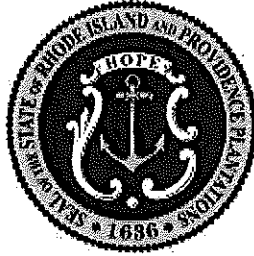


**STATE OF RHODE ISLAND
OFFICE OF THE CHILD ADVOCATE**



**Report of the
CHILD FATALITY REVIEW PANEL
A REVIEW OF TWO CHILD FATALITIES AND FOUR NEAR FATALITIES
DECEMBER, 2017**

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PREFACE

The Office of the Child Advocate is tasked with the responsibility of reviewing the fatality or near fatality of a child when it is the result of abuse or neglect, when the child was involved or recently involved with the Department of Children, Youth and Families or if a member of their household was recently involved with the Department of Children, Youth and Families in some capacity. These reviews provide the Office of the Child Advocate and the Child Fatality Review Panel the opportunity to review these cases to inform on needed systemic changes. This is the second report issued since I have been the Child Advocate. It reviews two fatalities and four near fatalities. The first report was released in March 2017 and reviewed four fatalities and two near fatalities. This office will be commencing a third review in January 2018. I would like to express my appreciation and gratitude for the hard work and commitment of the Child Fatality Review Panel who made the completion of this report possible. Each of our Review Panel members took time from their schedules to assist the Office of the Child Advocate with the review of thousands of pages of documentation and provide their expertise in the analysis of each case. This comprehensive report would not have been possible without the Panel, including:

Darlene Allen, MS

Kathryn R. Cortes

Molly Kapstein Cote, Esquire

Ken Fandetti, MS

Lisa Guillette

Detective Michael Iacone

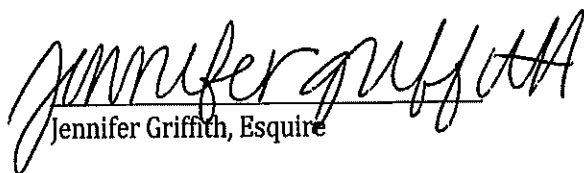
Catherine Lewis, MSW

Katelyn Medeiros, Esquire

Adam Pallant, MD

Thank you to all members of the panel for your continued commitment to improving the safety and well-being of children in the State of Rhode Island.

Sincerely,


Jennifer Griffith, Esquire

INTRODUCTION

The Office of the Child Advocate (hereinafter "OCA") is tasked with the responsibility of reviewing any child fatality or near fatality where the child was "...in the custody of, or involved with, the [Department of Children, Youth and Families], or if the child's family previously received services from the [Department of Children, Youth and Families]." (hereinafter "DCYF" or "Department"). See *R.I.G.L. § 42-73-2.3*. The OCA may also complete a review of a fatality or near fatality when "[a] sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months..." See *R.I.G.L. § 42-73-2.3*. Furthermore, the OCA shall review any child fatality or near fatality, "...alleged to be from abuse or neglect of the child". See *R.I.G.L. § 42-73-2.3*. The expectations of this office subsequent to notification of a child fatality or near fatality were delineated and expanded upon in the 2016 legislative session. This was codified in *Rhode Island General Laws § 42-73-2.3* and *Rhode Island General Laws § 42-73-6*. This legislation was signed in to effect by Governor Gina Raimondo on July 6, 2016. Acting upon the authority granted by this legislation, the OCA initiated an extensive review of two (2) child fatalities and four (4) near fatalities, starting on April 12, 2017. This second review was initiated just weeks after the completion of our first Child Fatality Review Panel report, which was released in March 2017. This is the third report issued by the Office of the Child Advocate since March 2016, reviewing nine (9) child fatalities and six (6) near fatalities.

Pursuant to *R.I.G.L. § 42-73-2.3* (e), which requires "[t]he child advocate ... [to] publicly announce the convening of a child-fatality-review panel, including the age of the child involved", the OCA issued its initial Press Release on April 5, 2017 announcing the convening of the Child Fatality Review Panel. The release disclosed that the near fatality of a three (3) month-old and the near fatality of a five (5) month-old child was now under review. On June 13, 2017 the OCA issued another Press Release announcing the expansion of the review to include the near fatality of a two (2) year-old. Although this case was classified as a near fatality pursuant to Rhode Island General Laws, at no point was the child involved "near death". However, this case fell within the scope of the OCA's statutory authority and due to significant risk factors present in this case and the family's prior and recent contact with the Department of Children, Youth and Families, the OCA found it pertinent to review this matter. On July 14, 2017, the OCA issued a third Press Release announcing that the review would be expanded once again to include the fatality of a three (3) month-old infant, open to the Department at the time of their passing. On November 30, 2017, the OCA issued a fourth and final Press Release announcing that the review would be amended and expanded to include the

near fatalities of a two (2) month old and a newborn and to announce that one of the near fatality cases under review had been changed to a fatality.

This reports constitutes a public record under Rhode Island General Laws 30-2-(d)(16). The names of the individuals involved have been omitted or altered to protect the identity of those involved. This is in conformity with the Office's confidentiality obligation mandated by Rhode Island General Laws 42-73-1 et seq.

The panel reviewed thousands of pages of documents and analyzed each case in great detail. This comprehensive report is the result of hours of investigation, research, review and discussion of the cases, policies, statutes and other relevant materials. Upon completing this extensive review, the Child Fatality Review Panel composed the recommendations included in this report with the intent of effectuating systemic change necessary to ensure the safety and well-being of all children involved with the Department.

THE CASES REVIEWED

The Child Fatality Review Panel reviewed six cases between April 12, 2017 and December 5, 2017. Four of the cases involved a near fatality of a child and two involved the fatality of a child, as defined by R.I.G.L. §42-42-8(c)(1) (*See Appendix B for full policy*). Four of the six families were known by DCYF due to previous Child Protective Services (CPS) reports or prior case openings. In four (4) of the cases under review, the parents and/or caretakers involved reported histories of CPS and/or DCYF involvement as children.

The cases reviewed included children ranging in age from two (2) months old to two years old. Both families who experienced a child fatality were open to the Department of Children, Youth and Families at the time of the child's death. In the four (4) near fatalities, three (3) of the cases had previous involvement with DCYF and the CPS Unit. The remaining near fatality case had no prior involvement with DCYF.

In the cases under review, multiple risk factors were present including but not limited to, previous DCYF contact, parental mental health issues and substance abuse. The families resided in different communities in Rhode Island and were of diverse ethnicities and different genders.

I. FATALITIES

a. *Fatality Summary #1*

The first fatality case under review, involved an infant. The infant's family was open to DCYF's Family Service Unit at the time of the child's death. Mother has a history of significant mental health issues resulting in multiple hospitalizations. This case first opened to the Department over two (2) years ago after calls to the Child Abuse Hotline were made by a local hospital reporting that a mother had just delivered a baby, she was presenting as unstable and was physically combative with the infant. The hospital staff was concerned for the infant's safety. The child was removed from mother's care and was placed in foster care. Mother was subsequently hospitalized. The CPS investigation was indicated as to mother for neglect. One note by CPS indicated that during her visit with mother that she appeared to be "nuts" and stood up and urinated on herself prior to the worker leaving the room. The note concludes with the line "Good Luck FSU!"

The Panel reviewed documentation from a provider that engaged mother in services throughout her pregnancy. After reviewing this documentation, the Panel raised concerns as to why mother's case was not brought to the attention of DCYF prior to her child's removal after the infant's birth. Throughout her pregnancy, mother had numerous psychiatric hospitalizations for suicidal ideation, including grabbing a knife three (3) months before the birth of this child stating she did not want to live. Mother expressed the desire to abort the baby, had issues with self-care, including a hospitalization for dehydration and not consuming enough food. Mother was moved to three (3) homes and a shelter during this pregnancy. The shelter director noted mother might need a higher level of care after having two (2) hospitalizations in one (1) week. None of the hospitalizations or concerns were brought to the attention of the Child Abuse Hotline.

Upon her release from the hospital, mother began court ordered supervised visits with the child and brought with her to DCYF a new boyfriend who communicated his desire to adopt the child. On one occasion during a supervised visit, mother became so escalated that Capitol Police intervention was required. Mother provided some level of cooperation and engaged in several services. However, there was significant delay with her cooperation for a parent-child evaluation as well as the signing of releases for the evaluator to communicate with mother's other providers. It took six months for mother to engage in this service.

A review of the DCYF court reports reveals that mother was "awkward" in her attempts to hold, feed and care for her child during visits, often needing redirection from the DCYF visit supervisors. A couple of months later, a DCYF court report notes that mother had been inconsistent with her

mental health appointments and medication management appointments. In May 2016, the DCYF court report provides inconsistent and incomplete information to the Court. One mental health provider reported to the Department that mother had been inquiring about whether she could reduce her medications or if she were to become pregnant, would she be able to reduce her medications. The provider notes that "...this caused me some concern as during the patient's last pregnancy, we reviewed the necessity of the patient staying on her medication regime without alterations." Additionally, the mental health provider reports that mother presented at a couple of local hospitals in an attempt to have her medications reduced. The provider notes in her letter to the Department that "...due to the patient's history, she requires someone to oversee her on a daily basis to ensure that she does not miss any medication doses or injections." However, the DCYF court report did not highlight any of this information. It is unclear as to whether the provider's letter was included in their report to the Court. In fact, the Department's letter provides a picture of mother as being completely compliant with all services with no mention of these concerns put forth by mother's mental health provider.

A doctor completed a psychological evaluation with mother after being referred by DCYF. A comprehensive assessment of her social, emotional and cognitive functioning was requested, and a parent/child interactive session was requested. A doctor met with Mother for her evaluation on six (6) occasions. Upon completion of the doctor's evaluation numerous findings and recommendations were reported to the Department. The doctor noted that "reunification between mother and her infant is at *moderate to serious risk*". Some of the findings of the doctor, which led him to this conclusion include but are not limited to: mother missed the first scheduled parent/child appointment, which had to be rescheduled; mother is charged with Neglect in the Rhode Island Family Court; mother's child was removed from her care at birth because of the severity of her mental health problems; that mother refused to sign releases of information so that her discharge summary and mental health notes could be reviewed; that mother minimized her issues and seriously underreported her symptoms and insisted that her difficulties were the result of situational depression; that the records reflect that mother was not consistent with her mental health appointments and was not taking her psychotropic medications as prescribed; that family reports mother had multiple psychiatric hospitalizations; that mother's mental health problems appear to be interfering with her cognitive functioning. Additionally, the doctor also noted that mother appeared to be an individual who would be resistant to psychotherapy and demonstrated poor judgment, indecisiveness and distorts the importance of problems. Also, mother demonstrated difficulty calming her baby, who cried hysterically for the first twenty minutes of a session. She kept

trying to feed the baby a bottle but would not tilt it at an angle so the baby could suck, which further upset the baby. She was repeatedly instructed to lean the baby back so the baby could drink from the bottle. Furthermore, mother was observed to speak to the baby in a very loud voice two or three inches of the baby's face, which startled the baby; during the session she made odd noises and rarely used words when interacting with the baby and mother was flustered and it took her five minutes to buckle the baby into the car seat. Lastly, the doctor noted that mother would not sign the releases for her service providers so they could obtain her mental health records.

Based on the observations of the doctor and the information provided, many recommendations were made including: that the mother should sign a release of information with her service providers so her mental health records can be reviewed so that DCYF could monitor mother's progress and compliance; that mother needs to be compliant with all aspects of her case plan; that DCYF should investigate her husband; that mother's service providers should have a copy of this evaluation to ensure they have a comprehensive understanding of their client and her mental status; that supervised visitation should continue and that mother needs to be compliant with her mental health providers and take her psychotropic medications as prescribed. After reviewing the report and evaluation by the doctor the panel noted several concerning factors. The doctor was unable to gain full insight into mother's mental health history and issues due to her refusal to sign release for the doctor. This prohibited the doctor's ability to adequately assess mother's mental health and her ability to parent. Without complete background information the doctor was unable to know the full scope of mother's mental health history. The doctor, relied solely on mother's self reporting, documentation provided by DCYF and his one session with mother and her baby. At the time of this evaluation, mother was pregnant with her second child and never disclosed this information to the doctor or to DCYF. During the parent/child visit mother showed an inability to appropriately care for her baby during the session with the doctor. Based on those few items the doctor made the recommendations outlined above, one of notable importance is: ***mother should sign releases of information with her mental health professionals so DCYF can monitor compliance and progress.*** This recommendation indicates mother had been uncooperative with DCYF and only providing the information she feels is pertinent. This being a notable risk factor in the evaluation and assessment completed by the doctor. Furthermore, it was recommended that the final evaluation be provided to all providers; it is unclear from the record whether DCYF ever distributed this evaluation as recommended.

Before DCYF was in receipt of the parent/child evaluation, a call was made to the Child Abuse Hotline by a local hospital reporting that mother was pregnant again. The hospital social worker

attempted to speak with mother, however mother left the hospital before she could be examined. A hospital alert was issued. Shortly after, mother was discharged from one of her services due to difficulty scheduling visits and a lack of communication between mother and this provider. During this same time frame, a third call was made to the Child Abuse Hotline by mother herself indicating that she would be removing her child from the child's current foster home. This call was not documented by CPS in the intake section of the RICHIST file. This call was not even categorized as being received by CPS but rather was placed in the Case Activity Notes of the RICHIST file and labeled merely as "phone call with parent". Upon review of the records, it appears that the Hotline worker made one phone call to the foster family and left a voicemail. There is no record of follow-up regarding this concerning phone call by the Social Caseworker or by CPS. Just a few weeks later, this matter was before the Family Court where the Social Caseworker provided a positive report of mother, with no mention of the peculiar behavior exhibited by mother just weeks prior. Considering mother's mental health history, the Panel believes this should have been provided more attention and detail.

Two months later, a fourth call was made to the Child Abuse Hotline reporting that mother gave birth to another child. The hospital was calling in response to the previous hospital alert issued, which called for a Physician's Record of Examination (PRE) to be issued with a seventy-two (72) hour hold. Upon receiving this call, CPS followed up with the Social Caseworker and the Administrators involved with the case. The reports provided were that mother was doing "really well" and that the plan was to reunify mother's first child with her. The Case Administrator authorized for a PRE with no hold. It is worth noting that at this point in time, mother was still only seeing her other child through supervised visits; these visits were weekly visits for two (2) hours. The plan was to initially increase these visits to three (3) hours, however this plan was not put into effect due to mother's lack of communication and follow through with one provider. It is also important to note that three month's prior to the birth of this child, this family received a new Social Caseworker. This was the family's third social worker in less than one (1) year.

Since the hold was lifted, the newborn was authorized to transition home with mother and father. ***The safety plan was that father would be present with the mother and baby at all times, that father would take a leave of absence from work and provide documentation and that mother would continue to take her medication and engage with providers.*** The child's Guardian *ad litem* noted to the Social Caseworker that the hospital reported that mother "appeared to be dysregulated" and provided the hospital social worker's phone number to the DCYF social worker to follow up. Despite the Guardian *ad litem*'s concerns, no formal motion was filed with the Family

Court in an attempt to prevent this safety plan from taking affect or to object to the child's transition home. The DCYF social worker did contact the hospital social worker regarding mother. The hospital social worker reported that mother had good eye contact, was friendly, was smiling and mother presented well. The hospital social worker also met with father "who appeared quiet". Based on these observations, the hospital social worker reported that no hold was necessary and the child transitioned home with the parents.

The DCYF social worker reviewed with father that he must be present at all times and never leave mother alone with the baby. Father indicated that he would be able to get six (6) weeks off to be home with mother and the baby. Also, father indicated that when he returned to work his plan was to send the baby to daycare. Father also reported that he had natural supports, however there was no identification of who these supports were, nor was there any follow-up on this by the social worker. Despite this plan relayed by father, just six (6) days later the case files indicate that the DCYF social worker contacted an individual who was identified as the family's full-time nanny. The hiring of this nanny contradicts what father reported less than a week prior. The DCYF social worker ran a background check on the nanny and reports that "there were no concerns at this time". There is no indication that the DCYF social worker met with the nanny, reviewed the safety plan with the nanny or independently verified any of the information provided before concluding that "there were no concerns".

Eight (8) days after the DCYF social worker received notice that a nanny would be assisting with the care of the child an unannounced visit was made. Mother was not present at the time and the nanny did not know where the mother was. The DCYF social worker reviewed with the nanny that mother cannot be alone with the baby, must continue to be compliant with medication and with her services. The nanny reported that she knew mother could not be alone with the baby however she did not know that mother was taking medication. The nanny was also concerned that there were no carbon monoxide detectors. The DCYF social worker did not make contact with mother during this visit. The DCYF social worker expressed no safety concerns. Just one day later, the DCYF social worker made contact with one of the providers who was a vital part of the safety plan. The provider reported that mother was "somewhat consistent" and at one point mother would not let the provider in the home. Despite this report, no additional follow-up was completed.

It is at this point in the case activity notes that the notes were entered sporadically. Upon receiving notice of this case, the Office of the Child Advocate immediately initiated a review of the RICHIST case file. Upon review of the file, no case activity notes had been entered into RICHIST for

over a month and a half. The notes for this time period were not entered into the system, until the Office of the Child Advocate contacted the Department regarding the absence of these vital notes. Furthermore, additional case activity notes were added at this time during months where there were some notes entered, however it became apparent that the record was incomplete and supplemented at this later date.

A couple of weeks later, father contacted the DCYF social worker to report that he no longer wanted the nanny to go to the house because "she is always sick". The father wanted the baby to go to a home daycare. The following day the DCYF social worker went to the home for a scheduled visit. Father reported again that he no longer wanted the nanny to care for the baby as "she was beginning to question the reason for the case opening." The father thought that this would lead to problems with his wife. Mother was not present for this visit. The father reported that he had already started to take the child to a home daycare that mother's other child goes to. There is no indication in the case file that the DCYF social worker verified the information provided by father, confirmed that the baby was enrolled in a new daycare or ensured that the daycare was appropriate.

A week later, foster parents for mother's first child voiced concerns to the DCYF social worker about the mother's ability to care for both children. The foster parents also informed the DCYF social worker that the mother attempted to visit the child at daycare, this is despite the order that all visits are to be supervised. The foster parents were very concerned about reunification and planned to discuss this with the child's Guardian *ad litem*. That same day the father of the child contacted the DCYF social worker to inform the social worker that they had moved the child to a different daycare and would provide DCYF with the information regarding this daycare. Two (2) days later the father contacted the social worker with the address and the name of the daycare provider. No additional follow-up, verification or visit to this daycare to ensure that it was appropriate was completed by DCYF. It was not until after the child presented with extensive injuries was it learned that the address provided was for a vacant building.

Additionally, part of DCYF's case plan with mother included mother participating in a visitation program to assess mother's ability to parent a child and keep them safe. The program was geared towards providing mother with the skills and knowledge to assist mother with parenting her child. This program was required to assist with her first child, however, her second child was sent home.

Two (2) months later, the Child Abuse Hotline received a phone call reporting that an infant presented to the emergency department in cardiac arrest. The child was resuscitated and admitted

to the Pediatric Intensive Care Unit (PICU). The infant had multiple injuries including injuries consistent with abusive head injury. The infant had multiple skeletal fractures in different ages of healing and multiple rib fractures (12) in different stages of healing. In addition, there were multiple cutaneous injuries including bruising, abrasions and excoriations to the face, chin, neck, right arm, chest and bilateral lower extremities. The bilateral lower extremities had overlapping patterned injury consistent with healing adult human bite injuries. These injuries were consistent with chronic child physical abuse. It was also reported that the infant had gained weight since birth but had not maintained adequate weight gain, resulting in a weight loss to below five percent, which is concerning for neglect. This child passed away.

b. Fatality Summary #2

In the second fatality case under review, a physician called the DCYF hotline to report a child death. The three (3) month old had been transported to the hospital after CPR was performed and was pronounced dead. This child's mother had a long and extensive history with the DCYF, including significant drug abuse, criminal activity and untreated mental health issues. The case had previously been open as to her other children; the biological fathers in those cases also had significant substance abuse issues and a criminal history. The initial biological father of the child as identified by mother also had a significant substance abuse and criminal history as well. However, later in the case, the son of foster mother/guardian to three of mother's other children was identified as the father to this infant.

Despite the numerous risk factors present in this case, this newborn was sent home from the hospital after birth. Within one week, the OCA sent an email to DCYF detailing the numerous concerns, specifically writing that "this is extremely reminiscent of previous safety plans wherein an infant subsequently died, was significantly abused or was placed in a high risk situation with detrimental results". The OCA requested legal intervention with this family to ensure the safety and well-being of this child. Our review of the family at that time revealed that mother readily admitted that she had not sought treatment for her significant mental health issues and tested positive for marijuana during her pregnancy, which she described as her way of self-medicating to cope with mental health issues. The safety plan was comprised of the maternal great grandmother who suffers from serious medical issues as being responsible for ensuring the execution of the safety plan with support from the guardian for two of the siblings (who was also serving as foster mother for mother's third child) and a longtime friend of mother's. Interestingly, the maternal great grandmother reports that she was aware that mother was using marijuana during her pregnancy, however this was never previously reported. But the foster mother and the longtime friend denied

any drug use by mother. The three people charged with the responsibility of ensuring the safety of this child had conflicting accounts of mother's substance use. The OCA wrote to the Department stating, "[r]ealistically this does not appear to be a safe environment when reviewing the totality of the circumstances". This mother had significant challenges with providing for her first three children, none of whom were placed with her at the time of this child's birth. During mother's pregnancy for the infant's case being reviewed, the OBGYN reported that she never had any concerns for mother, however she was aware that mother was engaging in marijuana use during her pregnancy but was quoted stating "who doesn't".

It is well documented throughout the case notes that mother has an official diagnosis of bipolar disorder. Mother reported that she was not receiving treatment during her pregnancy. However, following the birth of the baby mother reported that she was referred to a mental health provider and had an upcoming appointment. The Child Fatality Review Panel was very concerned that DCYF relied heavily on the statements of two of the three safety plan "coordinators" namely, the legal guardian to two of mother's other children and a longtime family friend. Both described mother's mental health as "stable". There is no documentation to support that either of these two individuals are mental health professionals or have the expertise to make such an assessment. In this case, the only individuals that should have been making a determination regarding the stability of mother's mental health should have been a licensed mental health professional. Prior to the birth of the child, a call was made to the Child Abuse Hotline by an anonymous caller. The caller reported that mother was using drugs and that she was almost full-term in her pregnancy. Despite mother's lengthy history with the Department, this call was dismissed as they had not received any calls from a medical professional about this issue, however due to mother's history of substance abuse and her criminal history a hospital alert was issued. Three (3) months later the opinions of friends and family members regarding mother's mental health were relied upon when making a determination to send a newborn home, not a medical professional.

On the night the child passed, all of mother's children were present in the home and remained there overnight. Among those present was mother's child who is presently in foster care and should not have been left in mother's care overnight. No investigation was ever initiated regarding the foster parent's decision to leave this child in the care of mother. Although it appears that poor judgment was exercised when leaving all four children in mother's care, for the two children who have had a guardianship completed, there is nothing legally preventing them from being in the presence of mother. This is not the case for the remaining child who was is in the care and custody of the Department.

Upon review of the record it appears that conflicting stories were provided by mother as to how the child died. Mother first reported that she found the child unresponsive in her crib; the crib was observed to be cluttered with belongings. Maternal great grandmother reported that the baby did not sleep in the bassinet or the crib; maternal great grandmother was one of the individuals identified as a support and vital component of the safety plan for mother and child. Mother then reported that she put the baby on the bottom bunk in a room with one of her other children and when mother went to check on her she was unresponsive. However, one of mother's children reports that in the middle of the night, the baby was crying so she went to get the baby and brought her to bed with her. Just five (5) hours before this child was pronounced dead, a Police Department found mother and her friend unresponsive in the friend's driveway. They admitted to drinking and smoking marijuana. The DCYF critical event review report reads "it has been determined that the mother's behaviors contributed to the critical event as she knowingly consumed alcohol and left the home without ensuring proper supervision of her two (2) month old [baby]. Mother was not truthful about the events leading up to this baby's death."

Following the baby's death, two individuals came forward who also reported that during the night in question mother was drinking with her friend in the home until approximately midnight and then left to drink and smoke marijuana with her friend at her home. The two individuals also reported that mother was never around the child and often left the baby in the care of her other children, the oldest of which was fourteen. Additionally, upon review of the record, the Panel discovered that the family was receiving services from an in-home service provider. The provider reported that they confirmed with mother that she had a crib, *but the provider never went into the bedroom to confirm that the crib was being utilized.*

I. NEAR FATALITIES

A report was made to DCYF that a five (5) month old had been admitted to the PICU at Hasbro with severe swelling and conjunctival hemorrhages in the baby's eyes. This child also sustained bilateral bleeding (a subdural hemorrhage) in their brain, bruising on the right temple, bruising on the left femur and an abrasion to the lower lip. This baby was under the care of a family friend who was also a household member. This caretaker had a prior DCYF history, however the parents had no knowledge of his prior history with DCYF. The parents did not have any DCYF history. This household member/caretaker admitted to assaulting this baby once he was questioned by the police. He has been charged with First Degree Felony Child Abuse. The call to CPS was categorized as a routine investigation and ultimately indicated the caretaker for physical abuse and neglect.

In the second near fatality reviewed, a report was made to the CPS Hotline informing DCYF that two children under the age of four (4) were transported to the hospital. The two (2) year old child was admitted to the Pediatric Intensive Care Unit (PICU) due to an altered mental and respiratory status. The toxicology screens tested positive for Tetrahydrocannabinol (THC). The child was evaluated and the doctor reports that the child's status is consistent with cannabinoid (marijuana) ingestion and intoxication. The investigation was completed and both parents were indicated for physical abuse and physical neglect. This was the third call to the Hotline regarding this family. The first call alleged potential domestic violence between mother and father, which was categorized as an Information/Referral (I/R). Additionally, this family was the subject of the March 2016 Child Fatality Review after a relative foster child died while in their care; both parents were indicated for physical neglect resulting in the death of a child. One day after the close of the investigation due to the child's ingestion of marijuana, an additional call was made to the Hotline regarding an incident of domestic violence. This case was categorized as a routine investigation and father was indicated for neglect.

In the third near fatality case reviewed, the family was open to the Family Services Unit (FSU) due to ongoing involvement with a sibling. Prior to the occurrence of the near fatality, there were six calls to the Hotline regarding this family. Three of the calls were categorized as investigations and three calls were categorized as an Information/Referral (I/R). Two of the I/R's were calls made due to mother's drug use during her pregnancy for the child who would then become the subject of this report who was sent to the intensive care unit at birth. Upon delivery, the child tested positive for cocaine and mother had no pre-natal care. Child was admitted to the NICU at birth due to drug exposure. An ex parte petition was filed following the child's birth and subsequent admission to the NICU.

In the fourth near fatality case reviewed, the child was two (2) months old. The parents had no DCYF history as this was this was the parents first child. Both parents previously sought treatment for mental health. The only call to the Department was to report the extensive injuries to the child including bruising on the body and a subdermal hemorrhage. The reporter also informed the Department that the child was to be admitted in to the Pediatric Intensive Care Unit. The parents were working with one provider in the home. The provider reported having concerns about the parents due to inquiries made about shaken baby syndrome and reports that one of the parents was "rough" with the child. No call was made to the DCYF Hotline until the child's admission to the PICU. Father was subsequently arrested for First Degree Child Abuse.

DISCUSSION AND FINDINGS

I. RISK ASSESSMENTS AND SAFETY ASSESSMENTS

A Child Protective Investigator (CPI) is required to complete a child safety assessment for every investigation. DCYF policy identifies the importance of keeping “in mind the difference between safety and risk when completing the assessment. Safety assessment differs from risk assessment in that it assesses the child(ren)’s present danger and the intervention(s) currently needed to protect the child(ren). In contrast, the risk assessment looks at the likelihood of repeated, future, abuse and/or neglect by caretaker(s).”

DCYF policy/protocol states, one Child Safety Assessment and Plan is completed for each family. Answer ‘Yes’ if the safety factor is present for any child. The child safety assessment form has two sections.

1. Safety Assessment/Response and Section
2. Safety Decision

The Child Safety Assessment form consists of ten (10) Safety Factor Tabs and a Safety Decision Tab. These tabs are used to indicate the presence of each Safety Factor by clicking the ‘yes’ or ‘no’ button. For each Safety Factor identified, the CPI is to consider the resources available in the family and the community that might help to keep the child(ren) safe. CPI is then to check each response taken to protect the child(ren) and explain each response and describe all safety interventions taken or immediately planned and explain how each intervention protects or (protected) the child(ren). Once the ten (10) Safety Factor tabs are completed the CPI completes the Safety Decision. The Safety Decision should be based on the assessment of all Safety Factors and any other information known about the case. All pertinent information related to the decision should be entered.

The list of safety factors are behaviors or conditions that may be associated with a child(ren) being in danger or serious harm. The vulnerability of each child needs to be considered throughout the assessment. Children who are between the ages of 0-6 cannot protect themselves. For children, an inability to protect themselves may result from diminished mental capacity or repeated victimization. The worker determines presence or absence of Safety Factors 1-9 and any other impediments to safety, (Factor 10) and considers controlling interventions on any factors indicated as present. A narrative is then written explaining each safety factor with a safety issue present. The worker will then make a determination of safe/conditionally safe/unsafe, based on

whether controlling interventions can mitigate the unsafe factor(s) identified. A controlling intervention is, "any action taken by staff or others that remediate the unsafe condition identified in the assessment while services are provided to the family. Safety responses 1-7 are used to indicate the controlling intervention utilized by the family and/or worker and require supervisory approval."

Calculations of these factors will affect any decision surrounding removal of the child. When safety factors are present the worker may remove the child or put other monitoring interventions in place designed to protect the child(ren). If a child(ren) is removed during the investigation or any time following the investigation, the safety assessment is used to guide decision making on the return of the child(ren). Children must be safe or conditionally safe prior to a return home.

DCYF issues an alert to area hospitals when it is believed there may be a risk of harm to a child born to a parent with a history of substantiated child abuse or neglect or a child abuse/neglect conviction. Reasons a hospital alert may be issued including but not limited to are; parent has exhibited behavior or conduct that is seriously detrimental to a child of a duration that renders it improbable for the parent to care for a child for an extended period; one or both parents have a history of chronic substance abuse; parent(s) have a history of mental or emotional disability which has proven to render the parent unable to care effectively for his or her child(ren). Once the parent gives birth the hospital is required to respond and report the information to DCYF. DCYF then determines whether the report is assigned for investigation, downgraded to an Information Referral (I/R), or if the case is active with DCYF the information may be forwarded to the assigned social worker to conduct a safety/risk/family assessment.

In the two above fatalities, hospital alerts were issued by DCYF. One was issued based on significant prior psychiatric history for mother and removal of her first child, and the other alert was for mother's having three (3) of her children under Guardianship with others due to mother's chronic drug use and allegations she was using drugs during her pregnancy. Upon notification of the birth's DCYF initiated one investigation and the other was an I/R with a notification to the active social worker assigned to the family.

When an I/R is relative to an active case is received, an I/R e-mail notification is sent to the primary caseworker, supervisor, administrator, licensing worker and any other staff assigned to the case. The following steps are then taken per RICHIST:

1. If the I/R Report appears to require immediate attention, telephone notification is made by the Hotline supervisor directly to the primary service worker/supervisor to ensure their awareness of the circumstances.
2. Since an I/R Report is generally not investigated, the primary service worker/supervisor must review the information upon receipt and respond accordingly within three working days, except in instances requiring immediate attention.
3. The primary service worker/supervisor acknowledges receipt of the I/R Report and documents the initial response by creating an Information/Referral Response Note within the CPS Report itself.
4. Any subsequent responses pertaining to the I/R Report are documented by creating a Case Activity Note and selecting "CPS Related Information" as the category.

In the I/R'd case the active social worker was notified of the birth via Child Protective Investigator (CPI). The CPI spoke with the assigned active social worker who stated mother has been doing well, has been receiving her medication injections as prescribed and is stable as long as she is on her medication. The plan for the older child is reunification with his mother, no timeline given and at this point visits were two hours per week and supervised. CPI spoke with an Administrator who recommended a PRE-with no hold for the newborn. It is noted when the hospital alerts were completed three (3) months prior DCYF had requested a 72-hour hold on the newborn as mother was not consistent with treatment. DCYF allegedly spoke with mother's providers who acknowledged mother received her last medication injection during a home visit. DCYF agreed for the newborn to go home with mother under the conditions father is present at all times with mother and baby mother continues to take medication, father provides documentation of leave from work, family continue to engage with providers. CPI advised the active social worker hospital is reporting mother, appears to be dysregulated. DCYF SW contacted the hospital and was advised mother seemed to be doing well and was friendly and smiling. The hospital SW reported mother presented and appeared well, and father appeared quiet. The DCYF SW spoke with father and explained the newborn would be allowed to go home based upon him being present all the time and never leaving mom alone with the newborn. Father explained to DCYF SW his plan is to stay home until the newborn is able to go to day care and enroll the baby in day care so when he is out of the home the newborn is also out of the home. Father agrees mother will never be left alone with the infant. Father advised DCYF SW he has natural supports willing to be available to mother should he need to leave the home. These natural supports were never identified nor vetted for clearance. Father informed DCYF he works in construction and based on the fact he has only been

employed for one (1) year he does not want to lose his job by missing work; but knows he can get six (6) weeks out of work.

On December 27, 2016, the DCYF SW meets with the foster parents of the older child. Both parents express distrust of mother's new husband and feel he is using her for specific reasons. Foster parents relayed concerns about reunification with the older child. On December 29, 2016, the DCYF SW is notified the infant will have a nanny. SW meets with the identified nanny who agrees to work with the family and has been asked to be in the home from 11 AM-9 PM. The DCYF worker expresses no concerns with the identified nanny.

On January 5, 2017, the DCYF SW makes an unannounced home visit to the newborn. Upon arrival SW contact mother via telephone to open the door. Mother states she is not in the home but the nanny is available. After a few minutes SW contacted mother again as she was still waiting outside. Once SW gained access to the home she observed the infant sleeping in a bassinet swing. The nanny did not know where mother was, just that she had left and would be right back. Nanny reported she is in the home every day from 11-9 at night. Nanny explained she is aware mother is not to be left alone with the infant, as father made her aware of the situation. Nanny asked how mother was doing and SW explained mother is doing good complying with services and needs to continue to take her medication. The nanny expressed having no idea mother was taking medication.

On January 6, 2017, the DCYF SW contacted a provider who reported mother has been "somewhat consistent" with services, and reported mother would not allow her into the home December 2016. Although this information was reported several weeks after the newborn is sent home, no safety assessment and/or risk assessment is completed to gauge mother's ability to safely care for this newborn despite receiving contradictory information from a professional provider. On January 17, 2017 infant was referred to a provider for a developmental screening. On January 23, 2017 DCYF SW was notified by father of infant the family did not want the Nanny to care for the infant anymore and wanted the infant to attend a home day care.

On January 24, 2017 the DCYF SW arrived at the family home and father was present. Infant was sleeping in a crib. Father advised he does not want the nanny to care for the infant anymore because she was beginning to question the reason for the DCYF case being open. Father was afraid the questions would cause a problem with his wife and he did not want any problems. Father explained he began taking the infant to the same home day care mother's other child attended but did not want the foster parents to know. Father signed releases for the infant's doctor and stated the infant is doing well and up to date on his medical appointments. Worker reminded the parents

they needed to complete a program and mother questioned why they needed to complete the program.

DCYF documentation indicates the newborn was placed at home January 26, 2017. However, records indicate the newborn was home well before this date. SW spoke with a woman father identified as a nanny for the infant on December 29, 2017. On January 31, 2017 father informed the DCYF SW he moved the infant to a new home day care, and he would call the SW to provide her with the details of the new home day care. On February 2, 2017 father called the DCYF SW and provide the name and address of the home day care.

On February 3, 2017 the DCYF SW completes the paperwork for the family's provider, mother continues to question why she and father need to participate in services as they feel they need privacy. DCYF SW once again explained to mother the programs will be able to help assess her ability to reunify with her older child and her ability to have unsupervised visits with the newborn. This program is scheduled to start on February 22, 2017. On March 22, 2017 mother and the DCYF SW have a phone call regarding the case and DCYF SW advises mother she is waiting for updates from one of her providers. Later this day the DCYF SW receives a report from one provider that mother is doing okay and has been consistent with her medication.

April 3, 2017 is a note by a CPS Investigator, observing the infant in the PICU. Infant is nonresponsive and intubated. CPI observes scratches on the child's lip and under his right arm with bruising and a possible human bite mark on his left thigh. From the time of the birth of baby there has been no safety assessment and no risk assessment documented in this case, despite the newborn being sent home. No service plan is developed for this newborn until February 6, 2017 although a service plan is required within thirty-days. The only risk and protective capacity assessment completed in this case was upon the birth of the first baby in December 2015, who had yet to be reunified and was only having supervised visitation with mother two (2) hours per week.

DCYF Policy 700.0075 states...

" B. The assessment completed in partnership with the Department worker, child (if age appropriate), parent(s)/caregiver(s), formal providers, informal providers and natural supports to the family.

1. The assessment of safety and risk and subsequent decisions are made while considering the child's need for permanency and well-being and occur throughout the duration of the family's involvement the

Department, specifically at critical decision points including, but not limited to:

- a. Initial opening to the Department,
- b. Change in family circumstances,
- c. Change in placement of child(ren) and
- d. Reunification and case closure..."

