HPIO Addiction Evidence Project

Detailed policy scorecard

November 2018

Overdose reversal and other forms of harm reduction

Purpose and overview

This detailed policy scorecard provides information about addiction-related policy changes enacted in Ohio from January 2013 to May 2018. The scorecard:

- Describes the current status of evidence-based policies, programs and practices in Ohio
- Rates the extent to which these policies and programs align with evidence on what works
- Rates the extent to which these policies and program are reaching Ohioans in need
- Identifies opportunities for improvement

For a summary of the scorecard's key findings and a description of the scorecard methodology, see the **full report**.

This document contains the following sections:

- Definitions of the detailed scorecard rating levels and a list of acronyms
- Tables that describe Ohio's implementation of evidence-based policies, programs and practices
- Tables that list the sources of evidence used to develop this scorecard

Definition of scorecard levels

	Ohio alignment with evidence	Extent of implementation reach in Ohio
Strong	Services, programs and policies being implemented in Ohio are highly consistent with the most rigorously-evaluated and effective evidence-based approaches in this category.	Services and programs are being implemented throughout the entire state (statewide or > 80 counties) and are reaching a majority of intended groups of Ohioans. Policies are being monitored, implemented and enforced as intended.
Moderate	Services, programs and policies being implemented in Ohio are mostly consistent with recommended evidence-based approaches in this category.	Services and programs are being implemented in at least 40-80 counties and/ or are reaching large numbers of intended groups of Ohioans. Policies are likely being implemented and enforced as intended, although rigorous monitoring information may not be available.
Mixed	Some services, programs or policies being implemented in Ohio have moderate or weak alignment with evidence, but a significant number of services, programs or policies being implemented have weak alignment.	Within this category, Ohio is implementing some services or programs with "strong" or "moderate" implementation reach (defined above), but is also implementing a significant number of services or programs with "weak" implementation reach (defined below). Some policies are being implemented as intended and enforced, while others are not.
Weak	Services, programs and policies being implemented in Ohio are not consistent with recommended evidence-based approaches within this category.	Services and programs are being implemented in fewer than 40 counties and/or are only reaching a small proportion of intended groups of Ohioans. Policies are not being implemented as intended and/or are not being enforced.
Unknown/ More information needed	Adequate information to determine evidence alignment is not currently available.*	Adequate information to determine implementation reach is not currently available.*

*Note that this information may be available within specific counties, but is not available for an overall statewide basis.

Acronyms

General terms

Blood alcohol concentration (BAC)
Deaths Avoided with Naloxone (DAWN)
Direct-acting antivirals (DAAs)
General Assembly (GA)
Hepatitis C Virus (HCV)
House Bill (HB)
Human Immunodeficiency Virus (HIV)
Morphine Equivalent Dose (MED)
Ohio Administrative Code (OAC)
Operating a Vehicle Under Influence (OVI)
Syringe services program (SSP)
Terminal Distributor of Dangerous Drugs (TDDD)

Government agencies and data sources

State/local

Ohio Department of Administrative Services (DAS)
Ohio Department of Health (ODH)
Ohio Department of Medicaid (ODM)
Ohio Department of Mental Health and Addiction Services (OMHAS)
Ohio Department of Public Safety (DPS)
Ohio Department of Rehabilitation and Correction (DRC)
Ohio Public Employees Retirement System (OPERS)

Federal

Behavioral Risk Factor Surveillance System (BRFSS)
Centers for Disease Control and Prevention (CDC)
US Preventive Service Task Force (USPSTF)

