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# Model Overdose Mapping and Response Act

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# Model Overdose Mapping and Response Act

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**SECTION I. SHORT TITLE.**

This Act may be cited as the Model Overdose Mapping and Response Act, “the Model Act,” or “the Act.”

**SECTION II. LEGISLATIVE FINDINGS.**

- (a) The [legislature]<sup>1</sup> finds that substance use disorder and drug overdose is a major health problem that affects the lives of many people, multiple service systems, and leads to profound consequences including permanent injury or death.
- (b) Accidental overdoses caused by heroin, fentanyl, other opiates, stimulants, controlled substance analogs, novel psychoactive substances, and other legal or illegal drugs are a national security crisis that stress and strain the financial, public health, health care, and public safety resources in [state]. This impact is because there are [few or no] central databases that can quickly help identify this problem and limited funding for support to mitigate the crisis and risks statewide.
- (c) There is a need for collaboration among local, regional, and state agencies, service systems, program offices within [state], and other partners such as federal agencies to establish a comprehensive system addressing the problems associated with overdoses and to reduce duplicative requirements across local, county, state, public safety, and health care agencies. Formalized collaboration allows these entities to combine their numerous resources and strengths, thus reducing insular decision-making.
- (d) Contemporaneous data collection about, and public surveillance of, confirmed or suspected overdoses within [state] will allow state and local agencies to focus on specific areas where the following are needed most in order to maximize resources: (1) interventions to reduce supply; (2) public education about substance misuse; (3) treatment and other health care options to reduce demand; and (4) implementation of risk reduction strategies.

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<sup>1</sup> This Act contains certain bracketed words and phrases (*e.g.*, “[legislature]”). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

## Commentary<sup>2</sup>

Legislative findings are by nature somewhat state-specific and may not be necessary everywhere. The language in Section II is modeled after the findings within the 2017 Florida legislation that provides for reporting of controlled substance overdoses.<sup>3</sup>

Subsection (b) notes the stress and strain to financial, health care, and public safety resources in [state] caused by accidental overdoses. The effects are staggering, even when looking only at opioid-related incidents. In October 2019, the Society of Actuaries (SOA) released a report estimating the economic impact of “non-medical opioid use” in the United States.<sup>4</sup> The report looked at costs associated with health care, premature mortality, criminal justice, child and family assistance, education programs, and lost productivity. In total, the SOA estimates the economic burden of the opioid crisis from 2015 through 2018 to be “at least \$631 billion,” with an additional \$171 to \$214 billion for 2019 depending on assumptions.<sup>5</sup> According to the SOA, 40 percent of the costs (\$253 billion through 2018) directly relate to mortality, “predominantly driven by lost lifetime earnings for those who died prematurely due to drug overdoses involving opioids.”<sup>6</sup> Other recent estimates for the economic value lost are even higher. The Council of Economic Advisers (CEA) within the Executive Office of the President estimates that the opioid crisis cost the U.S. \$696 billion in 2018—or 3.4 percent of GDP—and more than \$2.5 trillion for years 2015 to 2018.<sup>7</sup>

In the commentary to Section VIII below, the Model Act’s drafters address the financial investment needed to implement and use the overdose mapping and response system. This investment is quite modest, and pales in comparison to the alarming economic loss that continues as a result of substance use disorder and drug overdose.

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<sup>2</sup> The commentary area serves two primary purposes. The first purpose is to provide the reader with background information about the genesis of language in the Act. To the extent that the model language is based on already-proposed legislation or a particular document, the commentary notes this. The second purpose is to provide explanation about why the Act contains particular provisions and the rationale behind these decisions, along with a discussion of issues (occasionally controversial) with which policymakers must grapple when state-specific legislation is introduced, negotiated, and amended.

<sup>3</sup> 2017 Florida Laws Chapter 54 (House Bill 249), enacting F.S.A. § 401.253.

<sup>4</sup> Society of Actuaries, *Economic Impact of Non-Medical Opioid Use in the United States: Annual Estimates and Projections for 2015 through 2019* (October 2019), available at <https://www.soa.org/globalassets/assets/files/resources/research-report/2019/econ-impact-non-medical-opioid-use.pdf> (last accessed February 24, 2020).

<sup>5</sup> *Ibid.* at 4-5.

<sup>6</sup> *Ibid.*

<sup>7</sup> Council of Economic Advisors, Executive Office of the President, *The Full Cost of the Opioid Crisis: \$2.5 Trillion Over Four Years* (October 28, 2019), available at <https://www.whitehouse.gov/articles/full-cost-opioid-crisis-2-5-trillion-four-years/> (last accessed February 24, 2020). The CEA’s estimate is several times higher than the SOA’s estimate primarily due to a difference in methodology calculating the economic cost of premature death. Instead of measuring the value of lost lifetime earnings due to early death, the CEA relies on the value of a statistical life (VSL), a measurement often used by federal agencies to compare policies, regulations, or programs. As the SOA notes, this approach differs “conceptually in that it estimates the loss of economic value associated with early mortality, rather than the loss of economic activity.” Society of Actuaries, *supra* note 4, at 7.