Despite the above policy and this case meeting at least two of those critical decision points, no assessment is completed by DCYF. The safety assessment documented by the DCYF SW was on April 3, 2017, the day the infant was admitted to the PICU. This infant was allowed home with parents although there was no verification by DCYF of any information reported by mother or father.

In the second fatality case when DCYF CPS Hotline received information of the birth of the baby an investigation was initiated. CPI report stated mother has a lengthy history with DCYF notable for substance abuse and neglect. Mother has three (3) other children placed under Guardianship of other individuals. Mother tested positive for drugs at the birth of this child and admits to using marijuana during her pregnancy. Mother admits she smokes marijuana as a way to self-medicate for her bi-polar disorder and admits to not being engaged in treatment for this mental health diagnosis. Mother states she and the father of the baby are together and they have a healthy supportive relationship and have sustained their friendship for years. Mother advises she has many supports including her elderly grandmother who lives in the home. Grandmother reports she suffers from her own medical conditions but is a good support to mother. Grandmother is aware mother uses marijuana but states she does not use when the children are present.

Father of the newborn states he is not together with mother, but they are good friends. Father reports having no concerns regarding mother's drug use.

Legal guardian to two of mother's other children states there no concerns of neglect or risk to the children and often lets mother spend time with the two children. This guardian denies mother uses drugs and states mother is stable in terms of her mental health.

A friend of mother's states mother does not use drugs and is stable in terms of her mental health and feels the newborn would be safe with mother.

This case is indicated for Physical Abuse (Drug and Alcohol Abuse) as to newborn based on the fact mother admitted to smoking marijuana during her last trimester as well as substance abuse being a long-standing issue in mother's history.

This newborn is allowed home with mother and a safety plan is set up wherein Maternal Great Grandmother, father of the baby and other supports will be present with mother, and provide support and supervision to mother and newborn to ensure the safety of the baby. Mother is planning to follow up with mental health counseling. The Decision in the Child Safety Assessment indicates newborn is conditionally safe with mother.

While it is clear the policy and protocol regarding an assessment was followed in this case the information presented in mother's history and the above investigation indicates a significant risk to the infant, as an infant has zero ability to protect itself. Additionally, mother consistently told her DCYF SW there would be no co-sleeping, mother unfortunately allowed co-sleeping to take place in her home and allowed her other children to share the bed with the infant. On the night of this infant's death mother had left the home and the newborn was in the care of siblings. Mother came home after 3 AM and noticed infant in bed with a sibling. Despite mother's safety plan and re-occurring conversations with her DCYF SW about the dangers of co-sleeping, mother allowed the infant to remain in the bed with sibling.

II. VERIFICATION OF SELF-REPORTED INFORMATION

In March 2016 and March 2017, the Child Fatality Review Panels raised concerns related to the verification of information by the Department when reported by a case participant. Specifically, information related to compliance with services or the health and safety of the child should be independently verified by the Department. For example, if a parent reports that they have been taking their child to a particular provider or have followed through with referred services, it would be important to follow through and ensure that the information being provided is in fact accurate.

In one of the cases under review, the father reported that the child had been moved to a new daycare facility. The verification of this information was vital. One of the main components of the safety plan for this family was that the child would never be left alone with the mother. Unfortunately, it was not learned until after the fatal injuries to the child were inflicted that the "daycare" the child was attending was actually the address for a vacant building. The Department had possessed this information for several months without ever verifying its validity.

Additionally, in another case under review, the mother was advised of the dangers of co-sleeping. Mother assured those involved in her case that she was utilizing safe sleep practices. However, after the child's death, it was discovered that mother rarely, if ever, had the child sleep in their crib or bassinet. While on scene the CPI noted that both the crib and the bassinet were

cluttered with items and it appeared as though the areas were used for storage. At the time there were in-home providers working with the family as well as DCYF involvement. Both the provider and the DCYF social worker note that they reviewed safe sleeping practices with the mother. However, it appears from the record that the provider openly admits to their failure to observe where the infant was sleeping. It is unclear from the record whether this was reviewed by the social worker.

The ramifications of reliance on information provided by case participants without verification of accuracy or validity was evident in the cases reviewed. The Department needs to strongly consider their practices pursuant to the verification of information prior to making vital decisions within a case. This can be addressed through policy reform, additional training and heightened supervision.

III. LEGAL REPRESENTATION OF A CHILD

In fulfilling the role as a child's Guardian *ad litem* the sole purpose is to ensure that the best interests of the child are being met. This is done through legal advocacy, visiting the child to ensure that there are no concerns with their placement, attending meetings, contacting providers involved with the family and child and ensuring that the plan set forth for a child is in their best interest. When working with children involved with the child welfare system, you are representing a vulnerable population who are often in high-risk situations. Ensuring the child's safety and well-being is a vital component of this role; as the Guardian *ad litem* you are the voice of the child. This is not a role which should be taken lightly, not a job where you can be complacent, as the Guardian *ad litem* (GAL) you must be vigilant in your duties as a child with no protective capacity is relying on you.

In one of the cases under review, the GAL noted concerns to the DCYF Social Worker regarding the plan for the child to go home after the GAL spoke with the hospital SW and described Mother as being dysregulated. After voicing these concerns for the safety of the child going home, no formal motion was ever filed in objection to this plan. The child was subsequently sent home with an inadequate safety plan. Additionally, it does not appear that any formal Court reports were submitted by the GAL to outline these concerns or to provide the information relayed to the GAL. Furthermore, it is unclear from the record whether the GAL went to see the child in their placement providing the opportunity to make observations regarding the placement and the well-being of the child.

The GAL has a unique obligation to present the facts of the case and make recommendations pursuant to ensuring the best interests of the child only. Court reports should be submitted for every Court appearance. Prior to submitting these reports, the GAL should take the opportunity to contact providers, the Department and the child to ensure that information provided is accurate and up to date. Should a problem be identified, this will provide the GAL with the opportunity to file a motion and prepare arguments.

IV. PARENTAL SUBSTANCE ABUSE

a. Strict Adherence to DCYF Policy 500.0010, Alert to Area Hospitals—Safety of Unborn Child

In one of the cases under review, a professional reporter contacted the Hotline to let them know that mother had sought medical treatment. During this visit it was discovered that mother was approximately twenty-five (25) weeks pregnant; had no prenatal care and tested positive for a variety of substances including cocaine and opiates. The mother signed herself out, against medical advice. At the time of this phone call, mother was open to the Family Services Unit and did not have custody of her other children. Based on the current DCYF policies, this call was correctly categorized as an Information/Referral. However, pursuant to policy 500.0010, investigation criteria 5, which states that "...the Department [is allowed] to release information if it is determined that there is a risk of physical injury by a person to himself/herself or others and that disclosure of the records is necessary to reduce that risk. The Department issues an alert to area hospitals when a parent has a history of substantiated child abuse/neglect or a child abuse/neglect conviction and there is a concern about the safety of the child." Reasons for an alert may include, but are not limited to: "a. Parent has exhibited behavior or conduct that is seriously detrimental to a child of a duration that renders it improbable for the parent to care for a child for an extended period...e. Parent has had his/her parental rights to a sibling of the child terminated involuntarily...f. There is a history of chronic substance abuse by one or both parents...h. Parent has a history of mental or emotional disability, which has proven to render the parent unable to care effectively for his or her children." The alert instructs local area hospitals to contact the CPS Hotline when the child is born, providing the Department with the opportunity to take legal action when necessary, provide services to the family and make necessary arrangements to ensure the newborn's safety and well-being. If this policy is not adhered to, the opportunity can be missed, thus putting newborns and infants at a significant safety risk.

Unfortunately, in the aforementioned case, a hospital alert was not issued following the call to the Hotline by the professional reporter. It was not until a second call was made six (6) days later

reporting similar allegations of substance abuse by mother who is pregnant was a hospital alert then issued. However, if the second call had not been made, this case could have been overlooked and the opportunity to plan for the infant's safety could have been missed. Strict adherence to this policy provides the Department with the opportunity to be proactive in their planning for the child, avoiding the placement of newborns into high-risk situations. Child welfare workers and other state agencies must be proactive, not reactive with parental substance abuse on the rise in our state.

b. Strict Adherence to DCYF Policy 500.0125—Drug Usage During Pregnancy

Pursuant to DCYF Policy 500.0125, all calls to the Child Abuse Hotline alleging drug use or alcohol use by a pregnant woman shall be considered. Calls making such allegations can be received "...during the pregnancy, after delivery while the newborn is at the hospital or after a newborn is already home." *DCYF Policy 500.0125*. This policy also states that "...[b]abies born with drugs in their systems, as evidenced by a positive toxicology screen at birth or observable withdrawal symptoms, babies born to mothers who admit using drugs during pregnancy or who have been observed ingesting drugs and babies born with fetal alcohol syndrome must be reported to the Child Abuse Hotline. A Report of Examination is completed by the attending physician/nurse practitioner. All such reports are investigated by the Department. If the investigation is founded and to ensure these babies and their families are provided with necessary intervention, treatment and services, the assigned Child Protective Investigator (CPI) consults his/her supervisor and DCYF Legal Counsel as to the advisability of requesting an Order of Detention, Ex Parte, or a Straight Petition. Whether or not a Straight Petition is filed, the assigned Child Protective Investigator (CPI) refers the family to community services as appropriate." *DCYF Policy 500.0125*.

In one of the cases under review, allegations were also made that she was using marijuana and Adderall during pregnancy; this call was made an I/R, however a hospital alert was sent. Upon delivery of her child, mother admitted to using marijuana during the course of her pregnancy and tested positive for both marijuana and opiates during the birth of her child. The hospital does note that she was provided an opiate during her delivery, which may have accounted for the positive screen. Pursuant to this policy, both mother's admission to drug use during her pregnancy and her positive screen at the birth of her child prompted a legal consult and CPS was directed to file a Straight Petition. However, due to the admission of drug use, a long-standing history of substance abuse and the removal of her prior three children, it is the opinion of the Panel this was a high-risk situation, which should have prompted further legal action. Upon review of this matter, the Office of the Child Advocate recognized the risk factors present in this case and realized no petition had been

filed in the matter, despite the result of the legal consult. Furthermore, due to the risk factors involved and the aforementioned policy, the mother and the child should have been aligned with the appropriate level of services, which in this matter should have included in-home services at the very least to ensure the safety of the infant. The Office of the Child Advocate contacted the Department with these concerns. The following email was sent to the Department on April 21, 2017:

The OCA is following up on a recent I/R regarding XXXX. XXXX has a history with DCYF significant for drug abuse, criminal activity and untreated mental health issues. Mother gave birth on April 18, 2017. Upon completion of an investigation mother was indicated for physical abuse (drug and alcohol abuse). The biological father also has a significant substance abuse history as well as criminal history. The OCA has grave concerns for this newborn. The most significant concern for the OCA is the newborn was sent home with mother. While the OCA understands a safety plan was put into place, this is extremely reminiscent of previous safety plans wherein an infant subsequently died, was significantly abused or was placed in a high-risk situation with detrimental results. Mother also has three other children that are under the Guardianship with her mother and while she spends time with these children they are also of an age of increased capacity to protect themselves, wherein an infant has no capacity to self-protect. The maternal great grandmother has her own medical issues, the bio father has his own substance abuse issues and mother readily admits having bi-polar disorder, self-medicates and has not received any kind of therapy/treatment to adapt to her living with her mental illness. It is reported mother has made an appointment with [a mental health provider], however scheduling an appointment does not appear to be a strong factor to measure mother's level of engagement or motivation. Realistically this does not appear to be a safe environment when reviewing the totality of circumstances. Please do not hesitate to contact this office with any questions.

c. Comprehensive Addiction and Recovery Act of 2016

On July 22, 2016, President Barack Obama signed the Comprehensive Addiction and Recovery Act of 2016 ("CARA") into law. One section of this legislation addresses the effects of substance use on infants, children and families. More specifically, Section 503 adds requirements to the Child Abuse Prevention and Treatment Act ("CAPTA") providing that when it is discovered that a baby was exposed to substances, both legal and illegal, this must be called in to the DCYF Hotline.

Furthermore, each infant exposed to substances must leave the hospital with an Infant Plan of Care addressing the treatment needs of the infant due to substance exposure. There also needs to be a plan of care for the mother and her family who have been affected by this substance use.

Furthermore, the plans of care must now be monitored by a designated person or entity. The person tasked with the responsibility to monitor the care plans must ensure that treatment needs are being met and referrals are being completed. At this time, it remains unclear whether a monitor has been identified, however, as the oversight agency for the Department, the Office of the Child Advocate would not be opposed to fulfilling this role if provided the adequate staff, resources and data necessary to fulfill this function.

Additionally, the Comprehensive Addiction and Recovery Act of 2016 outlines changes to the federal reporting requirements within the Child Abuse Prevention and Treatment Act. In accordance with CAPTA, the Department is now required to report the number of infants affected by substance use disorder, the number of children who have been provided with safe care plans and the number of infants for whom service referrals were made, including services for parent or caregiver.

Although it is our understanding that the Department has started the process to implement the changes set forth by this legislation; nothing has been finalized as of yet. It is also the Panel's understanding the State of Rhode Island has yet to develop a uniform Plan of Care document nor has a person or agency been identified to monitor in accordance with the new federal legislation. With the number of children affected by parental substance use on the rise, it is imperative the Department finalizes the necessary changes, implements corresponding policies and ensures that any gaps in the service array to utilized to support children and families affected by substance use, are addressed. CARA provides for grant funding for states to enhance their service array for children and families affected by substance use. Specifically, CARA amends the Public Health Service Act, 42 U.S.C. 290bb-1, to provide funding to assist substance abuse agencies address gaps in services provided to women along the continuum of care, including community-based services; provide support for family-based services for pregnant and post-partum women struggling with substance use disorder and assist with therapeutic, comprehensive child care while a mother is engaging in therapy or other rehabilitative activities. If the Department has not done so already, they should utilize the grant funding available to enhance the service array in Rhode Island to support families affected by substance use.

V. POTENTIAL LEGISLATIVE CHANGE FOR THE 2018 SESSION

a. R.I.G.L. § 42-73-2.3

R.I.G.L. § 42-73-2.3 requires the Office of the Child Advocate to review any child fatality or near fatality when “[a] sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months...” This is the first time the OCA is reviewing a fatality or near fatality pursuant to this section of *R.I.G.L. § 42-73-2.3*. Although the OCA is committed to enforcing each component of our statutory mandate, we encountered some barriers with obtaining records to appropriately review this type of case. Pursuant to *R.I.G.L. § 42-73-8 and R.I.G.L. § 42-73-9*, the OCA has access to records for children and families involved with the Department of Children, Youth and Families.

In one of the near fatalities reviewed, a caretaker/household member had prior involvement with the Department; the OCA had the ability to access any and all records of his involvement. However, since the victim and the child’s parents did not have any prior DCYF involvement the panel did not have any access to their records. This hindered the OCA and the Panel’s ability to effectively review the circumstances surrounding the injuries of their child by another household member. It is unclear as to whether this case presents a unique scenario, however, the Panel believes that providing the OCA with statutory authority access to records for any case to be reviewed pursuant to the office’s statutory mandate will prevent such barriers in the future.

RECOMMENDATIONS

Subsequent to careful consideration of the six (6) cases before the Child Fatality Review Panel, the Panel has developed numerous recommendations, which we are seeking to have implemented in a timely manner. The panel’s goal is to implement change to target systemic issues and ultimately improve the safety and well-being of children. It should be noted that the OCA completed a review of four (4) child fatalities and two (2) near fatalities and released a report outlining the findings and recommendations of the panel in March 2017. Some of the recommendations made in March 2017 were the same recommendations made by the Child Fatality Review Panel in March 2016, which reviewed three additional cases involving infants. Since the release of the March 2017 report the Department has worked to implement many of the recommendations made by the Panel. The OCA is cognizant of the fact that for the proper implementation of some of these recommendations it will take an investment in the system but it will also take time. However, there are several vital recommendations, which have yet to be executed and remain relevant after analyzing the cases before the current Child Fatality Review Panel. The panel believed it was important to continue to

highlight each one to illustrate their importance and the necessity. After careful consideration, the Child Fatality Review Panel is proposing the following recommendations:

1. The Department should adopt and integrate a comprehensive set of standardized, evidence-based investigation and risk assessment tools that address the needs of children and families at every level of their involvement. Particular attention to determining the best tools and process for children under the age of six with multiple reports to the Department. Explore investigation and assessment tools that utilize Structured Decision Making and screening tools for Adverse Childhood Experiences (ACES). *This was a recommendation made by the March, 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel. **The Department is actively working to upgrade RICHIST and implement the Structured Decision Making and standardized screening tools. However, since this is still a “work in progress” and would have assisted in some of the cases under review, the Panel felt it was important to reiterate this recommendation.*** Realizing that implementing a change of this magnitude will take much research, planning, funding and most importantly time, the Child Fatality Review Panel would like the following changes to be implemented under the current system, effective immediately:
 - a. Following the receipt of a call involving allegations of abuse or neglect of a child under the age of six (6), a Child Protective Investigator should be mandated to respond to the home and put eyes on the child, to assess potential risks and ensure the safety and well-being of the child. *This was a recommendation made by the March, 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.*
 - b. That the Department develop a policy, which outlines in great detail the way in which a call made to the Child Abuse and Neglect Hotline, should be recorded into RICHIST, DCYF’s electronic database. This policy should reflect that any and all calls made to the Hotline should be recorded in the “Intake” section so the system reflects the proper number of calls, which have been made regarding a specific family. The policy should also state that a call should never be recorded solely in the “Case Activity Notes”. This will prevent a skew in the data regarding the number of calls that have been made to the Hotline, will provide a more accurate and readily available depiction of what has transpired with a particular family, and to provide workers and other entities an enhanced ability to rapidly assess the risks involved

with a family. ***This was a recommendation made by the March, 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***

- c. Complete overhaul or repeal of DCYF Policy 500.0040, *Information/Referral (I/R) Reports*. A more strict procedure for the use of the category must be developed to prevent its misuse. Although, the OCA has observed that the use of the Information/Referral category has been subject to additional administrative oversight with cases being upgraded to investigations, the Panel still recommends the repeal of this policy and the development of various categories, which are more indicative of the type of call received rather than the use of a catch-all category. Additionally, should a call rise to the level of warranting an investigation under DCYF Policies, an investigation should in fact be completed by a CPS employee and should not be categorized as an "Information/Referral". ***This was a recommendation made by the March 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***
- d. The Department should improve the verification of reports indicating participation in medical and other services, which are self-reported by families or foster families. This information should be verified with the service provider or other relevant entities prior to closing a CPS investigation, termination of DCYF involvement, or approving relative or other foster care licenses. ***This was a recommendation made by the March 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***
- e. That DCYF, more specifically CPS, should not categorize a child fatality or near fatality as an "Information/Referral", especially when the family has had prior involvement with DCYF. The Department should develop a specific policy and protocol when processing this information and develop an unambiguous category for this information. This will provide a more accurate depiction in the record of what has transpired within a particular case and will assist with the computation of accurate statistics regarding child fatalities and near fatalities for public reporting. ***This was a recommendation made by the March, 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***

- f. Training of CPS and Intake staff to ensure quality of information recorded and reports distributed. Ensure that all pertinent information is being recorded in RICHIST, in a timely manner, to provide subsequent users with all necessary information to properly assess each case. Enhance the quality of service provided to reporters and families. Provide extensive training to staff on any newly implemented model utilized by CPS in response to the recommendations provided in this report. ***This was a recommendation made by the March 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***
2. The Department should improve the verification of reports indicating participation in medical and other services, which are self-reported by families or foster families. This information should be verified with the service provider or other relevant entities prior to closing a CPS investigation, termination of DCYF involvement, while a case is open or prior to approving relative or other foster care licenses. The ramifications of reliance on information provided by case participants without verification of accuracy or validity, was evident in the cases reviewed. ***This was a recommendation made by the March 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***
3. The Department should implement a policy, which requires increased oversight and heightened scrutiny by Regional Directors for cases deemed to be high-risk situations. The Regional Director should have access to any and all reports, records and other pertinent information prior to making a decision regarding the case.
4. Training of staff to ensure quality of information recorded and reports distributed. Ensure that all pertinent information is being recorded in RICHIST, in a timely manner, to provide users with all information to properly assess each case. Additionally, heightened oversight to ensure that the information being distributed is complete and provides an accurate depiction of the current status of the case.
 - a. That the Department draft a policy which will outline specifications and timing for record entry to ensure timely and accurate completion of records.

- b. That all case files including but not limited to, case activity notes and court letters be reviewed on a supervisory level regularly to ensure consistent administrative review of cases and oversight of each worker. Additionally, the Department should ensure that Supervisors and/or Social Workers independently verify information provided to them by case participants, including but not limited to providers, psychiatrists and self-reporters. Thus ensuring accuracy before finalizing risk assessments, safety plans or making other vital decisions about the plan for the case.
5. The Department needs to ensure strict adherence by their staff of *DCYF Policy 700.0075—Comprehensive Assessment and Service Planning* and the corresponding protocol to ensure the safety of children in state care.
6. The Department look to national best practices and create a standardized assessment tool. This tool should be utilized by CPS and FSU in their evaluation of risk and safety of a child. This will ensure that consistent and quality evaluations are being completed.
7. That any attorney, including but not limited to Court Appointed Special Advocates, serving as a child's Guardian *ad litem*, provide the Family Court with a written report for each court appearance documenting the progress of the case, reports from providers and any other information pertinent to the case. Additionally, prior to each court appearance the Guardian *ad litem* shall collect information independently from case participants, providers and DCYF to verify that the information provided to the Court is complete and accurate. In this report the Guardian *ad litem* should make recommendations in pursuit of ensuring the best interests of the child.
8. That any attorney serving as a child's Guardian *ad litem* meet with their clients face to face in their residence and attend any and all meetings necessary to be an effective advocate for the child.
9. That the Office of the Child Advocate's statutory mandate provides the ability to complete trainings for Guardian *ad litem*s. In collaboration with the Rhode Island Family Court, the Office of the Child Advocate will seek to hold a training in 2018.

10. The Department needs to develop a robust array of community-based services to meet the complex needs of the children and families they serve. Focus on the needs of infants and young children with parental substance abuse, mental health, domestic violence and other risk factors, is recommended. ***This was a recommendation made by the March, 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***

11. That the use of medical marijuana by a primary caretaker, regardless of its legality, be assessed by the Department as a risk factor, similar to alcohol and prescription medication when determining risk and need for a family. ***This was a recommendation made by the March 2017 Child Fatality Review Panel and is being recommended again by the current panel based on the issues presented in the cases under review.***

12. That the Department strictly adhere to *DCYF Policy 500.0125*, to ensure the appropriate level of DCYF involvement upon the confirmation of drug use by a parent during their pregnancy. ***This was a recommendation made by the March 2017 Child Fatality Review Panel and is being recommended again by the current panel based on the issues presented in the cases under review.***
 - a. That the Department review *DCYF Policy 500.0125* and implement clear procedures as to when an Ex-Parte opposed to a Straight Petition should be filed when there is a confirmed case of parental substance abuse. This will ensure a more consistent application of this policy by the Department. Additionally, the policy should require that in a case when an infant is to be discharged home with a parent after confirmed substance use during pregnancy, that any and all support services be in place prior to the infant's discharge home.

13. That the Department strictly adhere to *DCYF Policy 500.0010, Alert to Area Hospitals—Safety of Unborn Child*. When the Department receives a call reporting drug use during pregnancy and it is verified by one of the forms of evidence outlined in *DCYF Policy 500.0125*, this should prompt an immediate hospital alert. This will ensure that the hospital is on notice to test the mother and baby upon birth and subsequently alert the Department of the birth of the child to provide the opportunity for further assessment for services or potential legal intervention. ***This was a recommendation made by the March 2017 Child Fatality***

Review Panel and is being recommended again by the current panel based on the issues presented in the cases under review.

14. That the Department implement policies and procedures to ensure compliance with the new CAPTA requirements set forth in the Comprehensive Addiction and Recovery Act of 2016.
15. That pursuant to the requirements outlined in the Comprehensive Addiction and Recovery Act of 2016, a monitor for the infant care plans and oversight of timely referrals for children and families affected by substance use, be identified.
16. That the Department assess and identify gaps in the service array for families affected by substance abuse. If gaps are identified, pursue grant funding provided for by the Comprehensive Addiction and Recovery Act of 2016.
17. That Child Protective Service Unit and Family Service Unit undergo routine training on the Department's policies and Rhode Island General Laws, to ensure consistency amongst the workforce in the application of the policies and laws in the field. With numerous changes being made to the current policies, this will be particularly important once those changes are executed.
 - a. Pursuant to *R.I.G.L. § 42-73-11(3)*, that the Department, “ [d]evelop a policy and procedure manual to be available to all staff workers”.
18. That service providers, Family Service Unit and Child Protective Services Unit, participate in a training facilitated by a specialist in child abuse pediatrics to gain more experience on the early signs/symptoms of child abuse and neglect and what to look for during a home visit or investigation.
19. Ensure compliance with mandatory training requirements for all DCYF employees. In accordance with *R.I.G.L. § 42-72-5 (10)*, which requires the employees of DCYF to complete a minimum of twenty (20) hours of training per year. ***This was a recommendation made by the March 2016 and March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***

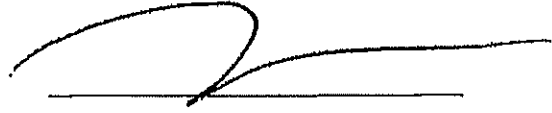
20. That the Department of Health, local hospitals, the Department of Children, Youth and Families and the Office of the Child Advocate collaborate to develop strategies to increase public awareness of the dangers of co-sleeping. Also, begin a pilot program in a high- risk community to test any recommendations of the inter-agency collaboration. ***This was a recommendation made by the March 2017 Child Fatality Review Panel and is being recommended again by the current panel based on the issues presented in the cases under review.***
21. That a mandatory training on safe sleep practices be provided to all community based providers working with children ages 0-3 by an expert in the field. Part of the curriculum should include observations to be made when conducting home visits. That all community based providers working with children ages 0-3 be contractually required to include a review of sleep practices with participating parents and observe a child's sleeping arrangements to ensure that safe sleep practices are being implemented.
22. That the Office of Vital Statistics reinstitute their previous Memorandum of Understanding with the OCA, to provide the OCA with notice of every recorded child death from ages 0-21. This will provide the OCA with the opportunity to ensure that there has been no previous involvement with the Department and assist the OCA with the necessary data to better inform policy and legislative change. ***This was a recommendation made by the March 2017 Child Fatality Review Panel and is being recommended again by the current panel.***
23. That the timely implementation of each of these recommendations be overseen by an Oversight Committee.
- a. That the Department submit a work plan to address each of the current and past recommendations, outlining the resources necessary to fully implement the recommendations, the approximate timeline for completion and any identified barriers for the successful execution of the recommendation.
 - b. That the Department submit progress reports for each convening of the Oversight Committee.

24. That the Department, in collaboration with the OCA, evaluate the methods utilized in other states to determine best practices for tracking data on child fatalities and near fatalities.
This was a recommendation made by the March 2017 Child Fatality Review Panel and is being recommended again by the current panel.
25. That R.I.G.L. § 42-73-2.3 be reviewed to determine whether the Office of the Child Advocate's statutory authority for access to records needs to be expanded upon to alleviate barriers when obtaining records for review of a child fatality or near fatality.
26. For the Department to strictly adhere to the statutory obligations delineated in R.I.G.L. § 42-72-8, including but not limited to R.I.G.L. § 42-72-8 (c)(2) which states "The director shall make public disclosure of a confirmed fatality and near fatality of a child that is the subject of a DCYF case within 48 hours of confirmation, provided disclosure of such information is in general terms and does not jeopardize a pending criminal investigation." **NOTE:** There has been a drastic improvement regarding the public disclosure of child fatalities and near fatalities, however, for one of the cases under review no public disclosure was made.
27. That the OCA be provided with appropriate staff and resources to have the ability to effectively monitor the Department and provide a heightened level of oversight, which has become increasingly necessary to ensure the safety and well-being of children in state care.

Respectfully Submitted By,



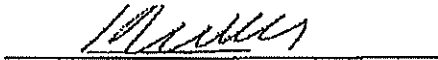
Darlene Allen, MS



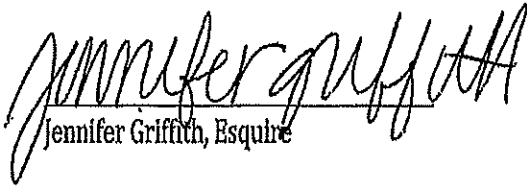
Molly Kapstein Cote, Esquire



Kathryn R. Cortes



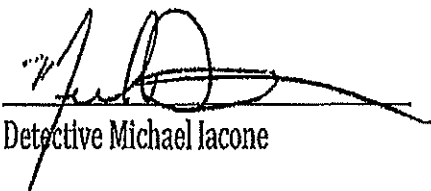
Ken Fandetti, MS



Jennifer Griffith, Esquire




Lisa Guillette



Detective Michael Iacone



Catherine Lewis



Katelyn Medeiros, Esquire



Adam Pallant, MD

APPENDIX A

Child Fatality Review Panel and Staff

Darlene Allen, MS Darlene joins the panel as a representative of the RI Coalition for Children and Families, an advocacy organization with 28 organizations serving thousands of children across the state. Darlene is an experienced child welfare leader who has dedicated her career to helping at-risk children and families. She has worked in both public and private organizations. Her focus has included child protective services, family preservation, permanency and adoption. For the past 16 years, Darlene has been the Executive Director of Adoption Rhode Island, a private non-profit organization that provides a range of trauma-focused and evidenced-informed services for foster and adopted children and their families.

Darlene is also a consultant for JBS International where she has participated in federal child and family service reviews in numerous states across the nation. Darlene is the Treasurer for the Adoption Exchange Association, the national non-profit that oversees the AdoptUSKids partnership, a member of the Family Builders Association Network, Vice-Chair of the Rhode Island Coalition for Children and Families and a member of the Healthy Youth Transition Subcommittee of the Governor's Council on Behavioral Health. Darlene has been a member of numerous workgroups that address safety, well-being and permanency for children and youth impacted by foster care over her many years in the field. She is a frequent presenter and public speaker on behalf of children in foster care. Darlene received her undergraduate degree at Providence College and her Master's Degree at the University of Massachusetts, Boston. Darlene has also participated in numerous non-degree conferring educational opportunities. She recently completed an executive education course in leadership at the Harvard Kennedy School of Government.

Kathryn Cortes Kathryn Cortes is currently the Senior Monitoring & Evaluation Specialist at the Rhode Island Office of the Child Advocate (OCA). Kathryn previously served as the Chief Field Investigator for the OCA from 2007 to 2013, until she was promoted. Kathryn has a Bachelor of Arts in Criminal Justice and Juvenile Justice from Salve Regina University located in Newport, RI. Prior to joining the OCA staff in 2007, Kathryn worked as the Senior Residential Counselor at Child and Family Services of Newport County in Newport RI. There, Kathryn worked to maintain a safe and therapeutic living environment for boys ages 6 through 12, which provided a structured program that promoted daily life skills, mental health services, and educational skills for the boys. Following her six years at Child and Family Services, Kathryn moved onto Civigenics, Inc. in Marlborough, MA where she spent four years as the Program Director of a therapeutic milieu program located in the Rhode Island Training School for Youth (RITS).

Kathryn remains an involved member of both the professional and personal community in RI. Her activities and volunteer positions include: serving as a Member of the Rhode Island Child Death Review Team, Member of the LGBTQ Youth Committee, Executive Board Member of the RI Chapter of the American Foundation for Suicide Prevention (AFSP), Member of the JDAI Girls Work Group, Member of the Youth Suicide Prevention Subcommittee, and acts as the Legislative Field Advocate for AFSP. Kathryn is also very involved with the Smithfield High School Football team, where her son currently plays.

Molly Kapstein Cote, Esquire Molly earned her B.A. from the University of Michigan and her Juris Doctorate from Suffolk University Law School. Molly began her legal career as a law clerk for the Rhode Island Supreme Court from 2001-2002. Subsequent to working for the Supreme Court, Molly served as a state prosecutor with the Rhode Island Department of Attorney General from 2003-2010. During her career as a Special Assistant Attorney General, she was assigned to the Providence Trial Calendar where she handled a variety of cases ranging from child molestation to homicide matters. After working at the Department of Attorney General, Molly joined Lynch, Lynch & Friel in 2010 where she practiced for six years before opening her own office. Since leaving the Attorney General's office, Molly's practice has focused in the areas of criminal defense and domestic relations, including matters involving DCYF. In 2014, the Chief Judge of the United States District Court for the District of Rhode Island appointed Molly to serve as an attorney to the H.O.P.E. Court Program in that court. The H.O.P.E. Court is a re-entry court program designed to prevent high-risk criminal defendants from re-offending upon their release from Federal custody. Molly continues to work in that capacity. Molly also serves as a Bail Commissioner with the Rhode Island District Court and is a member of

the Rhode Island District Court Criminal Rules Committee which is tasked with advising that court on matters relating to the District Court rules of criminal procedure. Molly has presented at the annual Rhode Island Bar Association Meeting on the topics of resolving a criminal case by way of civil settlement and also about the consequences of a plea in a criminal case. Since 2010, in addition to her law practice, Molly has worked as an adjunct professor of law at Roger Williams University Law School where she teaches Trial Advocacy and is the director of the Prosecution Externship Program.

Ken Fandetti Ken earned his BA in Sociology from Providence College and a Master of Science in Social Services from the Boston University School of Social Work. Throughout his career, Ken served in a variety of public social service roles bringing a wealth of knowledge and experience to the team. Some of his past roles include, Social Caseworker for the Rhode Island Department of Children, Youth and Families; Family Court Liaison Worker for Child Welfare Services; Residential Services Coordinator Department of Corrections Juvenile Division; Assistant to the Director Department of Corrections; Superintendent Rhode Island Training School for Youth; Assistant Director of the Division of Direct Service of the Department of Children, Youth and Families; Project Director to establish the Rhode Island Child Abuse and Neglect Tracking System (CANTS); Assistant Director of the Child Protective Services Division at the Department of Children, Youth and families; the Executive Director of the Rhode Island Department of Children, Youth and Families and the Acting Director of the Rhode Island Department of Children, Youth and Families. Additionally, Ken served as an Ad Hoc Committee Member reporting on abusive treatment of children at the Rhode Island Children's Center, Rhode Island's State Liaison Officer to the National Center on Child Abuse and Neglect (NCCAN) and was the founding member of the New England Association of Child Welfare Commissioners and Directors. Ken has since become a certified sea kayak instructor for both the American Canoe Association and the British Canoe Union.

Jennifer Griffith, Esquire Jennifer Griffith was appointed by Governor Gina Raimondo on March 17, 2016 and received the advice and consent of the Rhode Island State Senate on April 7, 2016 for a five year term as the Child Advocate for the State of Rhode Island. She is a graduate of the College of the Holy Cross and Roger Williams School of Law. She is admitted to practice law in Rhode Island, Massachusetts and the United States Federal District Court of Rhode Island. Previously, she was a staff attorney at Rhode Island Legal Services for ten years handling all family law matters. She is a member of the Rhode Island Women's Bar Association, the Executive Board of the Rhode Island Family Inn of Court, the Rhode Island Family Court Bench Bar Committee, the Rhode Island Children's Cabinet, the Rhode Island Child Care Commission, the Rhode Island Child Support Advisory Committee, the Human Trafficking Task Force and the Rhode Island Juvenile Justice Advisory Committee.

Lisa Guillette Lisa Guillette is the Executive Director of Foster Forward, a statewide non-profit organization supporting foster families and children and youth in state care. Ms. Guillette has twenty-five years of professional experience in education and child welfare in Rhode Island, and has served in her current role for over thirteen years. During her tenure, Foster Forward (formerly the Rhode Island Foster Parents Association) has grown from being a small grassroots association to a recognized leader in child welfare practice: earning multi-million dollar competitive contracts and grant awards from the State of Rhode Island, the federal government and private funders.

Ms. Guillette served on the Rhode Island Joint Legislative Commission on the Education of Children and Youth in DCYF care and is an appointed representative to the Governor's Advisory Council on Homelessness. She is an active member of the United Way's Women's Leadership Council, chairing the Executive Committee and serving on the Membership Committee. Ms. Guillette was honored in 2005 with a United States Congressional *Angels in Adoption* Award, was recognized by the YWCA of Northern Rhode Island in 2007 as a "Woman of

Achievement” and in 2011 was the recipient of the national Rama Ramanathan Commitment to Service Award from the Jim Casey Youth Opportunities Initiative. She holds a Bachelor of Arts Degree in Social Work and a Master’s Degree in Business Administration from Providence College. Ms. Guillette resides in Providence with her husband and three children.

Detective Michael Iacone Detective Michael Iacone has been a police officer for the City of Cranston since 2002. He is currently assigned as a Detective in the Special Victims Unit where he handles all sexually-based crimes, as well as crimes against children and the elderly. In 2002, Detective Iacone graduated from Salve Regina University with a Bachelor’s Degree in Administration of Justice. He went on to earn his Master’s Degree in Administration of Justice and Homeland Security from Salve Regina University in 2009.

