or their agents and employees as directed, supervised and inspected by the pharmacist or practitioner may prepare, compound, dispense, or prepare for delivery for a patient any prescription drug.

SECTION 12. 450.11 (4) (a) 5. a. of the statutes is amended to read:

450.11 **(4)** (a) 5. a. Except as provided in subd. 5. b. and c., the full name of the patient.

SECTION 13. 450.11 (4) (a) 5. c. of the statutes is created to read:

450.11 **(4)** (a) 5. c. For the drug naloxone when delivered or dispensed under sub. (1i), the name of the person to whom the drug will be delivered or dispensed as specified in s. 441.18 (2) or 448.037 (2).

SECTION 14. 450.11 (7) (h) of the statutes is amended to read:

450.11 **(7)** (h) ~~No~~ Except as provided in sub. (1i) (b), no person may possess a prescription drug unless the prescription drug is obtained in compliance with this section.

SECTION 15. 895.48 (1) of the statutes is amended to read:

895.48 **(1)** ~~Any~~ Except as provided in sub. (1g), any person who renders emergency care at the scene of any emergency or accident in good faith shall be immune from civil liability for his or her acts or omissions in rendering such emergency care. ~~This~~

(1g) The immunity described in sub. (1) and s. 450.11 (1i) (c) 3. does not extend when employees trained in health care or health care professionals render emergency care for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, enroute to a hospital or other institution equipped with hospital facilities or at a physician's office.

(END)

Duchek, Michael

From: Zadrazil, Chad J - DSPS <Chad.Zadrazil@wisconsin.gov>
Sent: Wednesday, November 27, 2013 3:44 PM
To: Duchek, Michael
Subject: RE: Naloxone legislation

Will do. You have a nice Thanksgiving as well!

Chad J. Zadrazil

Prescription Drug Monitoring Program Director
Wisconsin Department of Safety and Professional Services
608-266-0011

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: 27 Nov 2013 3:40 PM
To: Zadrazil, Chad J - DSPS
Subject: RE: Naloxone legislation

OK I put 11:30 down. I'll call then. If that won't work, let me know. Have a good Thanksgiving,

-Mike

From: Zadrazil, Chad J - DSPS [mailto:Chad.Zadrazil@wisconsin.gov]
Sent: Wednesday, November 27, 2013 3:39 PM
To: Duchek, Michael
Subject: RE: Naloxone legislation

Great! I can make myself available at your convenience.

Chad J. Zadrazil

Prescription Drug Monitoring Program Director
Wisconsin Department of Safety and Professional Services
608-266-0011

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: 27 Nov 2013 3:38 PM
To: Zadrazil, Chad J - DSPS
Subject: RE: Naloxone legislation

Thanks Chad. Monday should be fine. Let me know if there's a good time that works for you and I'll give you a call then.

-Mike

From: Zadrazil, Chad J - DSPS [mailto:Chad.Zadrazil@wisconsin.gov]

Sent: Wednesday, November 27, 2013 3:37 PM
To: Duchek, Michael
Subject: RE: Naloxone legislation

Hi Mike,

Sorry for the delay. I am free most of Monday 12/2, if that works for you. Otherwise, we can try to connect later next week.

Thanks,
Chad J. Zadrazil

Prescription Drug Monitoring Program Director
Wisconsin Department of Safety and Professional Services
608-266-0011

From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: 25 Nov 2013 9:40 AM
To: Zadrazil, Chad J - DSPS
Subject: Naloxone legislation

Hey Chad,

We met with you the other week about Rep. Nygren's naloxone legislation. At the meeting, you mentioned, I believe, the suggestion of taking out some references to dispensing because direct dispensing by practitioners is already lawful. However, as I look at it again it still seems to me that you might need to retain some references to dispensing the drug because you don't necessarily know if the person to whom the drug will be given will be the ultimate user or not and it seems to me that if you only refer to "delivery," that this discounts the possibility that it might actually be a dispensing. As I understand it, it might be prescribed to a person who might use it on a 3rd party, but that person might be a drug user as well and might himself/herself end up being the ultimate user.