**SECTION III. PURPOSE.**

(a) The [legislature's] purpose in enacting this Act is to:

- (1) provide near real-time drug overdose surveillance of confirmed or suspected overdoses occurring within [state], using a specialized program to collect information about overdose incidents, that supports public safety and public health efforts to mobilize an immediate response to a sudden increase in overdoses;
- (2) provide a centralized resource that can collect information about overdose incidents and make the data available to the health care community, public safety agencies, and municipal, county, and state agencies to quickly identify needs and provide short and long-term solutions while protecting and respecting the privacy rights of individuals;
- (3) discourage substance misuse and accidental overdoses by quickly identifying the areas within [state] where overdoses pose the highest risk to the community;
- (4) enable local, regional, and state agencies, service systems, and program offices to develop effective strategies for addressing confirmed or suspected overdoses occurring within their jurisdictions and implement interventional strategies; and
- (5) encourage formal collaborative agreements among local, regional, and state agencies, service systems, and program offices that enhance present and future work pertaining to the various health care and public safety aspects of this crisis, including substance use disorders, co-occurring disorders, unemployment, homelessness, drug supply chains, and other health care and public safety issues.

(b) By way of this Act, the [legislature] intends to maximize the efficiency of financial, public education, public health, health professional, and public safety resources so that these resources are concentrated on the most needy and at-risk areas and groups [in state].

**Commentary**

The overall framework of this section is based on the 2017 Florida legislation that provides for reporting of controlled substance overdoses.<sup>8</sup> The purpose described in subsection (a) contains several of the stated goals of the most commonly-used information technology platform, the Overdose Detection and Mapping Application Program (ODMAP), as documented

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<sup>8</sup> *Ibid.*

in the ODMAP Operating Policies and Procedures.<sup>9</sup>

#### SECTION IV. DEFINITIONS.

- (a) For the purposes of this Act, unless the context clearly indicates otherwise, the words and phrases listed below have the meanings given to them in this section.
- (b) Application programming interface.— “**Application programming interface**” or “**API**” means a set of tools, definitions, and protocols for building and integrating application software and services with different software programs.
- (c) Coroner.— “**Coroner**” means the elected or appointed officer in each [county] whose responsibility is to investigate the cause of death in cases [specified by state law].
- (d) Emergency department personnel.— “**Emergency department personnel**” means paid or volunteer health care professionals licensed by [state] who work in an emergency department, including but not limited to physicians, nurses, medical assistants, [and others as applicable in the particular state].
- (e) Information technology platform.— “**Information technology platform**” means the Washington/Baltimore High Intensity Drug Trafficking Areas’ Overdose Detection Mapping Application Program (ODMAP), which has the ability to:
- (1) allow secure access to the system by authorized users to report information about an **overdose incident** required by this Act;
  - (2) allow secure access to the system by authorized users to view, in near real-time, certain information about **overdose incidents** reported pursuant to this Act;
  - (3) produce a map in near real-time of the approximate locations of confirmed or suspected overdoses reported pursuant to this Act;
  - (4) interface with other information systems and applications via an **API**; and
  - (5) enable access to overdose information that assists in state and local decisions regarding the allocation of public health, public safety, and educational resources.

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<sup>9</sup> ODMAP Policies and Procedures (last revised November 2019), available at <http://www.odmap.org/Content/docs/training/general-info/ODMAP-Policies-and-Procedures.pdf> (last accessed February 24, 2020).



- (f) Law enforcement officer.— “**Law enforcement officer**” means a paid or volunteer employee of a police department or sheriff's office, which is a part of, or administered by, the [state] or any political subdivision thereof, or any full-time or part-time employee of a private police department, and who is responsible for the prevention and detection of crime and the enforcement of the penal, traffic, or highway laws of the [state].
- (g) Medical examiner.— “**Medical examiner**” means an individual appointed pursuant by [state law] to perform death investigations and to establish the cause and manner of death, and includes any person designated by such person to perform duties required by [state law].
- (h) Overdose.— “**Overdose**” means injury to the body that happens when one or more substances is taken in excessive amounts. An overdose can be fatal or nonfatal.
- (i) Overdose incident.— “**Overdose incident**” means an occurrence where a **law enforcement officer, person who administers emergency services, coroner, or medical examiner** encounters a person experiencing, or who recently experienced, a confirmed or suspected **overdose**.
- (j) Overdose reversal drug.— “**Overdose reversal drug**” means naloxone hydrochloride or other similarly acting drug that is approved by the federal Food and Drug Administration (FDA) for the emergency treatment of an **overdose**.
- (k) Overdose spike.— “**Overdose spike**” means the occurrence of a significant increase in the number of confirmed or suspected overdoses in a certain timeframe that triggers the **overdose spike response plan** within a specific geographic area.
- (l) Overdose spike response plan.— “**Overdose spike response plan**” means a compilation of recommendations for coordinated responses to **overdose spikes** identified through use of the **information technology platform**.
- (m) Person who administers emergency services.— “**Person who administers emergency services**” means a paid or volunteer professional, other than a **law enforcement officer**, who is trained and licensed in [state] to provide emergency services to the public, including

but not limited to a firefighter, emergency medical technician, emergency medical responder, paramedic, **emergency department personnel**, [and others as applicable in the state].

### Commentary

The Model Act’s drafters are aware that individual states likely have currently-in-force statutory definitions for many of the terms contained in Section IV and that lawmakers understandably will default to that language. Nevertheless, this Act contains illustrative definitions designed to articulate the intended scope of each term as it relates to the overdose mapping and reporting system. In particular, the definitions section addresses the following four areas: (1) the meaning of overdose and overdose incident; (2) the information system used to report and collect overdose incident information; and (3) the individuals who submit to or access information from that system. Each of these areas is discussed in more detail.