At this time, Detective Iacone is assigned to both the FBI and HSI Task Force dealing with the commercial sexual exploitation of women and children. Detective Iacone is the law enforcement representative for the Citizens Review Panel at Hasbro Children’s Hospital/Aubin Child Protection Center. This multi-disciplinary team consists of physicians, as well as representatives from the Attorney General’s Office, DCYF, Office of the Child Advocate, and Day One. The team meets weekly to discuss cases of child maltreatment and to determine appropriate measures for each case. Detective Iacone has shown a particular interest in the long-term mental health outcomes of his victims, and he has taken an active role by co-facilitating a support group for adolescent female victims of sexual abuse.

Catherine Lewis, MSW Catherine Lewis is a clinical social worker. She worked at the Department for Children, Youth and Families for nine years, then at Casey Family Services for 20 years specializing in foster care and adoption services. She is currently in private practice.

Katelyn Medeiros, Esquire Katelyn has worked as the Staff Attorney III for the Office of the Child Advocate since May 2014. In February, 2017, Ms. Medeiros was promoted to serve as the Assistant Child Advocate. Ms. Medeiros graduated *summa cum laude* from Rhode Island College in 2010 with a Bachelor’s Degree in Justice Studies and Sociology. She then pursued her Juris Doctorate at Roger Williams School of Law, graduating *magna cum laude* in 2013. In addition, she was a member of the Roger Williams School of the Law Honors Program. She was admitted to the Rhode Island and Massachusetts Bar in November 2013 and the U.S. District Court of Rhode Island in 2014. Ms. Medeiros first worked for the OCA from 2012-2013 as a Rule 9 Intern. She worked in private practice prior to her career with the OCA. Presently, Ms. Medeiros serves as the program director for Project Victim Services for the Office of the Child Advocate.

APPENDIX B

TITLE 42

State Affairs and Government

CHAPTER 42-73

Child Advocate Office

SECTION 42-73-2.3

§ 42-73-2.3. Child fatality reviews.

(a) The department of children, youth and families shall notify the office of the child advocate verbally and electronically within forty-eight (48) hours of a confirmed fatality or near fatality of a child who is the subject of a DCYF case and shall provide the office of the child advocate with access to any written material about the case.

(b) The child advocate, working with a voluntary and confidential child-fatality-review panel, whose members may vary on a case-by-case basis, shall review the case records of all notifications in accordance with § 42-73-2.3(a) of fatalities and near fatalities of children under twenty-one (21) years of age, if:

(1) The fatality or near fatality occurs while in the custody of, or involved with, the department, or if the child's family previously received services from the department;

(2) The fatality or near fatality is alleged to be from abuse or neglect of the child; or

(3) A sibling, household member, or day care provider has been the subject of a child abuse and neglect investigation within the previous twelve (12) months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending.

(c) The child-fatality-review panel shall assess and analyze such cases; make recommendations regarding such cases; and make recommendations for improvements to laws, policies, and practices that support the safety of children. Each report shall be made public within thirty (30) days of its completion.

(d) The members of the child-fatality-review panel, established in accordance with this section, shall be subject to the confidentiality provisions of § 42-73-10.

(e) The child advocate shall publically announce the convening of a child-fatality-review panel, including the age of the child involved.

History of Section.

(P.L. 2016, ch. 342, § 3[4]; P.L. 2016, ch. 368, § 3[4].)

TITLE 42
State Affairs and Government
CHAPTER 42-72
Department of Children, Youth and Families
SECTION 42-72-8

§ 42-72-8. Confidentiality of records.

- (a) Any records of the department pertaining to children and their families in need of service pursuant to the provisions of this chapter; or for whom an application for services has been made, shall be confidential and only disclosed as provided by law.
- (b) Records may be disclosed when necessary:
- (1) To individuals, or public or private agencies engaged in medical, psychological, or psychiatric diagnosis or treatment or education of the person under the supervision of the department;
 - (2) To individuals or public or private agencies for the purposes of temporary or permanent placement of the person, and when the director determines that the disclosure is needed to accomplish that placement, including any and all health-care information obtained by the department in accordance with the provisions of chapter 37.3 of title 5 of the general laws and applicable federal laws and regulations;
 - (3) When the director determines that there is a risk of physical injury by the person to himself or herself or others, and that disclosure of the records is necessary to reduce that risk;
 - (4) To the family court, including periodic reports regarding the care and treatment of children; provided, that if a child is represented by a guardian ad litem or attorney, a copy of the family court report will be made available to the guardian ad litem or attorney prior to its submission;
 - (5) To inform any person who made a report of child abuse or neglect pursuant to § 40-11-3, whether services have been provided the child as a result of the report; provided, however, that no facts or information shall be released pursuant to this subsection other than the fact that services have been, or are being, provided;
 - (6) To permit access to computer records relating to child-abuse and -neglect investigations by physicians who are examining a child when the physician believes that there is reasonable cause to suspect that a child may have been abused or neglected;
 - (7) To the office of the department of attorney general, upon the request of the attorney general or assistant attorney general, when the office is engaged in the investigation of, or prosecution of, criminal conduct by another relating to the child or other children within the same family unit;

(e) If a public panel is convened or established by the department, this panel, in the course of its evaluation, may review, but shall not investigate, any child fatality that is under the jurisdiction of the child advocate in accordance with the provisions of § 42-73-7(2).

(f) In the event records and information contained within DCYF records are shared with individuals or public or private agencies as specified in subsection (b) above, any such individual, and/or public or private agency, shall be advised that the shared information cannot be further disclosed, except as specifically provided for under applicable federal and/or state law and regulation. Any individual and/or public or private agency who or that violates this subsection shall be subject to civil sanctions as provided in chapter 37.3 of title 5, and any other federal or state law pertinent thereto.

History of Section.

(P.L. 1979, ch. 248, § 1; P.L. 1984, ch. 203, § 1; P.L. 1985, ch. 255, § 1; P.L. 1992, ch. 432, § 1; P.L. 1994, ch. 97, § 1; P.L. 1996, ch. 142, § 1; P.L. 1996, ch. 156, § 2; P.L. 1997, ch. 49, § 1; P.L. 1997, ch. 64, § 1; P.L. 1998, ch. 67, § 1; P.L. 1998, ch. 302, § 1; P.L. 1998, ch. 322, § 1; P.L. 1998, ch. 374, § 1; P.L. 1999, ch. 54, § 1; P.L. 1999, ch. 122, § 1; P.L. 2004, ch. 136, § 1; P.L. 2004, ch. 139, § 1; P.L. 2016, ch. 342, § 2; P.L. 2016, ch. 368, § 2.)

Comprehensive Assessment and Service Planning

Rhode Island Department of Children, Youth and Families

Policy: 700.0075

Effective Date: 700.0075

Revised Date: January 24, 2011

Version: 2

The Rhode Island Department of Children, Youth and Families (DCYF) is mandated by federal and state law and Department policy to make reasonable efforts to prevent the child's removal from his/her home, to reunify the child and family and to make and finalize an alternate permanent placement when the child and family cannot be reunited. The Department utilizes a comprehensive assessment and service planning process for each child and family receiving DCYF services from the initial point of contact throughout case closure. This process is guided by principles of family-centered, culturally competent practice and utilizes standardized tools at various points throughout the Department's involvement with a family. Family represents the focus of all work and family members are engaged through the development and implementation of any plan. The family is defined broadly and includes biological parents, adoptive families, extended kinship networks, legal guardians and foster families.

Department staff engage families in accordance with DCYF's vision, mission and family centered practice principles. Department staff:

- Believe family engagement contributes to child safety, recognize that the family is the constant in the child's life and ensure that children maintain connections with those who matter to them;
- Partner with families and community providers through open, honest, respectful, ongoing discussions regarding rights, responsibilities, permanency, time frames and access to timely services to meet the safety needs of the children and families;
- Recognize and respect the racial, ethnic, cultural, sexual orientation and expression, special needs and socioeconomic diversity of all families and learn how such areas impact a family's parenting and decision making;
- Understand and incorporate the developmental needs of infants, children and adolescents and their families into service delivery systems;
- Link families to services that are flexible, culturally and linguistically competent and responsive to family needs;
- Continually assess family and child strengths, individual needs and modify plans accordingly; and
- Facilitate family and professional collaboration with formal, informal and natural supports, including family-to-family support and networking.

The comprehensive assessment and service planning process identifies, considers and weighs factors that affect child safety, permanency and well-being. This process recognizes patterns in behavior over time and examines family strengths and protective factors to identify resources that can support the family's ability to protect the children. A child is considered safe when evaluation of all available information leads to the conclusion that the child in his or her current living arrangement is not in immediate danger of harm and no interventions are necessary to ensure the child's safety. If the child is not safe, immediate interventions must be taken to ensure the child's safety. Safety interventions are responsive to the immediate and imminent danger of harm to the child and are not expected to impact identified risks of future harm. Risk assessments address the likelihood of future maltreatment. While safety concerns require immediate interventions to ensure that children are protected, risk of future harm is addressed over time with services that result in long-term positive behavioral changes.

Rhode Island General Law (RIGL) 42-72-10 and Department policy require a written Service Plan for the care and treatment of each child under the Department's supervision. Rhode Island Family Court Rules, Rules of Juvenile Proceedings: Rule 17C, requires a Service Plan be submitted within 30 (thirty) days when there is a finding of Dependency/Neglect/Abuse on a

petition filed by the Department. If a child is placed in substitute care, federal law (42 USC 675) and federal regulations (45 CFR 1356.21) require that each Service Plan for the child must include specific information to determine the appropriateness of and necessity for out-of-home placement. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) amended 42 USC 671 to require the State to make reasonable efforts to place siblings removed from their home in the same foster care, adoption or guardianship placement, or facilitate visitation or ongoing contacts with those that cannot be placed together, unless it is contrary to the safety or well-being of any of the siblings. PL 110-351 also requires the development of a transition plan for youth leaving DCYF care and the Patient Protection and Affordable Care Act (PL 111-148) amended 42 USC 675 to require that additional information be included in the transition plan. The Service Plan must include the following:

- A plan for assuring that the child receives safe and proper care and that appropriate services are provided to parents, child and foster parents;
- The health and education records of the child, to the extent available and accessible;
- Where appropriate, for a child age 16 or over, a written description of the program and services which will help prepare the youth for the transition toward a self-sufficient and productive adult life; and,
- In the case of a child with respect to whom the permanency plan is adoption, guardianship or another planned permanent living arrangement (APPLA), documentation of the steps the agency is taking to find an adoptive family or other permanent living arrangement.

The Department has an appeals process for parents/guardians and children, to the extent of their ability to participate, who disagree with portions of the Service Plan and wish to appeal its implementation (refer to Policy 100.0055, Complaints and Hearings).

Related Procedures

Child Protective Services Child Safety Assessment

Child Protective Services Intake Summary

Juvenile Correctional Services Initial Assessments

Family Story, Risk and Protective Capacity Assessment and Service Plan

Child Protective Services Child Safety Assessment

Procedure from Policy 700.0075: Comprehensive Assessment and Service Planning

- A. A Child Safety Assessment is completed during each investigation to determine if a child or youth is likely to suffer maltreatment in the immediate future, guide and document decision making in the removal or return of a child to the child's family during investigations and guide decision making on child safety factors, that if not addressed, pose a safety threat to a child.
1. Child Protective Investigator (CPI) completes a Child Safety Assessment (DCYF #184) during each investigation for children at home.
 2. CPI completes a Safety Assessment - Investigation Institutional (DCYF #184A) for children living in foster care.
 3. The RICHIST generated DCYF #184 and DCYF #184A are created through the Investigation window as part of the investigation process (refer to RICHIST Window Help: Child Safety Assessment Window [Investigative]).
 4. Responsibilities of the CPI during a CPS Investigation are outlined in DCYF Policy 500.0075, Removal of Child from Home.
- B. A Safety Plan is developed when a safety threat has been identified in the DCYF #184 or #184A and a protective intervention is put into place to remediate the unsafe condition.
1. The Safety Plan contains one or both of the following elements depending on the individual safety needs of each child in the family:
 - a. In-Home Safety Plan is developed when the protective capacity of the parent or caregiver can be enhanced or supported to create safety for the child.
 - b. Out-of-Home Safety Plan is developed if reasonable efforts have been unsuccessful in preventing the removal of the child from the home, or:
 - i. Existing protective capacity of the parent or caregiver cannot be enhanced or supported to provide for the child's safety; or
 - ii. There is no parent or caregiver to provide for the child's safety needs.
 2. The safety plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to assure a child is protected.
 3. The Safety Plan is the initial stage of the comprehensive family assessment process and contains information that must be reviewed at critical points through DCYF involvement and documented in the family's Service Plan
 4. The safety plan must be well planned and then written in a detailed manner. Each safety plan will:
 - a. Specify what foreseeable danger threats exist.
 - b. Identify how the foreseeable danger will be managed, including by whom, under what circumstances and agreements and in accordance with specification of time requirements, availability, accessibility and suitability of those involved.
 - c. Consider caregiver awareness and acknowledgement of safety threats and caregiver acceptance and willingness for the plan to be implemented.
 - d. Include how the plan will be overseen by Department staff across divisions.

Child Protective Services Intake Summary

Procedure from Policy 700.0075: Comprehensive Assessment and Service Planning

- A. Communication between the initial CPI and Intake staff occurs upon case transfer to Intake to ensure that the safety threats identified during investigation and the safety plan are fully communicated to and understood by the Intake worker receiving the case.
 1. In addition to transmission of necessary documentation, the primary staff assigned to the family engages DCYF workers, family members, caregivers, formal providers, informal providers and natural supports to the family in the ongoing monitoring of safety management.
 2. The safety plan is updated, if appropriate, to reflect the protective interventions in place to ensure child safety and manage risk factors.
- B. Intake staff completes the RICHIST generated Intake Summary (DCYF #071) as part of the intake process for non child abuse/neglect matters and new cases resulting from completed or pending child abuse/neglect investigations (refer to DCYF Policy 600.0000, Intake Process - Child Welfare (Non Child Abuse/Neglect) Matters, and DCYF Policy 600.0005, Intake Process for New Cases Resulting from Completed Child Abuse/Neglect Investigation - Indicated Case).
- C. The DCYF #071 builds upon the safety plan outlined in the Child Safety Assessment (DCYF #184) or Child Safety Assessment - Investigation Institutional (DCYF #184A) completed during the investigation and contains a summary of identifying family information on active and inactive children, current agency involvement and identification of issues impacting family functioning, prior DCYF history, protective capacity, risk factors and interventions, family strengths, formal and informal supports and receptiveness to intervention and the disposition of the case (refer to RICHIST Window Help: Intake Summary).
- D. The family may be assigned to a DCYF Family Services Unit or Juvenile Probation for further services or closed to DCYF. The family may be referred to:
 - a. Family Community Care Partnership (FCCP) with an agreed upon risk management plan.
 - b. Another community partner.
- E. If the family becomes active with DCYF, information from the DCYF #071 relating to current and prior DCYF involvement as well as protective capacities pre-fills into the RICHIST generated Family Story (DCYF #148 A) and Risk and Protective Capacity Assessment (DCYF #148 B) (refer to Procedure: Family Story, Risk and Protective Capacity Assessment and Service Plan.)

Juvenile Correctional Services Initial Assessments

Procedure from Policy 700.0075: Comprehensive Assessment and Service Planning

- A. Juvenile Probation Staff
- 1 A Probation Risk/Needs Assessment is used to identify risk to the community relating to the youth placed on Probation as well as family needs for the necessary supervision level of the youth (refer to DCYF Policy 800.0005, Juvenile Probation Supervision).
 - 2 Juvenile Corrections worker completes the RICHIST generated Probation Risk/Needs Assessment upon assignment to a youth on Probation and quarterly throughout the length of time the youth is on Probation (refer to RICHIST Window Help: Probation Risk/Needs Assessment Window and Probation Risk/Needs Re-assessment Window).
 - 3 The Family Story (DCYF #148 A) and Risk and Protective Capacity Assessment (RPCA) (DCYF #148 B) are completed in accordance with **Procedure: Family Story and Risk and Protective Capacity Assessment**.
- B. Rhode Island Training School (RITS)
- 1 The Intake process for the RITS is outlined in DCYF Policy 1200.1100, Clinical Services at the Rhode Island Training School and includes, but is not limited to, the following:
 - a. Massachusetts Youth Screening Instrument Version 2 (MAYSI-2)
 - i. The MAYSI-2 determines the presence of acute mental health issues which may require prompt intervention for residents.
 - ii. The MAYSI-2 is administered by RITS staff to youth within forty-eight (48) hours of detention at the RITS.
 - b. The Global Appraisal of Individual Needs (GAIN) assessment
 - i. The GAIN evaluates a broad spectrum of mental health and substance abuse issues to determine necessary levels of treatment and placement of youth sentenced to the RITS.
 - ii. The GAIN is completed by the RITS Clinical Social Worker within thirty (30) days of a youth's adjudication to direct further assessment and service planning while the youth is at the RITS.
 - 2 The Family Story (DCYF 148 A) and Risk and Protective Capacity Assessment (RPCA) (DCYF #148 B) are completed in accordance with **Procedure: Family Story and Risk and Protective Capacity Assessment**.

Family Story, Risk and Protective Capacity Assessment and Service Plan

Procedure from Policy 700.0075: Comprehensive Assessment and Service Planning

- A. The documents used in the assessment process are the Family Story (DCYF 148 A) and the Risk and Protective Capacity Assessment (RPCA) (DCYF #148 B).
1. The Family Story is a social and assessment summary that is continually developed throughout the course of DCYF involvement and includes information relating to agency involvement, parent and child history, family network, current assessment, current progress and case transfer/closure.
 2. The Risk and Protective Capacity Assessment (RPCA) is a tool used to document family information related to validated risk areas that, if present, may contribute to child maltreatment or repeat maltreatment. The RPCA determines, through the collection and analysis of information, the degree to which key risk factors impacting safety, permanency and well-being are present in a family situation that increase the likelihood of maltreatment to a child or adolescent and identifies protective capacities to mitigate identified risk.
- B. The assessment is completed in partnership with the DCYF worker, child (if age appropriate), parent(s)/caregiver(s), formal providers, informal providers and natural supports to the family.
1. The assessment of safety and risk and subsequent decisions are made while considering the child's need for permanency and well-being and occur throughout the duration of the family's involvement with the Department, specifically at critical decision points including, but not limited to:
 - a. Initial opening to the Department
 - b. Change in family circumstances
 - c. Change in placement of child(ren)
 - d. Reunification and case closure
 2. The Family Story and RPCA are completed for all families receiving services through Family Services Units (FSU) and for all families of youth active with Juvenile Correctional Services (JCS) including youth assigned to a Probation Unit, adjudicated Rhode Island Training School (RITS) residents and pre-adjudicated residents anticipated to remain beyond thirty (30) days (refer to [RICHIST Window Help: Family Story and RICHIST Window Help: Risk and Protective Capacity Assessment](#)).
 - a. For families open to the Department as a result of a CPS investigation relating to an allegation of child abuse and/or neglect, the assessment process:
 - i. Includes parent(s)/caregiver(s) who have contact with the child and are providing care.
 - ii. Is used to assess every child in the household at the initial assessment and formal six month re-assessments.
 - iii. Is used to re-assess risk on every child in the household prior to reunification or significant changes in family situation.
 - b. For families open to the Department for issues that do not involve a CPS investigation relating to an allegation of child abuse and/or neglect (Truancy, Wayward, Delinquency, Drug Court, Children's Behavioral Health or JCS), the assessment process:
 - i. Includes parent(s)/caregiver(s) who have contact with the child and are providing care.
 - ii. Is used to assess every active child in the household at the initial assessment and formal six month re-assessments.
 - iii. Is used to screen inactive children for safety and risk issues documenting safety and well-being of inactive children at the

- initial assessment and formal six month re-assessments. Documentation includes the status of a child's substance use, mental health and developmental stability, educational stability, medical/dental needs and vulnerability and self protection.
- iv. Is used to re-assess risk on every active child in the household prior to reunification or significant changes in family situation.
 - c. In dual supervision cases, staff communicate and collaborate around casework responsibilities and decisions (refer to Policy 800.0000, Transfer and Dual Supervision of Youth by Juvenile Probation and Family Services).
3. Worker must attempt to engage all members of the family in the assessment process and document efforts in a case activity note. Worker is responsible to complete as much of the DCYF #148 A and #148 B as possible to effectively evaluate and address risk factors requiring DCYF's involvement.
 4. Once termination of parental rights occurs, the Family Story (DCYF #148 A) and RPCA (DCYF # 148 B) become child specific and documentation on each inactive child and parent(s)/caregiver(s) is no longer required.
 5. Assessment of safety and assessment of risk are two distinct, yet integrated critical functions in child protection. Communication between the Intake staff and ongoing primary worker is critical and occurs upon case transfer to ensure that the safety threats identified during investigation and/or intake and the safety plan are fully communicated to and understood by the primary worker receiving the case assignment.
 - a. In addition to transmission of necessary documentation, the primary staff assigned to the family engages DCYF workers, family members, caregivers, formal providers, informal providers and natural supports to the family in the ongoing monitoring of safety management.
 - b. The safety plan is updated, if appropriate, to reflect the protective interventions in place to ensure child safety and reduce risk of future maltreatment.
- C. The Service Plan is time-limited, individualized and strength-based.
1. The Service Plan outlines how the family will mobilize their strengths and protective capacities to mitigate behaviors identified through the assessment process that contributed to child maltreatment leading to DCYF involvement.
 2. The Service Plan addresses the necessary behavior changes linked to risk factors that affect safety, permanency and child well-being and identifies the mutual responsibilities and expectations of each parent, child, the Department and formal, informal and natural supports toward achieving the identified permanency goal.
 3. For youth involved with Juvenile Corrections, the Service Plan also incorporates youth conditions of probation and the major factors that affect community safety.
- D. Action steps are written in the Service Plan, in language the family can understand, to provide detail on the services and supports that are available to assist the family to reach the behavior change goal (refer to RICHIST Window Help: RPCA Link to Service Plan and RICHIST Window Help: Service Plan Procedures).
- E. Engaging family systems and collateral contacts during assessment and service planning
1. DCYF staff must make every effort to personally interview family members, including children, in the family's home, when appropriate. If not appropriate, worker documents reasons in the DCYF record (refer to DCYF Policy: 700.0165, Worker Client Contact).
 2. Ongoing communication and visits with the family, including individual, parent/child and/or family interviews, are utilized to continuously gather

- information and assess family dynamics and functioning relating to safety and risk.
3. Coordinated meetings occur with formal providers, informal providers and natural supports to the family throughout DCYF's involvement to capture comprehensive information about the family and to ensure ongoing family engagement. Meetings occur at a location appropriate to meet the needs of the family. A signed Authorization to Obtain or Release Confidential Information (DCYF #007 A and DCYF #007 B) must be obtained when appropriate.
 - a. The capacity of a child to participate will vary among children. Most school-aged children can be expected to participate to some extent if they are verbal and understand most of the events occurring in their lives.
 - b. As age appropriate, worker consults the child on the child's goals and services, reviews the plan with the child to ensure the child's input, explains the plan and terms used in language the child can understand, and includes the child in periodic service planning meetings.
 4. The Department is responsible to locate and engage absent parents. Efforts to engage and re-engage the family are documented in the DCYF record (refer to DCYF Policy 700.0235, Locating and Engaging Absent Parents).
 5. If a putative father notifies the Department that he may be the father of a child in care, steps must be taken to determine paternity. Once paternity is established, the father is included in the assessment and service planning process.
- F. Information collected by the Department relating to the family is entered into RICHIST in accordance with the time frames detailed in DCYF Policy 700.0100, Rhode Island Children's Information System (RICHIST).
- G. Workers obtain signatures on the Service Plan to confirm that all parties participated in the development, review, and revision of the plan and were provided the opportunity to agree or disagree with the content.
1. Each party signing the Service Plan has the right to disagree with the content of the plan and appeal implementation of the plan (refer to DCYF Policy 100.0055, Complaints and Hearings).
 - a. The primary worker explains the Department's appeal procedure to the parents and child, to the extent of his/her ability to understand, at each signing of the Service Plan (DCYF #032).
 - b. Worker assists each parent and child to participate in the appeal process by providing at a minimum a copy of the DCYF form #016, Formal Request for Hearing, instructions for completing the form, and guidance as to how to process the appeal through the various stages.
 2. The following individuals sign the Service Plan:
 - a. Parents/guardians
 - b. Children twelve (12) years of age or older (with capacity to participate)
 - c. DCYF primary service workers and supervisors
 - d. Foster parents or provider agency representatives who are involved in the development of the Service Plan and are directly responsible to provide the services prescribed in the Service Plan
 - e. Department staff person, other than the primary service worker, who is involved with the family
 - f. Pre-adoptive parents in cases where parental rights have been terminated and the child is in a pre-adoptive home where the foster parents have initiated the adoption process
- H. Timeframes for completion, review and approval of the Service Plan
1. Family Services and Juvenile Corrections youth assigned to Probation

- a. The initial DCYF #032 is completed by the assigned Family Services Caseworker or Juvenile Corrections worker within sixty (60) days of removal from the home or assignment to FSU/JCS.
 - b. In the event adjudication occurs on a Dependency, Neglect and/or Abuse petition prior to the timeframe above, the Service Plan is developed and submitted to the Court within thirty (30) days of the adjudication.
 - c. Subsequent Service Plans are completed by the assigned primary service worker at six (6) month intervals or within thirty (30) days of a change in the permanency goal.
 - d. For a child active in FSU/Probation where child abuse or neglect is subsequently indicated, the primary service worker is responsible for any needed changes in an existing DCYF #032 within thirty (30) days of the completed investigation.
 - e. Transition planning occurs during the appropriate timeframe outlined below in K.
2. Rhode Island Training School (RITS) adjudicated residents and pre-adjudicated residents anticipated to remain beyond thirty (30) days
- a. The initial Service Plan (DCYF #032) is completed thirty (30) days following adjudication for adjudicated residents and within 30 days following admission for residents anticipated to remain beyond thirty (30) days.
 - i. The DCYF #032 is developed during the initial service planning meeting, during which the treatment team examines all material gathered during intake.
 - ii. The treatment team is chaired by the Clinical Director or his or her clinical designee and includes the Unit Manager, a member of the education/vocational education staff, the Clinical Social Worker, a Juvenile Program Worker (JPW), the resident, the resident's parents/guardians and other resource personnel, including, as appropriate, a psychiatrist, psychologist, physician or other staff.
 - iii. The Family Story (DCYF 148 A) is prepared for this meeting and includes, but is not limited to, social history, family background, educational and vocational, behavioral, medical, applicable psychological, psychiatric and neurological information.
 - iv. For residents who are eligible for Special Education Services, the Service Planning and Individual Education Plan (IEP) processes are closely coordinated.
 - b. The primary JCS worker is responsible for creating and maintaining the DCYF #032 for the resident in RICHIST.
 - c. The RI Training School Education Program representative is responsible for entering educational information for the resident in RICHIST.
 - d. The Unit Manager is responsible for overseeing the implementation of the resident's Service Plan and for bringing it to the attention of appropriate staff.
 - e. The Service Plan is reviewed and, if appropriate, revised at the bi-monthly review meeting (refer to RICHIST Window Help: RITS ITP/Bi-Monthly Review Completion).
 - i. A bi-monthly review is chaired by the Unit Manager and attended by the treatment team. This review is required for all adjudicated residents and pre-adjudicated residents anticipated to remain beyond thirty (30) days.
 - ii. The treatment team considers progress in locating community placements for residents and in providing other services prescribed in the DCYF #032.

- iii. Unit Manager documents in RICHIST the date of the bi-monthly review, individuals who were invited and individuals who attended.
 - iv. The Clinical Social Worker revises the Service Plan if appropriate.
 - f. A new DCYF # 032 is completed in RICHIST by the assigned primary service worker at six (6) month intervals.
 - i. This generally occurs at the third bi-monthly review.
 - ii. A new DCYF #032 is also completed within thirty (30) days of a change in the permanency goal.
 - g. Transition planning occurs during the appropriate timeframe outlined below in L.
 - 3. In dual supervision cases, staff communicate and collaborate around casework responsibilities and decisions (refer to DCYF Policy 800.0000, Transfer and Dual Supervision of Youth by Juvenile Probation and Family Services).
 - 4. Any change in the DCYF #032 which does not alter the permanency goal for the child is entered as an Addendum to the DCYF #032. Changes must be acknowledged by the signature of all parties who originally signed the DCYF #032 (refer to RICHIST Window Help FCRPCA/Service Plan Addendum).
 - 5. Once a Service Plan is incorporated into a court order, any change in the plan must be put before the court in the form of a motion filed in advance of the court date. This motion must be filed in conjunction with DCYF legal staff with notice provided to other involved parties.
 - 6. The completed Service Plan is sent to the primary worker's supervisor for approval.
- I. Each Service Plan includes a Visitation Plan (refer to DCYF Policy 700.0040, Visitation Policy) if the child is in care including details specific to the following:
- 1. Parent/Guardian Visits
 - 2. Sibling Visits
 - a. The Department must make reasonable efforts to place siblings together in the same foster care, adoption or guardianship placement unless it is contrary to the safety or well-being of any of the siblings.
 - b. If siblings cannot be placed together because it is contrary to the safety or well-being of any of the siblings or because a sibling is a RITS resident, the Department must make reasonable efforts to facilitate visitation or ongoing contacts with siblings that cannot be placed together.
- J. Each Service Plan includes an Educational/Medical Statement, which contains federally required health and education information that must be provided to the foster care provider when a child enters placement. The Educational/Medical Statement contains information on the educational stability of each child including the most recent information required as follows:
- 1. Name and address of health and educational providers
 - 2. Grade level performance
 - 3. School record
 - 4. Assurances that the child's placement in foster care takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement; and
 - 5. Assurances that the Department has coordinated with appropriate local educational agencies to allow the child to remain in the school in which the child is enrolled at the time of placement; or, if remaining in such school is not in the best interests of the child, assurances that DCYF and the local educational agencies provide immediate and appropriate enrollment in a new school, with all of the educational records of the child provided to the school. Reimbursement is

provided to the foster care provider for reasonable travel for the child to remain in the same school he or she was attending prior to placement in foster care.

6. Record of immunizations
7. Known medical problems
8. Medication
9. Any other relevant health and education information concerning the child deemed appropriate by the agency
10. Documentation to support if a child is not enrolled in school

K. Each Service Plan includes a permanency goal specific to the family's situation including a projected date for achieving the identified permanency goal. The Department, in compliance with Federal Law, confers with the family to review the permanency plan of each child in placement at least every six (6) months (refer to DCYF Policy 700.0030, Administrative Review). The goals include:

1. Maintenance at home
 - a. For a child remaining at home, the permanency goal is maintenance of the child at home.
 - b. The child's safety must be assured.
 - c. The Service Plan must describe the services offered and provided to prevent removal of the child from the home including the individual services provided to each parent and child.
 - d. When this goal is selected, worker determines if the child is at imminent risk to be placed in substitute care in RICHIST (refer to RICHIST Window Help: Service Plan Window).
2. Reunification
 - a. For a child in placement, the initial permanency goal is reunification in nearly all situations with specific exceptions as approved by the Family Court.
 - b. Family reunification is the planned process of reconnecting children in out-of-home care with their families by means of a variety of services and supports to the children, their families, and their foster parents or other service providers.
 - c. Service planning is directed toward addressing those behaviors associated with safety and risk factors which led to the child being removed from his or her home.
 - d. The Department assesses and refers the family to the appropriate array of services to achieve reunification in the shortest time possible with consideration for the child's safety and well-being.
 - e. The Service Plan must be designed to achieve a safe placement for the child in the least restrictive (most family-like) setting available, discuss the proximity of the child's placement to the home of the parents, and discuss how the placement is consistent with the best interests and special needs of the child.
 - f. For youth sentenced to the RITS, the initial permanency goal is generally reunification. For youth transferring from FSU or Probation, the goal then reflects prior history. At the time of the discharge/transition meeting, an appropriate permanency goal will be identified after a review of the youth's individual/family needs.
3. Adoption
 - a. When reunification is not viable, adoption by relatives, foster parents, or a licensed adoptive resource is the preferred permanency goal.
 - b. The Service Plan must document the steps to finalize a placement including child-specific recruitment efforts to facilitate an orderly and timely in-State and interstate permanency placement when the permanency goal is or becomes adoption.
4. Guardianship

- a. If the Department and the Family Court have determined that reunification and adoption are not viable permanency options and that it is in the best interest of the child to be placed with a kinship guardian, the Service Plan permanency goal is changed to guardianship (refer to DCYF Policy, 700.0045 Legal Guardianship and Kinship Guardianship Assistance).
 - b. The Service Plan must document the steps that the agency has taken to determine that it is not appropriate for the child to be returned home or adopted. The Service Plan must also address the following:
 - i. The reasons for any separation of siblings during placement;
 - ii. The reasons why a permanent placement with a fit and willing relative through a kinship guardianship assistance arrangement is in the child's best interests;
 - iii. The ways in which the child meets the eligibility requirements for a kinship guardianship assistance payment;
 - iv. The efforts the agency has made to discuss adoption by the child's relative foster parent as a more permanent alternative to legal guardianship and, in the case of a relative foster parent who has chosen not to pursue adoption, documentation of the reasons; and
 - v. The efforts made by the Department to discuss with the child's parent or parents the kinship guardianship assistance arrangement, or the reasons why the efforts were not made.
5. Another Planned Permanent Living Arrangement (APPLA) includes; Permanent Placement with a Fit and Willing Relative, Planned Living Arrangement /Independent living, when appropriate for youth over age 16, and Planned Living Arrangement/Other.
- a. APPLA is a permanent placement for the child that identifies a lifelong connection.
 - b. The Service Plan must document the steps to finalize a placement including child-specific recruitment efforts to facilitate an orderly and timely in-State and interstate permanency placement when the permanency goal is or becomes APPLA. The Service Plan must specify who will be the permanent connection for that youth, if identified, and how DCYF is working to maintain that connection.
 - c. APPLA is appropriate only when the court has been provided with documentation that compelling reasons exist which make all other permanency options unacceptable. These reasons will be re-examined at each Administrative Review and every permanency hearing to assess whether a more preferred permanency option is possible.
 - d. ASFA indicates that a fit and willing relative can provide APPLA and that termination of parental rights does not have to occur within the allotted time frame if a compelling reason is provided to the Court.
 - e. A relative may be fit and willing to care for the child without being prepared to consider legal guardianship or adoption.
 - f. When determining if placement with a fit and willing relative is appropriate, the worker must consider the relationship between the child and parent(s), the child and relative(s) and the relative(s) and the child's parent(s). A compelling reason is documented and provided to the Court addressing the established relationships and why neither adoption nor guardianship is a viable permanency option.
- L. Transition planning occurs during the ongoing assessment process. Service Plans are updated to reflect behavior changes and actions steps to achieve permanency for each child. In compliance with Section 475 of the Social Security Act transition planning

occurs, and is documented in the Service Plan at minimum, during the following timeframes:

1. For each child age sixteen (16) or older, where appropriate, the Service Plan includes a written description of the programs and services that will help the youth prepare for the transition from foster care to independence (refer to DCYF Policy 700.0200, Independent Living). The Service Plan must address the following:
 - a. Housing
 - b. Financial support
 - c. Health care
 - d. Education/vocation planning
 - e. Procurement of necessary documents
 - f. Personal community support systems
 2. During the 90-day period immediately prior to the date on which a youth in foster care will attain eighteen (18) years of age, the assigned worker and, as appropriate, other representatives of the child provide the child with assistance and support in developing a transition plan, documented in the Service Plan, that is personalized at the direction of the child and detailed as the child may elect.
 - a. The transition plan is focused around skills to gain independence and includes specific options on following areas:
 - i. Housing
 - ii. Health insurance
 - iii. Education
 - iv. Local opportunities for mentors and continuing support services
 - v. Work force supports and employment services
 - b. The transition plan includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under RI law to make such decisions, and provides the child with the option to execute a health care power of attorney in accordance with RIGL 23-4.10-1 - 12,
 3. Sixty (60) to ninety (90) days prior to the resident's anticipated end of RITS sentence, a bi-monthly review meeting, specifically designated a transition planning meeting, is held. (Refer to RICHIST Window Help: Transitional Living & Discharge Plan Templates.)
 - a. The purpose of this meeting is to delineate transition needs and to begin coordination of services that the resident will receive in the community.
 - b. If the treatment team concludes that a resident has completed all required programming and has suitable discharge/transition plans in place, the team recommends to the Superintendent that the Family Court be petitioned to consider early release. This recommendation is accompanied by a report, which includes the post-release plan summarizing the resident's progress at RITS, specifying any community placements, noting where the resident will live upon release and what after-care programming the resident will receive, and setting out the grounds for the recommendation.
 - c. The treatment team may also conclude that the resident has critical treatment needs which cannot be met at the RITS and should follow the same plan as above to seek the child's release.
- M. Distribution of the Family Story, Risk and Protective Capacity Assessment and Service Plan
1. The primary service worker must use discretion to maintain the family's right to privacy. A signed Authorization to Release Confidential Information (DCYF #007

A) must be obtained when appropriate (refer to DCYF Policy 100.0000, Confidentiality).