Anyway, I wanted to know if you have a chance to chat about it or what you think would be the best way to clarify the language. Again I think we basically want this language to be able to be used regardless of whether the practitioner knows whether the person who will be given the drug will be the ultimate user or not. I have attached a copy of the legislation once more in case you need it. Let me know if you have some time this week before Thanksgiving or if not after or if you have some markup you want to send me. Thanks a lot,

Mike Duchek
Legislative Attorney
Wisconsin Legislative Reference Bureau
(608) 266-0130

<< File: 13-3360_P2.pdf >>

Duchek, Michael

From: Malcore, Jennifer
Sent: Monday, November 25, 2013 9:27 AM
To: Duchek, Michael
Subject: Re: AB 446

Absolutely!! Thanks for checking.

Jenny

On Nov 25, 2013, at 9:20 AM, "Duchek, Michael" <Michael.Duchek@legis.wisconsin.gov> wrote:

> Jennifer,
>
> I am working on the substitute amendment. Is it OK to call Chad at DSPS who we met with about the pharmacy stuff to make sure I am making the right changes to LRB-3360 (which will become a part of the substitute amendment)? Thanks,
>
> -Mike
>
> ---
>
> **From:** Malcore, Jennifer
> **Sent:** Thursday, November 21, 2013 8:37 AM
> **To:** Duchek, Michael
> **Subject:** RE: AB 446
>
> Good Morning,
>
> Substitute would be best.
>
> Thank you,
>
> ***Jennifer Malcore***
> Office of State Representative John Nygren
> Co-Chair , Joint Committee on Finance
> 89th Assembly District
> 309 East, State Capitol
> 608.266.2344
>
> ---
>
> **From:** Duchek, Michael
> **Sent:** Thursday, November 21, 2013 7:14 AM
> **To:** Malcore, Jennifer
> **Subject:** RE: AB 446
>
> I don't know of anything else I need, other than for you to let me know whether you would like a substitute or simple amendment. The substitute would be easier for me, would have an analysis, and would allow us to have one document that has everything in it (which could then be more easily further amended if needed). But if you want a simple amendment, I could try to do that as well.
>
> ---
>
> **From:** Malcore, Jennifer
> **Sent:** Wednesday, November 20, 2013 4:02 PM

To: Duchek, Michael
Subject: AB 446

Mike,

I just sent an e-mail to Peggy Hurley, she drafted the Good Samaritan bill for us. I suggested she talk to you about removing the language that states immunity from criminal prosecution for possessing naloxone.

Also, I am checking in to make sure I am getting what we need for the legislation. We need language from DHS regarding what current practice is for carrying naloxone that takes responsibility off individual EMT's. What else did you need?

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

Duchek, Michael

From: Malcore, Jennifer
Sent: Thursday, November 21, 2013 8:37 AM
To: Duchek, Michael
Subject: RE: AB 446

Good Morning,

Substitute would be best.

Thank you,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Duchek, Michael
Sent: Thursday, November 21, 2013 7:14 AM
To: Malcore, Jennifer
Subject: RE: AB 446

I don't know of anything else I need, other than for you to let me know whether you would like a substitute or simple amendment. The substitute would be easier for me, would have an analysis, and would allow us to have one document that has everything in it (which could then be more easily further amended if needed). But if you want a simple amendment, I could try to do that as well.

From: Malcore, Jennifer
Sent: Wednesday, November 20, 2013 4:02 PM
To: Duchek, Michael
Subject: AB 446

Mike,

I just sent an e-mail to Peggy Hurley, she drafted the Good Samaritan bill for us. I suggested she talk to you about removing the language that states immunity from criminal prosecution for possessing naloxone.