There are a variety of definitions of “overdose” that could be used, which span from the simple to the more involved. The version used in the Model Act is very simple, and is based on a definition listed on the website of the Centers for Disease Control and Prevention.<sup>10</sup> Several states that enacted or considered enacting overdose reporting legislation use more expansive definitions of overdose that include physical symptoms or signs, perhaps to make it clearer to the first responders covered by these laws what could be a potential overdose. Examples include statutes in Florida, Maryland, and West Virginia.<sup>11</sup> Several commentators to an earlier draft of this Model Act worried that defining a medical condition based on an enumerated list of symptoms would put too much focus on the listed symptoms, to the exclusion of others. Instead, those commentators believe that symptom-based discussions are better left to the training courses for first responders, rather than statutory code. Also worth noting is the intentional choice to use “substance” in the definition of overdose, rather than “controlled substance” or “drug.” The drafters’ intent is for the Model Act to contain an inclusive definition of overdose as opposed to a more exclusive one, especially when overdoses are often the result of a combination of substances. If the definition allows only a “controlled substance” to cause an overdose, then one could argue that certain overdoses do not qualify for reporting; for example, would an overdose involving alcohol, a new synthetic drug that is not a controlled substance analog (thus, not treated as a controlled substance under state law) or kratom (not scheduled in most states) qualify? In addition, the definition makes clear that non-fatal overdoses are included.

The term “overdose incident,” defined in subsection (j), acts as the triggering event for reporting information to the overdose reporting and mapping system. There are two components to this triggering event; one that acts to expand the universe of incidents and one that acts to limit

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<sup>10</sup> Centers for Disease Control and Prevention, “Opioid Overdose” Commonly Used Terms, available at <https://www.cdc.gov/drugoverdose/opioids/terms.html> (last accessed January 8, 2020).

<sup>11</sup> F.S.A. § 401.253(1)(c) (Florida); MD Code, Health - General, § 13-3601 (Maryland); W. Va. Code, § 16-5T-4(e) (West Virginia). Florida’s definition, for example, is “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 any controlled substance that requires medical attention, assistance or treatment, and clinical suspicion for drug overdose, such as respiratory depression, unconsciousness, or altered mental status, without other conditions to explain the clinical condition.”

it. First, an overdose incident encompasses both known and suspected overdoses. In cases where it is unclear—but possible—that a person is experiencing an overdose, the incident should be reported. It is beyond the scope of many first responders' responsibilities to diagnose the exact cause of an individual's serious medical event and the Model Act recognizes this. Second, an overdose incident only occurs when one of the individuals authorized to report to the system (a law enforcement officer, person who administers emergency services, coroner, or medical examiner, as those terms are defined) encounters the person suffering from the confirmed or suspected overdose. The idea behind this qualification is not complex—first responders cannot report about overdoses for which they are unaware—but including it in the triggering event should make it clearer to policymakers that the system will not be able to capture all overdoses, such as those where an overdose reversal drug is provided by a friend or family member and no first responder is called.

Subsection (c) defines the information technology platform to be used, which is specified as the ODMAP system developed by the Washington / Baltimore High Intensity Drug Trafficking Areas (W/B HIDTA). The specific functionality of the system is based upon language contained in Illinois and Maryland law, in addition to proposed legislation in Nevada.<sup>12</sup> The reason for identifying a specific system, as opposed to allowing states to design their own or contract with private parties, is four-fold. First, ODMAP is a known and highly-tested application that performs as expected and has been doing so for over three years. Second, W/B HIDTA offers the use of ODMAP to participating agencies at no cost.<sup>13</sup> Using ODMAP eliminates the concern that the state contracts with a private information provider who ends up more concerned with maximizing profit than providing useful, reliable, timely, and consistent assistance. Third, using ODMAP promotes consistency and ease of information sharing among the states. Related overdose incidents may cross state lines, particularly where a major population center is near the border. If bordering states are using different overdose mapping and response systems, each state's ability to react to nearby overdose incidents is hampered. Fourth, ODMAP is a national system. This national perspective provides a broader indication of the risk overdoses pose nationally. Using ODMAP supports an enterprise risk reduction management strategy for participating agencies, states and organizations.

The definition of information technology platform notes that ODMAP can interface with other data collection systems via an application programming interface (API). The definition for API comes from Red Hat, Inc., a well-known U.S. software company.<sup>14</sup>

Section V (Establishing the Overdose Mapping and Response System) directs law enforcement officers, persons who administer emergency services, coroners, and medical examiners to report overdose incident information via the information technology platform. This

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<sup>12</sup> 210 ILCS 50/3.233 (Illinois); MD Code, Health - General, § 13-3601 (Maryland); Assembly Bill No. 38, BDR 40-413 (Nevada).

<sup>13</sup> Participating agencies may choose to report some overdose incident information from already existing databases using an application programming interface (API). As noted in Section VIII (Financial Considerations), using an API will involve some IT work for the participating agency; the extent of the costs associated with this work depends on individual circumstances.