2. The Family Story, Risk and Protective Capacity Assessment and Service Plan are included in referral packets for treatment providers and placement providers.
3. The Family Story, Risk and Protective Capacity Assessment and Service Plan are accessible in RICHIST to quality assurance staff in DCYF Data and Evaluation for review prior to scheduled administrative reviews or during routine child and family service reviews.
4. The original signed Service Plan is filed in the case record. A copy is given to the parents, and copies are provided to children, if age appropriate, and to each outside agency involved in the development of the Service Plan or directly responsible to provide services prescribed in the Service Plan.
5. The Educational/Medical Statement is updated and provided to the foster parent/provider at the time of each placement. Federal Law requires the Department to provide, at no cost, a copy of the child's health and education record to the child at the time the child exits foster care at age of majority.
6. The Educational/Medical Statement is provided to the foster parents separate from the Service Plan if it is not appropriate for the caretakers to receive the entire Service Plan.
7. Copies of the Service Plan are periodically provided to the Family Court in situations where there is Court involvement with the family.
 - a. Within thirty (30) days of adjudication on a Dependency/Neglect/Abuse petition;
 - b. No less frequently than on an annual basis at the time of the Permanency Hearing (refer to DCYF Policy 1100.0000, Obtaining Custody of Child through the Dependent/Neglect/Abuse Petition), and;
 - c. At the time of the Family Court review of voluntary placements
8. A copy of the Service Plan is given to the CASA or Guardian Ad Litem (GAL).

Criteria for a Child Protective Services Investigation

Rhode Island Department of Children, Youth and Families

Policy: 500.0010

Effective Date: July 7, 1984 Revised Date: December 9, 2011 Version: 5

The Department of Children, Youth and Families initiates a Child Protective Services (CPS) investigation when a report that meets Investigation Criteria is made to the CPS Hotline. Reports may involve families new to the Department, families actively being serviced by the Department, families previously active with the Department and incidents of institutional abuse and/or neglect. The report must involve a child under 18 years of age or under 21 years of age if the youth is residing in foster or institutional care or if the youth is in Department custody, regardless of placement.

Investigation Criteria 1 - Child Abuse/Neglect (CA/N) Report - RIGL 40-11-3 requires the Department to immediately investigate reports of child abuse and neglect. The circumstances reported, if true, must constitute child abuse/neglect as defined by RIGL 40-11-2.

Investigation Criteria 2 - Non-Relative Caretaker - RIGL 42-72.1-4 requires that no parent shall assign or otherwise transfer to another, not related to him or her by blood or marriage, his or her rights or duties with respect to the permanent care and custody of his or her child under eighteen (18) years of age unless duly authorized by an order or decree of the court.

Investigation Criteria 3 - Sexual Abuse of a Child by Another Child - RIGL 40-11-3 requires the Department to immediately investigate sexual abuse of a child by another child.

Investigation Criteria 4 - Duty to Warn - RIGL 42-72-8 allows the Department to release information if it is determined that there is a risk of physical injury by a person to himself/herself or others and that disclosure of the records is necessary to reduce that risk. If the Hotline receives a report that a perpetrator of sexual abuse or serious physical abuse has access to another child in a family dwelling, that report is classified as an investigation and assigned for investigation.

Investigation Criteria 5 - Alert to Area Hospitals – Safety of Unborn Child - RIGL 42-72-8 allows the Department to release information if it is determined that there is a risk of physical injury by a person to himself/herself or others and that disclosure of the records is necessary to reduce that risk. The Department issues an alert to area hospitals when a parent has a history of substantiated child abuse/neglect or a child abuse/neglect conviction and there is concern about the safety of a child.

A report made to the CPS Hotline that contains a concern about the well-being of a child, but does not meet the criteria for an investigation, may be classified as an Information/Referral (I/R) Report. Refer to [DCYF Policy 500.0040, Information/Referral \(I/R\) Reports](#).

Related Procedure

[Criteria for a Child Protective Services Investigation](#)

Related Policy

[Information/Referral \(I/R\) Reports](#)

[Processing and Notifications for an Alleged Institutional Abuse/Neglect Case](#)

[Kinship Care](#)

Criteria for a Child Protective Services Investigation

Procedure from Policy 500.0010: Criteria for a Child Protective Services Investigation

I. Investigation Criteria 1

- A. The Department investigates reports that allege child abuse and/or neglect when reasonable cause to believe that abuse or neglect exists. Child Abuse/Neglect (CA/N) Reports accepted for investigation contain the following elements:
1. Harm or substantial risk of harm to the child (under 18 or under 21 years of age if in Department placement or custody) is present.
 2. A specific incident or pattern of incidents suggesting child abuse and/or neglect.
 3. A "person responsible for the child's welfare" has allegedly abused or neglected the child. RIGL 40-11-2 defines a "person responsible for the child's welfare" as the child's parent or guardian, any individual, eighteen (18) years of age or older, who resides in the home of a parent or guardian and has unsupervised access to a child, a foster parent (relative or non-relative), an employee of a public or private residential home or facility or any staff person providing out-of-home care, which includes family child care, group child care and center-based child care.
- B. Call Floor Child Protective Investigator (CPI) completes a Child Protective Services (CPS) report in RICHIST for all reports alleging child abuse and neglect.
- C. Field CPI initiates an investigation within twenty-four hours if the report is accepted for investigation.
- D. An investigation relating to a foster home or child care facility is conducted in conformance with DCYF Policy 500.0060, Processing and Notifications for an Alleged Institutional Abuse/Neglect Case.

II. Investigation Criteria 2: Non-Relative Caretaker

- A. A CPS investigation is initiated when the Department receives a report that a parent has assigned or otherwise transferred to another, not related to him or her by blood or marriage, his or her rights or duties with respect to the permanent care and custody of his or her child under eighteen (18) years of age, unless the arrangement was authorized by an order or decree of the court.
- B. During the investigation, it is determined if the home is suitable for the child. If the placement is deemed appropriate, the Department licenses the caretaker if she/he meets licensing standards and is able to meet the needs of the child.
- C. If the placement is unsuitable, the Department removes the child and places him or her in an appropriate living arrangement. If the child must be placed in out of home care, the Department must first explore potential relatives as placement resources (refer to DCYF Policy 900.0025, Kinship Care).
- D. The Call Floor CPI completes a CPS report.
- E. The Field CPI initiates an investigation within twenty-four hours if the report is accepted for investigation.

III. Investigation Criteria 3 – Sexual Abuse of a Child by another Child

- A. The Department is required by RIGL 40-11-3 to immediately investigate sexual abuse of a child by another child. The Department initiates an investigation when:
 - 1. The incident appears to have occurred as a result of parental abuse or neglect.
 - 2. The nature of the sexual activity is determined to be unexpected, abusive and exploitative, even if there is no indication of parental abuse or neglect. The following factors are considered:
 - a. Coercion-based
 - b. Bullying and lack of parity
 - c. Age difference
 - d. One child is physically or mentally disabled
 - e. Explicit reenactment of adult sexual activity
 - f. Fear, shame or discomfort
 - g. One child's physical or mental health or welfare is harmed or threatened with harm as a result of the abuse.
- B. The Department does not consider behavior to be sexual abuse and does not initiate a CPS investigation when the activity is determined to be expected, healthy and normative. The following factors are considered:
 - 1. Curiosity-based.
 - 2. Mutual interest and consent.
 - 3. Looking, touching.
 - 4. Often fun and silly.
- C. The Hotline CPI completes a CPS report.
- D. The Field CPI initiates an investigation within twenty-four hours if the report is accepted for investigation.

IV Investigation Criteria 4: Duty to Warn

- A. RIGL 42-72-8 allows the Department to release information if there is a risk of physical injury by the person to himself/herself or others and that disclosure of the records is necessary to reduce that risk.
- B. In accordance with the law, a CPS Investigation is initiated when the Hotline receives a report that a perpetrator, who has been convicted, adjudicated or indicated for the following categories of sexual abuse or serious physical abuse, has physical access to other children in a family.
 - 1. Convictions
 - a. Murder (involving a child)
 - b. First degree child abuse
 - c. Battery by an adult upon children ten years of age or younger - serious bodily injury
 - d. First degree child molestation
 - e. Second degree child molestation
 - 2. Adjudications in Family Court
 - a. Termination of Parental Rights based on finding of conduct toward a child of a cruel and abusive nature
 - b. Sexual abuse
 - 3. Indicated Abuse Findings (CPS)
 - a. Death
 - b. Brain damage
 - c. Subdural hematoma
 - d. Internal injuries
 - e. Intercourse

- f. Sexual exploitation
 - g. Molestation
- C. The Hotline CPI completes a CPS report.
- D. The Field CPI initiates an investigation within twenty-four hours if the report is accepted for investigation.
- E. Field CPI attempts to verify any prior adjudication on a Dependency/Neglect/ Abuse petition, criminal conviction in Family, District or Superior Court or a CPS indicated finding of allegations of sexual abuse and/or serious physical abuse pertaining to the alleged perpetrator.
- F. Field CPI attempts to verify the identity of the person previously been adjudicated, convicted and/or been the subject of a prior CPS finding on charges/allegations of sexual abuse and/or serious physical abuse.
- G. Prior to responding to the home, the Field CPI contacts legal counsel to determine what, if any, information can be disclosed to the primary caretaker pursuant to the provisions of RIGL 42-72-8. After-hour inquiries are referred to the on-call administrator who consults the Chief Legal Counsel.
- H. Field CPI responds to the home and interviews the child to determine if he/she has been a victim of any act of abuse and/or neglect by the alleged perpetrator.
- I. Field CPI determines if there is a substantial risk of imminent physical or emotional harm to any child residing in the same household as the alleged perpetrator or to whom the alleged perpetrator has frequent access. The CPI and his/her supervisor consider any appropriate factors in assessing risk to the child, which include but are not limited to:
1. How long ago the conviction, adjudication and/or indicated finding occurred;
 2. Whether the alleged perpetrator has engaged or is engaging in clinical treatment to address the issues of prior sexual abuse and/or serious physical abuse;
 3. The age of the child(ren) residing in the household;
 4. Whether there has been any prior Department involvement with the child who is the subject of the current investigation;
 5. Whether or not the family is amenable to services; and
 6. Whether the child has disclosed any acts of abuse and/or neglect by the alleged perpetrator.
- J. If the CPI, in consultation with his/her supervisor, determines that there exists a substantial risk of imminent harm to the child, the CPI advises the primary caretaker that the alleged perpetrator must not be allowed further access to the child.
- K. If the alleged perpetrator is a natural parent or legal guardian of the child and agrees to leave the home of the primary caretaker, the CPI consults with Department's Legal Counsel regarding the filing of a Dependency/Neglect/Abuse petition.
- L. If the primary caretaker is unwilling or unable to ensure that the alleged perpetrator will not be allowed access to the child and/or the alleged perpetrator is unwilling to leave the residence of the primary caretaker, the CPI consults with legal counsel and takes immediate action to ensure the protection of the child.
- V. Investigation Criteria 5: Alert to Area Hospitals – Safety of Unborn Child

- A. RIGL 42-72-8 allows the Department to release information if it is determined that there is a risk of physical injury by the person to himself or herself or others, and that disclosure of the records is necessary to reduce that risk.
- B. In accordance with this law, the Department issues an alert to area hospitals when it is believed that there may be risk of harm to a child born to a parent with a history of substantiated child abuse or neglect or a child abuse/neglect conviction.
1. Reasons for an alert may include, but are not limited to:
 - a. Parent has exhibited behavior or conduct that is seriously detrimental to a child of a duration that renders it improbable for the parent to care for a child for an extended period of time.
 - b. Parent has subjected another child to aggravated circumstances, including abandonment, torture, chronic abuse or sexual abuse.
 - c. Parent has committed voluntary manslaughter of another child.
 - d. Parent has aided or abetted, attempted, conspired or solicited to commit such a murder or such a voluntary manslaughter.
 - e. Parent has had his/her parental rights to a sibling of the child terminated involuntarily.
 - f. There is a history of chronic substance abuse by one or both parents.
 - g. Parent has inflicted excessive corporal punishment upon a child, resulting in physical injury to the child.
 - h. Parent has a history of mental or emotional disability which has proven to render the parent unable to care effectively for his or her children.
 2. The alert requests that the hospital contact the CPS Hotline upon the birth of the infant as a result of the Department's concerns about the welfare of the child.
- C. Issuing an Alert
1. An alert regarding the safety of an unborn child may be initiated by a Family Service Unit (FSU) worker, by a CPS worker or by a Juvenile Correctional Services (JCS) worker.
 - a. An alert may be initiated by an FSU worker on an open case, on a case that will close during the pregnancy due to a Termination of Parental Rights or on a recently closed case.
 - b. An alert may be initiated by a Call Floor CPI on a case not open to the Department.
 - c. An alert may be initiated by a JCS worker, which includes Juvenile Probation and the Rhode Island Training School.
 2. Worker discusses the need for an alert with his/her supervisor and administrator in order to obtain approval.
 3. Upon approval, the following processes are completed:
 - a. FSU, CPS or JCS supervisor completes a Case Activity Note (CAN) in RICHIST, indicating any special instructions, such as an available placement resource.
 - b. Supervisor sends an e-mail to all CPS administrators informing them of the alert.
 - c. Worker completes the DCYF # 199, Alert to Area Hospitals - Safety of Unborn Child.
 4. FSU, CPS or JCS supervisor and administrator sign the alert.
 5. FSU, CPS or JCS supervisor sends the alert to area hospitals.
- D. When the Hotline receives a response to the alert upon the birth of the child, the report is reviewed. A determination is made whether the report is assigned for investigation or downgraded to an I/R Report in conformance with [DCYF Policy 500.0040, Information/Referral \(I/R\) Reports](#).

Drug Usage During Pregnancy

Rhode Island Department of Children, Youth and Families

Policy: 500.0125

Effective Date: January 22, 1990 Version: 1

Substance abuse is a major problem in the United States. Assisting the children of substance abusing families has become a major aspect of the Department's role in the community. About 11 percent of the children born in the United States have had some exposure to licit and/or illicit drugs. The number of pregnant women using illegal drugs and/or excessive amounts of alcohol continues to grow despite warnings about effects on the fetus and possible long term problems for the child after birth. As examples, the use of cocaine during pregnancy may cause long term problems including malformed genital and urinary organs, a tendency to stop breathing, a higher risk of crib death, retarded growth, stiff limbs, irritability, a missing small intestine and strokes and seizures. Babies born to women who abuse alcohol may have fetal alcohol syndrome, a complex of birth defects including retarded growth and cardiac abnormalities. Other drugs may also cause birth defects when used by pregnant women. For purposes of this policy, the term drugs means a controlled or illegal substance and/or chemical (including, but not limited to, PCP, heroin, cocaine and methamphetamines.)

The Department carefully considers all calls to the Child Abuse Hotline made by prenatal clinic workers, professionals, or other concerned individuals alleging that a pregnant woman is using drugs and/or alcohol. If there are specific allegations of abuse and/or neglect of children in the home, an investigation is conducted. If there are no specific allegations and/or no children in the home, the information alleging drug and/or alcohol abuse is put into RICHIST as an Early Warning. When a woman has tested positive for drugs and/or alcohol during prenatal treatment, there is good cause to test both her and her baby for the presence of drugs immediately after the birth.

Babies born with drugs in their systems, as evidenced by a positive toxicology screen at birth or observable withdrawal symptoms, babies born to mothers who admit using drugs during pregnancy or who have been observed ingesting drugs, and babies born with fetal alcohol syndrome must be reported to the Child Abuse Hotline. A Report of Examination should be completed by the attending physician/nurse practitioner. It is important that, if the method of use is known, such information be given to DCYF as there is a greater risk of HIV infection for both mother and child when drugs are used intravenously. All such reports are investigated by DCYF.

When a call alleging drug/alcohol abuse by mother is received on the Child Abuse Hotline after a newborn is already home, an investigation will be conducted if there is a specific allegation of abuse and/or neglect of the newborn and/or other children in the home. If during the course of the investigation, credible evidence is uncovered which proves that mother used drugs and/or alcohol during pregnancy (i.e. positive prenatal drug screen(s), positive toxicology screen on mother or newborn while in the hospital or admission by mother that she used drugs during pregnancy), an allegation of drug/alcohol abuse will be added to the investigation. An indicated

allegation of drug/alcohol abuse usually warrants legal action whether the facts are substantiated prior to the newborn leaving the hospital, or after the newborn is at home.

To ensure that these babies and their families are provided with necessary intervention, drug/alcohol treatment and social services, the assigned CPI consults with his/her supervisor and DCYF Legal Counsel as to the advisability of requesting an Order of Detention, ex parte. If an Order of Detention is not requested, the CPI will file a straight petition. When the matter comes before the court, DCYF will recommend that mother (and father, if appropriate) receive drug treatment.

Legal and investigative/casework staff will, however, be allowed some discretion in determining whether or not the Department should pursue legal action and may decide not to initiate legal action if an indicated allegation of drug/alcohol abuse is based on a situation containing both of the following factors. First, the mother admits to using drugs/alcohol only during the first trimester of her pregnancy and second, there is no evidence (i.e. positive prenatal drug screen(s) during the second or third trimester, positive toxicology screen on mother or newborn, baby displaying withdrawal symptoms, or admission of drug use during second or third trimester) that mother used drugs and/or alcohol after the first trimester of pregnancy. During this Legal Consult, staff review all the facts of the case, including the type and frequency of drug usage.

Related Procedures...

Reports that a Pregnant Woman is Using Drugs

Allegation that a Newborn's Mother Used Drugs During Pregnancy

Alleging that the Mother of a Newborn who is Already Home from the Hospital is Using Drugs

Reports that a Pregnant Woman is Using Drugs

Procedure From Policy 500.0125: Drug Usage During Pregnancy

- A. A CPS report is completed by the Call Floor worker for all reports that a pregnant woman is using drugs:
 - 1. An investigation will be initiated if there are specific allegations of abuse and/or neglect of child(ren) in the home.
 - 2. An Early Warning will be entered into RICHIST if there are no specific allegations of abuse and/or neglect and/or there are no child(ren) in the home.

Allegation that a Newborn's Mother Used Drugs During Pregnancy

Procedure From Policy 500.0125: Drug Usage During Pregnancy

- A. A CPS report is completed by the Call Floor worker for all reports alleging that a newborn's mother used drugs during pregnancy. The allegation is drug/alcohol abuse:
1. The CPS report is forwarded through the Call Floor Supervisor to the Investigative Unit for assignment.
 2. An investigation of the report is initiated by a CPI.
 3. The CPI gathers all information pertinent to the case and completes the investigation:
 - a. If the investigation is indicated (i.e. positive prenatal drug screen(s), positive toxicology screen on mother or newborn while in the hospital, baby having withdrawal symptoms or admission by mother that she used drugs during pregnancy), the CPI confers with his/her supervisor as to the advisability of requesting an Order of Detention, ex parte. The CPI consults with DCYF Legal staff. If it is determined that an Order of Detention is not warranted, the Child Protective CPI files a straight petition.
 - b. If the mother admits to using drugs/alcohol only during the first trimester of her pregnancy and there is no evidence (i.e. positive prenatal drug screen(s) during the second or third trimester, positive toxicology screen on mother or newborn, baby displaying withdrawal symptoms, or admission of drug use during second or third trimester) that mother used drugs and/or alcohol after the first trimester of pregnancy, legal and investigative/casework staff will be allowed some discretion in determining if the Department should pursue legal action:
 - (1) Staff review all the facts of the case.
 - (2) The type and frequency of the drug/alcohol usage is discussed in detail.
 - (3) A decision may be made not to pursue legal action.
 - c. The case is transferred to the Intake Unit.

Alleging that the Mother of a Newborn Who is Already Home from the Hospital is Using Drugs

Procedure From Policy 500.0125: Drug Usage During Pregnancy

- A. A CPS report is completed by the Call Floor worker for all reports alleging that the mother of a newborn who is already home from the hospital is using drugs:
 1. The allegation to be used is determined by the Call Floor worker depending on the information given by the caller. If, during the course of the investigation, substantive information is learned which indicates that the mother used drugs and/or alcohol during pregnancy (i.e. positive prenatal drug screen(s), positive toxicology screen on mother or newborn while in the hospital or admission by the mother that she used drugs and/or alcohol during pregnancy), an allegation of drug/alcohol abuse is added by the CPI.
 2. The CPI gathers all information pertinent to the case and completes the investigation:
 - a. If the investigation is Indicated, the CPI confers with his/her supervisor as to the advisability of requesting an Order of Detention, ex parte.
 - b. The CPI consults with DCYF Legal staff. If it is determined that an Order of Detention is not warranted, the CPI files a straight petition.
 - c. If the mother admits to using drugs/alcohol only during the first trimester of her pregnancy and there is no evidence (i.e. positive prenatal drug screen(s) during the second or third trimester, positive toxicology screen on mother or newborn, baby displaying withdrawal symptoms, or admission of drug use during second or third trimester) that mother used drugs and/or alcohol after the first trimester of pregnancy, legal and investigative/casework staff will be allowed some discretion in determining if the Department should pursue legal action:
 - (1) Staff review all the facts of the case.
 - (2) The type and frequency of the drug/alcohol usage is discussed in detail.
 - (3) A decision may be made not to pursue legal action.
 - d. The case is transferred to the Intake Unit.
 3. If there is no specific allegation of abuse and/or neglect, the information is put into RICHIST as an Early Warning.

Public Law 114-198
114th Congress

An Act

To authorize the Attorney General and Secretary of Health and Human Services to award grants to address the prescription opioid abuse and heroin use crisis, and for other purposes.

July 22, 2016
[S. 524]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Comprehensive Addiction and Recovery Act of 2016”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—PREVENTION AND EDUCATION

- Sec. 101. Task force on pain management.
- Sec. 102. Awareness campaigns.
- Sec. 103. Community-based coalition enhancement grants to address local drug crises.
- Sec. 104. Information materials and resources to prevent addiction related to youth sports injuries.
- Sec. 105. Assisting veterans with military emergency medical training to meet requirement for becoming civilian health care professionals.
- Sec. 106. FDA opioid action plan.
- Sec. 107. Improving access to overdose treatment.
- Sec. 108. NIH opioid research.
- Sec. 109. National All Schedules Prescription Electronic Reporting Reauthorization.
- Sec. 110. Opioid overdose reversal medication access and education grant programs.

TITLE II—LAW ENFORCEMENT AND TREATMENT

- Sec. 201. Comprehensive Opioid Abuse Grant Program.
- Sec. 202. First responder training.
- Sec. 203. Prescription drug take back expansion.

TITLE III—TREATMENT AND RECOVERY

- Sec. 301. Evidence-based prescription opioid and heroin treatment and interventions demonstration.
- Sec. 302. Building communities of recovery.
- Sec. 303. Medication-assisted treatment for recovery from addiction.

TITLE IV—ADDRESSING COLLATERAL CONSEQUENCES

- Sec. 401. GAO report on recovery and collateral consequences.

TITLE V—ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

- Sec. 501. Improving treatment for pregnant and postpartum women.
- Sec. 502. Veterans treatment courts.
- Sec. 503. Infant plan of safe care.
- Sec. 504. GAO report on neonatal abstinence syndrome (NAS).

Comprehensive
Addiction and
Recovery Act
of 2016.
42 USC 201 note.

TITLE VI—INCENTIVIZING STATE COMPREHENSIVE INITIATIVES TO ADDRESS PRESCRIPTION OPIOID ABUSE

Sec. 601. State demonstration grants for comprehensive opioid abuse response.

TITLE VII—MISCELLANEOUS

- Sec. 701. Grant accountability and evaluations.
 Sec. 702. Partial fills of schedule II controlled substances.
 Sec. 703. Good samaritan assessment.
 Sec. 704. Programs to prevent prescription drug abuse under Medicare parts C and D.
 Sec. 705. Excluding abuse-deterrent formulations of prescription drugs from the Medicaid additional rebate requirement for new formulations of prescription drugs.
 Sec. 706. Limiting disclosure of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse.
 Sec. 707. Medicaid Improvement Fund.
 Sec. 708. Sense of the Congress regarding treatment of substance abuse epidemics.

TITLE VIII—KINGPIN DESIGNATION IMPROVEMENT

Sec. 801. Protection of classified information in Federal court challenges relating to designations under the Narcotics Kingpin Designation Act.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

- Sec. 901. Short title.
 Sec. 902. Definitions.

Subtitle A—Opioid Therapy and Pain Management

- Sec. 911. Improvement of opioid safety measures by Department of Veterans Affairs.
 Sec. 912. Strengthening of joint working group on pain management of the Department of Veterans Affairs and the Department of Defense.
 Sec. 913. Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs.
 Sec. 914. Mandatory disclosure of certain veteran information to State controlled substance monitoring programs.
 Sec. 915. Elimination of copayment requirement for veterans receiving opioid antagonists or education on use of opioid antagonists.

Subtitle B—Patient Advocacy

- Sec. 921. Community meetings on improving care furnished by Department of Veterans Affairs.
 Sec. 922. Improvement of awareness of patient advocacy program and patient bill of rights of Department of Veterans Affairs.
 Sec. 923. Comptroller General report on patient advocacy program of Department of Veterans Affairs.
 Sec. 924. Establishment of Office of Patient Advocacy of the Department of Veterans Affairs.

Subtitle C—Complementary and Integrative Health

- Sec. 931. Expansion of research and education on and delivery of complementary and integrative health to veterans.
 Sec. 932. Expansion of research and education on and delivery of complementary and integrative health to veterans.
 Sec. 933. Pilot program on integration of complementary and integrative health and related issues for veterans and family members of veterans.

Subtitle D—Fitness of Health Care Providers

- Sec. 941. Additional requirements for hiring of health care providers by Department of Veterans Affairs.
 Sec. 942. Provision of information on health care providers of Department of Veterans Affairs to State medical boards.
 Sec. 943. Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities.

Subtitle E—Other Matters

- Sec. 951. Modification to limitation on awards and bonuses.

TITLE I—PREVENTION AND EDUCATION**SEC. 101. TASK FORCE ON PAIN MANAGEMENT.**

Establishment.

(a) **DEFINITIONS.**—In this section:(1) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.(2) **TASK FORCE.**—The term “task force” means the Pain Management Best Practices Inter-Agency Task Force convened under subsection (b).(b) **INTER-AGENCY TASK FORCE.**—Not later than 2 years after the date of enactment of this Act, the Secretary, in cooperation with the Secretary of Veterans Affairs and the Secretary of Defense, shall convene a Pain Management Best Practices Inter-Agency Task Force.(c) **MEMBERSHIP.**—The task force shall be comprised of—

(1) representatives of—

(A) the Department of Health and Human Services and relevant agencies within the Department of Health and Human Services;

(B) the Department of Veterans Affairs;

(C) the Department of Defense; and

(D) the Office of National Drug Control Policy;

(2) currently licensed and practicing physicians, dentists, and nonphysician prescribers;

(3) currently licensed and practicing pharmacists and pharmacies;

(4) experts in the fields of pain research and addiction research, including adolescent and young adult addiction research;

(5) representatives of—

(A) pain management professional organizations;

(B) the mental health treatment community;

(C) the addiction treatment community, including individuals in recovery from substance use disorder;

(D) pain advocacy groups, including patients;

(E) veteran service organizations;

(F) groups with expertise on overdose reversal, including first responders;

(G) State medical boards; and

(H) hospitals;

(6) experts on the health of, and prescription opioid use disorders in, members of the Armed Forces and veterans; and

(7) experts in the field of minority health.

(d) **REPRESENTATION.**—The Secretary shall ensure that the membership of the task force includes individuals representing rural and underserved areas.(e) **DUTIES.**—The task force shall—

(1) identify, review, and, as appropriate, determine whether there are gaps in or inconsistencies between best practices for pain management (including chronic and acute pain) developed or adopted by Federal agencies;

(2) not later than 1 year after the date on which the task force is convened under subsection (b), propose updates to best practices and recommendations on addressing gaps or inconsistencies identified under paragraph (1), as appropriate, and submit to relevant Federal agencies and the general public

Deadline.
Recommendations.
Public
information.

such proposed updates and recommendations, taking into consideration—

(A) existing pain management research and other relevant research;

(B) recommendations from relevant conferences and existing relevant evidence-based guidelines;

(C) ongoing efforts at the State and local levels and by medical professional organizations to develop improved pain management strategies, including consideration of differences within and between classes of opioids, the availability of opioids with abuse deterrent technology, and pharmacological, nonpharmacological, and medical device alternatives to opioids to reduce opioid monotherapy in appropriate cases;

(D) the management of high-risk populations who receive opioids in the course of medical care, other than for pain management;

(E) the 2016 Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention; and

(F) private sector, State, and local government efforts related to pain management and prescribing pain medication;

(3) provide the public with at least 90 days to submit comments on any proposed updates and recommendations under paragraph (2); and

(4) develop a strategy for disseminating information about best practices for pain management (including chronic and acute pain) to stakeholders, if appropriate.

(f) **LIMITATION.**—The task force shall not have rulemaking authority.

(g) **SUNSET.**—The task force under this section shall sunset after 3 years.

Public
information.
Time period.

42 USC
290bb-25g.
Coordination.

SEC. 102. AWARENESS CAMPAIGNS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services, in coordination with the heads of other departments and agencies, shall, as appropriate, through existing programs and activities, advance the education and awareness of the public (including providers, patients, and consumers) and other appropriate entities regarding the risk of abuse of prescription opioids if such drugs are not taken as prescribed.

(b) **TOPICS.**—The education and awareness campaigns under subsection (a) shall address—

(1) the dangers of opioid abuse;

(2) the prevention of opioid abuse, including through safe disposal of prescription medications and other safety precautions; and

(3) the detection of early warning signs of addiction.

(c) **OTHER REQUIREMENTS.**—The education and awareness campaigns under subsection (a) shall, as appropriate—

(1) take into account any association between prescription opioid abuse and heroin use;

(2) emphasize—

(A) the similarities between heroin and prescription opioids; and

(B) the effects of heroin and prescription opioids on the human body; and
 (3) bring greater public awareness to the dangerous effects of fentanyl when mixed with heroin or abused in a similar manner.

SEC. 103. COMMUNITY-BASED COALITION ENHANCEMENT GRANTS TO ADDRESS LOCAL DRUG CRISES. 21 USC 1536.

(a) **DEFINITIONS.**—In this section:

(1) **ADMINISTRATOR.**—The term “Administrator” means the Administrator of the Substance Abuse and Mental Health Services Administration.

(2) **DIRECTOR.**—The term “Director” means the Director of the Office of National Drug Control Policy.

(3) **DRUG-FREE COMMUNITIES ACT OF 1997.**—The term “Drug-Free Communities Act of 1997” means chapter 2 of the National Narcotics Leadership Act of 1988 (21 U.S.C. 1521 et seq.).

(4) **ELIGIBLE ENTITY.**—The term “eligible entity” means an organization that—

(A) on or before the date of submitting an application for a grant under this section, receives or has received a grant under the Drug-Free Communities Act of 1997; and

(B) has documented, using local data, rates of abuse of opioids or methamphetamines at levels that are—

(i) significantly higher than the national average as determined by the Secretary (including appropriate consideration of the results of the Monitoring the Future Survey published by the National Institute on Drug Abuse and the National Survey on Drug Use and Health published by the Substance Abuse and Mental Health Services Administration); or

(ii) higher than the national average, as determined by the Secretary (including appropriate consideration of the results of the surveys described in clause (i)), over a sustained period of time.

(5) **EMERGING DRUG ABUSE ISSUE.**—The term “emerging drug abuse issue” means a substance use disorder within an area involving—

(A) a sudden increase in demand for particular drug abuse treatment services relative to previous demand; and

(B) a lack of resources in the area to address the emerging problem.

(6) **LOCAL DRUG CRISIS.**—The term “local drug crisis” means, with respect to the area served by an eligible entity—

(A) a sudden increase in the abuse of opioids or methamphetamines, as documented by local data;

(B) the abuse of prescription medications, specifically opioids or methamphetamines, that is significantly higher than the national average, over a sustained period of time, as documented by local data; or

(C) a sudden increase in opioid-related deaths, as documented by local data.

(7) **OPIOID.**—The term “opioid” means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

Coordination.

(b) PROGRAM AUTHORIZED.—The Director, in coordination with the Administrator, may make grants to eligible entities to implement comprehensive community-wide strategies that address local drug crises and emerging drug abuse issues within the area served by the eligible entity.

(c) APPLICATION.—

(1) IN GENERAL.—An eligible entity seeking a grant under this section shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(2) CRITERIA.—As part of an application for a grant under this section, the Director shall require an eligible entity to submit a detailed, comprehensive, multisector plan for addressing the local drug crisis or emerging drug abuse issue within the area served by the eligible entity.

(d) USE OF FUNDS.—An eligible entity shall use a grant received under this section—

(1) for programs designed to implement comprehensive community-wide prevention strategies to address the local drug crisis in the area served by the eligible entity, in accordance with the plan submitted under subsection (c)(2);

(2) to obtain specialized training and technical assistance from the organization funded under section 4 of Public Law 107-82 (21 U.S.C. 1521 note); and

(3) for programs designed to implement comprehensive community-wide strategies to address emerging drug abuse issues in the community.

(e) SUPPLEMENT NOT SUPPLANT.—An eligible entity shall use Federal funds received under this section only to supplement the funds that would, in the absence of those Federal funds, be made available from other Federal and non-Federal sources for the activities described in this section, and not to supplant those funds.

(f) EVALUATION.—A grant under this section shall be subject to the same evaluation requirements and procedures as the evaluation requirements and procedures imposed on the recipient of a grant under the Drug-Free Communities Act of 1997, and may also include an evaluation of the effectiveness at reducing abuse of opioids or methamphetamines.

(g) LIMITATION ON ADMINISTRATIVE EXPENSES.—Not more than 8 percent of the amounts made available to carry out this section for a fiscal year may be used to pay for administrative expenses.

Contracts.

(h) DELEGATION AUTHORITY.—The Director may enter into an interagency agreement with the Administrator to delegate authority for the execution of grants and for such other activities as may be necessary to carry out this section.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$5,000,000 for each of fiscal years 2017 through 2021.

42 USC
290bb-25g note.

SEC. 104. INFORMATION MATERIALS AND RESOURCES TO PREVENT ADDICTION RELATED TO YOUTH SPORTS INJURIES.

Public
information.
Web posting.

(a) REPORT.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall, not later than 24 months after the date of the enactment of this section, make publicly available on the appropriate website of the Department of Health and Human Services a report determining the extent to which informational materials and resources described

in subsection (c) are available to teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups.

(b) **DEVELOPMENT OF INFORMATIONAL MATERIALS AND RESOURCES.**—The Secretary may, for purposes of preventing substance use disorder in teenagers and adolescents who are injured playing youth sports and are subsequently prescribed an opioid, not later than 12 months after the report is made publicly available under subsection (a), and taking into consideration the findings of such report and in coordination with relevant health care provider groups, facilitate the development of informational materials and resources described in subsection (c) for teenagers and adolescents who play youth sports, families of such teenagers and adolescents, nurses, youth sports groups, and relevant health care provider groups. Deadline.

(c) **MATERIALS AND RESOURCES DESCRIBED.**—For purposes of this section, the informational materials and resources described in this subsection are informational materials and resources with respect to youth sports injuries for which opioids are potentially prescribed, including materials and resources focused on the risks associated with opioid use and misuse, treatment options for such injuries that do not involve the use of opioids, and how to seek treatment for addiction.

(d) **NO ADDITIONAL FUNDS.**—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.

SEC. 105. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENT FOR BECOMING CIVILIAN HEALTH CARE PROFESSIONALS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

“SEC. 315. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO MEET REQUIREMENTS FOR BECOMING CIVILIAN HEALTH CARE PROFESSIONALS. 42 USC 247.

“(a) PROGRAM.—

“(1) IN GENERAL.—The Secretary may establish a program, in consultation with the Secretary of Labor, consisting of awarding demonstration grants to States to streamline State requirements and procedures in order to assist veterans who held certain military occupational specialties related to medical care or who have completed certain medical training while serving in the Armed Forces of the United States to meet certification, licensure, and other requirements applicable to civilian health care professions (such as emergency medical technician, paramedic, licensed practical nurse, registered nurse, physical therapy assistant, or physician assistant professions) in the State. Consultation.

“(2) CONSULTATION AND COLLABORATION.—In determining the eligible military occupational specialties or training courses and the assistance required as described in paragraph (1), the Secretary shall consult with the Secretary of Defense, the Secretary of Veterans Affairs, and the Assistant Secretary of Labor for Veterans’ Employment and Training, and shall collaborate with the initiatives carried out under section 4114

of title 38, United States Code, and sections 1142 through 1144 of title 10, United States Code.

“(b) USE OF FUNDS.—Amounts received as a demonstration grant under this section shall be used to—

Plan.

“(1) prepare and implement a plan to streamline State requirements and procedures as described in subsection (a), including by—

Determination.

“(A) determining the extent to which the requirements for the education, training, and skill level of civilian health care professions (such as emergency medical technicians, paramedics, licensed practical nurses, registered nurses, physical therapy assistants, or physician assistants) in the State are equivalent to requirements for the education, training, and skill level of veterans who served in medical related fields while a member of the Armed Forces of the United States; and

“(B) identifying methods, such as waivers, for veterans who served in medical related fields while a member of the Armed Forces of the United States to forgo or meet any such equivalent State requirements; and

“(2) if necessary to meet workforce shortages or address gaps in education, training, or skill level to meet certification, licensure or other requirements applicable to becoming a civilian health care professional (such as an emergency medical technician, paramedic, licensed practical nurse, registered nurse, physical therapy assistant, or physician assistant professions) in the State, develop or expand career pathways at institutions of higher education to support veterans in meeting such requirements.

“(c) REPORT.—Upon the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program.

“(d) FUNDING.—No additional funds are authorized to be appropriated for the purpose of carrying out this section. This section shall be carried out using amounts otherwise available for such purpose.