Overdose reversal

Table 1. **Naloxone distribution, access and awareness**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Naloxone education, outreach and distribution	**Strong evidence alignment** / **Moderate implementation reach** • Project DAWN, Ohio's opioid overdose education and naloxone distribution program, is well-established in the state and has existed since 2012. • The program provides training on overdose prevention and naloxone use. Naloxone is also available through walk-in sites and pharmacies. • Project DAWN distributes naloxone to individuals regardless of their insurance status or ability to pay. • There are Project DAWN sites in 59 counties (as of Oct. 24, 2018), and five counties with high overdose death rates do not have Project DAWN sites.	• Increase the number of Project DAWN sites, including innovative delivery methods to reach populations at highest risk for overdose (i.e., jails, drug courts, etc.) • Establish Project DAWN sites in all counties with high overdose death rates, including Darke, Fayette, Huron, Pike and Preble counties • Improve tracking of distribution and use of naloxone to evaluate effectiveness of current distribution system • Improve awareness of publicly available naloxone • Integrate Project DAWN sites with other services for populations at risk (i.e., hepatitis C and HIV testing) • Identify models to increase the sustainability of the Project DAWN program, including billing services to insurers
Required co-prescribing of naloxone with prescription for any controlled opioid	**Moderate evidence alignment** / **Strong implementation reach** • There is currently no co-prescribing requirement in Ohio. • In May 2018, Governor Kasich **announced** that the administration will implement rules that will establish new thresholds for monitoring opioid prescribing. When a patient is being prescribed 80 MED, clinicians will be required to look for signs of prescription misuse, consult with a specialist, obtain a written pain-management agreement and consider a co-prescription for naloxone. • The Medical, Nursing and Dental Boards have been charged with writing the rules, which are expected to go into effect in fall 2018.	• Ensure that the new rules emphasize the importance of co-prescribing • Consider adding a requirement to co-prescribe

Table 1. **Naloxone distribution, access and awareness** (cont.)

Evidence-based policy, program or practice*	Ohio status (brief description of Ohio implementation)**	Opportunities for improvement
Insurance coverage of naloxone Require private insurers to reimburse for naloxone and include naloxone on Medicaid preferred drug list	**Weak evidence alignment** / **Unknown implementation reach** • There is no state law requiring private insurers to cover naloxone. • It is possible that some private insurers cover naloxone. • Naloxone is not on the **2018 Ohio Medicaid Preferred Drug List**. • However, Ohio Medicaid does reimburse for naloxone and naloxone is also included on the Medicaid **list of drugs covered without prior authorization**. • All Medicaid Managed Care Plans, except Buckeye Health Plan, pay for all formulations of naloxone (intranasal, intramuscular and auto-injector) when dispensed to a plan member. Buckeye Health Plan covers the intranasal formulation only.	• Require private insurers to cover naloxone without prior authorization • Require private insurers to cover patient co-pays for naloxone • Add naloxone to the Ohio Medicaid Preferred Drug List • Require all Medicaid Managed Care Plans to cover injectable and intranasal formulations of naloxone
Lay distribution and possession without a prescription Allow laypersons (family and friends) to obtain and administer naloxone and supply them with adequate supply of medication; allow possession without a prescription	**Strong evidence alignment** / **Moderate implementation reach** • Ohio's Medicaid program covers naloxone for use in overdose reversal by laypersons. • HB 4 (131st GA) allows physicians to authorize delegates to distribute naloxone to individuals at risk of an opioid related overdose or friends and family members of individuals at risk. This allows community organizations to distribute naloxone without a TDDD license. • Physicians in Ohio can also authorize pharmacists and pharmacist interns under their supervision to dispense naloxone under a protocol. Pharmacists and pharmacist interns under a physician protocol can dispense naloxone without a prescription. • There are **pharmacies** in 87 counties that are able to dispense naloxone under a physician protocol. • Not all participating pharmacies have naloxone in stock or have trained all staff to know that naloxone can be dispensed under the protocol (see **Cleveland Plain Dealer article**). • In response to this concern, the Ohio Board of Pharmacy has developed rules related to the training of pharmacy staff (OAC 4729:1-3-04 and 4729:2-3-04), which are currently pending.	• Increase awareness among drug users and their family members and friends of availability of naloxone through pharmacies (via physician protocols) and community organizations (via physician delegates) • Increase awareness among community organizations that the physician delegate system may allow them to distribute naloxone without a TDDD license • Establish a statewide standing order so that all pharmacists and pharmacist interns in Ohio could prescribe naloxone without a prescription and without the need for physician protocols
Third party prescribing permitted	**Strong evidence alignment** / **Unknown implementation reach** • HB 170 (130th GA) specified that physicians, physician assistants, clinical nurse specialists, certified nurse-midwifes and certified nurse practitioners can prescribe naloxone to a friend or family member without having examined the individual to whom it may be administered. • More information is needed on how many clinicians are prescribing to friends and family.	Create e-prescribing requirements for controlled substances, similar to New York's electronic prescribing of controlled substances requirement

Table 1. **Naloxone distribution, access and awareness** (cont.)