<sup>14</sup> See <https://www.redhat.com/en/topics/api/what-are-application-programming-interfaces> (noting that APIs “let your product or service communicate with other products and services without having to know how they’re implemented”).

segmenting of data reporters is based upon proposed legislation in Nevada and avoids creating a “laundry-list” of reporting individuals within the primary program authorization section.<sup>15</sup> As compared to the Nevada legislation, the Model Act adds “emergency department personnel” to the definition of persons who administer emergency services, in order to clarify that those medical professionals must also report. It is possible to imagine a scenario where an overdose victim’s first encounter with medical services is at an emergency department, rather than with law enforcement or fire/EMS. (For example, if family or friends bring an overdose victim directly to the hospital without calling 911.) In such case, overdose information might not be reported to the information technology platform unless done by emergency department personnel. The drafters expect that states have statutory definitions for many of the various professionals included within the term “person who administers emergency services.” As a result, the Act does not contain definitions for those professions. The term “emergency department personnel,” however, includes several types of health care providers. In order to show the intended scope of that term, the Model Act uses a definition that originated in a different model law developed in recent years.<sup>16</sup>

The definitions of law enforcement officer, coroner, and medical examiner are based on statutory language in Virginia, Wyoming, and West Virginia, respectively.<sup>17</sup>

The identification of overdose spikes and creation of overdose spike response plans are a key purpose for developing an overdose reporting system using ODMAP or another information technology platform. Among other things, Section VI (Using the Overdose Mapping and Response System) requires these activities, as is the case in an overdose reporting ordinance proposed in 2019 in New Orleans, LA.<sup>18</sup> The definitions in subsections (k) and (l) come from that ordinance.

Defined terms are in **bold text** throughout the Model Act, to more easily identify them.

## SECTION V. ESTABLISHING THE OVERDOSE MAPPING AND RESPONSE SYSTEM.

(a) In general.— The [state agency] is directed to:

- (1) ascertain and document the number, trends, patterns, and risk factors associated with known and suspected **overdoses** in [state], both fatal and non-fatal; and
- (2) develop strategies for public health and public safety interventions that may be effective in reducing the rate of fatal or non-fatal **overdoses**.

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<sup>15</sup> Assembly Bill No. 38, BDR 40-413 (Nevada).

<sup>16</sup> National Alliance for Model State Drug Laws, *Model Act Providing for the Warm Hand-off of Overdose Survivors to Treatment (2<sup>nd</sup> Edition)*, Section IV(e), July 2019.

<sup>17</sup> Va. Code Ann § 9.1-101 (Virginia); W.S.1977 § 7-4-104 (Wyoming); W. Va. Code, § 16-19-3 (West Virginia).

<sup>18</sup> Ordinance, City of New Orleans, Calendar No. 32,780 (proposed September 19, 2019).

- (b) Overdose mapping and response system.— In furtherance of the directive in subsection (a) of this section, no later than [twelve (12) months] after the effective date of this Act, the [state agency] will develop an overdose mapping and response system in which a central repository containing information about **overdose incidents** is established and maintained using the **information technology platform**.
- (c) Statewide adoption.— No later than twenty-four (24) months after the effective date of this Act, the overdose mapping and response system will capture information about all **overdose incidents** in at least eighty (80) percent of the counties in the state.
- (d) User convenience.— The overdose mapping and response system must be designed to avoid data entry duplication wherever possible, which may include using one or more **APIs** to transfer information about **overdose incidents** that are currently reported to active databases existing in [state] to the **information technology platform**.
- (e) Reporting by law enforcement officers.— A **law enforcement officer** who goes to an **overdose incident** must report information about the **overdose incident** to the **information technology platform**, as directed by subsection (h) of this section, as soon as possible but no later than twenty-four (24) hours after the **overdose incident**, to the extent that such information is known.
- (f) Reporting by persons who administer emergency services.— A **person who administers emergency services** who goes to an **overdose incident**, or who transports a person experiencing a confirmed or suspected **overdose** to a medical facility, must report information about the **overdose incident** to the **information technology platform**, as directed by subsection (h) of this section, as soon as possible but no later than twenty-four (24) hours after the **overdose incident**, to the extent that such information is known.
- (g) Reporting by coroners and medical examiners.— When a **coroner** or **medical examiner** determines that the death of a person was caused by an overdose, the **coroner** or **medical examiner** must report information about the **overdose incident** to the **information technology platform**, as directed by subsection (h) of this section, or give such information to a person authorized to report it, as soon as possible but no later than twenty-four (24)

hours after the determination of death, to the extent that such information is known.

(h) Information reported.— The following information about an **overdose incident** must be reported by the individuals identified in subsections (e), (f), and (g) of this section using the **information technology platform**:

- (1) the date and time of the **overdose incident**;
- (2) the location of the **overdose incident**;
- (3) whether an **overdose reversal drug** was administered, and if so the number of doses and the type of delivery;
- (4) whether the confirmed or suspected **overdose** was fatal or non-fatal;
- (5) the gender and approximate age of the person suffering the **overdose incident**; and
- (6) the suspected substance involved.

(i) Other reporting requirements.— A person's or entity's report of information about an **overdose incident** pursuant to this Act does not preempt or replace any other reporting requirement applicable to that person or entity.

(j) Implementation process.— During the course of implementing the overdose mapping and response system, the [state agency]:

- (1) will consult with all affected entities, including but not limited to, law enforcement agencies, health care providers, emergency management, emergency service providers, public health agencies, **coroners** and **medical examiners**, tribal authorities, state drug court judges, federal and state prosecutors [and any additional categories that the state wishes to add];
- (2) will enter into, or direct other state, county or local entities to enter into, all participation agreements, data sharing agreements, and other memoranda of understanding necessary to fully implement the overdose mapping and response system; and
- (3) may promulgate rules, regulations, or standard operating procedures necessary to carry out the requirements of this Act, the [legislature] finding that for the purposes of [state law allowing emergency rulemaking], an emergency exists requiring the promulgation of emergency rules to preserve the public peace, health, safety or welfare and to

prevent substantial harm to the public interest.