“(e) SUNSET.—The demonstration program under this section shall not exceed 5 years.”.

21 USC 355 note.

SEC. 106. FDA OPIOID ACTION PLAN.

(a) IN GENERAL.—

(1) NEW DRUG APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), prior to the approval pursuant to an application submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) of a new drug that is an opioid, the Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall refer the application to an advisory committee of the Food and Drug Administration to seek recommendations from such advisory committee.

(B) PUBLIC HEALTH EXEMPTION.—A referral to an advisory committee under subparagraph (A) is not required with respect to a new opioid drug or drugs if the Secretary—

(i) finds that such a referral is not in the interest of protecting and promoting public health;

(ii) finds that such a referral is not necessary based on a review of the relevant scientific information; and

(iii) submits a notice containing the rationale for such findings to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives. Notice.

(2) PEDIATRIC OPIOID LABELING.—The Secretary shall convene the Pediatric Advisory Committee of the Food and Drug Administration to seek recommendations from such Committee regarding a framework for the inclusion of information in the labeling of drugs that are opioids relating to the use of such drugs in pediatric populations before the Secretary approves any labeling or change to labeling for any drug that is an opioid intended for use in a pediatric population. Recommendations.

(3) SUNSET.—The requirements of paragraphs (1) and (2) shall cease to be effective on October 1, 2022.

(b) PRESCRIBER EDUCATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary, acting through the Commissioner of Food and Drugs, as part of the Food and Drug Administration's evaluation of the Extended-Release/Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy, and in consultation with relevant stakeholders, shall develop recommendations regarding education programs for prescribers of opioids pursuant to section 505-1 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355-1), including recommendations on—

(1) which prescribers should participate in such programs;

and

(2) how often participation in such programs is necessary.

(c) GUIDANCE ON EVALUATING THE ABUSE DETERRENCE OF GENERIC SOLID ORAL OPIOID DRUG PRODUCTS.—Not later than 18 months after the end of the period for public comment on the draft guidance entitled “General Principles for Evaluating the Abuse Deterrence of Generic Solid Oral Opioid Drug Products” issued by the Center for Drug Evaluation and Research of the Food and Drug Administration in March 2016, the Commissioner of Food and Drugs shall publish in the Federal Register a final version of such guidance. Deadline. Consultation. Recommendations. 21 USC 355-1 note.

SEC. 107. IMPROVING ACCESS TO OVERDOSE TREATMENT.

(a) GRANTS FOR REDUCING OVERDOSE DEATHS.—Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

“SEC. 544. GRANTS FOR REDUCING OVERDOSE DEATHS.

42 USC 290dd-3.

“(a) ESTABLISHMENT.—

“(1) IN GENERAL.—The Secretary shall award grants to eligible entities to expand access to drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(2) MAXIMUM GRANT AMOUNT.—A grant awarded under this section may not be for more than \$200,000 per grant year.

“(3) ELIGIBLE ENTITY.—For purposes of this section, the term ‘eligible entity’ means a Federally qualified health center (as defined in section 1861(aa) of the Social Security Act), an opioid treatment program under part 8 of title 42, Code Definition.

Definition.

of Federal Regulations, any practitioner dispensing narcotic drugs pursuant to section 303(g) of the Controlled Substances Act, or any other entity that the Secretary deems appropriate.

“(4) **PRESCRIBING.**—For purposes of this section, the term ‘prescribing’ means, with respect to a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, the practice of prescribing such drug or device—

“(A) in conjunction with an opioid prescription for patients at an elevated risk of overdose;

“(B) in conjunction with an opioid agonist approved under section 505 of the Federal Food, Drug, and Cosmetic Act for the treatment of opioid use disorder;

“(C) to the caregiver or a close relative of patients at an elevated risk of overdose from opioids; or

“(D) in other circumstances in which a provider identifies a patient is at an elevated risk for an intentional or unintentional drug overdose from heroin or prescription opioid therapies.

“(b) **APPLICATION.**—To be eligible to receive a grant under this section, an eligible entity shall submit to the Secretary, in such form and manner as specified by the Secretary, an application that describes—

“(1) the extent to which the area to which the entity will furnish services through use of the grant is experiencing significant morbidity and mortality caused by opioid abuse;

“(2) the criteria that will be used to identify eligible patients to participate in such program; and

“(3) a plan for sustaining the program after Federal support for the program has ended.

Criteria.

Plan.

“(c) **USE OF FUNDS.**—An eligible entity receiving a grant under this section may use amounts under the grant for any of the following activities, but may use not more than 20 percent of the grant funds for activities described in paragraphs (3) and (4):

“(1) To establish a program for prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(2) To train and provide resources for health care providers and pharmacists on the prescribing of drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(3) To purchase drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, for distribution under the program described in paragraph (1).

“(4) To offset the co-payments and other cost sharing associated with drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(5) To establish protocols to connect patients who have experienced a drug overdose with appropriate treatment, including medication-assisted treatment and appropriate counseling and behavioral therapies.

“(d) **EVALUATIONS BY RECIPIENTS.**—As a condition of receipt of a grant under this section, an eligible entity shall, for each year for which the grant is received, submit to the Secretary an

evaluation of activities funded by the grant which contains such information as the Secretary may reasonably require.

“(e) REPORTS BY THE SECRETARY.—Not later than 5 years after the date on which the first grant under this section is awarded, the Secretary shall submit to the appropriate committees of the House of Representatives and of the Senate a report aggregating the information received from the grant recipients for such year under subsection (d) and evaluating the outcomes achieved by the programs funded by grants awarded under this section.

“(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$5,000,000 for the period of fiscal years 2017 through 2021.”

(b) IMPROVING ACCESS TO OVERDOSE TREATMENT.—

(1) INFORMATION ON BEST PRACTICES.—Not later than 180 days after the date of enactment of this Act: Deadline.

(A) The Secretary of Health and Human Services may provide information to prescribers within Federally qualified health centers (as defined in paragraph (4) of section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa))), and the health care facilities of the Indian Health Service, on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(B) The Secretary of Defense may provide information to prescribers within Department of Defense medical facilities on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(C) The Secretary of Veterans Affairs may provide information to prescribers within Department of Veterans Affairs medical facilities on best practices for prescribing or co-prescribing a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose, including for patients receiving chronic opioid therapy and patients being treated for opioid use disorders.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection should be construed to establish or contribute to a medical standard of care.

SEC. 108. NIH OPIOID RESEARCH.

42 USC 284q-1.

(a) IN GENERAL.—The Director of the National Institutes of Health (referred to in this section as the “NIH”) may intensify and coordinate fundamental, translational, and clinical research of the NIH with respect to—

- (1) the understanding of pain;
- (2) the discovery and development of therapies for chronic pain; and
- (3) the development of alternatives to opioids for effective pain treatments.

(b) **PRIORITY AND DIRECTION.**—The prioritization and direction of the Federally funded portfolio of pain research studies shall consider recommendations made by the Interagency Pain Research Coordinating Committee in concert with the Pain Management Best Practices Inter-Agency Task Force, and in accordance with the National Pain Strategy, the Federal Pain Research Strategy, and the NIH-Wide Strategic Plan for Fiscal Years 2016–2020, the latter of which calls for the relative burdens of individual diseases and medical disorders to be regarded as crucial considerations in balancing the priorities of the Federal research portfolio.

SEC. 109. NATIONAL ALL SCHEDULES PRESCRIPTION ELECTRONIC REPORTING REAUTHORIZATION.

(a) **AMENDMENT TO PURPOSE.**—Paragraph (1) of section 2 of the National All Schedules Prescription Electronic Reporting Act of 2005 (Public Law 109–60) is amended to read as follows:

42 USC 280g–3
note.

“(1) foster the establishment of State-administered controlled substance monitoring systems in order to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction in order to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction; and”.

(b) **AMENDMENTS TO CONTROLLED SUBSTANCE MONITORING PROGRAM.**—Section 3990 of the Public Health Service Act (42 U.S.C. 280g–3) is amended—

(1) in subsection (a)(1)—

(A) in the matter preceding subparagraph (A), by inserting “, in consultation with the Administrator of the Substance Abuse and Mental Health Services Administration and Director of the Centers for Disease Control and Prevention,” after “the Secretary”;

(B) in subparagraph (A), by striking “or”;

(C) in subparagraph (B), by striking the period at the end and inserting “, or”; and

(D) by adding at the end the following:

“(C) to maintain an existing State-controlled substance monitoring program.”;

(2) by amending subsection (b) to read as follows:

“(b) **MINIMUM REQUIREMENTS.**—The Secretary shall maintain and, as appropriate, supplement or revise (after publishing proposed additions and revisions in the Federal Register and receiving public comments thereon) minimum requirements for criteria to be used by States for purposes of clauses (ii), (v), (vi), and (vii) of subsection (c)(1)(A).”;

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) in the matter preceding clause (i), by striking “(a)(1)(B)” and inserting “(a)(1)(B) or (a)(1)(C)”;

(ii) in clause (i), by striking “program to be improved” and inserting “program to be improved or maintained”;

(iii) by redesignating clauses (iii) and (iv) as clauses (iv) and (v), respectively;

(iv) by inserting after clause (ii), the following:

Federal Register,
publication.
Public
information.

“(iii) a plan to apply the latest advances in health information technology, to the extent practicable, in order to incorporate prescription drug monitoring program data directly into the workflow of prescribers and dispensers to ensure timely access to patients’ controlled prescription drug history;”;

(v) in clause (iv) (as so redesignated), by striking “; and” and inserting the following: “and at least one health information technology system such as electronic health records, health information exchanges, or e-prescribing systems;”;

(vi) in clause (v) (as so redesignated)—

(I) by striking “public health” and inserting “public health or safety”; and

(II) by striking the period and inserting “; and”; and

(vii) by adding at the end the following:

“(vi) information, where applicable, on how the controlled substance monitoring program jointly works with the applicant’s respective State substance abuse agency to ensure information collected and maintained by the controlled substance monitoring program is used to inform the provision of clinically appropriate substance use disorder services to individuals in need.”;

(B) in paragraph (3)—

(i) by striking “If a State that submits” and inserting the following:

“(A) IN GENERAL.—If a State that submits”;

(ii) by inserting before the period at the end “and include timelines for full implementation of such interoperability. The State shall also describe the manner in which it will achieve interoperability between its monitoring program and health information technology systems, as allowable under State law, and include timelines for the implementation of such interoperability”; and

(iii) by adding at the end the following:

“(B) MONITORING OF EFFORTS.—The Secretary shall monitor State efforts to achieve interoperability, as described in subparagraph (A).”; and

(C) in paragraph (5)—

(i) by striking “implement or improve” and inserting “establish, improve, or maintain”; and

(ii) by adding at the end the following: “The Secretary shall redistribute any funds that are so returned among the remaining grantees under this section in accordance with the formula described in subsection (a)(2)(B).”;

(4) in subsection (d)—

(A) in the matter preceding paragraph (1)—

(i) by striking “In implementing or improving” and all that follows through “(a)(1)(B)” and inserting “In establishing, improving, or maintaining a controlled substance monitoring program under this section, a State shall comply, or with respect to a State that applies for a grant under subparagraph (B) or (C) of subsection (a)(1)”; and

Reports.

- (ii) by striking “public health” and inserting “public health or safety”; and
- (B) by adding at the end the following:
- “(5) The State shall report on interoperability with the controlled substance monitoring program of Federal agencies, where appropriate, interoperability with health information technology systems such as electronic health records, health information exchanges, and e-prescribing, where appropriate, and whether or not the State provides automatic, up-to-date, or daily information about a patient when a practitioner (or the designee of a practitioner, where permitted) requests information about such patient.”;
- (5) in subsections (e), (f)(1), and (g), by striking “implementing or improving” each place it appears and inserting “establishing, improving, or maintaining”;
- (6) in subsection (f)—
- (A) in paragraph (1)—
- (i) in subparagraph (B), by striking “misuse of a schedule II, III, or IV substance” and inserting “misuse of a controlled substance included in schedule II, III, or IV of section 202(c) of the Controlled Substances Act”; and
- (ii) in subparagraph (D)—
- (I) by inserting “a State substance abuse agency,” after “State health department,”; and
- (II) by striking “such department, program, or administration” each place it appears and inserting “such department, program, agency, or administration” in each such place; and
- (B) by adding at the end the following:
- “(3) EVALUATION AND REPORTING.—Subject to subsection (g), a State receiving a grant under subsection (a) shall provide the Secretary with aggregate data to enable the Secretary—
- “(A) to evaluate the success of the State’s program in achieving its purposes; or
- “(B) to prepare and submit the report to Congress required by subsection (k)(2).
- “(4) RESEARCH BY OTHER ENTITIES.—A department, program, agency, or administration receiving nonidentifiable information under paragraph (1)(D) may make such information available to other entities for research purposes.”;
- (7) by striking subsection (k);
- (8) by redesignating subsections (h) through (j) as subsections (i) through (k), respectively;
- (9) in subsections (c)(1)(A)(iv) and (d)(4), by striking “subsection (h)” each place it appears and inserting “subsection (i)”;
- (10) by inserting after subsection (g) the following:
- “(h) EDUCATION AND ACCESS TO THE MONITORING SYSTEM.—A State receiving a grant under subsection (a) shall take steps to—
- “(1) facilitate prescriber and dispenser use of the State’s controlled substance monitoring system, to the extent practicable; and
- “(2) educate prescribers and dispensers on the benefits of the system.”;
- (11) in subsection (k)(2)(A), as so redesignated—

(A) in clause (ii), by striking “or affected” and inserting “, established or strengthened initiatives to ensure linkages to substance use disorder services, or affected”; and

(B) in clause (iii), by striking “including an assessment” and inserting “and between controlled substance monitoring programs and health information technology systems, including an assessment”;

(12) in subsection (l)(1), by striking “establishment, implementation, or improvement” and inserting “establishment, improvement, or maintenance”;

(13) in subsection (m)(8), by striking “and the District of Columbia” and inserting “, the District of Columbia, and any commonwealth or territory of the United States”; and

(14) by amending subsection (n) to read as follows:

“(n) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated, \$10,000,000 for each of fiscal years 2017 through 2021.”

SEC. 110. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS.

(a) IN GENERAL.—Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 107, is further amended by adding at the end the following:

“SEC. 545. OPIOID OVERDOSE REVERSAL MEDICATION ACCESS AND EDUCATION GRANT PROGRAMS. 42 USC 290ee.

“(a) GRANTS TO STATES.—The Secretary shall make grants to States to—

“(1) implement strategies for pharmacists to dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, as appropriate, pursuant to a standing order;

“(2) encourage pharmacies to dispense opioid overdose reversal medication pursuant to a standing order;

“(3) develop or provide training materials that persons authorized to prescribe or dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose may use to educate the public concerning—

“(A) when and how to safely administer such drug or device; and

“(B) steps to be taken after administering such drug or device; and

“(4) educate the public concerning the availability of drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose without a person-specific prescription.

“(b) CERTAIN REQUIREMENT.—A grant may be made under this section only if the State involved has authorized standing orders to be issued for drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(c) PREFERENCE IN MAKING GRANTS.—In making grants under this section, the Secretary may give preference to States that have a significantly higher rate of opioid overdoses than the national average, and that—

“(1) have not implemented standing orders regarding drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose;

“(2) authorize standing orders to be issued that permit community-based organizations, substance abuse programs, or other nonprofit entities to acquire, dispense, or administer drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; or

“(3) authorize standing orders to be issued that permit police, fire, or emergency medical services agencies to acquire and administer drugs or devices approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(d) GRANT TERMS.—

“(1) NUMBER.—A State may not receive more than one grant under this section at a time.

“(2) PERIOD.—A grant under this section shall be for a period of 3 years.

“(3) LIMITATION.—A State may use not more than 20 percent of a grant under this section for educating the public pursuant to subsection (a)(4).

“(e) APPLICATIONS.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may reasonably require, including detailed proposed expenditures of grant funds.

Evaluation.

“(f) REPORTING.—A State that receives a grant under this section shall, at least annually for the duration of the grant, submit a report to the Secretary evaluating the progress of the activities supported through the grant. Such reports shall include information on the number of pharmacies in the State that dispense a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose under a standing order, and other information as the Secretary determines appropriate to evaluate the use of grant funds.

“(g) DEFINITIONS.—In this section the term ‘standing order’ means a document prepared by a person authorized to prescribe medication that permits another person to acquire, dispense, or administer medication without a person-specific prescription.

“(h) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—To carry out this section, there are authorized to be appropriated \$5,000,000 for the period of fiscal years 2017 through 2019.

“(2) ADMINISTRATIVE COSTS.—Not more than 3 percent of the amounts made available to carry out this section may be used by the Secretary for administrative expenses of carrying out this section.”

Effective date.
42 USC 257 note.

(b) TECHNICAL CLARIFICATION.—Effective as if included in the enactment of the Children’s Health Act of 2000 (Public Law 106-310), section 3405(a) of such Act (114 Stat. 1221) is amended by striking “Part E of title III” and inserting “Part E of title III of the Public Health Service Act”.

TITLE II—LAW ENFORCEMENT AND TREATMENT

SEC. 201. COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.

(a) COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—
(1) IN GENERAL.—Title I of the Omnibus Crime Control
and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended
by adding at the end the following:

“PART LL—COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM

“SEC. 3021. DESCRIPTION.

42 USC 3797ff.

“(a) GRANTS AUTHORIZED.—From amounts made available to
carry out this part, the Attorney General may make grants to
States, units of local government, and Indian tribes, for use by
the State, unit of local government, or Indian tribe to provide
services primarily relating to opioid abuse, including for any one
or more of the following:

“(1) Developing, implementing, or expanding a treatment
alternative to incarceration program, which may include—

“(A) prebooking or postbooking components, which may
include the activities described in part DD or HH of this
title;

“(B) training for criminal justice agency personnel on
substance use disorders and co-occurring mental illness
and substance use disorders;

“(C) a mental health court, including the activities
described in part V of this title;

“(D) a drug court, including the activities described
in part EE of this title;

“(E) a veterans treatment court program, including
the activities described in subsection (i) of section 2991
of this title;

“(F) a focus on parents whose incarceration could result
in their children entering the child welfare system; and

“(G) a community-based substance use diversion pro-
gram sponsored by a law enforcement agency.

“(2) In the case of a State, facilitating or enhancing plan-
ning and collaboration between State criminal justice agencies
and State substance abuse agencies in order to more efficiently
and effectively carry out activities or services described in any
paragraph of this subsection that address problems related
to opioid abuse.

“(3) Providing training and resources for first responders
on carrying and administering an opioid overdose reversal drug
or device approved or cleared by the Food and Drug Administra-
tion, and purchasing such a drug or device for first responders
who have received such training to so carry and administer.

“(4) Locating or investigating illicit activities related to
the unlawful distribution of opioids.

“(5) Developing, implementing, or expanding a medication-
assisted treatment program used or operated by a criminal
justice agency, which may include training criminal justice

agency personnel on medication-assisted treatment, and carrying out the activities described in part S of this title.

“(6) In the case of a State, developing, implementing, or expanding a prescription drug monitoring program to collect and analyze data related to the prescribing of schedules II, III, and IV controlled substances through a centralized database administered by an authorized State agency, which includes tracking the dispensation of such substances, and providing for interoperability and data sharing with each other such program in each other State, and with any interstate entity that shares information between such programs.

“(7) Developing, implementing, or expanding a program to prevent and address opioid abuse by juveniles.

“(8) Developing, implementing, or expanding a program (which may include demonstration projects) to utilize technology that provides a secure container for prescription drugs that would prevent or deter individuals, particularly adolescents, from gaining access to opioid medications that are lawfully prescribed for other individuals.

“(9) Developing, implementing, or expanding a prescription drug take-back program.

“(10) Developing, implementing, or expanding an integrated and comprehensive opioid abuse response program.

“(b) **CONTRACTS AND SUBAWARDS.**—A State, unit of local government, or Indian tribe may, in using a grant under this part for purposes authorized by subsection (a), use all or a portion of that grant to contract with, or make one or more subawards to, one or more—

“(1) local or regional organizations that are private and nonprofit, including faith-based organizations;

“(2) units of local government; or

“(3) tribal organizations.

“(c) **PROGRAM ASSESSMENT COMPONENT; WAIVER.**—

Coordination.

“(1) **PROGRAM ASSESSMENT COMPONENT.**—Each program funded under this part shall contain a program assessment component, developed pursuant to guidelines established by the Attorney General, in coordination with the National Institute of Justice.

“(2) **WAIVER.**—The Attorney General may waive the requirement of paragraph (1) with respect to a program if, in the opinion of the Attorney General, the program is not of sufficient size to justify a full program assessment.

“(d) **ADMINISTRATIVE COSTS.**—Not more than 10 percent of a grant made under this part may be used for costs incurred to administer such grant.

“(e) **PERIOD.**—The period of a grant made under this part may not be longer than 4 years, except that renewals and extensions beyond that period may be granted at the discretion of the Attorney General.

42 USC 3797ff-1. **“SEC. 3022. APPLICATIONS.**

Certification.

“To request a grant under this part, the chief executive officer of a State, unit of local government, or Indian tribe shall submit an application to the Attorney General at such time and in such form as the Attorney General may require. Such application shall include the following:

“(1) A certification that Federal funds made available under this part will not be used to supplant State, local, or tribal funds, but will be used to increase the amounts of such funds that would, in the absence of Federal funds, be made available for the activities described in section 3021(a).

“(2) An assurance that, for each fiscal year covered by an application, the applicant shall maintain and report such data, records, and information (programmatic and financial) as the Attorney General may reasonably require.

“(3) A certification, made in a form acceptable to the Attorney General and executed by the chief executive officer of the applicant (or by another officer of the applicant, if qualified under regulations promulgated by the Attorney General), that—

“(A) the activities or services to be funded by the grant meet all the requirements of this part;

“(B) all the information contained in the application is correct;

“(C) there has been appropriate coordination with affected agencies; and

“(D) the applicant will comply with all provisions of this part and all other applicable Federal laws.

“(4) An assurance that the applicant will work with the Drug Enforcement Administration to develop an integrated and comprehensive strategy to address opioid abuse.

“SEC. 3023. REVIEW OF APPLICATIONS.

Notice.
42 USC 3797ff-2.

“The Attorney General shall not finally disapprove any application (or any amendment to that application) submitted under this part without first affording the applicant reasonable notice of any deficiencies in the application and an opportunity for correction of any such deficiencies and reconsideration.

“SEC. 3024. EQUITABLE DISTRIBUTION OF FUNDS.

42 USC 3797ff-3.

“In awarding grants under this part, the Attorney General shall distribute funds in a manner that—

“(1) equitably addresses the needs of underserved populations, including rural and tribal communities; and

“(2) focuses on communities that have been disproportionately impacted by opioid abuse as evidenced in part by—

“(A) high rates of primary treatment admissions for heroin and other opioids;

“(B) high rates of drug poisoning deaths from heroin and other opioids; and

“(C) a lack of accessibility to treatment providers and facilities and to emergency medical services.

“SEC. 3025. DEFINITIONS.

42 USC 3797ff-4.

“In this part:

“(1) The term ‘first responder’ includes a firefighter, law enforcement officer, paramedic, emergency medical technician, or other individual (including an employee of a legally organized and recognized volunteer organization, whether compensated or not), who, in the course of his or her professional duties, responds to fire, medical, hazardous material, or other similar emergencies.

“(2) The term ‘medication-assisted treatment’ means the use of medications approved by the Food and Drug Administration for the treatment of opioid abuse.

“(3) The term ‘opioid’ means any drug, including heroin, having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

“(4) The term ‘schedule II, III, or IV controlled substance’ means a controlled substance that is listed on schedule II, schedule III, or schedule IV of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)).

“(5) The terms ‘drug’ and ‘device’ have the meanings given those terms in section 201 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321).

“(6) The term ‘criminal justice agency’ means a State, local, or tribal—

“(A) court;

“(B) prison;

“(C) jail;

“(D) law enforcement agency; or

“(E) other agency that performs the administration of criminal justice, including prosecution, pretrial services, and community supervision.

“(7) The term ‘tribal organization’ has the meaning given that term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

“(8) The term ‘State substance abuse agency’ has the meaning given that term in section 508(r)(6) of the Public Health Service Act (42 U.S.C. 290bb-1).”.

(2) AUTHORIZATION OF APPROPRIATIONS.—Section 1001(a) of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3793(a)) is amended by inserting after paragraph (26) the following:

“(27) There are authorized to be appropriated to carry out part LL \$103,000,000 for each of fiscal years 2017 through 2021.”.

(b) EMERGENCY FEDERAL LAW ENFORCEMENT ASSISTANCE.—Section 609Y(a) of the Justice Assistance Act of 1984 (42 U.S.C. 10513(a)) is amended by striking “September 30, 1984” and inserting “September 30, 2021”.

(c) INCLUSION OF SERVICES FOR PREGNANT WOMEN UNDER FAMILY-BASED SUBSTANCE ABUSE GRANTS.—Part DD of title I of the Omnibus Crime Control and Safe Streets Act (42 U.S.C. 3797s et seq.) is amended—

42 USC 3797s.

(1) in section 2921(2), by inserting before the period at the end “or pregnant women”; and

42 USC 3797s-6.

(2) in section 2927—

(A) in paragraph (1)(A), by inserting “pregnant or” before “a parent”; and

(B) in paragraph (3), by inserting “or pregnant women” after “incarcerated parents”.

(d) GAO STUDY AND REPORT ON FEDERAL AGENCY PROGRAMS AND RESEARCH RELATIVE TO SUBSTANCE USE AND SUBSTANCE USE DISORDERS AMONG ADOLESCENTS AND YOUNG ADULTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on how Federal agencies, through grant programs, are addressing prevention of, treatment for, and

recovery from, substance use by, and substance use disorders among, adolescents and young adults. Such study shall include an analysis of each of the following:

(A) The research that has been, and is being, conducted or supported pursuant to grant programs operated by Federal agencies on prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of—

(i) such research relative to any unique circumstances (including social and biological circumstances) of adolescents and young adults that may make adolescent-specific and young adult-specific treatment protocols necessary, including any effects that substance use and substance use disorders may have on brain development and the implications for treatment and recovery; and

(ii) areas of such research in which greater investment or focus is necessary relative to other areas of such research.

(B) Federal agency nonresearch programs and activities that address prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including an assessment of the effectiveness of such programs and activities in preventing substance use by and substance use disorders among adolescents and young adults, treating such adolescents and young adults in a way that accounts for any unique circumstances faced by adolescents and young adults, and supports long-term recovery among adolescents and young adults.

(C) Gaps that have been identified by officials of Federal agencies or experts in the efforts supported by grant programs operated by Federal agencies relating to prevention of, treatment for, and recovery from substance use by and substance use disorders among adolescents and young adults, including gaps in research, data collection, and measures to evaluate the effectiveness of such efforts, and the reasons for such gaps.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit to the appropriate committees of the Congress a report containing the results of the study conducted under paragraph (1), including—

(A) a summary of the findings of the study; and

(B) recommendations based on the results of the study, including recommendations for such areas of research and legislative and administrative action as the Comptroller General determines appropriate.

Summary.
Recommendations.

SEC. 202. FIRST RESPONDER TRAINING.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 110, is further amended by adding at the end the following:

“SEC. 546. FIRST RESPONDER TRAINING.

42 USC 290ee-1.

“(a) PROGRAM AUTHORIZED.—The Secretary shall make grants to States, local governmental entities, and Indian tribes and tribal

organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) to allow first responders and members of other key community sectors to administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose.

“(b) APPLICATION.—

“(1) IN GENERAL.—An entity seeking a grant under this section shall submit an application to the Secretary—

“(A) that meets the criteria under paragraph (2); and

“(B) at such time, in such manner, and accompanied by such information as the Secretary may require.

“(2) CRITERIA.—An entity, in submitting an application under paragraph (1), shall—

“(A) describe the evidence-based methodology and outcome measurements that will be used to evaluate the program funded with a grant under this section, and specifically explain how such measurements will provide valid measures of the impact of the program;

“(B) describe how the program could be broadly replicated if demonstrated to be effective;

“(C) identify the governmental and community agencies with which the entity will coordinate to implement the program; and

“(D) describe how the entity will ensure that law enforcement agencies will coordinate with their corresponding State substance abuse and mental health agencies to identify protocols and resources that are available to overdose victims and families, including information on treatment and recovery resources.

“(c) USE OF FUNDS.—An entity shall use a grant received under this section to—

“(1) make a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose available to be carried and administered by first responders and members of other key community sectors;

“(2) train and provide resources for first responders and members of other key community sectors on carrying and administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

“(3) establish processes, protocols, and mechanisms for referral to appropriate treatment, which may include an outreach coordinator or team to connect individuals receiving opioid overdose reversal drugs to followup services.

“(d) TECHNICAL ASSISTANCE GRANTS.—The Secretary shall make a grant for the purpose of providing technical assistance and training on the use of a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, and mechanisms for referral to appropriate treatment for an entity receiving a grant under this section.

“(e) GEOGRAPHIC DISTRIBUTION.—In making grants under this section, the Secretary shall ensure that not less than 20 percent of grant funds are awarded to eligible entities that are not located

in metropolitan statistical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

“(f) **EVALUATION.**—The Secretary shall conduct an evaluation of grants made under this section to determine—

“(1) the number of first responders and members of other key community sectors equipped with a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose;

“(2) the number of opioid and heroin overdoses reversed by first responders and members of other key community sectors receiving training and supplies of a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose, through a grant received under this section;

“(3) the number of responses to requests for services by the entity or subgrantee, to opioid and heroin overdose; and

“(4) the extent to which overdose victims and families receive information about treatment services and available data describing treatment admissions.

“(g) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated \$12,000,000 for each of fiscal years 2017 through 2021.”

SEC. 203. PRESCRIPTION DRUG TAKE BACK EXPANSION.

21 USC 822a.

(a) **DEFINITION OF COVERED ENTITY.**—In this section, the term “covered entity” means—

- (1) a State, local, or tribal law enforcement agency;
- (2) a manufacturer, distributor, or reverse distributor of prescription medications;
- (3) a retail pharmacy;
- (4) a registered narcotic treatment program;
- (5) a hospital or clinic with an onsite pharmacy;
- (6) an eligible long-term care facility; or
- (7) any other entity authorized by the Drug Enforcement Administration to dispose of prescription medications.

(b) **PROGRAM AUTHORIZED.**—The Attorney General, in coordination with the Administrator of the Drug Enforcement Administration, the Secretary of Health and Human Services, and the Director of the Office of National Drug Control Policy, shall coordinate with covered entities in expanding or making available disposal sites for unwanted prescription medications.

Coordination.

TITLE III—TREATMENT AND RECOVERY

SEC. 301. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by adding at the end the following:

“SEC. 514B. EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

42 USC
290bb-10.

“(a) **GRANTS TO EXPAND ACCESS.**—

Contracts.

“(1) **AUTHORITY TO AWARD GRANTS.**—The Secretary shall award grants, contracts, or cooperative agreements to State substance abuse agencies, units of local government, nonprofit organizations, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) that have a high rate, or have had a rapid increase, in the use of heroin or other opioids, in order to permit such entities to expand activities, including an expansion in the availability of evidence-based medication-assisted treatment and other clinically appropriate services, with respect to the treatment of addiction in the specific geographical areas of such entities where there is a high rate or rapid increase in the use of heroin or other opioids, such as in rural areas.

“(2) **NATURE OF ACTIVITIES.**—Funds awarded under paragraph (1) shall be used for activities that are based on reliable scientific evidence of efficacy in the treatment of problems related to heroin or other opioids.

“(b) **APPLICATION.**—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

“(c) **EVALUATION.**—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or agreement a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and an evaluation at the completion of such project as the Secretary determines to be appropriate.

“(d) **GEOGRAPHIC DISTRIBUTION.**—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall ensure that not less than 15 percent of funds are awarded to eligible entities that are not located in metropolitan statistical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

“(e) **ADDITIONAL ACTIVITIES.**—In administering grants, contracts, and cooperative agreements under subsection (a), the Secretary shall—

Evaluation.

“(1) evaluate the activities supported under such subsection;

“(2) disseminate information, as appropriate, derived from evaluations as the Secretary considers appropriate;

“(3) provide States, Indian tribes and tribal organizations, and providers with technical assistance in connection with the provision of treatment of problems related to heroin and other opioids; and

“(4) fund only those applications that specifically support recovery services as a critical component of the program involved.

“(f) **AUTHORIZATION OF APPROPRIATIONS.**—To carry out this section, there are authorized to be appropriated \$25,000,000 for each of fiscal years 2017 through 2021.”.

SEC. 302. BUILDING COMMUNITIES OF RECOVERY.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 202, is further amended by adding at the end the following:

“SEC. 547. BUILDING COMMUNITIES OF RECOVERY.

42 USC 290ee-2.

“(a) **DEFINITION.**—In this section, the term ‘recovery community organization’ means an independent nonprofit organization that—

“(1) mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from substance use disorders; and

“(2) is wholly or principally governed by people in recovery for substance use disorders who reflect the community served.

“(b) **GRANTS AUTHORIZED.**—The Secretary shall award grants to recovery community organizations to enable such organizations to develop, expand, and enhance recovery services.

“(c) **FEDERAL SHARE.**—The Federal share of the costs of a program funded by a grant under this section may not exceed 50 percent.

“(d) **USE OF FUNDS.**—Grants awarded under subsection (b)—

“(1) shall be used to develop, expand, and enhance community and statewide recovery support services; and

“(2) may be used to—

“(A) build connections between recovery networks, between recovery community organizations, and with other recovery support services, including—

“(i) behavioral health providers;

“(ii) primary care providers and physicians;

“(iii) the criminal justice system;

“(iv) employers;

“(v) housing services;

“(vi) child welfare agencies; and

“(vii) other recovery support services that facilitate recovery from substance use disorders;

“(B) reduce the stigma associated with substance use disorders; and

“(C) conduct outreach on issues relating to substance use disorders and recovery, including—

“(i) identifying the signs of addiction;

“(ii) the resources available to individuals struggling with addiction and to families with a family member struggling with, or being treated for, addiction, including programs that mentor and provide support services to children;

“(iii) the resources available to help support individuals in recovery; and

“(iv) related medical outcomes of substance use disorders, the potential of acquiring an infectious disease from intravenous drug use, and neonatal abstinence syndrome among infants exposed to opioids during pregnancy.

“(e) **AUTHORIZATION OF APPROPRIATIONS.**—There are authorized to be appropriated to carry out this section \$1,000,000 for each of fiscal years 2017 through 2021.”.

SEC. 303. MEDICATION-ASSISTED TREATMENT FOR RECOVERY FROM ADDICTION.

(a) **IN GENERAL.**—

(1) **IN GENERAL.**—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended—

(A) in subparagraph (B), by striking clauses (i), (ii), and (iii) and inserting the following:

“(i) The practitioner is a qualifying practitioner (as defined in subparagraph (G)).

“(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to provide directly, by referral, or in such other manner as determined by the Secretary—

“(I) all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder, including for maintenance, detoxification, overdose reversal, and relapse prevention; and

“(II) appropriate counseling and other appropriate ancillary services.

“(iii)(I) The total number of such patients of the practitioner at any one time will not exceed the applicable number. Except as provided in subclause (II), the applicable number is 30.

“(II) The applicable number is 100 if, not sooner than 1 year after the date on which the practitioner submitted the initial notification, the practitioner submits a second notification to the Secretary of the need and intent of the practitioner to treat up to 100 patients.

“(III) The Secretary may by regulation change such applicable number.

“(IV) The Secretary may exclude from the applicable number patients to whom such drugs or combinations of drugs are directly administered by the qualifying practitioner in the office setting.”;

(B) in subparagraph (D)—

(i) in clause (ii), by striking “Upon receiving a notification under subparagraph (B)” and inserting “Upon receiving a determination from the Secretary under clause (iii) finding that a practitioner meets all requirements for a waiver under subparagraph (B)”;

and

(ii) in clause (iii)—

(I) by inserting “and shall forward such determination to the Attorney General” before the period at the end of the first sentence; and

(II) by striking “physician” and inserting “practitioner”;

(C) in subparagraph (G)—

(i) by amending clause (ii)(I) to read as follows:

“(I) The physician holds a board certification in addiction psychiatry or addiction medicine from the American Board of Medical Specialties.”;

(ii) by amending clause (ii)(II) to read as follows:

“(II) The physician holds an addiction certification or board certification from the American Society of Addiction Medicine or the American Board of Addiction Medicine.”;

(iii) in clause (ii)(III), by striking “subspecialty”;

(iv) by amending clause (ii)(IV) to read as follows:
 “(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than 8 hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause. Such training shall include—

- “(aa) opioid maintenance and detoxification;
- “(bb) appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder;
- “(cc) initial and periodic patient assessments (including substance use monitoring);
- “(dd) individualized treatment planning, overdose reversal, and relapse prevention;
- “(ee) counseling and recovery support services;
- “(ff) staffing roles and considerations;
- “(gg) diversion control; and
- “(hh) other best practices, as identified by the Secretary.”; and

(v) by adding at the end the following:
 “(iii) The term ‘qualifying practitioner’ means—

“(I) a qualifying physician, as defined in clause (ii);

Definition.

or

“(II) during the period beginning on the date of enactment of the Comprehensive Addiction and Recovery Act of 2016 and ending on October 1, 2021, a qualifying other practitioner, as defined in clause (iv).