Evidence-based policy, program or practice*	**Ohio status** (brief description of Ohio implementation)**	Opportunities for improvement
Allow organizations not otherwise permitted to dispense prescription medications (including SSPs) to obtain, store and dispense naloxone	**Moderate evidence alignment** / **Weak implementation reach** • In Ohio, individuals and entities typically must have a TDDD license in order to possess or control dangerous drugs for any purpose other than personal use or consumption. • With respect to purchasing and possessing naloxone, **law enforcement agencies** are exempt from licensure as TDDDs. • Additionally, **service entities** (i.e., colleges and universities, local health departments, community addiction services providers, courts, prisons, jails, homeless shelters, etc.) who are not licensed TDDDs may purchase naloxone for emergency use, but are not permitted to distribute.	• Increase training and awareness for service entities to encourage widespread and appropriate use of naloxone • Allow service entities to distribute naloxone without a TDDD license or provide assistance to entities so that they can obtain a TDDD license • Develop guidance for different types of service entities to increase naloxone distribution

*As identified in the HPIO **Evidence Resource Page: Overdose reversal and other forms of harm reduction**
**As of May 2018, as identified in the Ohio policy inventory in this report and information from state agencies. Note that the inventory includes policy changes enacted in Jan. 2013 to May 2018. Some policies prior to 2013 are included when highly relevant.

Table 2. **Immunity for naloxone prescribing and dispensing and Good Samaritan law**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Immunity for prescribers and dispensers	**Strong evidence alignment** | **Strong implementation reach** • Ohio law provides civil, criminal and disciplinary immunity for medical professionals who dispense or personally furnish naloxone in good faith without a prescription. • These immunities extend to physicians, physician-authorized individuals, pharmacists, pharmacy interns and boards of health.	Maintain this law and evaluate implementation and effectiveness
Immunity for emergency responders	**Strong evidence alignment** | **Strong implementation reach** • A law enforcement officer is not subject to administrative action or criminal prosecution if the peace officer, acting in good faith, administers naloxone to an individual who is apparently experiencing an opioid-related overdose. • Law enforcement officers also have civil immunity for any injury, death or loss to person or property that may arise from obtaining, maintaining, accessing or administering naloxone.	Maintain this law and evaluate implementation and effectiveness
Immunity for lay administrators	**Moderate evidence alignment** | **Strong implementation reach** • An individual who assists someone in an opioid-related overdose is not subject to criminal prosecution if they administer naloxone that they obtained from a licensed healthcare professional and call emergency services immediately before or immediately after administering the naloxone. • There is no civil immunity for lay administrators of naloxone.	Extend civil immunity to lay administrators of naloxone

Table 2. **Immunity for naloxone prescribing and dispensing and Good Samaritan law** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Good Samaritan law: Immunity for controlled substance possession	**Moderate evidence alignment**	**Weak implementation reach**	Assess the impact of Ohio's Good Samaritan law, including the restrictions on Good Samaritan immunity, and adjust the law as needed so that bystanders are encouraged to call for help during an overdose Potential improvements include: • Expand the range of drug possession offenses that are covered • Evaluate the impact of Ohio's Good Samaritan law, particularly on the connection between overdose, screening and treatment • If the evaluation results are negative, meaning that people who overdose are not being screened and entering treatment within 30 days, consider removing 30 day requirement so that more people have access to immunity • Remove the provision of Ohio's Good Samaritan law that limits the number of times a person can be granted immunity • Include people who are on community control or post-release control among people who can be granted immunity • Increase public education about Ohio's Good Samaritan law so that people know that immunity may be available to them.
	• **Ohio's Good Samaritan law** provides immunity from arrest, charge and prosecution for a minor drug possession offense for individuals who seek medical help for their own or another person's drug overdose. The person who has overdosed also has immunity from minor drug possession offenses. • Immunity is only granted if the person seeking immunity, within 30 days of seeking or obtaining assistance, "seeks and obtains a screening and receives a referral for treatment." • The Good Samaritan law applies only to individuals who have been previously granted immunity under the law not more than twice. People in community control or post-release control do not qualify for immunity. • Ohio law also requires EMS personnel or firefighters to disclose to law enforcement, upon request, the name and address of any person to whom they administered naloxone.		

Table 2. **Immunity for naloxone prescribing and dispensing and Good Samaritan law** (cont.)