- (k) **Limitation of liability.**— Persons or entities reporting information about an **overdose incident** pursuant to this Act in good faith are not subject to civil or criminal liability or damages for making the report, unless their acts or omissions constitute willful and wanton misconduct.
- (l) **Compliance.**— The failure of a person identified in subsections (e), (f), or (g) of this section to report information about an **overdose incident** as required by this Act constitutes a form of unprofessional conduct, and the [state agency] may refer matters of non-compliance to the appropriate [state] licensing board for investigation.
- (m) **Report to legislature.**— The [state agency] will report to the [state legislature] regarding the status of overdose mapping and response system implementation at six (6) months, eighteen (18) months, and thirty (30) months after the effective date of this Act. The report at thirty (30) months is not required if statewide adoption, as defined in subsection (c) of this section, is attained prior to the eighteen (18) month report.

### **Commentary**

The purpose of Section V is to require implementation of an overdose mapping and response system, lay out the parameters of that system, and direct the implementing state agency to collaborate with state and local agencies to implement and oversee the system. In short, Section V addresses the information coming into, and warehoused within, the overdose mapping and response system; Section VI relates to using the information reported out of the system.

Throughout this and other sections, the Model Act directs the placeholder “[state agency]” to implement and oversee the mapping and response system. During the development of the Model Act, the drafters posed the question to a number of stakeholders of what state agency is best suited to handle this responsibility. The group’s consensus was that it is a decision best left to the individual states to determine during the legislative process based on their individual government structures and cultures. In West Virginia, a state where overdose reporting/mapping legislation has been enacted, the state office of drug control policy within the state department of health is responsible for the program. In several other states who have enacted or considered statewide reporting/mapping legislation, oversight is granted (either expressly or impliedly) to the state department of health. On balance, it may be that states create a lead “hybrid” organization that can manage a multi-disciplinary task force approach that includes health care, policy, public safety, and the intelligence community to deliver comprehensive health security to the state’s population.

Subsection (a), based upon a provision in Nevada law,<sup>19</sup> expressly establishes the overarching reason for developing an overdose mapping and response system—to examine drug overdoses within the state and develop strategies to try to limit them. Providing a state agency or organization with this express authority supports the conclusion that a primary goal of the system is public health surveillance.

Subsection (b) is the primary directive in the Act, requiring the state agency or organization to establish an overdose mapping and response system via information technology platform, as defined. The state agency must begin implementation of the system no later than 12 months after enactment, although there is no prohibition on beginning sooner. Pursuant to subsection (c), statewide adoption occurs when overdose incident information is collected in at least 80 percent of the counties of the state. This must occur within two years of enactment. Subsection (m) is designed to force the state agency in charge of implementation to keep things moving, by requiring regular reports to the legislature until statewide adoption is achieved. The 80 percent requirement is based on how statewide adoption is defined in the Overdose Detection Mapping Application Program (ODMAP) Statewide Expansion and Response Grant jointly sponsored/administered by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance and the Centers for Disease Control and Prevention.<sup>20</sup>

Subsection (d) is based upon a similar provision in West Virginia’s law establishing an overdose reporting system,<sup>21</sup> and is designed to alleviate fears that the reporting system will greatly complicate first responders’ jobs. The language provides an example of how data entry can be simplified with APIs to pull data into the information technology platform from other already-existing data sets.

Subsections (e), (f), and (g) address the “who” and the “what:” Who is required to report overdose incident information, and what overdose incident information must be reported? Using the structure from proposed Nevada legislation,<sup>22</sup> data reporters are placed into one of three categories, law enforcement officers, those providing emergency services in the field other than law enforcement (fire department, EMS, hospital emergency department workers), and coroners or medical examiners who encounter overdose victims in much different circumstances. In state legislation enacted and considered to date, data reporting requirements vary from 24 to 72 hours. The Model Act sets a 24-hour reporting requirement, under the philosophy that a shorter period better achieves real-time data reporting. This real-time reporting provides the foundation for risk response strategies. Although the 24-hour requirement means that reporting about a late Friday or Saturday night overdose cannot “wait until Monday,” overdose spikes should not have to wait. Based upon reviewing stakeholder comment about the overwhelming workload often faced by coroners and medical examiners, the Model Act allows both types of individuals to satisfy the

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<sup>19</sup> N.R.S. § 453C.130

<sup>20</sup> [https://www.coapresources.org/Content/Documents/Funding/ODMAP\\_Statewide\\_Expansion\\_and\\_Response\\_Grant.pdf](https://www.coapresources.org/Content/Documents/Funding/ODMAP_Statewide_Expansion_and_Response_Grant.pdf) (last accessed February 27, 2020).

<sup>21</sup> W. Va. Code, § 16-5T-3(b).

<sup>22</sup> Assembly Bill No. 38, BDR 40-413.



reporting requirement by directing others to report overdose incident information within the 24-hour period.

In terms of information reported to the system, subsection (h) lays out the information that is required. The first four items are the four types of information that are required to be reported to ODMAP for any overdose incident.<sup>23</sup> Nevertheless, in the context of overdose reporting, there are data fields beyond those four that are useful for public health and safety agencies to know, including the age and gender of the victim, as well as drug suspected to have caused the overdose. Several states with enacted overdose reporting legislation include these data points.<sup>24</sup> As it is currently designed, ODMAP allows the Level 1 reporting of a multitude of additional optional data points for an overdose incident besides the four required elements. These include case number, additional drugs involved, if the victim was one of multiple victims at the incident location, if the victim was taken to the hospital, and if the incident involved a motor vehicle. States should consider if some of these or other data fields (*e.g.* notes about substance packaging) warrant inclusion in the statutory directive for collection. Three optional data fields in ODMAP are required reporting fields in this Model Act, the gender and approximate age of person receiving attention or treatment, and the suspected controlled substance involved in the overdose. These items of information are very important for public health professionals and others in assessing and intervening in an overdose spike or other pattern of overdoses. Lacking this information also makes it harder for public safety to identify and focus on sources and marketing of drugs involved in overdoses.