Time period.

“(iv) The term ‘qualifying other practitioner’ means a nurse practitioner or physician assistant who satisfies each of the following:

Definition.

“(I) The nurse practitioner or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain.

“(II) The nurse practitioner or physician assistant has—

“(aa) completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or

“(bb) has such other training or experience as the Secretary determines will demonstrate the ability of

the nurse practitioner or physician assistant to treat and manage opiate-dependent patients.

“(III) The nurse practitioner or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

The Secretary may, by regulation, revise the requirements for being a qualifying other practitioner under this clause.”; and (D) in subparagraph (H)—

(i) in clause (i), by inserting after subclause (II) the following:

“(III) Such other elements of the requirements under this paragraph as the Secretary determines necessary for purposes of implementing such requirements.”; and

(ii) by amending clause (ii) to read as follows:

Deadline. “(ii) Not later than 18 months after the date of enactment of the Opioid Use Disorder Treatment Expansion and Modernization Act, the Secretary shall update the treatment improvement protocol containing best practice guidelines for the treatment of opioid-dependent patients in office-based settings. The Secretary shall update such protocol in consultation with experts in opioid use disorder research and treatment.”.

Consultation.

(2) OPIOID DEFINED.—Section 102(18) of the Controlled Substances Act (21 U.S.C. 802(18)) is amended by inserting “or ‘opioid’” after “The term ‘opiate’”.

21 USC 823 note.
Consultation.

(3) REPORTS TO CONGRESS.—

(A) IN GENERAL.—Not later than 3 years after the date of enactment of this Act and not later than 3 years thereafter, the Secretary of Health and Human Services, in consultation with the Drug Enforcement Administration and experts in opioid use disorder research and treatment, shall—

(i) perform a thorough review of the provision of opioid use disorder treatment services in the United States, including services provided in opioid treatment programs and other specialty and nonspecialty settings; and

(ii) submit a report to the Congress on the findings and conclusions of such review.

Assessment.

(B) CONTENTS.—Each report under subparagraph (A) shall include an assessment of—

(i) compliance with the requirements of section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), as amended by this section;

(ii) the measures taken by the Secretary of Health and Human Services to ensure such compliance;

(iii) whether there is further need to increase or decrease the number of patients a practitioner, pursuant to a waiver under section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)), is permitted to treat;

(iv) the extent to which, and proportions with which, the full range of Food and Drug Administration-approved treatments for opioid use disorder are used

in routine health care settings and specialty substance use disorder treatment settings;

(v) access to, and use of, counseling and recovery support services, including the percentage of patients receiving such services;

(vi) changes in State or local policies and legislation relating to opioid use disorder treatment;

(vii) the use of prescription drug monitoring programs by practitioners who are permitted to dispense narcotic drugs to individuals pursuant to a waiver described in clause (iii);

(viii) the findings resulting from inspections by the Drug Enforcement Administration of practitioners described in clause (vii); and

(ix) the effectiveness of cross-agency collaboration between Department of Health and Human Services and the Drug Enforcement Administration for expanding effective opioid use disorder treatment.

(b) STATE FLEXIBILITY.—Section 303(g)(2) of the Controlled Substances Act (21 U.S.C. 823(g)(2)) is amended by striking subparagraphs (I) and (J), and inserting the following:

“(I) Notwithstanding section 708, nothing in this paragraph shall be construed to preempt any State law that—

“(i) permits a qualifying practitioner to dispense narcotic drugs in schedule III, IV, or V, or combinations of such drugs, for maintenance or detoxification treatment in accordance with this paragraph to a total number of patients that is more than 30 or less than the total number applicable to the qualifying practitioner under subparagraph (B)(iii)(II) if a State enacts a law modifying such total number and the Attorney General is notified by the State of such modification; or

“(ii) requires a qualifying practitioner to comply with additional requirements relating to the dispensing of narcotic drugs in schedule III, IV, or V, or combinations of such drugs, including requirements relating to the practice setting in which the qualifying practitioner practices and education, training, and reporting requirements.”.

(c) UPDATE REGULATIONS.—Not later than 18 months after the date of enactment of this Act, the Attorney General and the Secretary of Health and Human Services, as appropriate, shall update regulations regarding practitioners described in subsection (a)(3)(B)(vii) (as amended by this section) to include nurse practitioners and physician assistants to ensure the quality of patient care and prevent diversion.

Deadline.
21 USC 823 note.

TITLE IV—ADDRESSING COLLATERAL CONSEQUENCES

SEC. 401. GAO REPORT ON RECOVERY AND COLLATERAL CONSEQUENCES.

(a) REPORT REQUIRED.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on the Judiciary of the Senate and the Committee on the Judiciary of the House of Representatives a report that—

(1) describes the collateral consequences for individuals with convictions for nonviolent drug-related offenses;

(2) describes the effect of the collateral consequences described in paragraph (1) on individuals in resuming their personal and professional activities, especially, to the extent data are available, the effect on individuals who are participating in or have completed a recovery program for a substance use disorder;

(3) discusses policy bases and justifications for imposing collateral consequences on individuals convicted of nonviolent drug-related offenses identified under paragraph (1); and

(4) provides perspectives on the potential for mitigating the effect of the collateral consequences described in paragraph (1) on individuals who are participating in or have completed a recovery program, while also taking into account the policy interests described in paragraph (3).

(b) DEFINITION.—In this section, the term “collateral consequence”—

(1) means a penalty, disability, or disadvantage imposed upon an individual as a result of a criminal conviction for a drug-related offense—

(A) automatically by operation of law; or

(B) by authorized action of an administrative agency or court on a case-by-case basis; and

(2) does not include a direct consequence imposed as part of the judgment of a court at sentencing, including a term of imprisonment or community supervision, or a fine.

TITLE V—ADDICTION AND TREATMENT SERVICES FOR WOMEN, FAMILIES, AND VETERANS

SEC. 501. IMPROVING TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN.

(a) GENERAL AMENDMENTS TO THE RESIDENTIAL TREATMENT PROGRAM FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb-1) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by inserting “(referred to in this section as the ‘Director’)” after “Substance Abuse Treatment”;

(ii) by striking “grants, cooperative agreement,” and inserting “grants, including the grants under subsection (r), cooperative agreements”; and

(iii) by striking “for substance abuse” and inserting “for substance use disorders”; and

(B) in paragraph (1), by inserting “or receive outpatient treatment services from” after “reside in”;

(2) in subsection (b)(2), by inserting “and her children” before the period at the end;

(3) in subsection (c)—

(A) in paragraph (1), by striking “to the woman of the services” and inserting “of services for the woman and her children”; and

(B) in paragraph (2)—

- (i) in subparagraph (A), by striking “substance abuse” and inserting “substance use disorders”; and
 - (ii) in subparagraph (B), by striking “such abuse” and inserting “such a disorder”;
- (4) in subsection (d)—
- (A) in paragraph (3)(A), by striking “maternal substance abuse” and inserting “a maternal substance use disorder”;
 - (B) by amending paragraph (4) to read as follows:
“(4) Providing therapeutic, comprehensive child care for children during the periods in which the woman is engaged in therapy or in other necessary health and rehabilitative activities.”;
 - (C) in paragraphs (9), (10), and (11), by striking “women” each place such term appears and inserting “woman”;
 - (D) in paragraph (9), by striking “units” and inserting “unit”; and
 - (E) in paragraph (11)—
 - (i) in subparagraph (A), by striking “their children” and inserting “any child of such woman”;
 - (ii) in subparagraph (B), by striking “; and” and inserting a semicolon;
 - (iii) in subparagraph (C), by striking the period and inserting “; and”; and
 - (iv) by adding at the end the following:
“(D) family reunification with children in kinship or foster care arrangements, where safe and appropriate.”;
- (5) in subsection (e)—
- (A) in paragraph (1)—
 - (i) in the matter preceding subparagraph (A), by striking “substance abuse” and inserting “substance use disorders”; and
 - (ii) in subparagraph (B), by striking “substance abuse” and inserting “substance use disorders”; and
 - (B) in paragraph (2)—
 - (i) by striking “(A) Subject” and inserting the following:
“(A) IN GENERAL.—Subject”;
 - (ii) in subparagraph (B)—
 - (I) by striking “(B)(i) In the case” and inserting the following:
“(B) WAIVER OF PARTICIPATION AGREEMENTS.—
“(i) IN GENERAL.—In the case”; and
(II) by striking “(ii) A determination” and inserting the following:
“(ii) DONATIONS.—A determination”; and
(iii) by striking “(C) With respect” and inserting the following:
“(C) NONAPPLICATION OF CERTAIN REQUIREMENTS.—
With respect”;
- (6) in subsection (g)—
- (A) by striking “who are engaging in substance abuse” and inserting “who have a substance use disorder”; and
 - (B) by striking “such abuse” and inserting “such disorder”;
- (7) in subsection (j)—

(A) in the matter preceding paragraph (1), by striking “to on” and inserting “to or on”; and

(B) in paragraph (3), by striking “Office for” and inserting “Office of”;

(8) by amending subsection (m) to read as follows:

“(m) ALLOCATION OF AWARDS.—In making awards under subsection (a), the Director shall give priority to an applicant that agrees to use the award for a program serving an area that is a rural area, an area designated under section 332 by the Secretary as a health professional shortage area, or an area determined by the Director to have a shortage of family-based substance use disorder treatment options.”; and

(9) in subsection (q)—

(A) in paragraph (3), by striking “funding agreement under subsection (a)” and inserting “funding agreement”; and

(B) in paragraph (4), by striking “substance abuse” and inserting “a substance use disorder”.

(b) REAUTHORIZATION OF PROGRAM.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb-1), as amended by subsection (a), is further amended—

(1) in subsection (p), in the first sentence, by inserting “(other than subsection (r))” after “section”; and

(2) in subsection (r), by striking “such sums” and all that follows through “2003” and inserting “\$16,900,000 for each of fiscal years 2017 through 2021”.

(c) PILOT PROGRAM GRANTS FOR STATE SUBSTANCE ABUSE AGENCIES.—

(1) IN GENERAL.—Section 508 of the Public Health Service Act (42 U.S.C. 290bb-1), as amended by subsections (a) and (b), is further amended—

(A) by redesignating subsection (r), as amended by subsection (b), as subsection (s); and

(B) by inserting after subsection (q) the following new subsection:

“(r) PILOT PROGRAM FOR STATE SUBSTANCE ABUSE AGENCIES.—

“(1) IN GENERAL.—From amounts made available under subsection (s), the Director of the Center for Substance Abuse Treatment shall carry out a pilot program under which competitive grants are made by the Director to State substance abuse agencies—

“(A) to enhance flexibility in the use of funds designed to support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

“(B) to help State substance abuse agencies address identified gaps in services furnished to such women along the continuum of care, including services provided to women in nonresidential-based settings; and

“(C) to promote a coordinated, effective, and efficient State system managed by State substance abuse agencies by encouraging new approaches and models of service delivery.

“(2) REQUIREMENTS.—In carrying out the pilot program under this subsection, the Director shall—

“(A) require State substance abuse agencies to submit to the Director applications, in such form and manner

and containing such information as specified by the Director, to be eligible to receive a grant under the program;

“(B) identify, based on such submitted applications, State substance abuse agencies that are eligible for such grants;

“(C) require services proposed to be furnished through such a grant to support family-based treatment and other services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorders;

“(D) not require that services furnished through such a grant be provided solely to women that reside in facilities;

“(E) not require that grant recipients under the program make available through use of the grant all the services described in subsection (d); and

“(F) consider not applying the requirements described in paragraphs (1) and (2) of subsection (f) to an applicant, depending on the circumstances of the applicant.

“(3) REQUIRED SERVICES.—

“(A) IN GENERAL.—The Director shall specify a minimum set of services required to be made available to eligible women through a grant awarded under the pilot program under this subsection. Such minimum set of services—

“(i) shall include the services requirements described in subsection (c) and be based on the recommendations submitted under subparagraph (B); and

“(ii) may be selected from among the services described in subsection (d) and include other services as appropriate.

“(B) STAKEHOLDER INPUT.—The Director shall convene and solicit recommendations from stakeholders, including State substance abuse agencies, health care providers, persons in recovery from substance abuse, and other appropriate individuals, for the minimum set of services described in subparagraph (A).

Recommendations.

“(4) DURATION.—The pilot program under this subsection shall not exceed 5 years.

“(5) EVALUATION AND REPORT TO CONGRESS.—

“(A) IN GENERAL.—The Director of the Center for Behavioral Health Statistics and Quality shall evaluate the pilot program at the conclusion of the first grant cycle funded by the pilot program.

“(B) REPORT.—The Director of the Center for Behavioral Health Statistics and Quality, in coordination with the Director of the Center for Substance Abuse Treatment shall submit to the relevant committees of jurisdiction of the House of Representatives and the Senate a report on the evaluation under subparagraph (A). The report shall include, at a minimum—

Coordination.

“(i) outcomes information from the pilot program, including any resulting reductions in the use of alcohol and other drugs;

“(ii) engagement in treatment services;

“(iii) retention in the appropriate level and duration of services;

“(iv) increased access to the use of medications approved by the Food and Drug Administration for the treatment of substance use disorders in combination with counseling; and

“(v) other appropriate measures.

“(C) RECOMMENDATION.—The report under subparagraph (B) shall include a recommendation by the Director of the Center for Substance Abuse Treatment as to whether the pilot program under this subsection should be extended.

“(6) STATE SUBSTANCE ABUSE AGENCIES DEFINED.—For purposes of this subsection, the term ‘State substance abuse agency’ means, with respect to a State, the agency in such State that manages the Substance Abuse Prevention and Treatment Block Grant under part B of title XIX.”

(2) FUNDING.—Subsection (s) of section 508 of the Public Health Service Act (42 U.S.C. 290bb-1), as amended by subsection (a) and redesignated by paragraph (1), is further amended by adding at the end the following new sentences: “Of the amounts made available for a year pursuant to the previous sentence to carry out this section, not more than 25 percent of such amounts shall be made available for such year to carry out subsection (r), other than paragraph (5) of such subsection. Notwithstanding the preceding sentence, no funds shall be made available to carry out subsection (r) for a fiscal year unless the amount made available to carry out this section for such fiscal year is more than the amount made available to carry out this section for fiscal year 2016.”

SEC. 502. VETERANS TREATMENT COURTS.

Section 2991 of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3797aa) is amended—

- (1) by redesignating subsection (i) as subsection (j); and
- (2) by inserting after subsection (h) the following:

“(i) ASSISTING VETERANS.—

“(1) DEFINITIONS.—In this subsection:

“(A) PEER-TO-PEER SERVICES OR PROGRAMS.—The term ‘peer-to-peer services or programs’ means services or programs that connect qualified veterans with other veterans for the purpose of providing support and mentorship to assist qualified veterans in obtaining treatment, recovery, stabilization, or rehabilitation.

“(B) QUALIFIED VETERAN.—The term ‘qualified veteran’ means a preliminarily qualified offender who—

“(i) served on active duty in any branch of the Armed Forces, including the National Guard or Reserves; and

“(ii) was discharged or released from such service under conditions other than dishonorable, unless the reason for the dishonorable discharge was attributable to a substance abuse disorder.

“(C) VETERANS TREATMENT COURT PROGRAM.—The term ‘veterans treatment court program’ means a court program involving collaboration among criminal justice, veterans, and mental health and substance abuse agencies that provides qualified veterans with—

“(i) intensive judicial supervision and case management, which may include random and frequent drug testing where appropriate;

“(ii) a full continuum of treatment services, including mental health services, substance abuse services, medical services, and services to address trauma;

“(iii) alternatives to incarceration; or

“(iv) other appropriate services, including housing, transportation, mentoring, employment, job training, education, or assistance in applying for and obtaining available benefits.

“(2) VETERANS ASSISTANCE PROGRAM.—

“(A) IN GENERAL.—The Attorney General, in consultation with the Secretary of Veterans Affairs, may award grants under this subsection to applicants to establish or expand—

Consultation.

“(i) veterans treatment court programs;

“(ii) peer-to-peer services or programs for qualified veterans;

“(iii) practices that identify and provide treatment, rehabilitation, legal, transitional, and other appropriate services to qualified veterans who have been incarcerated; or

“(iv) training programs to teach criminal justice, law enforcement, corrections, mental health, and substance abuse personnel how to identify and appropriately respond to incidents involving qualified veterans.

“(B) PRIORITY.—In awarding grants under this subsection, the Attorney General shall give priority to applications that—

“(i) demonstrate collaboration between and joint investments by criminal justice, mental health, substance abuse, and veterans service agencies;

“(ii) promote effective strategies to identify and reduce the risk of harm to qualified veterans and public safety; and

“(iii) propose interventions with empirical support to improve outcomes for qualified veterans.”.

SEC. 503. INFANT PLAN OF SAFE CARE.

(a) BEST PRACTICES FOR DEVELOPMENT OF PLANS OF SAFE CARE.—Section 103(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5104(b)) is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9), respectively; and

(2) by inserting after paragraph (4) the following:

“(5) maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;”.

(b) STATE PLANS.—Section 106(b)(2)(B) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)) is amended—

(1) in clause (ii), by striking “illegal substance abuse” and inserting “substance abuse”; and

(2) in clause (iii)—

(A) by striking “illegal substance abuse” and inserting “substance abuse”; and

(B) by inserting before the semicolon at the end the following: “to ensure the safety and well-being of such infant following release from the care of health care providers, including through—

“(I) addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

“(II) the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver”.

(c) DATA REPORTS.—

(1) IN GENERAL.—Section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by adding at the end of the following:

“(17) The number of infants—

“(A) identified under subsection (b)(2)(B)(ii);

“(B) for whom a plan of safe care was developed under subsection (b)(2)(B)(iii); and

“(C) for whom a referral was made for appropriate services, including services for the affected family or caregiver, under subsection (b)(2)(B)(iii).”.

(2) REDESIGNATION.—Effective on May 29, 2017, section 106(d) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(d)) is amended by redesignating paragraph (17) (as added by paragraph (1)) as paragraph (18).

(d) MONITORING AND OVERSIGHT.—

(1) AMENDMENT.—Title I of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq.) is amended by adding at the end the following:

“SEC. 114. MONITORING AND OVERSIGHT.

“The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which—

“(1) shall—

“(A) be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and

“(B) include monitoring of State policies and procedures required under clauses (ii) and (iii) of section 106(b)(2)(B); and

“(2) may include—

“(A) a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;

“(B) a review of information available on the website of the State relating to its compliance with the requirements of section 106(b);

Effective date.
42 USC 5106a
note.

42 USC 5108.

“(C) site visits, as may be necessary to carry out such monitoring; and

“(D) a review of information available in the State’s Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).”.

(2) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 note) is amended by inserting after the item relating to section 113, the following:

“Sec. 114. Monitoring and oversight.”.

(e) RULE OF CONSTRUCTION.—Nothing in this section, or the amendments made by this section, shall be construed to authorize the Secretary of Health and Human Services or any other officer of the Federal Government to add new requirements to section 106(b) of the Child Abuse Prevention and Treatment Act (42 U.S.C. 5106a(b)), as amended by this section.

42 USC 5106a
note.

SEC. 504. GAO REPORT ON NEONATAL ABSTINENCE SYNDROME (NAS).

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate a report on neonatal abstinence syndrome (in this section referred to as “NAS”) in the United States.

(b) INFORMATION TO BE INCLUDED IN REPORT.—Such report shall include information on the following:

(1) The prevalence of NAS in the United States, including the proportion of children born in the United States with NAS who are eligible for medical assistance under State Medicaid programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) at birth, and the costs associated with coverage under such programs for treatment of infants with NAS.

(2) The services for which coverage is available under State Medicaid programs for treatment of infants with NAS.

(3) The settings (including inpatient, outpatient, hospital-based, and other settings) for the treatment of infants with NAS and the reimbursement methodologies and costs associated with such treatment in such settings.

(4) The prevalence of utilization of various care settings under State Medicaid programs for treatment of infants with NAS and any Federal barriers to treating such infants under such programs, particularly in non-hospital-based settings.

(5) What is known about best practices for treating infants with NAS.

(c) RECOMMENDATIONS.—Such report also shall include such recommendations as the Comptroller General determines appropriate for improvements that will ensure access to treatment for infants with NAS under State Medicaid programs.

TITLE VI—INCENTIVIZING STATE COM- PREHENSIVE INITIATIVES TO AD- DRESS PRESCRIPTION OPIOID ABUSE

SEC. 601. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.

Part D of title V of the Public Health Service Act (42 U.S.C. 290dd et seq.), as amended by section 302, is further amended by adding at the end the following:

42 USC 290ee-3. “SEC. 548. STATE DEMONSTRATION GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.

“(a) DEFINITIONS.—In this section:

“(1) DISPENSER.—The term ‘dispenser’ has the meaning given the term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

“(2) PRESCRIBER.—The term ‘prescriber’ means a dispenser who prescribes a controlled substance, or the agent of such a dispenser.

“(3) PRESCRIBER OF A SCHEDULE II, III, OR IV CONTROLLED SUBSTANCE.—The term ‘prescriber of a schedule II, III, or IV controlled substance’ does not include a prescriber of a schedule II, III, or IV controlled substance that dispenses the substance—

“(A) for use on the premises on which the substance is dispensed;

“(B) in a hospital emergency room, when the substance is in short supply;

“(C) for a certified opioid treatment program; or

“(D) in other situations as the Secretary may reasonably determine.

“(4) SCHEDULE II, III, OR IV CONTROLLED SUBSTANCE.—The term ‘schedule II, III, or IV controlled substance’ means a controlled substance that is listed on schedule II, schedule III, or schedule IV of section 202(c) of the Controlled Substances Act.

“(b) GRANTS FOR COMPREHENSIVE OPIOID ABUSE RESPONSE.—

“(1) IN GENERAL.—The Secretary shall award grants to States, and combinations of States, to implement an integrated opioid abuse response initiative.

“(2) PURPOSES.—A State receiving a grant under this section shall establish a comprehensive response plan to opioid abuse, which may include—

“(A) education efforts around opioid use, treatment, and addiction recovery, including education of residents, medical students, and physicians and other prescribers of schedule II, III, or IV controlled substances on relevant prescribing guidelines, the prescription drug monitoring program of the State described in subparagraph (B), and overdose prevention methods;

“(B) establishing, maintaining, or improving a comprehensive prescription drug monitoring program to track dispensing of schedule II, III, or IV controlled substances, which may—

Response plan.

“(i) provide for data sharing with other States; and

“(ii) allow all individuals authorized by the State to write prescriptions for schedule II, III, or IV controlled substances to access the prescription drug monitoring program of the State;

“(C) developing, implementing, or expanding prescription drug and opioid addiction treatment programs by—

“(i) expanding the availability of treatment for prescription drug and opioid addiction, including medication-assisted treatment and behavioral health therapy, as appropriate;

“(ii) developing, implementing, or expanding screening for individuals in treatment for prescription drug and opioid addiction for hepatitis C and HIV, and treating or referring those individuals if clinically appropriate; or

“(iii) developing, implementing, or expanding recovery support services and programs at high schools or institutions of higher education;

“(D) developing, implementing, and expanding efforts to prevent overdose death from opioid abuse or addiction to prescription medications and opioids; and

“(E) advancing the education and awareness of the public, providers, patients, consumers, and other appropriate entities regarding the dangers of opioid abuse, safe disposal of prescription medications, and detection of early warning signs of opioid use disorders.

“(3) APPLICATION.—A State seeking a grant under this section shall submit to the Secretary an application in such form, and containing such information, as the Secretary may reasonably require.

“(4) USE OF FUNDS.—A State that receives a grant under this section shall use the grant for the cost, including the cost for technical assistance, training, and administration expenses, of carrying out an integrated opioid abuse response initiative as outlined by the State’s comprehensive response plan to opioid abuse established under paragraph (2).

“(5) PRIORITY CONSIDERATIONS.—In awarding grants under this section, the Secretary shall, as appropriate, give priority to a State that—

“(A)(i) provides civil liability protection for first responders, health professionals, and family members who have received appropriate training in administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

“(ii) submits to the Secretary a certification by the attorney general of the State that the attorney general has—

Certification.

“(I) reviewed any applicable civil liability protection law to determine the applicability of the law with respect to first responders, health care professionals, family members, and other individuals who—

“(aa) have received appropriate training in administering a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act

for emergency treatment of known or suspected opioid overdose; and

“(bb) may administer a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose; and

“(II) concluded that the law described in subclause (I) provides adequate civil liability protection applicable to such persons;

“(B) has a process for enrollment in services and benefits necessary by criminal justice agencies to initiate or continue treatment in the community, under which an individual who is incarcerated may, while incarcerated, enroll in services and benefits that are necessary for the individual to continue treatment upon release from incarceration;

“(C) ensures the capability of data sharing with other States, where applicable, such as by making data available to a prescription monitoring hub;

Records. “(D) ensures that data recorded in the prescription drug monitoring program database of the State are regularly updated, to the extent possible;

Notification. “(E) ensures that the prescription drug monitoring program of the State notifies prescribers and dispensers of schedule II, III, or IV controlled substances when overuse or misuse of such controlled substances by patients is suspected; and

“(F) has in effect one or more statutes or implements policies that maximize use of prescription drug monitoring programs by individuals authorized by the State to prescribe schedule II, III, or IV controlled substances.

Reports. “(6) EVALUATION.—In conducting an evaluation of the program under this section pursuant to section 701 of the Comprehensive Addiction and Recovery Act of 2016, with respect to a State, the Secretary shall report on State legislation or policies related to maximizing the use of prescription drug monitoring programs and the incidence of opioid use disorders and overdose deaths in such State.

“(7) STATES WITH LOCAL PRESCRIPTION DRUG MONITORING PROGRAMS.—

“(A) IN GENERAL.—In the case of a State that does not have a prescription drug monitoring program, a county or other unit of local government within the State that has a prescription drug monitoring program shall be treated as a State for purposes of this section, including for purposes of eligibility for grants under paragraph (1).

Records. “(B) PLAN FOR INTEROPERABILITY.—In submitting an application to the Secretary under paragraph (3), a county or other unit of local government shall submit a plan outlining the methods such county or unit of local government shall use to ensure the capability of data sharing with other counties and units of local government within the state and with other States, as applicable.

“(c) AUTHORIZATION OF FUNDING.—For the purpose of carrying out this section, there are authorized to be appropriated \$5,000,000 for each of fiscal years 2017 through 2021.”.

TITLE VII—MISCELLANEOUS**SEC. 701. GRANT ACCOUNTABILITY AND EVALUATIONS.**

(a) DEPARTMENT OF JUSTICE GRANT ACCOUNTABILITY.—Part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.), as added by section 201, is amended by adding at the end the following:

42 USC 3797ff-5.

“SEC. 3026. GRANT ACCOUNTABILITY.

“(a) DEFINITION OF APPLICABLE COMMITTEES.—In this section, the term ‘applicable committees’ means—

“(1) the Committee on the Judiciary of the Senate; and

“(2) the Committee on the Judiciary of the House of Representatives.

“(b) ACCOUNTABILITY.—All grants awarded by the Attorney General under this part shall be subject to the following accountability provisions:

“(1) AUDIT REQUIREMENT.—

Time periods.

“(A) DEFINITION.—In this paragraph, the term ‘unresolved audit finding’ means a finding in the final audit report of the Inspector General of the Department of Justice that the audited grantee has utilized grant funds for an unauthorized expenditure or otherwise unallowable cost that is not closed or resolved within 12 months after the date on which the final audit report is issued.

“(B) AUDIT.—Beginning in the first fiscal year beginning after the date of enactment of this section, and in each fiscal year thereafter, the Inspector General of the Department of Justice shall conduct audits of recipients of grants awarded by the Attorney General under this part to prevent waste, fraud, and abuse of funds by grantees. The Inspector General shall determine the appropriate number of grantees to be audited each year.

Effective date.

“(C) MANDATORY EXCLUSION.—A recipient of grant funds under this part that is found to have an unresolved audit finding shall not be eligible to receive grant funds under this part during the first 2 fiscal years beginning after the end of the 12-month period described in subparagraph (A).

“(D) PRIORITY.—In awarding grants under this part, the Attorney General shall give priority to eligible applicants that did not have an unresolved audit finding during the 3 fiscal years before submitting an application for a grant under this part.

“(E) REIMBURSEMENT.—If an entity is awarded grant funds under this part during the 2-fiscal-year period during which the entity is barred from receiving grants under subparagraph (C), the Attorney General shall—

“(i) deposit an amount equal to the amount of the grant funds that were improperly awarded to the grantee into the General Fund of the Treasury; and

“(ii) seek to recoup the costs of the repayment to the fund from the grant recipient that was erroneously awarded grant funds.

“(2) NONPROFIT ORGANIZATION REQUIREMENTS.—

“(A) DEFINITION.—For purposes of this paragraph and the grant programs under this part, the term ‘nonprofit organization’ means an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Code.

“(B) PROHIBITION.—A nonprofit organization that holds money in offshore accounts for the purpose of avoiding paying the tax described in section 511(a) of the Internal Revenue Code of 1986 may not—

“(i) be party to a contract entered into under section 3021(b); or

“(ii) receive a subaward under section 3021(b).

Contracts.

“(C) DISCLOSURE.—Each nonprofit organization that receives a subaward or is party to a contract entered into under section 3021(b) and uses the procedures prescribed in regulations to create a rebuttable presumption of reasonableness for the compensation of its officers, directors, trustees, and key employees, shall disclose, in the application for such contract or subaward, the process for determining such compensation, including the independent persons involved in reviewing and approving such compensation, the comparability data used, and contemporaneous substantiation of the deliberation and decision. Upon request, the Attorney General shall make the information disclosed under this subparagraph available for public inspection.

Public information.

“(3) CONFERENCE EXPENDITURES.—

“(A) LIMITATION.—No amounts made available to the Attorney General under this part may be used by the Attorney General, or by any State, unit of local government, or entity awarded a grant, subaward, or contract under this part, to host or support any expenditure for conferences that uses more than \$20,000 in funds made available by the Attorney General, unless the head of the relevant agency, bureau, or program office provides prior written authorization that the funds may be expended to host or support the conference.

Cost estimate.

“(B) WRITTEN AUTHORIZATION.—Written authorization under subparagraph (A) shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

“(C) REPORT.—The Deputy Attorney General shall submit to the applicable committees an annual report on all conference expenditures approved by the Attorney General under this paragraph.

Effective date.

“(4) ANNUAL CERTIFICATION.—Beginning in the first fiscal year beginning after the date of enactment of this section, the Attorney General shall submit to the applicable committees an annual certification—

“(A) indicating whether—

Audits.

“(i) all audits issued by the Inspector General of the Department of Justice under paragraph (1) have been completed and reviewed by the appropriate Assistant Attorney General or Director;

“(ii) all mandatory exclusions required under paragraph (1)(C) have been issued; and

“(iii) all reimbursements required under paragraph (1)(E) have been made; and

“(B) that includes a list of any grant recipients excluded under paragraph (1) from the previous year. List.

“(c) PREVENTING DUPLICATIVE GRANTS.—

“(1) IN GENERAL.—Before the Attorney General awards a grant to an applicant under this part, the Attorney General shall compare potential grant awards with other grants awarded under this part by the Attorney General to determine if duplicate grant awards are awarded for the same purpose. Determination.

“(2) REPORT.—If the Attorney General awards duplicate grants under this part to the same applicant for the same purpose, the Attorney General shall submit to the applicable committees a report that includes—

“(A) a list of all duplicate grants awarded under this part, including the total dollar amount of any duplicate grants awarded; and List.

“(B) the reason the Attorney General awarded the duplicate grants.”

(b) EVALUATION OF PERFORMANCE OF DEPARTMENT OF JUSTICE PROGRAMS.—

Deadlines.
42 USC 3797ff-6.

(1) EVALUATION OF JUSTICE DEPARTMENT COMPREHENSIVE OPIOID ABUSE GRANT PROGRAM.—Not later than 5 years after the date of enactment of this Act, the Attorney General shall complete an evaluation of the effectiveness of the Comprehensive Opioid Abuse Grant Program under part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968, as added by section 201, administered by the Department of Justice based upon the information reported under paragraph (4).

(2) INTERIM EVALUATION.—Not later than 3 years after the date of enactment of this Act, the Attorney General shall complete an interim evaluation assessing the nature and extent of the incidence of opioid abuse and illegal opioid distribution in the United States. Assessment.

(3) METRICS AND OUTCOMES FOR EVALUATION.—Not later than 180 days after the date of enactment of this Act, the Attorney General shall identify outcomes that are to be achieved by activities funded by the Comprehensive Opioid Abuse Grant Program and the metrics by which the achievement of such outcomes shall be determined. Determination.

(4) METRICS DATA COLLECTION.—The Attorney General shall require grantees under the Comprehensive Opioid Abuse Grant Program (and those receiving subawards under section 3021(b) of part LL of title I of the Omnibus Crime Control and Safe Streets Act of 1968, as added by section 201) to collect and annually report to the Department of Justice data based upon the metrics identified under paragraph (3). Reports.

(5) PUBLICATION OF DATA AND FINDINGS.—

(A) PUBLICATION OF OUTCOMES AND METRICS.—The Attorney General shall, not later than 30 days after completion of the requirement under paragraph (3), publish the outcomes and metrics identified under that paragraph.

(B) PUBLICATION OF EVALUATION.—In the case of the interim evaluation under paragraph (2), and the final Reports.

evaluation under paragraph (1), the entity conducting the evaluation shall, not later than 90 days after such an evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the Committee on the Judiciary of the House of Representatives and the Committee on the Judiciary of the Senate. Such report shall also be published along with the data used to make such evaluation.

Contracts.

(6) INDEPENDENT EVALUATION.—For purposes of paragraphs (1), (2), and (3), the Attorney General shall—

(A) enter into an arrangement with the National Academy of Sciences; or

(B) enter into a contract or cooperative agreement with an entity that is not an agency of the Federal Government, and is qualified to conduct and evaluate research pertaining to opioid use and abuse, and draw conclusions about overall opioid use and abuse on the basis of that research.

42 USC
290aa-15.

(c) DEPARTMENT OF HEALTH AND HUMAN SERVICES GRANT ACCOUNTABILITY.—

(1) DEFINITIONS.—In this subsection:

(A) APPLICABLE COMMITTEES.—The term “applicable committees” means—

(i) the Committee on Health, Education, Labor and Pensions of the Senate; and

(ii) the Committee on Energy and Commerce of the House of Representatives.

(B) COVERED GRANT.—The term “covered grant” means a grant awarded by the Secretary under a program established under this Act (or an amendment made by this Act, other than sections 703 through 707), including any grant administered by the Administrator of the Substance Abuse and Mental Health Services Administration under section 103.

(C) GRANTEE.—The term “grantee” means the recipient of a covered grant.

(D) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(2) ACCOUNTABILITY MEASURES.—Each covered grant shall be subject to the following accountability requirements:

(A) EFFECTIVENESS REPORT.—The Secretary shall require grantees to report on the effectiveness of the activities carried out with amounts made available to carry out the program under which the covered grant is awarded, including the number of persons served by such grant, if applicable, the number of persons seeking services who could not be served by such grant, and such other information as the Secretary may prescribe.

(B) REPORT ON PREVENTION OF FRAUD, WASTE, AND ABUSE.—

Coordination.

(i) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall submit to the applicable committees a report on the policies and procedures the Department has in place to prevent waste, fraud, and abuse in the administration of covered grants.

(ii) CONTENTS.—The policies and procedures referred to in clause (i) shall include policies and procedures that are designed to—

(I) prevent grantees from utilizing funds awarded through a covered grant for unauthorized expenditures or otherwise unallowable costs; and

(II) ensure grantees will not receive unwarranted duplicate grants for the same purpose.

(C) CONFERENCE EXPENDITURES.—

(i) IN GENERAL.—No amounts made available to the Secretary under this Act (or in a provision of law amended by this Act, other than sections 703 through 707) may be used by the Secretary, or by any individual or entity awarded discretionary funds through a cooperative agreement under a program established under this Act (or in a provision of law amended by this Act), to host or support any expenditure for conferences that uses more than \$20,000 in funds made available by the Secretary, unless the head of the relevant operating division or program office provides prior written authorization that the funds may be expended to host or support the conference. Such written authorization shall include a written estimate of all costs associated with the conference, including the cost of all food, beverages, audio-visual equipment, honoraria for speakers, and entertainment.

Cost estimate.

(ii) REPORT.—The Secretary (or the Secretary's designee) shall submit to the applicable committees an annual report on all conference expenditures approved by the Secretary under this subparagraph.

(d) EVALUATION OF PERFORMANCE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS.—

Deadlines.
42 USC
290aa-16.

(1) EVALUATIONS.—

(A) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, except as otherwise provided in this section, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall complete an evaluation of any program administered by the Secretary included in this Act (or an amendment made by this Act, excluding sections 703 through 707), including any grant administered by the Administrator of the Substance Abuse and Mental Health Services Administration under section 103, that provides grants for the primary purpose of providing assistance in addressing problems pertaining to opioid abuse based upon the outcomes and metrics identified under paragraph (2).

(B) PUBLICATION.—With respect to each evaluation completed under subparagraph (A), the Secretary shall, not later than 90 days after the date on which such evaluation is completed, publish the results of such evaluation and issue a report on such evaluation to the appropriate committees. Such report shall also be published along with the data used to make such evaluation.