Also, I am checking in to make sure I am getting what we need for the legislation. We need language from DHS regarding what current practice is for carrying naloxone that takes responsibility off individual EMT's. What else did you need?

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

Duchek, Michael

From: Malcore, Jennifer
Sent: Wednesday, November 13, 2013 4:39 PM
To: Duchek, Michael
Subject: Meeting on Friday

Mike,

Can you meet in 309E at 9:30 on Friday morning to go over the naloxone bill with DSPS?

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

Duchek, Michael

From: Malcore, Jennifer
Sent: Tuesday, November 12, 2013 3:38 PM
To: Duchek, Michael
Subject: RE: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

If you can before the meeting so they have some time to digest it, that would be great. I am asking to meet on Friday.

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Duchek, Michael
Sent: Tuesday, November 12, 2013 3:16 PM
To: Malcore, Jennifer
Subject: RE: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

Either one should be fine, and Tom would probably be a great one to offer feedback given his past experience. Should I try to get the /P2 out before the meeting or just wait so we can incorporate their feedback?

-Mike

From: Malcore, Jennifer
Sent: Tuesday, November 12, 2013 3:11 PM
To: Duchek, Michael
Subject: FW: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

Mike,

Please read below, can you make any of the times listed below?

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Weigand, Jeffrey - DSPS [mailto:Jeffrey.Weigand@wisconsin.gov]
Sent: Tuesday, November 12, 2013 3:00 PM
To: Malcore, Jennifer

Subject: RE: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

Jenny –

I'm sorry we never responded to you on this. If you are still interested we would love the opportunity to sit down with you to go over how we think the bill could be improved. If you are ok with that maybe we could set up a time later this week or next for myself, Tom Engels and Chad Zadrazil from our department to come and discuss with you.

Would you be available any of the following times?

9am on Thursday the 14th?
9am or 1pm on Friday the 15th

Thanks,

Jeff

From: Malcore, Jennifer [mailto:Jennifer.Malcore@legis.wisconsin.gov]
Sent: Tuesday, October 15, 2013 3:32 PM
To: Weigand, Jeffrey - DSPS
Subject: FW: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

Jeff ~

The drafter advised that I share this with you. This is the second part to a Naloxone bill that we are considering. Please read the drafter's notes and the bill and let me know what questions or problems that might come of this.

Thank you,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344

From: Rep.Nygren
Sent: Monday, October 14, 2013 5:19 PM
To: Malcore, Jennifer
Subject: FW: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

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From: LRB.Legal
Sent: Monday, October 14, 2013 5:11 PM
To: Rep.Nygren
Subject: Draft review: LRB -3360/P1 Topic: Allow for dispensing and posession of naloxone; immunity for administering and dispensing naloxone to OD victims

Following is the PDF version of draft LRB -3360/P1 and drafter's note.

Duchek, Michael

From: Malcore, Jennifer
Sent: Friday, November 08, 2013 10:16 AM
To: Duchek, Michael
Subject: Narcan Amendment

Mike,

I never heard back from DSPS about the Narcan bill so let's proceed with the amending the bill. Here are some things I would like to add...

There have been some concerns that have been brought to our attention, one is the language regarding EMT's "Every emergency medical technician...shall, at all times... carry of have.... Naloxone.... The worry is that because of this legislation we will increase demand for naloxone. We were told there is already a nationwide stocking shortage and naloxone remains on back-order. It was suggested that we not use naloxone but opioid antagonist. The problem with that is we know naloxone doesn't cause injury if given to someone by accident and we won't know that about any other drug that hits the market. So to solve this dilemma, we thought we could put a clause in that takes liability away from the individual EMT if there is a shortage of naloxone.

Let me know if you have any questions.

Thanks,

Jennifer Malcore
Office of State Representative John Nygren
Co-Chair , Joint Committee on Finance
89th Assembly District
309 East, State Capitol
608.266.2344