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Good Samaritan law: Immunity for paraphernalia	**Weak evidence alignment**	**Weak implementation reach**	Strengthen Ohio's Good Samaritan law by including immunity for paraphernalia
	Ohio does not have Good Samaritan immunity for possession of drug paraphernalia.		
Good Samaritan law: Immunity for other violations	**Weak evidence alignment**	**Weak implementation reach**	Strengthen Ohio's Good Samaritan law by including immunity for other violations, such as violating a protective or restraining order or pretrial, probation or parole violations
	There are no other Good Samaritan laws in Ohio for offenses such as: • Violation of a protective or restraining order • Pretrial, probation or parole violations • Other crimes		
Good Samaritan law: Reporting mitigating factor and civil forfeiture	**Moderate evidence alignment**	**Moderate implementation reach**	Strengthen Ohio's Good Samaritan law by including protection from civil forfeiture
	• Reporting an overdose is a mitigating factor in Ohio for people with two types of sanctions: community control sanctions (i.e., community-based correctional facilities, drug and alcohol treatment and house arrest) and post-release control sanctions (i.e., parole). • If a person violates a community control sanction or a post-release control sanction because they were either seeking medical assistance for someone experiencing a drug overdose, or because they were experiencing a drug overdose themselves, the court or parole board must consider mitigating their penalty or ordering the person to participate in a drug treatment program, whichever is applicable. • Ohio does not provide protection from civil forfeiture for individuals who assist someone experiencing an overdose or experience an overdose themselves.		

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Overdose reversal

Table 3. **Syringe services programs (SSPs)**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Access to sterile syringes/needles, such as through SSPs	**Moderate evidence alignment**	**Weak implementation reach**	• Increase the number of SSPs in Ohio, particularly in counties with the highest rates of hepatitis C and HIV • Identify sustained funding sources to support SSPs and explore ways to capture downstream savings to ODM and DRC to reinvest in infection prevention • Establish a statewide coordination hub for SSPs that can assist local programs with information sharing, technical assistance, evaluation and quality improvement • Develop a campaign to reduce stigma for harm reduction approaches, including SSPs
	• As of 2015 (HB 64), local health departments may establish a bloodborne infectious disease prevention program, ostensibly allowing for establishment of SSPs if warranted by community conditions. • Employees and volunteers in these prevention programs, and participants within 1,000 feet of the program facility, are not subject to criminal prosecution regarding possession of drug paraphernalia (i.e. syringes). • As of Nov. 2018, **18 Ohio counties had SSPs**. Prior to 2018, there were 4 SSPs operating in Ohio communities under emergency authority. • In July 2018, ODH submitted a "Determination of Need" (DON) letter to the CDC, requesting the opportunity to use existing federal funds to support SSPs. Thirty-three other states and territories have already requested and been approved for a DON, including all of Ohio's bordering states. • The DON was subsequently approved by CDC, which may result in additional resources for SSPs in the future.		
Law allowing legal sale of needles without a prescription	**Weak evidence alignment**	**Weak implementation reach**	Allow the purchase of needles without a prescription
	Ohio law requires a prescription to obtain needles.		
Remove syringes from list of illegal drug paraphernalia	**Weak evidence alignment**	**Weak implementation reach**	Remove syringes from Ohio's list of illegal drug paraphernalia
	Under Ohio law (ORC 2925.14), needles and syringes for injecting controlled substances are considered to be drug paraphernalia.		

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Table 4. **Hepatitis C and HIV screening and treatment**