Subsection (j) operates as a rough procedural guide for state drug policy agencies to walk through when implementing the overdose reporting system. At the regulatory and sub-regulatory levels, the specific groups involved in setting up the program will operate in a much more detailed fashion than can (or should) be described in a state statute. The “may” used to begin paragraph (j)(3) is in recognition that formal rules, regulations, or standard operating procedures may not be necessary in all cases.

As drafted, the Act requires collection of overdose information through ODMAP or a similar system as opposed to merely permitting it. There are two natural follow-ups to this position: (1) what is the “penalty” for failing to report the information; and (2) is there any room for reporting exceptions in certain cases? At this point, state lawmakers are of different minds with respect to point (1). On the one hand, Florida’s law expressly states that the failure to report an overdose is not grounds for disciplinary action or penalties.<sup>25</sup> On the other hand, legislators in

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<sup>23</sup> The area of ODMAP where overdose incident information is reported is called “Level 1.” Only authorized Level 1 users of ODMAP may report information. This area contrasts with ODMAP Level 2, which contains the data visualization of overdose incidents on a map. Only authorized Level 2 users of ODMAP may view the visualized information. Level 1 users own the data that they submit to ODMAP. Thus, at any time, a Level 1 user may export at no charge all overdose incident information it has reported to ODMAP (termed a “Level 1 data export”). The Level 1 user may also export another user’s Level 1 information if there is a data sharing agreement between the parties that covers this information.

<sup>24</sup> *E.g.*, F.S.A. § 401.253 (Florida); W. Va. Code, § 16-5T-4 (West Virginia)

<sup>25</sup> F.S.A. § 401.253(4).

Nevada proposed to make the failure to report a misdemeanor.<sup>26</sup> Subsection (1) aims for a middle ground, modeled after the requirement in some states for certain medical professionals to report information to prescription drug monitoring programs. The state agency with oversight of the overdose reporting system can refer instances of noncompliance to licensing boards for investigation/consideration of disciplinary action. As to point (2) to the need for reporting “exceptions,” a group of stakeholders discussed this question during the drafting process and could not identify any such exceptions, other than perhaps during times of temporary unavailability of the information technology platform. A considered exemption relates to overdose incidents caused by first responder exposure to substances. However, the stakeholders felt that there still is value to be gained by reporting those events.

## **SECTION VI. USING THE OVERDOSE MAPPING AND RESPONSE SYSTEM.**

- (a) Data availability.— The information about **overdose incidents** reported pursuant to this Act will be available to users of the **information technology platform** authorized to view the data in real time. The process by which such authorized users are decided upon and designated must be addressed in one or more of the participation agreements, data sharing agreements, and memoranda of understanding executed when implementing the overdose mapping and response system.
- (b) Overdose spike response plan.— Within [twelve (12) months] after the date of enactment of this Act, the [state agency], in conjunction with state and local law enforcement agencies and state and local public health departments, will:
- (1) identify parameters for identifying an **overdose spike** throughout the state; and
  - (2) create **overdose spike response plans** that coordinate the response of public health, public safety, emergency management, first responders, community organizations, health care providers, and the media with the goal of preventing and reducing the harm caused by **overdose spikes**.
- (c) Annual reports.— Commencing [twelve (12) months] after the date of enactment of this Act, and each year thereafter, the [state agency] will prepare a comprehensive report regarding the overdose mapping and response system established pursuant to this Act that is delivered to or immediately accessible by:

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<sup>26</sup> Assembly Bill No. 38, BDR 40-413, Section 5(4).

- (1) state legislature;
  - (2) state, county, and local departments of health;
  - (3) single state authority on drugs and alcohol;
  - (4) state department of children and youth services; and
  - (5) any other state or local agency designated by [statute or regulation].
- (d) Contents of report.— Each report required under subsection (c) of this section will contain at least the following information:
- (1) the number of **overdose incidents** reported and the approximate locations where the **overdose incidents** occurred, including any clusters of **overdose incidents**;
  - (2) the entities reporting, or who employed persons reporting, information about **overdose incidents**;
  - (3) the percentage of **overdose incidents** involving fatal versus non-fatal overdoses; and
  - (4) how the reported information about **overdose incidents** was used for public health and public safety responses, the outcomes of those responses, and the impact on affected communities.
- (e) Additional uses for information.— In addition to using the overdose mapping and response system as required in subsections (b), (c), and (d), the [state agency] may use the system to:
- (1) establish public safety, public health, and behavioral health partnerships within in the state;
  - (2) assist local communities to identify additional ways to use information about **overdose incidents** to deploy public health, behavioral health, and public safety interventions to address specific geographic areas or high-risk individuals;
  - (3) assist in the distribution of **overdose reversal drugs** throughout the state; and
  - (4) assist in implementing strategies to reduce drug supply and demand, especially in high risk areas and where there are high volumes of elevated risk populations.