(2) METRICS AND OUTCOMES.—

(A) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary shall identify—

- (i) outcomes that are to be achieved by activities funded by the programs described in paragraph (1)(A); and
- Determination. (ii) the metrics by which the achievement of such outcomes shall be determined.
- (B) PUBLICATION.—The Secretary shall, not later than 30 days after completion of the requirement under subparagraph (A), publish the outcomes and metrics identified under such subparagraph.
- Reports. (3) METRICS DATA COLLECTION.—The Secretary shall require grantees under the programs described in paragraph (1)(A) to collect, and annually report to the Secretary, data based upon the metrics identified under paragraph (2)(A).
- Contracts. (4) INDEPENDENT EVALUATION.—For purposes of paragraph (1), the Secretary shall—
- (A) enter into an arrangement with the National Academy of Sciences; or
- (B) enter into a contract or cooperative agreement with an entity that—
- (i) is not an agency of the Federal Government; and
- (ii) is qualified to conduct and evaluate research pertaining to opioid use and abuse and draw conclusions about overall opioid use and abuse on the basis of that research.
- (5) EXCEPTION.—If a program described in paragraph (1)(A) is subject to an evaluation similar to the evaluation required under such paragraph pursuant to another provision of Federal law, the Secretary may opt not to conduct an evaluation under such paragraph with respect to such program.
- 42 USC
290aa-15 note. (e) ADDITIONAL REPORT.—In the case of a report submitted under subsection (c) to the applicable committees, if such report pertains to a grant under section 103, that report shall also be submitted, in the same manner and at the same time, to the Committee on Oversight and Government Reform of the House of Representatives and to the Committee on the Judiciary of the Senate.
- (f) NO ADDITIONAL FUNDS AUTHORIZED.—No additional funds are authorized to be appropriated to carry out this section.

SEC. 702. PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Section 309 of the Controlled Substances Act (21 U.S.C. 829) is amended by adding at the end the following:

“(f) PARTIAL FILLS OF SCHEDULE II CONTROLLED SUBSTANCES.—

“(1) PARTIAL FILLS.—A prescription for a controlled substance in schedule II may be partially filled if—

“(A) it is not prohibited by State law;

“(B) the prescription is written and filled in accordance with this title, regulations prescribed by the Attorney General, and State law;

“(C) the partial fill is requested by the patient or the practitioner that wrote the prescription; and

“(D) the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

“(2) REMAINING PORTIONS.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), remaining portions of a partially filled prescription for a controlled substance in schedule II—

“(i) may be filled; and

“(ii) shall be filled not later than 30 days after the date on which the prescription is written. Deadline.

“(B) EMERGENCY SITUATIONS.—In emergency situations, as described in subsection (a), the remaining portions of a partially filled prescription for a controlled substance in schedule II—

“(i) may be filled; and

“(ii) shall be filled not later than 72 hours after the prescription is issued. Deadline.

“(3) CURRENTLY LAWFUL PARTIAL FILLS.—Notwithstanding paragraph (1) or (2), in any circumstance in which, as of the day before the date of enactment of this subsection, a prescription for a controlled substance in schedule II may be lawfully partially filled, the Attorney General may allow such a prescription to be partially filled.”

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Attorney General to allow a prescription for a controlled substance in schedule III, IV, or V of section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) to be partially filled. 21 USC 829 note.

SEC. 703. GOOD SAMARITAN ASSESSMENT.

(a) FINDING.—The Congress finds that the executive branch, including the Office of National Drug Control Policy, has a policy focus on preventing and addressing prescription drug misuse and heroin use, and has worked with States and municipalities to enact Good Samaritan laws that would protect caregivers, law enforcement personnel, and first responders who administer opioid overdose reversal drugs or devices.

(b) GAO STUDY ON GOOD SAMARITAN LAWS PERTAINING TO TREATMENT OF OPIOID OVERDOSES.—The Comptroller General of the United States shall submit to the Committee on the Judiciary of the House of Representatives, the Committee on Oversight and Government Reform of the House of Representatives, the Committee on the Judiciary of the Senate, and the Committee on Homeland Security and Governmental Affairs of the Senate a report on— Reports.

(1) the extent to which the Director of National Drug Control Policy has reviewed Good Samaritan laws, and any findings from such a review, including findings related to the potential effects of such laws, if available;

(2) efforts by the Director to encourage the enactment of Good Samaritan laws; and

(3) a compilation of Good Samaritan laws in effect in the States, the territories, and the District of Columbia.

(c) DEFINITIONS.—In this section—

(1) the term “Good Samaritan law” means a law of a State or unit of local government that exempts from criminal or civil liability any individual who administers an opioid overdose reversal drug or device, or who contacts emergency services providers in response to an overdose; and

(2) the term “opioid” means any drug, including heroin, having an addiction-forming or addiction-sustaining liability

similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

SEC. 704. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER MEDICARE PARTS C AND D.

(a) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

(1) **IN GENERAL.**—Section 1860D-4(c) of the Social Security Act (42 U.S.C. 1395w-10(c)) is amended by adding at the end the following:

“(5) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

“(A) AUTHORITY TO ESTABLISH.—A PDP sponsor may establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary’s access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by one or more prescribers selected under subparagraph (D), and dispensed for such beneficiary by one or more pharmacies selected under such subparagraph.

“(B) REQUIREMENT FOR NOTICES.—

“(i) IN GENERAL.—A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

“(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

“(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse.

“(ii) INITIAL NOTICE.—An initial notice described in this clause is a notice that provides to the beneficiary—

“(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

“(II) information describing all State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary has access, including mental health services and other counseling services;

“(III) notice of, and information about, the right of the beneficiary to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

“(IV) a request for the beneficiary to submit to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

Verification.

“(V) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

“(VI) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor; and

“(VII) contact information for other organizations that can provide the beneficiary with assistance regarding such drug management program (similar to the information provided by the Secretary in other standardized notices provided to part D eligible individuals enrolled in prescription drug plans under this part).

“(iii) SECOND NOTICE.—A second notice described in this clause is a notice that provides to the beneficiary notice—

“(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

“(II) that such beneficiary is subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

“(III) of the prescriber (or prescribers) and pharmacy (or pharmacies) selected for such individual under subparagraph (D);

“(IV) of, and information about, the beneficiary’s right to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

“(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subparagraph (D), submit such preferences to the PDP sponsor; and

“(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor.

“(iv) TIMING OF NOTICES.—

“(I) IN GENERAL.—Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 30 days after an initial notice described in clause (ii) is provided to the beneficiary.

“(II) EXCEPTION.—In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rulemaking by the Secretary regarding the health or safety of the beneficiary or regarding significant drug

Determination.
Regulations.

diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (I), the PDP sponsor may provide such second notice on such earlier date.

“(C) AT-RISK BENEFICIARY FOR PRESCRIPTION DRUG ABUSE.—

Definition.

“(i) IN GENERAL.—For purposes of this paragraph, the term ‘at-risk beneficiary for prescription drug abuse’ means a part D eligible individual who is not an exempted individual described in clause (ii) and—

Guidelines.
Consultation.

“(I) who is identified as such an at-risk beneficiary through the use of clinical guidelines that indicate misuse or abuse of prescription drugs described in subparagraph (G) and that are developed by the Secretary in consultation with PDP sponsors and other stakeholders, including individuals entitled to benefits under part A or enrolled under part B, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers; or

“(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under the prescription drug plan in which such individual was most recently previously enrolled and such identification has not been terminated under subparagraph (F).

“(ii) EXEMPTED INDIVIDUAL DESCRIBED.—An exempted individual described in this clause is an individual who—

“(I) receives hospice care under this title;

“(II) is a resident of a long-term care facility, of a facility described in section 1905(d), or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy; or

“(III) the Secretary elects to treat as an exempted individual for purposes of clause (i).

Guidelines.

“(iii) PROGRAM SIZE.—The Secretary shall establish policies, including the guidelines developed under clause (i)(I) and the exemptions under clause (ii)(III), to ensure that the population of enrollees in a drug management program for at-risk beneficiaries operated by a prescription drug plan can be effectively managed by such plans.

“(iv) CLINICAL CONTACT.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by a PDP sponsor, the PDP sponsor shall contact the beneficiary’s providers who have prescribed frequently abused drugs

regarding whether prescribed medications are appropriate for such beneficiary's medical conditions.

“(D) SELECTION OF PRESCRIBERS AND PHARMACIES.—

“(i) IN GENERAL.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(IV) and (iii)(V) of subparagraph (B) (except as otherwise provided in this subparagraph) select—

“(I) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, individual who is authorized to prescribe frequently abused drugs (referred to in this paragraph as a ‘prescriber’) who may write prescriptions for such drugs for such beneficiary; and

“(II) one, or, if the PDP sponsor reasonably determines it necessary to provide the beneficiary with reasonable access under clause (ii), more than one, pharmacy that may dispense such drugs to such beneficiary.

For purposes of subclause (II), in the case of a pharmacy that has multiple locations that share real-time electronic data, all such locations of the pharmacy shall collectively be treated as one pharmacy.

“(ii) REASONABLE ACCESS.—In making the selections under this subparagraph—

“(I) a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to frequently abused drugs (as defined in subparagraph (G)), taking into account geographic location, beneficiary preference, impact on costsharing, and reasonable travel time; and

“(II) a PDP sponsor shall ensure such access (including access to prescribers and pharmacies with respect to frequently abused drugs) in the case of individuals with multiple residences, in the case of natural disasters and similar situations, and in the case of the provision of emergency services.

“(iii) BENEFICIARY PREFERENCES.—If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

“(I) review such preferences;

“(II) select or change the selection of prescribers and pharmacies for the beneficiary based on such preferences; and

“(III) inform the beneficiary of such selection or change of selection.

“(iv) EXCEPTION REGARDING BENEFICIARY PREFERENCES.—In the case that the PDP sponsor determines that a change to the selection of prescriber or pharmacy under clause (iii)(II) by the PDP sponsor

Review.

Determination.

is contributing or would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in clause (iii). If the PDP sponsor changes the selection pursuant to the preceding sentence, the PDP sponsor shall provide the beneficiary with—

“(I) at least 30 days written notice of the change of selection; and

“(II) a rationale for the change.

Time period.
Notice.

Notification.

“(v) CONFIRMATION.—Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must notify the prescriber and pharmacy that the beneficiary involved has been identified for inclusion in the drug management program for at-risk beneficiaries and that the prescriber and pharmacy has been selected as the beneficiary’s designated prescriber and pharmacy.

“(E) TERMINATIONS AND APPEALS.—The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, the selection of prescriber or pharmacy under subparagraph (D), and information to be shared under subparagraph (I), with respect to such individual, shall be subject to reconsideration and appeal under subsection (h) and the option of an automatic escalation to external review to the extent provided by the Secretary.

“(F) TERMINATION OF IDENTIFICATION.—

Standards.

“(i) IN GENERAL.—The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such standards such identification shall terminate as of the earlier of—

“(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); and

“(II) the end of such maximum period of identification as the Secretary may specify.

“(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph (C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

Definition.

“(G) FREQUENTLY ABUSED DRUG.—For purposes of this subsection, the term ‘frequently abused drug’ means a drug that is a controlled substance that the Secretary determines to be frequently abused or diverted.

Regulations.
Procedures.

“(H) DATA DISCLOSURE.—

“(i) DATA ON DECISION TO IMPOSE LIMITATION.—In the case of an at-risk beneficiary for prescription

drug abuse (or an individual who is a potentially at-risk beneficiary for prescription drug abuse) whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this paragraph, the Secretary shall establish rules and procedures to require the PDP sponsor to disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part.

“(ii) DATA TO REDUCE FRAUD, ABUSE, AND WASTE.—The Secretary shall establish rules and procedures to require PDP sponsors operating a drug management program for at-risk beneficiaries under this paragraph to provide the Secretary with such data as the Secretary determines appropriate for purposes of identifying patterns of prescription drug utilization for plan enrollees that are outside normal patterns and that may indicate fraudulent, medically unnecessary, or unsafe use.

“(I) SHARING OF INFORMATION FOR SUBSEQUENT PLAN ENROLLMENTS.—The Secretary shall establish procedures under which PDP sponsors who offer prescription drug plans shall share information with respect to individuals who are at-risk beneficiaries for prescription drug abuse (or individuals who are potentially at-risk beneficiaries for prescription drug abuse) and enrolled in a prescription drug plan and who subsequently disenroll from such plan and enroll in another prescription drug plan offered by another PDP sponsor. Procedures.

“(J) PRIVACY ISSUES.—Prior to the implementation of the rules and procedures under this paragraph, the Secretary shall clarify privacy requirements, including requirements under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note), related to the sharing of data under subparagraphs (H) and (I) by PDP sponsors. Such clarification shall provide that the sharing of such data shall be considered to be protected health information in accordance with the requirements of the regulations promulgated pursuant to such section 264(c). Clarification.

“(K) EDUCATION.—The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

“(i) provided by Medicare administrative contractors through the improper payment outreach and education program described in section 1874A(h); and

“(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b-3 note)) and materials directed toward such enrollees.

“(L) APPLICATION UNDER MA-PD PLANS.—Pursuant to section 1860D-21(c)(1), the provisions of this paragraph apply under part D to MA organizations offering MA-PD plans to MA eligible individuals in the same manner as such provisions apply under this part to a PDP sponsor offering a prescription drug plan to a part D eligible individual.

Audits.

“(M) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that existing plan sponsor compliance reviews and audit processes include the drug management programs for at-risk beneficiaries under this paragraph, including appeals processes under such programs.”

(2) INFORMATION FOR CONSUMERS.—Section 1860D-4(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w-104(a)(1)(B)) is amended by adding at the end the following:

“(v) The drug management program for at-risk beneficiaries under subsection (c)(5).”

(3) DUAL ELIGIBLES.—Section 1860D-1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w-101(b)(3)(D)) is amended by inserting “, subject to such limits as the Secretary may establish for individuals identified pursuant to section 1860D-4(c)(5)” after “the Secretary”.

(b) UTILIZATION MANAGEMENT PROGRAMS.—Section 1860D-4(c) of the Social Security Act (42 U.S.C. 1395w-104(c)), as amended by subsection (a)(1), is further amended—

(1) in paragraph (1), by inserting after subparagraph (D) the following new subparagraph:

“(E) A utilization management tool to prevent drug abuse (as described in paragraph (6)(A)).”; and

(2) by adding at the end the following new paragraph:

“(6) UTILIZATION MANAGEMENT TOOL TO PREVENT DRUG ABUSE.—

“(A) IN GENERAL.—A tool described in this paragraph is any of the following:

“(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

“(ii) Retrospective utilization review to identify—

“(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

“(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

“(iii) Consultation with the contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

Consultation.
Verification.

Contracts.

“(B) REPORTING.—A PDP sponsor offering a prescription drug plan (and an MA organization offering an MA-PD plan) in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1893 with respect to such State a report, on a monthly basis, containing information on—

“(i) any provider of services or supplier described in subparagraph (A)(ii)(II) that is identified by such plan sponsor (or organization) during the 30-day period before such report is submitted; and

Time period.

“(ii) the name and prescription records of individuals described in paragraph (5)(C).

“(C) CMS COMPLIANCE REVIEW.—The Secretary shall ensure that plan sponsor compliance reviews and program audits biennially include a certification that utilization management tools under this paragraph are in compliance with the requirements for such tools.”

Audits.
Deadline.
Certification.

(c) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

(1) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

“(j) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

“(1) ACCESS TO INFORMATION.—Under contracts entered into under this section with Medicare drug integrity contractors (including any successor entity to a Medicare drug integrity contractor), the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, MA-PD plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1860D-4(c)(5)(C).

Records.
Determination.

“(2) REQUIREMENT FOR ACKNOWLEDGMENT OF REFERRALS.—If a PDP sponsor or MA organization refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

“(A) acknowledge to the sponsor or organization receipt of the referral; and

“(B) in the case that any PDP sponsor or MA organization contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described in such paragraph, shall inform such sponsor or organization of such determination on a date that is not later than 15 days after the date on which the sponsor or organization contacts the contractor.

Determination.
Deadline.

“(3) MAKING DATA AVAILABLE TO OTHER ENTITIES.—

“(A) IN GENERAL.—For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors and MA organizations, State prescription drug monitoring programs, and other entities delegated by such sponsors or organizations using available programs and systems in the effort to prevent fraud, waste, and abuse.

“(B) HIPAA COMPLIANT INFORMATION ONLY.—Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of

individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).”.

(2) OIG STUDY AND REPORT ON EFFECTIVENESS OF MEDICS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the effectiveness of Medicare drug integrity contractors with which the Secretary of Health and Human Services has entered into a contract under section 1893 of the Social Security Act (42 U.S.C. 1395ddd) in identifying, combating, and preventing fraud under the Medicare program, including under the authority provided under section 1893(j) of the Social Security Act, added by paragraph (1).

(B) REPORT.—Not later than 24 months after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the study conducted under subparagraph (A). Such report shall include such recommendations for improvements in the effectiveness of such contractors as the Inspector General determines appropriate.

Recommendations.

(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—Section 1860D-42 of the Social Security Act (42 U.S.C. 1395w-152) is amended by adding at the end the following new subsection:

“(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the individual to prescription drugs due to a drug management program for at-risk beneficiaries.”.

(e) SENSE OF CONGRESS REGARDING USE OF TECHNOLOGY TOOLS TO COMBAT FRAUD.—It is the sense of Congress that MA organizations and PDP sponsors should consider using e-prescribing and other health information technology tools to support combating fraud under MA-PD plans and prescription drug plans under parts C and D of the Medicare program.

(f) REPORTS.—

(1) REPORT BY SECRETARY ON APPEALS PROCESS.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of jurisdiction of Congress a report on ways to improve upon the appeals process for Medicare beneficiaries with respect to prescription drug coverage under part D of title XVIII of the Social Security Act. Such report shall include an analysis comparing appeals processes under parts C and D of such title XVIII.

Analysis.

(B) FEEDBACK.—In development of the report described in subparagraph (A), the Secretary of Health and Human Services shall solicit feedback on the current appeals process from stakeholders, such as beneficiaries, consumer advocates, plan sponsors, pharmacy benefit managers,

pharmacists, providers, independent review entity evaluators, and pharmaceutical manufacturers.

(2) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the implementation of the amendments made by this section, including the effectiveness of the at-risk beneficiaries for prescription drug abuse management programs authorized by section 1860D-4(c)(5) of the Social Security Act (42 U.S.C. 1395w-10(c)(5)), as added by subsection (a)(1). Such study shall include an analysis of—

(i) the impediments, if any, that impair the ability of individuals described in subparagraph (C) of such section 1860D-4(c)(5) to access clinically appropriate levels of prescription drugs;

(ii) the effectiveness of the reasonable access protections under subparagraph (D)(ii) of such section 1860D-4(c)(5), including the impact on beneficiary access and health;

(iii) the types of—

(I) individuals who, in the implementation of such section, are determined to be individuals described in such subparagraph (C); and

(II) prescribers and pharmacies that are selected under subparagraph (D) of such section; and

(iv) other areas determined appropriate by the Comptroller General.

(B) REPORT.—Not later than July 1, 2019, the Comptroller General of the United States shall submit to the appropriate committees of jurisdiction of Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines to be appropriate.

(g) EFFECTIVE DATE; RULEMAKING.—

(1) IN GENERAL.—The amendments made by this section shall apply to prescription drug plans (and MA-PD plans) for plan years beginning on or after January 1, 2019.

(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

(A) IN GENERAL.—Not later than January 1, 2017, the Secretary of Health and Human Services shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, advocacy groups representing such individuals, physicians, pharmacists, and other clinicians, retail pharmacies, plan sponsors, entities delegated by plan sponsors, and biopharmaceutical manufacturers for input regarding the topics described in subparagraph (B). The input described in the preceding sentence shall be provided to the Secretary in sufficient time in order for the Secretary to take such input into account in promulgating the regulations pursuant to paragraph (3).

(B) TOPICS DESCRIBED.—The topics described in this subparagraph are the topics of—

Analysis.

Recommendations.

42 USC
1395w-101 note.
Applicability.

Deadline.

(i) the anticipated impact of drug management programs for at-risk beneficiaries under paragraph (5) of section 1860D-4(c) of the Social Security Act (42 U.S.C. 1395w-104(c)) on cost-sharing and ensuring accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors, and enrollees in MA-PD plans, who are at-risk beneficiaries for prescription drug abuse (as defined in subparagraph (C) of such paragraph);

(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act that allow an automatic escalation to external review of claims submitted under such part);

(iii) the types of enrollees that should be treated as exempted individuals, as described in subparagraph (C)(ii) of such paragraph;

Determination.

(iv) the manner in which terms and definitions in such paragraph should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph;

(v) the information to be included in the notices described in subparagraph (B) of such paragraph and the standardization of such notices;

(vi) with respect to a PDP sponsor (or Medicare Advantage organization) that establishes a drug management program for at-risk beneficiaries under such paragraph, the responsibilities of such PDP sponsor (or organization) with respect to the implementation of such program;

(vii) notices for plan enrollees at the point of sale that would explain why an at-risk beneficiary has been prohibited from receiving a prescription at a location outside of the designated pharmacy;

(viii) evidence-based prescribing guidelines for opiates; and

(ix) the sharing of claims data under parts A and B of title XVIII of the Social Security Act with PDP sponsors.

Deadline.
Notice.

(3) RULEMAKING.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall, taking into account the input gathered pursuant to paragraph (2)(A) and after providing notice and an opportunity to comment, promulgate regulations to carry out the provisions of, and amendments made by this section.

(h) DEPOSIT OF SAVINGS INTO MEDICARE IMPROVEMENT FUND.—Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking “during and after fiscal year 2020, \$0” and inserting “during and after fiscal year 2021, \$140,000,000”.

SEC. 705. EXCLUDING ABUSE-DETERRENT FORMULATIONS OF PRESCRIPTION DRUGS FROM THE MEDICAID ADDITIONAL REBATE REQUIREMENT FOR NEW FORMULATIONS OF PRESCRIPTION DRUGS.

(a) **IN GENERAL.**—The last sentence of section 1927(c)(2)(C) of the Social Security Act (42 U.S.C. 1396r-8(c)(2)(C)) is amended by inserting before the period at the end the following: “, but does not include an abuse-deterrent formulation of the drug (as determined by the Secretary), regardless of whether such abuse-deterrent formulation is an extended release formulation”.

Determination.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to drugs that are paid for by a State in calendar quarters beginning on or after the date of the enactment of this Act.

Applicability.
42 USC 1396r-8
note.

SEC. 706. LIMITING DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

(a) **IN GENERAL.**—Title XI of the Social Security Act is amended by inserting after section 1128J (42 U.S.C. 1320a-7k) the following new section:

“SEC. 1128K. DISCLOSURE OF PREDICTIVE MODELING AND OTHER ANALYTICS TECHNOLOGIES TO IDENTIFY AND PREVENT WASTE, FRAUD, AND ABUSE.

42 USC
1320a-7n.

“(a) **REFERENCE TO PREDICTIVE MODELING TECHNOLOGIES REQUIREMENTS.**—For provisions relating to the use of predictive modeling and other analytics technologies to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children’s Health Insurance Program under title XXI, see section 4241 of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a-7m).

“(b) **LIMITING DISCLOSURE OF PREDICTIVE MODELING TECHNOLOGIES.**—In implementing such provisions under such section 4241 with respect to covered algorithms (as defined in subsection (c)), the following shall apply:

Applicability.

“(1) **NONAPPLICATION OF FOIA.**—The covered algorithms used or developed for purposes of such section 4241 (including by the Secretary or a State (or an entity operating under a contract with a State)) shall be exempt from disclosure under section 552(b)(3) of title 5, United States Code.

Contracts.

“(2) **LIMITATION WITH RESPECT TO USE AND DISCLOSURE OF INFORMATION BY STATE AGENCIES.**—

“(A) **IN GENERAL.**—A State agency may not use or disclose covered algorithms used or developed for purposes of such section 4241 except for purposes of administering the State plan (or a waiver of the plan) under the Medicaid program under title XIX or the State child health plan (or a waiver of the plan) under the Children’s Health Insurance Program under title XXI, including by enabling an entity operating under a contract with a State to assist the State to identify or prevent waste, fraud, and abuse with respect to such programs.

Contracts.

“(B) **INFORMATION SECURITY.**—A State agency shall have in effect data security and control policies that the Secretary finds adequate to ensure the security of covered

algorithms used or developed for purposes of such section 4241 and to ensure that access to such information is restricted to authorized persons for purposes of authorized uses and disclosures described in subparagraph (A).

“(C) PROCEDURAL REQUIREMENTS.—State agencies to which information is disclosed pursuant to such section 4241 shall adhere to uniform procedures established by the Secretary.

“(c) COVERED ALGORITHM DEFINED.—In this section, the term ‘covered algorithm’—

“(1) means a predictive modeling or other analytics technology, as used for purposes of section 4241(a) of the Small Business Jobs Act of 2010 (42 U.S.C. 1320a-7m(a)) to identify and prevent waste, fraud, and abuse with respect to the Medicare program under title XVIII, the Medicaid program under title XIX, and the Children’s Health Insurance Program under title XXI; and

“(2) includes the mathematical expressions utilized in the application of such technology and the means by which such technology is developed.”.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (80), by striking “and” at the end;

(B) in paragraph (81), by striking the period at the end and inserting “; and”; and

(C) by inserting after paragraph (81) the following new paragraph:

“(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).”.

(2) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7) of the Social Security Act (42 U.S.C. 1397bb(a)(7)) is amended—

(A) in subparagraph (A), by striking “, and” at the end and inserting a semicolon;

(B) in subparagraph (B), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following new subparagraph:

“(C) to ensure that the State agency involved is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2).”.

SEC. 707. MEDICAID IMPROVEMENT FUND.

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w-1(b)(1)) is amended to read as follows:

“(1) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund for fiscal year 2021 and thereafter, \$5,000,000.”.

SEC. 708. SENSE OF THE CONGRESS REGARDING TREATMENT OF SUBSTANCE ABUSE EPIDEMICS.

It is the sense of the Congress that decades of experience and research have demonstrated that a fiscally responsible approach to addressing the opioid abuse epidemic and other substance abuse

epidemics requires treating such epidemics as a public health emergency emphasizing prevention, treatment, and recovery.

TITLE VIII—KINGPIN DESIGNATION IMPROVEMENT

SEC. 801. PROTECTION OF CLASSIFIED INFORMATION IN FEDERAL COURT CHALLENGES RELATING TO DESIGNATIONS UNDER THE NARCOTICS KINGPIN DESIGNATION ACT.

Section 804 of the Foreign Narcotics Kingpin Designation Act (21 U.S.C. 1903) is amended by adding at the end the following:

“(i) PROTECTION OF CLASSIFIED INFORMATION IN FEDERAL COURT CHALLENGES RELATING TO DESIGNATIONS.—In any judicial review of a determination made under this section, if the determination was based on classified information (as defined in section 1(a) of the Classified Information Procedures Act) such information may be submitted to the reviewing court *ex parte* and *in camera*. This subsection does not confer or imply any right to judicial review.”.

Review.
Determination.

TITLE IX—DEPARTMENT OF VETERANS AFFAIRS

SEC. 901. SHORT TITLE.

This title may be cited as the “Jason Simcakoski Memorial and Promise Act”.

SEC. 902. DEFINITIONS.

In this title:

(1) The term “controlled substance” has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) The term “State” means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

(3) The term “complementary and integrative health” has the meaning given that term, or any successor term, by the National Institutes of Health.

(4) The term “opioid receptor antagonist” means a drug or device approved or cleared under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) for emergency treatment of known or suspected opioid overdose.

Jason
Simcakoski
Memorial and
Promise Act.
38 USC 1701
note.

Subtitle A—Opioid Therapy and Pain Management

SEC. 911. IMPROVEMENT OF OPIOID SAFETY MEASURES BY DEPARTMENT OF VETERANS AFFAIRS.

38 USC 1701
note.

(a) EXPANSION OF OPIOID SAFETY INITIATIVE.—

(1) INCLUSION OF ALL MEDICAL FACILITIES.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall expand the Opioid Safety

Deadline.

Initiative of the Department of Veterans Affairs to include all medical facilities of the Department.

(2) **GUIDANCE.**—The Secretary shall establish guidance that each health care provider of the Department of Veterans Affairs, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or any subsequent tool), which shall include information from the prescription drug monitoring program of each participating State as applicable, that includes the most recent information to date relating to the patient that accessed such program to assess the risk for adverse outcomes of opioid therapy for the patient, including the concurrent use of controlled substances such as benzodiazepines, as part of the comprehensive assessment conducted by the health care provider.

(3) **ENHANCED STANDARDS.**—The Secretary shall establish enhanced standards with respect to the use of routine and random urine drug tests for all patients before and during opioid therapy to help prevent substance abuse, dependence, and diversion, including—

(A) that such tests occur not less frequently than once each year or as otherwise determined according to treatment protocols; and

(B) that health care providers appropriately order, interpret and respond to the results from such tests to tailor pain therapy, safeguards, and risk management strategies to each patient.

(b) **PAIN MANAGEMENT EDUCATION AND TRAINING.**—

(1) **IN GENERAL.**—In carrying out the Opioid Safety Initiative of the Department, the Secretary shall require all employees of the Department responsible for prescribing opioids to receive education and training described in paragraph (2).

(2) **EDUCATION AND TRAINING.**—Education and training described in this paragraph is education and training on pain management and safe opioid prescribing practices for purposes of safely and effectively managing patients with chronic pain, including education and training on the following:

(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.

(B) The use of evidence-based pain management therapies and complementary and integrative health services, including cognitive-behavioral therapy, non-opioid alternatives, and non-drug methods and procedures to managing pain and related health conditions including, to the extent practicable, medical devices approved or cleared by the Food and Drug Administration for the treatment of patients with chronic pain and related health conditions.

(C) Screening and identification of patients with substance use disorder, including drug-seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appropriate addiction treatment professionals if addiction is identified or strongly suspected.

(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other controlled substances.

(E) Such other education and training as the Secretary considers appropriate to ensure that veterans receive safe and high-quality pain management care from the Department.

(3) USE OF EXISTING PROGRAM.—In providing education and training described in paragraph (2), the Secretary shall use the Interdisciplinary Chronic Pain Management Training Team Program of the Department (or successor program).

(c) PAIN MANAGEMENT TEAMS.—

(1) IN GENERAL.—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related.

(2) ESTABLISHMENT OF PROTOCOLS.—

(A) IN GENERAL.—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department. Consultation.

(B) CONSULTATION ON PRESCRIPTION OF OPIOIDS.—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

(3) REPORT.—

(A) IN GENERAL.—Not later than one year after the date of enactment of this Act, the director of each medical facility of the Department shall submit to the Under Secretary for Health and the director of the Veterans Integrated Service Network in which the medical facility is located a report identifying the health care professionals that have been designated as members of the pain management team at the medical facility pursuant to paragraph (1).

(B) ELEMENTS.—Each report submitted under subparagraph (A) with respect to a medical facility of the Department shall include—

(i) a certification as to whether all members of the pain management team at the medical facility have Certification.

Plan. completed the education and training required under subsection (b);
 (ii) a plan for the management and referral of patients to such pain management team if health care providers without expertise in prescribing analgesics prescribe opioid medications to treat acute and chronic pain that is non-cancer related; and

Certification. (iii) a certification as to whether the medical facility—

(I) fully complies with the stepped-care model, or successor models, of pain management and other pain management policies of the Department; or

(II) does not fully comply with such stepped-care model, or successor models, of pain management and other pain management policies but is carrying out a corrective plan of action to ensure such full compliance.

(d) TRACKING AND MONITORING OF OPIOID USE.—

(1) PRESCRIPTION DRUG MONITORING PROGRAMS OF STATES.—In carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool of the Department, the Secretary shall—

(A) ensure access by health care providers of the Department to information on controlled substances, including opioids and benzodiazepines, prescribed to veterans who receive care outside the Department through the prescription drug monitoring program of each State with such a program, including by seeking to enter into memoranda of understanding with States to allow shared access of such information between States and the Department;

(B) include such information in the Opioid Therapy Risk Report tool; and

(C) require health care providers of the Department to submit to the prescription drug monitoring program of each State with such a program information on prescriptions of controlled substances received by veterans in that State under the laws administered by the Secretary.

(2) REPORT ON TRACKING OF DATA ON OPIOID USE.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of improving the Opioid Therapy Risk Report tool of the Department to allow for more advanced real-time tracking of and access to data on—

(A) the key clinical indicators with respect to the totality of opioid use by veterans;

(B) concurrent prescribing by health care providers of the Department of opioids in different health care settings, including data on concurrent prescribing of opioids to treat mental health disorders other than opioid use disorder; and

(C) mail-order prescriptions of opioids prescribed to veterans under the laws administered by the Secretary.

(e) AVAILABILITY OF OPIOID RECEPTOR ANTAGONISTS.—

(1) INCREASED AVAILABILITY AND USE.—

(A) IN GENERAL.—The Secretary shall maximize the availability of opioid receptor antagonists, including naloxone, to veterans.

(B) AVAILABILITY, TRAINING, AND DISTRIBUTING.—In carrying out subparagraph (A), not later than 90 days after the date of the enactment of this Act, the Secretary shall—

(i) equip each pharmacy of the Department with opioid receptor antagonists to be dispensed to outpatients as needed; and

(ii) expand the Overdose Education and Naloxone Distribution program of the Department to ensure that all veterans in receipt of health care under laws administered by the Secretary who are at risk of opioid overdose may access such opioid receptor antagonists and training on the proper administration of such opioid receptor antagonists.

(C) VETERANS WHO ARE AT RISK.—For purposes of subparagraph (B), veterans who are at risk of opioid overdose include—

(i) veterans receiving long-term opioid therapy;

(ii) veterans receiving opioid therapy who have a history of substance use disorder or prior instances of overdose; and

(iii) veterans who are at risk as determined by a health care provider who is treating the veteran.

(2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on carrying out paragraph (1), including an assessment of any remaining steps to be carried out by the Secretary to carry out such paragraph.

(f) INCLUSION OF CERTAIN INFORMATION AND CAPABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF THE DEPARTMENT.—

(1) INFORMATION.—The Secretary shall include in the Opioid Therapy Risk Report tool of the Department—

(A) information on the most recent time the tool was accessed by a health care provider of the Department with respect to each veteran; and

(B) information on the results of the most recent urine drug test for each veteran.

(2) CAPABILITIES.—The Secretary shall include in the Opioid Therapy Risk Report tool the ability of the health care providers of the Department to determine whether a health care provider of the Department prescribed opioids to a veteran without checking the information in the tool with respect to the veteran.

(g) NOTIFICATIONS OF RISK IN COMPUTERIZED HEALTH RECORD.—The Secretary shall modify the computerized patient record system of the Department to ensure that any health care provider that accesses the record of a veteran, regardless of the reason the veteran seeks care from the health care provider, will be immediately notified whether the veteran—

(1) is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose;

Deadline.

Assessment.

Determination.

- (2) has a history of opioid abuse; or
- (3) is at risk of developing an opioid use disorder, as determined by a health care provider who is treating the veteran.

38 USC 1701
note.

SEC. 912. STRENGTHENING OF JOINT WORKING GROUP ON PAIN MANAGEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

Deadline.

(a) **IN GENERAL.**—Not later than 90 days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the Pain Management Working Group of the Health Executive Committee of the Department of Veterans Affairs—Department of Defense Joint Executive Committee (Pain Management Working Group) established under section 320 of title 38, United States Code, includes a focus on the following:

(1) The opioid prescribing practices of health care providers of each Department.

(2) The ability of each Department to manage acute and chronic pain among individuals receiving health care from the Department, including training health care providers with respect to pain management.

(3) The use by each Department of complementary and integrative health in treating such individuals.

(4) The concurrent use and practice by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines.

(5) The use of care transition plans by health care providers of each Department to address case management issues for patients receiving opioid therapy who transition between inpatient and outpatient care.

(6) The coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from the Department of Defense to receiving health care from the Department of Veterans Affairs.

(7) The ability of each Department to properly screen, identify, refer, and treat patients with substance use disorders who are seeking treatment for acute and chronic pain management conditions.

(b) **COORDINATION AND CONSULTATION.**—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a)—

(1) coordinates the activities of the working group with other relevant working groups established under section 320 of title 38, United States Code;

(2) consults with other relevant Federal agencies, including the Centers for Disease Control and Prevention, with respect to the activities of the working group; and

(3) consults with the Department of Veterans Affairs and the Department of Defense with respect to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, or any successor guideline, and reviews and provides comments before any update to the guideline is released.

(c) **CLINICAL PRACTICE GUIDELINES.**—

Deadline.

(1) **IN GENERAL.**—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall issue an update to the

VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(2) MATTERS INCLUDED.—In conducting the update under paragraph (1), the Pain Management Working Group, in coordination with the Clinical Practice Guideline VA/DoD Management of Opioid Therapy for Chronic Pain Working Group, shall work to ensure that the Clinical Practical Guideline includes the following:

(A) Enhanced guidance with respect to—

(i) the co-administration of an opioid and other drugs, including benzodiazepines, that may result in life-limiting drug interactions;

(ii) the treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; and

(iii) the use of opioid therapy to treat mental health disorders other than opioid use disorder.

(B) Enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, such as post-traumatic stress disorder or other psychiatric disorders, or a history of substance abuse or addiction, that requires a consultation or co-management of opioid therapy with one or more specialists in pain management, mental health, or addictions.

(C) Enhanced guidance with respect to health care providers— Assessments.