Evidence-based policy, program or practice*	Ohio status**	Opportunities for improvement
Insurance coverage of hepatitis C screening	**Strong evidence alignment** / **Strong implementation reach** • The Affordable Care Act requires most health insurance plans to cover preventive services recommended by USPSTF without imposing patient cost sharing. • USPSTF recommends screening for hepatitis C infection in persons at high risk for infection (B-level recommendation).	Increase awareness of the importance of hepatitis C screening among high-risk patients and their healthcare providers
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	**Weak evidence alignment** / **Unknown implementation reach** • There are no significant, statewide efforts led by ODH, OMHAS or ODM to increase awareness, prevention, screening or treatment of hepatitis C. • Starting in mid-2018, ODH is funding Federally Qualified Health Centers in three counties in southern Ohio to implement a hepatitis C prevention program.	• Launch intensive initiative to prevent hepatitis C transmission and reinfection, including awareness of the importance of prevention, treatment and harm reduction • Create an integrated state plan to reduce hepatitis C transmission and reinfection, similar to the Ohio HIV Prevention and Care Integrated Plan
Access to hepatitis C treatment medications (DAAs): Medicaid	**Moderate evidence alignment** / **Unknown implementation reach** Ohio Medicaid **currently has several restrictions** on access to DAAs: • Fibrosis score (patients must have moderate or severe liver damage) • Sobriety restrictions • Prescriber restrictions (must be prescribed by or in consultation with a specialist) Specific restrictions vary for Fee-for-Service and managed care plans. However, in November 2018, ODM issued a policy change that will eliminate the fibrosis score restriction. Starting January 1, 2019, all Medicaid patients who have been diagnosed with hepatitis C will have access to DAAs, as long as they meet the sobriety and prescriber restrictions.	• Monitor and evaluate the elimination of the fibrosis score restriction and its impact on hepatitis C access and infection rates • Continue to improve access to hepatitis C treatment for Medicaid enrollees by removing or reducing restrictions related to sobriety timeframes and provider restrictions • Engage primary care providers, including FQHCs, in providing DAA treatment for patients with hepatitis C • Implement one or more of the strategies identified by the National Governor's Association to ensure fiscal sustainability of hepatitis C treatment in the Medicaid program, such as: ◦ Consider options for excluding select drugs from Medicaid coverage to strengthen state negotiating power on drug prices ◦ Determine and pay value-based prices for assessments into policies and purchasing approaches

Table 4. **Hepatitis C and HIV screening and treatment** (cont.)

Access to hepatitis C treatment medications (DAAs): State employees and state retirees	**Strong evidence alignment**	**Strong implementation reach**	Maintain coverage for DAAs and explore strategies for reducing pharmaceutical costs (see above)
	• DAS and OPERS have fewer restrictions on DAA access than Ohio Medicaid. • DAAS must be prescribed by a specialist or in consultation with a specialist. • There is no liver damage (fibrosis) restriction or sobriety restriction.		
HIV screening, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	**Moderate evidence alignment**	**Weak implementation reach**	• Increase overall screening for HIV in accordance with USPSTF recommendation • Continue to implement the Ohio HIV Prevention and Care Integrated Plan • Utilize SSPs and other prevention efforts to focus HIV screening on the populations at greatest risk for exposure, including injection drug users
	• USPSTF recommends that all adolescents and adults 15 to 65 years old receive a screen for HIV infection (A-level recommendation). • In 2017, **34 percent** of adult Ohioans reported that they had ever been tested for HIV (BRFSS). • In 2016, ODH led the creation of the Ohio HIV Prevention and Care Integrated Plan, 2017-2021. The integrated plan addresses the needs, gaps, and barriers to HIV prevention and treatment within the state. • In the 2018-2019 budget, the state of Ohio dedicated all GRF spending for HIV (about $6 million in SFY 2018-2019) to HIV prevention, including education, training and screening. These GRF funds may be spent on SSPs. • The DON that ODH submitted to the CDC also allows some Ryan White and federal prevention funds to support HIV-specific services within SSPs.		

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Table 5. **Other harm reduction strategies**

Evidence-based policy, program or practice*	Ohio status**		Opportunities for improvement
Housing First programs	**Strong evidence alignment**	**Moderate implementation reach**	Extend the reach of Permanent Supportive Housing and the Housing First model to more counties
	• Housing First addresses chronic homelessness by providing rapid access to permanent housing without pre-condition of addiction treatment. • The Ohio Housing Finance Agency develops a Qualified Allocation Plan (QAP) each biennium, which sets out the procedures and policies for distributing Ohio's allocation of housing credits. There is a pool of funding in the QAP dedicated toward Permanent Supportive Housing, which utilizes a Housing First model. There is approximately $4.5 million available for Permanent Supportive Housing in the 2018-2019 QAP. • 43 counties in Ohio have at least one Permanent Supportive Housing development.		

Table 5. **Other harm reduction strategies** (cont.)