### Commentary

Whereas Section V of the Model Act pertains to getting overdose incident information into the information technology platform, Section VI addresses use of the information by public health and public safety. In terms of ODMAP parlance, Level 2 users are the users authorized to view overdose incident information visualized over a geographical map of the U.S. This section

addresses the use of Level 2 information. Four aspects of data use are addressed in this section: (1) a general directive about availability of overdose incident information (subsection (a)); (2) overdose spike response plans (subsection (b)); (3) annual reporting about the use of the overdose mapping and response system (subsections (c) and (d)); and (4) other uses for the information to be considered by the relevant state agency or organization (subsection (e)).

As noted in the comments to Section IV, the requirement to prepare one or more overdose spike response plans is rooted in a proposed New Orleans ordinance,<sup>27</sup> which expressly spells out a primary purpose for the overdose reporting system. Unlike a single city such as New Orleans, multiple overdose response plans may be necessary depending on the location of the population within the state. It is recommended that any agency using the overdose mapping and response system create an automatic spike alert notification based on the volume of reported incidents. Agencies can then determine how expansive to make the spike response. Typically, public safety and health leadership in a municipality are notified of a spike. For example, ODMAP provides an algorithm that calculates an agency's spike threshold which is conveyed through weekly reports. An additional aspect of an overdose spike response plan is notifying the local community of an ongoing overdose spike. In Shelby County, Tennessee, the public health department issues a press release to the community within two hours of determining that an overdose spike is occurring. W/B HIDTA itself developed a publicly available Overdose Spike Response Framework document for participating agencies that contains a compilation of recommendations for coordinated responses to overdose.<sup>28</sup>

Subsection (e) is a nod to certain aspects of the Overdose Detection Mapping Application Program (ODMAP) Statewide Expansion and Response Grant.<sup>29</sup> The intent is to suggest some of the required elements of that grant program within the model legislation so that states achieving statewide reporting outside of the grant may develop these necessary partnerships.

## SECTION VII. LIMITATIONS ON DATA USE.

- (a) Criminal investigation.— Information about **overdose incidents** reported to the overdose mapping and response system by a person or entity other than a **law enforcement officer** may not be used for a criminal investigation or prosecution of any person who satisfies the exemption from criminal liability contained in [the state's Good Samaritan law pertaining to overdoses.]

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<sup>27</sup> Ordinance, City of New Orleans, Calendar No. 32,780 (proposed September 19, 2019).

<sup>28</sup> Washington/Baltimore HIDTA, *Overdose Spike Response Framework (January 2018)*, available at <http://odmap.org/Content/docs/ODMap-Overdose-Response-Framework-2018-3.29.18.pdf> (last accessed March 20, 2020).

<sup>29</sup> *Supra* note 20

- (b) Confidentiality of data.— Information about **overdose incidents** reported to, and accessible through, the overdose mapping and response system will at all times remain confidential pursuant to all applicable federal, state, and local laws and regulations pertaining to the collection, storage, and dissemination of protected health information and controlled unclassified information.
- (c) Good Samaritan protections.—The reporting of information about **overdose incidents** as provided for in this Act does not in any way diminish the protections afforded by [state Good Samaritan law(s) pertaining to overdoses].

### Commentary

Some of the relatively few states who have already enacted overdose reporting legislation include a provision prohibiting use of the reported information for criminal investigation and prosecution, similar to subsection (a).<sup>30</sup> On the one hand, it is questionable if the information reported (approximate geo-location, fatal/non-fatal overdose, and overdose reversal drug administration) would have much value in such an investigation or prosecution. On the other hand, this provision serves to provide “comfort” that the overdose incident information will not be used for arrest, investigation, or other prosecutorial purpose, and thus there is not a good reason to exclude it.

As compared to in-force legislation, subsection (a) contains two modifications: (1) reporting by law enforcement is excepted; and (2) there is explicit extension of the prohibition against use of information to a person or persons who qualify for Good Samaritan protection under a state’s Good Samaritan law pertaining to overdoses. The first modification recognizes that if the first responder to a situation is law enforcement, the data gathered by the officer can be used for criminal investigation. The officer’s act of uploading certain overdose incident information to the information technology platform does not render the facts observed by him/her useless. Rather, the purpose of subsection (a) is to prohibit the “backwards” use of information for investigation of the overdose victim; that is, taking Level 2 information on ODMAP and trying to work “backwards” to determine the identity of the overdose victim or person calling for help for criminal investigative purposes.

Subsection (b) is based upon a provision in Connecticut law<sup>31</sup> and serves as a reminder that the information in the overdose mapping and response system should be protected from uncontrolled disclosure and is available only to authorized system users with a need to know that information. Indeed, ODMAP’s Operating Policies and Procedures provide that “[d]ata entered in to ODMAP must conform to all applicable federal, state, and local laws, rules and regulations pertaining to the collection, storage, and dissemination of Controlled Unclassified Information

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<sup>30</sup> *E.g.*, 210 ILCS 50/3.233(e) (Illinois); MD Code, Health - General, § 13-3602(e) (Maryland).

<sup>31</sup> C.G.S.A. § 19a-127q(d).