(i) conducting an effective assessment for patients beginning or continuing opioid therapy, including understanding and setting realistic goals with respect to achieving and maintaining an expected level of pain relief, improved function, or a clinically appropriate combination of both; and

(ii) effectively assessing whether opioid therapy is achieving or maintaining the established treatment goals of the patient or whether the patient and health care provider should discuss adjusting, augmenting, or discontinuing the opioid therapy.

(D) Guidelines to inform the methodologies used by health care providers of the Department of Veterans Affairs and the Department of Defense to safely taper opioid therapy when adjusting or discontinuing the use of opioid therapy, including—

(i) prescription of the lowest effective dose based on patient need;

(ii) use of opioids only for a limited time; and

(iii) augmentation of opioid therapy with other pain management therapies and modalities.

(E) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient health care settings, which may include the use of care transition plans.

(F) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition from receiving care during active duty to post-military health care networks.

(G) Guidelines with respect to providing options, before initiating opioid therapy, for pain management therapies

without the use of opioids and options to augment opioid therapy with other clinical and complementary and integrative health services to minimize opioid dependence.

(H) Guidelines with respect to the provision of evidence-based non-opioid treatments within the Department of Veterans Affairs and the Department of Defense, including medical devices and other therapies approved or cleared by the Food and Drug Administration for the treatment of chronic pain as an alternative to or to augment opioid therapy.

(I) Guidelines developed by the Centers for Disease Control and Prevention for safely prescribing opioids for the treatment of chronic, non-cancer related pain in outpatient settings.

(3) **RULE OF CONSTRUCTION.**—Nothing in this subsection shall be construed to prevent the Secretary of Veterans Affairs and the Secretary of Defense from considering all relevant evidence, as appropriate, in updating the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, as required under paragraph (1), or from ensuring that the final clinical practice guideline updated under such paragraph remains applicable to the patient populations of the Department of Veterans Affairs and the Department of Defense.

38 USC 1701
note.

**SEC. 913. REVIEW, INVESTIGATION, AND REPORT ON USE OF OPIOIDS
IN TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.**

(a) **COMPTROLLER GENERAL REPORT.**—

(1) **IN GENERAL.**—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Opioid Safety Initiative of the Department of Veterans Affairs and the opioid prescribing practices of health care providers of the Department.

Assessments.

(2) **ELEMENTS.**—The report submitted under paragraph (1) shall include the following:

(A) An assessment of the implementation and monitoring by the Veterans Health Administration of the Opioid Safety Initiative of the Department, including examining, as appropriate, the following:

(i) How the Department monitors the key clinical outcomes of such safety initiative (for example, the percentage of unique veterans visiting each medical center of the Department that are prescribed an opioid or an opioid and benzodiazepine concurrently) and how the Department uses that information—

(I) to improve prescribing practices; and

(II) to identify high prescribing or otherwise inappropriate prescribing practices by health care providers.

(ii) How the Department monitors the use of the Opioid Therapy Risk Report tool of the Department (as developed through such safety initiative) and compliance with such tool by medical facilities and health care providers of the Department, including

any findings by the Department of prescription rates or prescription practices by medical facilities or health care providers that are inappropriate.

(iii) The implementation of academic detailing programs within the Veterans Integrated Service Networks of the Department and how such programs are being used to improve opioid prescribing practices.

(iv) Recommendations on such improvements to the Opioid Safety Initiative of the Department as the Comptroller General considers appropriate.

Recommendations.

(B) Information made available under the Opioid Therapy Risk Report tool with respect to—

(i) deaths resulting from sentinel events involving veterans prescribed opioids by a health care provider;

(ii) overall prescription rates and, if applicable, indications used by health care providers for prescribing chronic opioid therapy to treat non-cancer, non-palliative, and non-hospice care patients;

(iii) the prescription rates and indications used by health care providers for prescribing benzodiazepines and opioids concomitantly;

(iv) the practice by health care providers of prescribing opioids to treat patients without any pain, including to treat patients with mental health disorders other than opioid use disorder; and

(v) the effectiveness of opioid therapy for patients receiving such therapy, including the effectiveness of long-term opioid therapy.

(C) An evaluation of processes of the Department in place to oversee opioid use among veterans, including procedures to identify and remedy potential over-prescribing of opioids by health care providers of the Department.

Evaluation. Procedures.

(D) An assessment of the implementation by the Secretary of Veterans Affairs of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any figures or approaches used by the Department to assess compliance with such guidelines by medical centers of the Department and identify any medical centers of the Department operating action plans to improve compliance with such guidelines.

(E) An assessment of the data that the Department has developed to review the opioid prescribing practices of health care providers of the Department, as required by this subtitle, including a review of how the Department identifies the practices of individual health care providers that warrant further review based on prescribing levels, health conditions for which the health care provider is prescribing opioids or opioids and benzodiazepines concurrently, or other practices of the health care provider.

Review.

(b) SEMI-ANNUAL PROGRESS REPORT ON IMPLEMENTATION OF COMPTROLLER GENERAL RECOMMENDATIONS.—Not later than 180 days after the date of the submittal of the report required under subsection (a), and not less frequently than annually thereafter until the Comptroller General of the United States determines that all recommended actions are closed, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of

Determination.

Representatives a progress report detailing the actions by the Secretary to address any outstanding findings and recommendations by the Comptroller General of the United States under subsection (a) with respect to the Veterans Health Administration.

(c) ANNUAL REPORT ON OPIOID THERAPY AND PRESCRIPTION RATES.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually for the following five years, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on opioid therapy and prescription rates for the one-year period preceding the date of the submission of the report. Each such report shall include each of the following:

(1) The number of patients and the percentage of the patient population of the Department who were prescribed benzodiazepines and opioids concurrently by a health care provider of the Department.

(2) The number of patients and the percentage of the patient population of the Department without any pain who were prescribed opioids by a health care provider of the Department, including those who were prescribed benzodiazepines and opioids concurrently.

(3) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were treated with opioids by a health care provider of the Department on an inpatient-basis and who also received prescription opioids by mail from the Department while being treated on an inpatient-basis.

(4) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were prescribed opioids concurrently by a health care provider of the Department and a health care provider that is not a health care provider of the Department.

(5) With respect to each medical facility of the Department, the collected and reviewed information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients, including—

(A) the prescription rate at which each health care provider at the facility prescribed benzodiazepines and opioids concurrently to such patients and the aggregate of such prescription rate for all health care providers at the facility;

(B) the prescription rate at which each health care provider at the facility prescribed benzodiazepines or opioids to such patients to treat conditions for which benzodiazepines or opioids are not approved treatment and the aggregate of such prescription rate for all health care providers at the facility;

(C) the prescription rate at which each health care provider at the facility prescribed or dispensed mail-order prescriptions of opioids to such patients while such patients were being treated with opioids on an inpatient-basis and the aggregate of such prescription rate for all health care providers at the facility; and

(D) the prescription rate at which each health care provider at the facility prescribed opioids to such patients who were also concurrently prescribed opioids by a health

care provider that is not a health care provider of the Department and the aggregate of such prescription rates for all health care providers at the facility.

(6) With respect to each medical facility of the Department, the number of times a pharmacist at the facility overrode a critical drug interaction warning with respect to an interaction between opioids and another medication before dispensing such medication to a veteran.

(d) INVESTIGATION OF PRESCRIPTION RATES.—If the Secretary determines that a prescription rate with respect to a health care provider or medical facility of the Department conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, the Secretary shall—

Determination.

(1) immediately notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of such determination, including information relating to such determination, prescription rate, and health care provider or medical facility, as the case may be; and

Notification.

(2) through the Office of the Medical Inspector of the Veterans Health Administration, conduct a full investigation of the health care provider or medical facility, as the case may be.

(e) PRESCRIPTION RATE DEFINED.—In this section, the term “prescription rate” means, with respect to a health care provider or medical facility of the Department, each of the following:

(1) The number of patients treated with opioids by the health care provider or at the medical facility, as the case may be, divided by the total number of pharmacy users of that health care provider or medical facility.

(2) The average number of morphine equivalents per day prescribed by the health care provider or at the medical facility, as the case may be, to patients being treated with opioids.

(3) Of the patients being treated with opioids by the health care provider or at the medical facility, as the case may be, the average number of prescriptions of opioids per patient.

SEC. 914. MANDATORY DISCLOSURE OF CERTAIN VETERAN INFORMATION TO STATE CONTROLLED SUBSTANCE MONITORING PROGRAMS.

38 USC 1701 note.

Section 5701(l) of title 38, United States Code, is amended by striking “may” and inserting “shall”.

SEC. 915. ELIMINATION OF COPAYMENT REQUIREMENT FOR VETERANS RECEIVING OPIOID ANTAGONISTS OR EDUCATION ON USE OF OPIOID ANTAGONISTS.

38 USC 1701 note.

(a) COPAYMENT FOR OPIOID ANTAGONISTS.—Section 1722A(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

“(4) Paragraph (1) does not apply to opioid antagonists furnished under this chapter to a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose.”

(b) COPAYMENT FOR EDUCATION ON USE OF OPIOID ANTAGONISTS.—Section 1710(g)(3) of such title is amended—

(1) by striking “with respect to home health services” and inserting “with respect to the following:”

“(A) Home health services”; and

(2) by adding at the end the following subparagraph:
 “(B) Education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances.”.

Subtitle B—Patient Advocacy

38 USC 1701
 note.

SEC. 921. COMMUNITY MEETINGS ON IMPROVING CARE FURNISHED BY DEPARTMENT OF VETERANS AFFAIRS.

Deadline.

(a) COMMUNITY MEETINGS.—

(1) **MEDICAL CENTERS.**—Not later than 90 days after the date of the enactment of this Act, and not less frequently than once every 90 days thereafter, the Secretary shall ensure that each medical facility of the Department of Veterans Affairs hosts a community meeting open to the public on improving health care furnished by the Secretary.

(2) **COMMUNITY-BASED OUTPATIENT CLINICS.**—Not later than one year after the date of the enactment of this Act, and not less frequently than annually thereafter, the Secretary shall ensure that each community-based outpatient clinic of the Department hosts a community meeting open to the public on improving health care furnished by the Secretary.

(b) ATTENDANCE BY DIRECTOR OF VETERANS INTEGRATED SERVICE NETWORK OR DESIGNEE.—

(1) **IN GENERAL.**—Each community meeting hosted by a medical facility or community-based outpatient clinic under subsection (a) shall be attended by the Director of the Veterans Integrated Service Network in which the medical facility or community-based outpatient clinic, as the case may be, is located. Subject to paragraph (2), the Director may delegate such attendance only to an employee who works in the Office of the Director.

(2) **ATTENDANCE BY DIRECTOR.**—Each Director of a Veterans Integrated Service Network shall personally attend not less than one community meeting under subsection (a) hosted by each medical facility located in the Veterans Integrated Service Network each year.

Deadline.

(c) **NOTICE.**—The Secretary shall notify the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and each Member of Congress (as defined in section 902) who represents the area in which the medical facility is located of a community meeting under subsection (a) by not later than 10 days before such community meeting occurs.

Deadline.
 38 USC 1701
 note.

SEC. 922. IMPROVEMENT OF AWARENESS OF PATIENT ADVOCACY PROGRAM AND PATIENT BILL OF RIGHTS OF DEPARTMENT OF VETERANS AFFAIRS.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients and family members of patients at each medical facility of the Department of Veterans Affairs—

(1) display the purposes of the Patient Advocacy Program of the Department and the contact information for the patient advocate at such medical facility; and

(2) display the rights and responsibilities of—

(A) patients and family members of patients at such medical facility; and

(B) with respect to community living centers and other residential facilities of the Department, residents and family members of residents at such medical facility.

SEC. 923. COMPTROLLER GENERAL REPORT ON PATIENT ADVOCACY PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS. 38 USC 1701 note.

(a) **IN GENERAL.**—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Patient Advocacy Program of the Department of Veterans Affairs (in this section referred to as the "Program").

(b) **ELEMENTS.**—The report required by subsection (a) shall include the following: Assessments.

(1) A description of the Program, including—

(A) the purpose of the Program;

(B) the activities carried out under the Program; and

(C) the sufficiency of the Program in achieving the purpose of the Program.

(2) An assessment of the sufficiency of staffing of employees of the Department responsible for carrying out the Program.

(3) An assessment of the sufficiency of the training of such employees.

(4) An assessment of—

(A) the awareness of the Program among veterans and family members of veterans; and

(B) the use of the Program by veterans and family members of veterans.

(5) Such recommendations and proposals for improving or modifying the Program as the Comptroller General considers appropriate. Recommendations.

(6) Such other information with respect to the Program as the Comptroller General considers appropriate.

SEC. 924. ESTABLISHMENT OF OFFICE OF PATIENT ADVOCACY OF THE DEPARTMENT OF VETERANS AFFAIRS. 38 USC 1701 note.

(a) **IN GENERAL.**—Subchapter I of chapter 73 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 7309A. Office of Patient Advocacy

38 USC 7309A.

"(a) **ESTABLISHMENT.**—There is established in the Department within the Office of the Under Secretary for Health an office to be known as the 'Office of Patient Advocacy' (in this section referred to as the 'Office').

"(b) **HEAD.**—(1) The Director of the Office of Patient Advocacy shall be the head of the Office.

"(2) The Director of the Office of Patient Advocacy shall be appointed by the Under Secretary for Health from among individuals qualified to perform the duties of the position and shall report directly to the Under Secretary for Health. Appointment.

"(c) **FUNCTION.**—(1) The function of the Office is to carry out the Patient Advocacy Program of the Department.

“(2) In carrying out the Patient Advocacy Program of the Department, the Director shall ensure that patient advocates of the Department—

“(A) advocate on behalf of veterans with respect to health care received and sought by veterans under the laws administered by the Secretary;

“(B) carry out the responsibilities specified in subsection (d); and

“(C) receive training in patient advocacy.

“(d) PATIENT ADVOCACY RESPONSIBILITIES.—The responsibilities of each patient advocate at a medical facility of the Department are the following:

“(1) To resolve complaints by veterans with respect to health care furnished under the laws administered by the Secretary that cannot be resolved at the point of service or at a higher level easily accessible to the veteran.

“(2) To present at various meetings and to various committees the issues experienced by veterans in receiving such health care at such medical facility.

“(3) To express to veterans their rights and responsibilities as patients in receiving such health care.

“(4) To manage the Patient Advocate Tracking System of the Department at such medical facility.

“(5) To compile data at such medical facility of complaints made by veterans with respect to the receipt of such health care at such medical facility and the satisfaction of veterans with such health care at such medical facility to determine whether there are trends in such data.

“(6) To ensure that a process is in place for the distribution of the data compiled under paragraph (5) to appropriate leaders, committees, services, and staff of the Department.

“(7) To identify, not less frequently than quarterly, opportunities for improvements in the furnishing of such health care to veterans at such medical facility based on complaints by veterans.

“(8) To ensure that any significant complaint by a veteran with respect to such health care is brought to the attention of appropriate staff of the Department to trigger an assessment of whether there needs to be a further analysis of the problem at the facility-wide level.

“(9) To support any patient advocacy programs carried out by the Department.

“(10) To ensure that all appeals and final decisions with respect to the receipt of such health care are entered into the Patient Advocate Tracking System of the Department.

“(11) To understand all laws, directives, and other rules with respect to the rights and responsibilities of veterans in receiving such health care, including the appeals processes available to veterans.

“(12) To ensure that veterans receiving mental health care, or the surrogate decision-makers for such veterans, are aware of the rights of veterans to seek representation from systems established under section 103 of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10803) to protect and advocate the rights of individuals with mental illness and to investigate incidents of abuse and neglect of such individuals.

“(13) To fulfill requirements established by the Secretary with respect to the inspection of controlled substances.

“(14) To document potentially threatening behavior and report such behavior to appropriate authorities.

“(e) TRAINING.—In providing training to patient advocates under subsection (c)(2)(C), the Director shall ensure that such training is consistent throughout the Department.

“(f) CONTROLLED SUBSTANCE DEFINED.—In this section, the term ‘controlled substance’ has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).”

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of such title is amended by inserting after the item relating to section 7309 the following new item:

38 USC
prec. 7301.

“7309A. Office of Patient Advocacy.”

(c) DATE FULLY OPERATIONAL.—The Secretary of Veterans Affairs shall ensure that the Office of Patient Advocacy established under section 7309A of title 38, United States Code, as added by subsection (a), is fully operational not later than the date that is one year after the date of the enactment of this Act.

38 USC 7309A
note.

Subtitle C—Complementary and Integrative Health

SEC. 931. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

38 USC 1701
note.

(a) ESTABLISHMENT.—There is established a commission to be known as the “Creating Options for Veterans’ Expedited Recovery” or the “COVER Commission” (in this section referred to as the “Commission”). The Commission shall examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health treatments available in non-Department facilities (as defined in section 1701 of title 38, United States Code).

Examination.

(b) DUTIES.—The Commission shall perform the following duties:

(1) Examine the efficacy of the evidence-based therapy model used by the Secretary for treating mental health illnesses of veterans and identify areas to improve wellness-based outcomes.

(2) Conduct a patient-centered survey within each of the Veterans Integrated Service Networks to examine—

(A) the experience of veterans with the Department of Veterans Affairs when seeking medical assistance for mental health issues through the health care system of the Department;

(B) the experience of veterans with non-Department facilities and health professionals for treating mental health issues;

(C) the preference of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective;

(D) the experience, if any, of veterans with respect to the complementary and integrative health treatment therapies described in paragraph (3);

(E) the prevalence of prescribing prescription medication among veterans seeking treatment through the health care system of the Department as remedies for addressing mental health issues; and

(F) the outreach efforts of the Secretary regarding the availability of benefits and treatments for veterans for addressing mental health issues, including by identifying ways to reduce barriers to gaps in such benefits and treatments.

(3) Examine available research on complementary and integrative health treatment therapies for mental health issues and identify what benefits could be made with the inclusion of such treatments for veterans, including with respect to—

(A) music therapy;

(B) equine therapy;

(C) training and caring for service dogs;

(D) yoga therapy;

(E) acupuncture therapy;

(F) meditation therapy;

(G) outdoor sports therapy;

(H) hyperbaric oxygen therapy;

(I) accelerated resolution therapy;

(J) art therapy;

(K) magnetic resonance therapy; and

(L) other therapies the Commission determines appropriate.

(4) Study the sufficiency of the resources of the Department to ensure the delivery of quality health care for mental health issues among veterans seeking treatment within the Department.

(5) Study the current treatments and resources available within the Department and assess—

(A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans;

(B) the number of veterans who have been diagnosed with mental health issues;

(C) the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues;

(D) the percentage of veterans who have completed counseling sessions offered by the Department; and

(E) the efforts of the Department to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by the Department.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 10 members, appointed as follows:

(A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(B) Two members appointed by the minority leader of the House of Representatives, at least one of whom shall be a veteran.

(C) Two members appointed by the majority leader of the Senate, at least one of whom shall be a veteran.

(D) Two members appointed by the minority leader of the Senate, at least one of whom shall be a veteran.

(E) Two members appointed by the President, at least one of whom shall be a veteran. President.

(2) QUALIFICATIONS.—Members of the Commission shall be individuals who—

(A) are of recognized standing and distinction within the medical community with a background in treating mental health;

(B) have experience working with the military and veteran population; and

(C) do not have a financial interest in any of the complementary and integrative health treatments reviewed by the Commission.

(3) CHAIRMAN.—The President shall designate a member of the Commission to be the Chairman. President.

(4) PERIOD OF APPOINTMENT.—Members of the Commission shall be appointed for the life of the Commission.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(6) APPOINTMENT DEADLINE.—The appointment of members of the Commission in this section shall be made not later than 90 days after the date of the enactment of this Act.

(d) POWERS OF COMMISSION.—

(1) MEETINGS.—

(A) INITIAL MEETING.—The Commission shall hold its first meeting not later than 30 days after a majority of members are appointed to the Commission. Deadline.

(B) MEETING.—The Commission shall regularly meet at the call of the Chairman. Such meetings may be carried out through the use of telephonic or other appropriate telecommunication technology if the Commission determines that such technology will allow the members to communicate simultaneously. Determination.

(2) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive evidence as the Commission considers advisable to carry out the responsibilities of the Commission.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission.

(4) INFORMATION FROM NONGOVERNMENTAL ORGANIZATIONS.—In carrying out its duties, the Commission may seek guidance through consultation with foundations, veteran service organizations, nonprofit groups, faith-based organizations, private and public institutions of higher education, and other organizations as the Commission determines appropriate.

(5) COMMISSION RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public information. Public information.

inspection and the Comptroller General of the United States may audit and examine such record.

Public
information.

(6) PERSONNEL RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such records.

(7) COMPENSATION OF MEMBERS; TRAVEL EXPENSES.—Each member shall serve without pay but shall receive travel expenses to perform the duties of the Commission, including per diem in lieu of substances, at rates authorized under subchapter I of chapter 57 of title 5, United States Code.

(8) STAFF.—The Chairman, in accordance with rules agreed upon the Commission, may appoint and fix the compensation of a staff director and such other personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(9) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The executive director and any personnel of the Commission are employees under section 2105 of title 5, United States Code, for purpose of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of such title.

(B) MEMBERS OF THE COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(10) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided in appropriations Acts, enter into contracts to enable the Commission to discharge the duties of the Commission under this Act.

(11) EXPERT AND CONSULTANT SERVICE.—The Commission may procure the services of experts and consultants in accordance with section 3109 of title 5, United States Code, at rates not to exceed the daily rate paid to a person occupying a position at level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(12) POSTAL SERVICE.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

(13) PHYSICAL FACILITIES AND EQUIPMENT.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act. These administrative services may include human resource management, budget, leasing accounting, and payroll services.

(e) REPORT.—

(1) INTERIM REPORTS.—

Time period.

(A) IN GENERAL.—Not later than 60 days after the date on which the Commission first meets, and each 30-day period thereafter ending on the date on which the

Commission submits the final report under paragraph (2), the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the President a report detailing the level of cooperation the Secretary of Veterans Affairs (and the heads of other departments or agencies of the Federal Government) has provided to the Commission.

(B) OTHER REPORTS.—In carrying out its duties, at times that the Commission determines appropriate, the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and any other appropriate entities an interim report with respect to the findings identified by the Commission.

(2) FINAL REPORT.—Not later than 18 months after the first meeting of the Commission, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate, the President, and the Secretary of Veterans Affairs a final report on the findings of the Commission. Such report shall include the following:

(A) Recommendations to implement in a feasible, timely, and cost-efficient manner the solutions and remedies identified within the findings of the Commission pursuant to subsection (b). Recommendations.

(B) An analysis of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating veterans with mental health care issues, and an examination of the prevalence and efficacy of prescription drugs as a means for treatment. Analysis.

(C) The findings of the patient-centered survey conducted within each of the Veterans Integrated Service Networks pursuant to subsection (b)(2).

(D) An examination of complementary and integrative health treatments described in subsection (b)(3) and the potential benefits of incorporating such treatments in the therapy models used by the Secretary for treating veterans with mental health issues. Examination.

(3) PLAN.—Not later than 90 days after the date on which the Commission submits the final report under paragraph (2), the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the following:

(A) An action plan for implementing the recommendations established by the Commission on such solutions and remedies for improving wellness-based outcomes for veterans with mental health care issues.

(B) A feasible timeframe on when the complementary and integrative health treatments described in subsection (b)(3) can be implemented Department-wide. Timeframe.

(C) With respect to each recommendation established by the Commission, including any complementary and integrative health treatment, that the Secretary determines is not appropriate or feasible to implement, a justification for such determination and an alternative solution to improve the efficacy of the therapy models used by the Secretary for treating veterans with mental health issues.

(f) **TERMINATION OF COMMISSION.**—The Commission shall terminate 30 days after the Commission submits the final report under subsection (e)(2).

38 USC 1701
note.

SEC. 932. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

Deadline.

(a) **DEVELOPMENT OF PLAN TO EXPAND RESEARCH, EDUCATION, AND DELIVERY.**—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall develop a plan to expand materially and substantially the scope of the effectiveness of research and education on, and delivery and integration of, complementary and integrative health services into the health care services provided to veterans.

(b) **ELEMENTS.**—The plan required by subsection (a) shall provide for the following:

(1) Research on the following:

(A) The effectiveness of various complementary and integrative health services, including the effectiveness of such services integrated with clinical services.

(B) Approaches to integrating complementary and integrative health services into other health care services provided by the Department of Veterans Affairs.

(2) Education and training for health care professionals of the Department on the following:

(A) Complementary and integrative health services selected by the Secretary for purposes of the plan.

(B) Appropriate uses of such services.

(C) Integration of such services into the delivery of health care to veterans.

(3) Research, education, and clinical activities on complementary and integrative health at centers of innovation at medical centers of the Department.

(4) Identification or development of metrics and outcome measures to evaluate the effectiveness of the provision and integration of complementary and integrative health services into the delivery of health care to veterans.

(5) Integration and delivery of complementary and integrative health services with other health care services provided by the Department.

(c) **CONSULTATION.**—

(1) **IN GENERAL.**—In carrying out subsection (a), the Secretary shall consult with the following:

(A) The Director of the National Center for Complementary and Integrative Health of the National Institutes of Health.

(B) The Commissioner of Food and Drugs.

(C) Institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and integrative health and the integration of complementary and integrative health practices into the delivery of health care.

(D) Nationally recognized providers of complementary and integrative health.

(E) Such other officials, entities, and individuals with expertise on complementary and integrative health as the Secretary considers appropriate.

(2) SCOPE OF CONSULTATION.—The Secretary shall undertake consultation under paragraph (1) in carrying out subsection (a) with respect to the following:

(A) To develop the plan.

(B) To identify specific complementary and integrative health practices that, on the basis of research findings or promising clinical interventions, are appropriate to include as services to veterans.

(C) To identify barriers to the effective provision and integration of complementary and integrative health services into the delivery of health care to veterans, and to identify mechanisms for overcoming such barriers.

SEC. 933. PILOT PROGRAM ON INTEGRATION OF COMPLEMENTARY AND INTEGRATIVE HEALTH AND RELATED ISSUES FOR VETERANS AND FAMILY MEMBERS OF VETERANS. 38 USC 1701 note.

(a) PILOT PROGRAM.—

(1) IN GENERAL.—Not later than 180 days after the date on which the Secretary of Veterans Affairs receives the final report under section 931(e)(2), the Secretary shall commence a pilot program to assess the feasibility and advisability of using complementary and integrative health and wellness-based programs (as defined by the Secretary) to complement the provision of pain management and related health care services, including mental health care services, to veterans.

(2) MATTERS ADDRESSED.—In carrying out the pilot program, the Secretary shall assess the following:

(A) Means of improving coordination between Federal, State, local, and community providers of health care in the provision of pain management and related health care services to veterans.

(B) Means of enhancing outreach, and coordination of outreach, by and among providers of health care referred to in subparagraph (A) on the pain management and related health care services available to veterans.

(C) Means of using complementary and integrative health and wellness-based programs of providers of health care referred to in subparagraph (A) as complements to the provision by the Department of Veterans Affairs of pain management and related health care services to veterans.

(D) Whether complementary and integrative health and wellness-based programs described in subparagraph (C)—

(i) are effective in enhancing the quality of life and well-being of veterans;

(ii) are effective in increasing the adherence of veterans to the primary pain management and related health care services provided such veterans by the Department;

(iii) have an effect on the sense of well-being of veterans who receive primary pain management and related health care services from the Department; and

(iv) are effective in encouraging veterans receiving health care from the Department to adopt a more healthy lifestyle.

Assessments.
Deadline.

(b) DURATION.—The Secretary shall carry out the pilot program under subsection (a)(1) for a period of three years.

(c) LOCATIONS.—

(1) FACILITIES.—The Secretary shall carry out the pilot program under subsection (a)(1) at facilities of the Department providing pain management and related health care services, including mental health care services, to veterans. In selecting such facilities to carry out the pilot program, the Secretary shall select not fewer than 15 geographically diverse medical centers of the Department, of which not fewer than two shall be polytrauma rehabilitation centers of the Department.

(2) MEDICAL CENTERS WITH PRESCRIPTION RATES OF OPIOIDS THAT CONFLICT WITH CARE STANDARDS.—In selecting the medical centers under paragraph (1), the Secretary shall give priority to medical centers of the Department at which there is a prescription rate of opioids that conflicts with or is otherwise inconsistent with the standards of appropriate and safe care.

(d) PROVISION OF SERVICES.—Under the pilot program under subsection (a)(1), the Secretary shall provide covered services to covered veterans by integrating complementary and integrative health services with other services provided by the Department at the medical centers selected under subsection (c).

(e) COVERED VETERANS.—For purposes of the pilot program under subsection (a)(1), a covered veteran is any veteran who—

(1) has a mental health condition diagnosed by a clinician of the Department;

(2) experiences chronic pain;

(3) has a chronic condition being treated by a clinician of the Department; or

(4) is not described in paragraph (1), (2), or (3) and requests to participate in the pilot program or is referred by a clinician of the Department who is treating the veteran.

(f) COVERED SERVICES.—

(1) IN GENERAL.—For purposes of the pilot program, covered services are services consisting of complementary and integrative health services as selected by the Secretary.

(2) ADMINISTRATION OF SERVICES.—Covered services shall be administered under the pilot program as follows:

(A) Covered services shall be administered by professionals or other instructors with appropriate training and expertise in complementary and integrative health services who are employees of the Department or with whom the Department enters into an agreement to provide such services.

(B) Covered services shall be included as part of the Patient Aligned Care Teams initiative of the Office of Patient Care Services, Primary Care Program Office, in coordination with the Office of Patient Centered Care and Cultural Transformation.

(C) Covered services shall be made available to—

(i) covered veterans who have received conventional treatments from the Department for the conditions for which the covered veteran seeks complementary and integrative health services under the pilot program; and

(ii) covered veterans who have not received conventional treatments from the Department for such conditions.

(g) REPORTS.—

(1) IN GENERAL.—Not later than 30 months after the date on which the Secretary commences the pilot program under subsection (a)(1), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the pilot program.

(2) ELEMENTS.—The report under paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program under subsection (a)(1), including with respect to—

(i) the use and efficacy of the complementary and integrative health services established under the pilot program;

(ii) the outreach conducted by the Secretary to inform veterans and community organizations about the pilot program; and

(iii) an assessment of the benefit of the pilot program to covered veterans in mental health diagnoses, pain management, and treatment of chronic illness.

Assessment.

(B) Identification of any unresolved barriers that impede the ability of the Secretary to incorporate complementary and integrative health services with other health care services provided by the Department.

(C) Such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

Recommendations.

Subtitle D—Fitness of Health Care Providers

SEC. 941. ADDITIONAL REQUIREMENTS FOR HIRING OF HEALTH CARE PROVIDERS BY DEPARTMENT OF VETERANS AFFAIRS.

38 USC 1701 note.

As part of the hiring process for each health care provider considered for a position at the Department of Veterans Affairs after the date of the enactment of the Act, the Secretary of Veterans Affairs shall require from the medical board of each State in which the health care provider has or had a medical license—

(1) information on any violation of the requirements of the medical license of the health care provider during the 20-year period preceding the consideration of the health care provider by the Department; and

Time period.

(2) information on whether the health care provider has entered into any settlement agreement for a disciplinary charge relating to the practice of medicine by the health care provider.

SEC. 942. PROVISION OF INFORMATION ON HEALTH CARE PROVIDERS OF DEPARTMENT OF VETERANS AFFAIRS TO STATE MEDICAL BOARDS.

38 USC 1701 note.

Notwithstanding section 552a of title 5, United States Code, with respect to each health care provider of the Department of Veterans Affairs who has violated a requirement of the medical

license of the health care provider, the Secretary of Veterans Affairs shall provide to the medical board of each State in which the health care provider is licensed detailed information with respect to such violation, regardless of whether such board has formally requested such information.

38 USC 1701
note.

SEC. 943. REPORT ON COMPLIANCE BY DEPARTMENT OF VETERANS AFFAIRS WITH REVIEWS OF HEALTH CARE PROVIDERS LEAVING THE DEPARTMENT OR TRANSFERRING TO OTHER FACILITIES.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the compliance by the Department of Veterans Affairs with the policy of the Department—

Review.

(1) to conduct a review of each health care provider of the Department who transfers to another medical facility of the Department, resigns, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider; and

(2) to take appropriate action with respect to any such concern, complaint, or allegation.

Subtitle E—Other Matters

38 USC 1701
note.

SEC. 951. MODIFICATION TO LIMITATION ON AWARDS AND BONUSES.

Section 705 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146; 38 U.S.C. 703 note) is amended to read as follows:

“SEC. 705. LIMITATION ON AWARDS AND BONUSES PAID TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

“(a) **LIMITATION.**—The Secretary of Veterans Affairs shall ensure that the aggregate amount of awards and bonuses paid by the Secretary in a fiscal year under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title or title 38, United States Code, does not exceed the following amounts:

“(1) With respect to each of fiscal years 2017 through 2018, \$230,000,000.

“(2) With respect to each of fiscal years 2019 through 2021, \$225,000,000.

“(3) With respect to each of fiscal years 2022 through 2024, \$360,000,000.

“(b) **SENSE OF CONGRESS.**—It is the sense of Congress that the limitation under subsection (a) should not disproportionately impact lower-wage employees and that the Department of Veterans

Affairs is encouraged to use bonuses to incentivize high-performing employees in areas in which retention is challenging.”.

Approved July 22, 2016.

LEGISLATIVE HISTORY—S. 524 (H.R. 1725) (H.R. 1818) (H.R. 3680) (H.R. 3691) (H.R. 4063) (H.R. 4586) (H.R. 4599) (H.R. 4641) (H.R. 4843) (H.R. 4892) (H.R. 4969) (H.R. 4976) (H.R. 4978) (H.R. 4981) (H.R. 4982) (H.R. 4985) (H.R. 5046) (H.R. 5048) (H.R. 5052):

HOUSE REPORTS: Nos. 114-669 (Comm. of Conference), 114-245 (Comm. on Energy and Commerce) accompanying H.R. 1725, 114-552 (Comm. on Energy and Commerce) accompanying H.R. 1818, 114-553 (Comm. on Energy and Commerce) accompanying H.R. 3680, 114-554 (Comm. on Energy and Commerce) accompanying H.R. 3691, 114-646 (Comm. on Veterans' Affairs) accompanying H.R. 4063, 114-555 (Comm. on Energy and Commerce) accompanying H.R. 4586, 114-556 (Comm. on Energy and Commerce) accompanying H.R. 4599, 114-536 (Comm. on Energy and Commerce) accompanying H.R. 4641, 114-548 (Comm. on Education and the Workforce) accompanying H.R. 4843, 114-558 (Comm. on Energy and Commerce) accompanying H.R. 4969, 114-557 (Comm. on Energy and the Workforce) accompanying H.R. 4976, 114-559 (Comm. on Energy and Commerce) accompanying H.R. 4978, 114-561 (Comm. on Energy and Commerce) accompanying H.R. 4981, 114-560 (Comm. on Energy and Commerce) accompanying H.R. 4982, 114-547, Pt. 1 (Comm. on the Judiciary) accompanying H.R. 4985, 114-539 (Comm. on the Judiciary) accompanying H.R. 5046, 114-540 (Comm. on the Judiciary) accompanying H.R. 5048, and 114-541, Pt. 1 (Comm. on the Judiciary) accompanying H.R. 5052.

CONGRESSIONAL RECORD, Vol. 162 (2016):

Mar. 2, 3, 7-10, considered and passed Senate.

May 13, considered and passed House, amended.

July 8, House agreed to conference report.

July 11-13, Senate considered and agreed to conference report.

DAILY COMPILATION OF PRESIDENTIAL DOCUMENTS (2016):

July 22, Presidential statement.

TITLE 42

State Affairs and Government

CHAPTER 42-73

Child Advocate Office

SECTION 42-73-8

§ 42-73-8. Access to information.

The child advocate shall have access to the following information:

- (1) The names of all children in protective services, treatment, or other programs under the jurisdiction of the department of children, youth, and families, and their location if in custody;
- (2) All written reports of child abuse and neglect; and
- (3) All current records required to be maintained under the provisions of chapter 72 of this title.

History of Section.

(P.L. 1979, ch. 248, § 2.)

TITLE 42

State Affairs and Government

CHAPTER 42-73

Child Advocate Office

SECTION 42-73-9

§ 42-73-9. Rights and powers of advocate.

The child advocate shall have the following rights and powers:

- (1) To communicate privately, by mail or orally, with any child in treatment, or under protective services;
- (2) To have access, including the right to inspect, copy and/or subpoena records held by the clerk of the family court, law enforcement, agencies, and institutions, public or private, and other agencies, or persons with whom a particular child has been either voluntarily or otherwise placed for care, or has received treatment within or without the state;
- (3) To take whatever steps are appropriate to see that persons are made aware of the services of the child advocate's office, its purpose, and how it can be contacted;
- (4) To apply for and accept grants, gifts and bequests of funds from other states, federal and interstate agencies and independent authorities, and private firms, individuals and foundations, for the purpose of carrying out his or her lawful responsibilities. The funds shall be deposited with the general treasurer in a restricted receipt account established within the office to permit funds to be expended in accordance with the provisions of the grant or bequest; and
- (5) To exercise the powers conferred upon a trustee pursuant to the provisions of § 18-4-2 and to be exempt from the provisions of chapter 15 of title 33.

History of Section.

(P.L. 1979, ch. 248, § 2; P.L. 1992, ch. 317, § 2.)