(CUI).”<sup>32</sup> CUI is “information that requires safeguarding or dissemination controls pursuant to and consistent with applicable law, regulations, and government-wide policies but is not classified.”<sup>33</sup>

The discussion about confidentiality touches upon one of the biggest concerns expressed to W/B HIDTA team members by state and local agencies during W/B HIDTA’s many informational workshops and training sessions. These sessions have been conducted around the country and are geared to increase interest in the use of ODMAP. Concerns expressed at those sessions include questioning if the reporting of overdose incident information violates federal (*e.g.*, Health Insurance Portability and Accountability Act (HIPAA)) or state law governing the use of protected health information (PHI)? The short answer to this with respect to federal law is no. A much more thorough discussion of the issues can be found in the recently released document from the Legislative Analysis and Public Policy Association (LAPPA), entitled, “ODMAP and Protected Health Information Under HIPAA: Guidance Document.”<sup>34</sup> In particular, it is important to note that HIPAA allows covered entities to disclose an individual’s protected health information without getting prior authorization from the individual “to the extent that such use or disclosure is required by law and the use or disclosure complies with, and is limited to, the relevant requirements of such law.”<sup>35</sup> LAPPA’s document provides in depth aspects of ODMAP that implicate certain HIPAA Privacy Rule exceptions in some instances. However, enacting a law that requires use of ODMAP—as this Model Act does—eliminates the need to apply any other HIPAA Privacy Rule exception other than the “required by law” provision.

Subsection (c) is another “comfort” provision. Although it is perhaps not technically necessary within the legislation, it makes clear that the Model Act does not preempt any state law governing Good Samaritan protections for overdose victims or persons assisting those victims. The subsection is inspired by a similar provision in an existing model law.<sup>36</sup>

## SECTION VIII. FINANCIAL CONSIDERATIONS.

(a) Budget allocation.— The state legislature will appropriate [\$ \_\_\_\_\_ for fiscal years \_\_\_\_\_] to the [state agency] for the purpose of funding, in whole or in part, the initial start-up and ongoing activities required as part of this Act.

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<sup>32</sup> ODMAP Policies and Procedures, *supra* note 9, at 1.

<sup>33</sup> National Archives, *About Controlled Unclassified Information*, <https://www.archives.gov/cui/about> (last accessed February 26, 2020).

<sup>34</sup> Legislative Analysis and Public Policy Association, *ODMAP and Protected Health Information Under HIPAA: Guidance Document*, March 2020, available at <https://legislativeanalysis.org/research/>.

<sup>35</sup> 45 CFR § 164.512(a)(1).

<sup>36</sup> National Alliance for Model State Drug Laws, *Model Universal Access to Naloxone Act (Third Edition)*, Section XVII(c), July 2019.

- (b) Federal funds.— The [state agency] will pursue all federal funding, matching funds, and foundation funding for the initial start-up and ongoing activities required under this Act.
- (c) Receipt of funding.— The [state agency] may receive such gifts, grants, and endowments from public or private sources as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the term of the gifts, grants, or endowments.

### Commentary

Funding sections in model laws can be tricky, as states fund projects through legislation in a variety of ways, and there is no one size fits all. However, if the Model Act omits the funding discussion altogether, then the legislation gives the appearance of an “unfunded mandate.”

As currently drafted, the Act references three potential sources of funds or some or all of the cost: (1) a state budget allocation; (2) federal funds, such as the expansion grant noted herein; and (3) public or private gifts. The drafters considered adding to this language a requirement that some portion of a state’s settlement funds from ongoing opioid litigation go towards the overdose mapping and response system. This idea is inspired by recent legislation proposed in at least one state that looks to earmark the litigation recovery for substance use disorder treatment programs.<sup>37</sup> Stakeholders had a tepid response to this draft language, however, because of the many current unknowns associated with these funds. These unknowns include the timeline for the availability of funds, conditions on the use of the funds (likely to be a part of the settlement agreements), and the number of state and local entities likely to be competing for the funding. However, to the extent that such a source of funding becomes available in a state, policymakers should consider using some of it to help fund the overdose mapping and response system.

It is important to note the small financial investments necessary to implement this Model Act. According to individuals with experience implementing ODMAP, it may be best to think of the costs of implementation in two separate “buckets:” (1) the cost to implement the overdose mapping and response system; and (2) the cost to develop a response strategy based on the information. As discussed below, these costs are quite modest, especially when compared to the economic cost associated with substance use disorder in general as well as losing members of the labor force due to premature death.<sup>38</sup>

The amount of funding needed to complete item (1) is dependent on individual circumstances but could be as low as \$0. As noted in the Commentary to Section IV above, W/B HIDTA does not charge participating agencies to import data to, or access information in, ODMAP. The primary cost associated with item (1) is for any IT work necessary to get a participating agency’s already-established database to connect to ODMAP through an API

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<sup>37</sup> *E.g.*, South Carolina S.J.R. 929 (introduced January 14, 2020).

<sup>38</sup> *See* the discussion in the Commentary to Section II (Legislative Findings).

already developed by W/B HIDTA (colloquially, the costs for the agency to “turn on” the API). In a case where a participating agency has direct access to its own database and IT staffing, this can mean as little as an hour or two of work by one person, amounting to very little cost. In a case where a third-party IT vendor is needed because the vendor owns the rights to the agency’s data or the agency does not have IT staffing, this process could cost \$50,000 to \$100,000.

As compared to item (1), however, the larger “bucket” of potential cost is for item (2), the state’s development and operation of a response strategy using the overdose incident information available in ODMAP. Again, this cost is very dependent on the specific choices made by states. Potential costs included within item (2) include adding new staff to interpret the ODMAP data, such as ODMAP data analysts or data coordinators, developing training materials for system use, and most importantly, implementing intervention plans to reach individuals who have recently suffered overdose incidents and encourage them to enter into substance use disorder treatment, where appropriate.

#### **SECTION IX. SEVERABILITY.**

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

#### **SECTION X. EFFECTIVE DATE.**

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