Publicized sobriety checkpoint programs	**Strong evidence alignment** **Unknown implementation reach** • Sobriety checkpoints are police stops in which law enforcement officers stop random vehicles to check for impaired and intoxicated driving. • Sobriety checkpoints are implemented by the Ohio State Highway Patrol, county sheriffs, city police and other law enforcement agencies. • Information about the number and location of sobriety checkpoints is not collected uniformly at the state level.	Track the number of sobriety checkpoints conducted throughout the state and identify counties with high motor vehicle death rates that would benefit from increased sobriety checkpoint programs
Ignition interlocks	**Moderate evidence alignment** **Strong implementation reach** • Ignition interlocks are devices that can be installed in vehicles to prevent operation by a driver who has a BAC above a specified level. • Ignition interlock installation is mandated via a court order, and DPS has a list of approved interlock systems and locations to have them installed. • Ohio requires ignition interlocks for repeat offenders convicted of alcohol-impaired driving, but ignition interlocks may be imposed for a first offense.	Require ignition interlocks for first offense of impaired driving, as **recommended by the CDC**
0.08% Blood Alcohol Concentration (BAC) laws	**Strong evidence alignment** **Strong implementation reach** • Ohio has implemented a 0.08% BAC law, meaning individuals age 21 or over may not drive a vehicle, streetcar or trackless trolley in the state while their BAC is over 0.08%. • Penalties for violating Ohio's 0.08% BAC law may include jail time, fines and penalties, license suspension and interlock ignition device installation.	Maintain this law
Lower BAC for younger drivers	**Strong evidence alignment** **Strong implementation reach** • In addition to Ohio's 0.08% BAC law for drivers over 21, the legal BAC limit for commercial drivers and drivers under age 21 is 0.02%. • If a person under 21 has an alcohol test results over 0.02% but under 0.08%, they are charged with Operating a Vehicle after Underage Consumption (OVUC). • If the test is over 0.08%, the driver can be charged with OVI.	Maintain this law

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Evidence sources

Overdose reversal

Table 6. **Naloxone distribution, access and awareness**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Naloxone education, outreach and distribution	What Works for Health, County Health Rankings and Roadmaps, 2017	Naloxone education and distribution programs
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Required co-prescribing of naloxone with prescription for any controlled opioid	American Medical Association, 2017	Help save lives: Co-prescribe naloxone to patients at risk of overdose
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Insurance coverage of naloxone Require private insurers to reimburse for naloxone and include naloxone on Medicaid preferred drug list	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
	National Safety Council, 2018	Prescription Nation 2018: Facing America's Opioid Epidemic
Lay distribution and possession without a prescription Allow laypersons (family and friends) to obtain and administer naloxone and supply them with adequate supply of medication; allow possession without a prescription	The Network for Public Health Law, 2017	Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws
	National Academies of Sciences, Engineering and Medicine, 2017	Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Third party prescribing permitted	The Network for Public Health Law, 2017	Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws
	National Academies of Sciences, Engineering and Medicine, 2017	Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use
	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers
Allow organizations not otherwise permitted to dispense prescription medications (including SSPs) to obtain, store and dispense naloxone	The National Center on Addiction and Substance Abuse, 2017	Ending the Opioid Crisis: A Practical Guide for State Policymakers

Table 7. **Immunity for naloxone prescribing and dispensing and Good Samaritan law**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Immunity for prescribers and dispensers	The Network for Public Health Law, 2017	**Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws**
	National Academies of Sciences, Engineering and Medicine, 2017	**Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use**
Immunity for emergency responders	National Academies of Sciences, Engineering and Medicine, 2017	**Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use**
Immunity for lay administrators	The Network for Public Health Law, 2017	**Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws**
Good Samaritan law: Immunity for controlled substance possession	The Network for Public Health Law, 2017	**Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws**
	National Academies of Sciences, Engineering and Medicine, 2017	**Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use**
Good Samaritan law: Immunity for paraphernalia	The Network for Public Health Law, 2017	**Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws**
Good Samaritan law: Immunity for other violations		
Good Samaritan law: Reporting mitigating factor and civil forfeiture		

Other forms of harm reduction

Table 8. **Syringe service programs (SSPs)**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Access to sterile syringes/needles, such as through SSPs	Institute of Medicine (now the National Academies of Sciences, Engineering and Medicine), 2010	**Hepatitis and liver cancer: A national strategy for prevention and control of hepatitis B and C (Recommendation 5-3)**
	Centers for Disease Control and Prevention, 2016	**Health Impact in 5 Years (Hi-5), Access to Clean Syringes**
Law allowing legal sale of needles without a prescription	Centers for Disease Control and Prevention, 2016	**Health Impact in 5 Years (Hi-5), Access to Clean Syringes**
Remove syringes from list of illegal drug paraphernalia		

Table 9. **Hepatitis C and HIV screening and treatment**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Insurance coverage of hepatitis C screening	U.S. Preventive Services Task Force, 2013	Final Recommendation Statement Hepatitis C: Screening
Hepatitis C screening education and awareness, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)		
Access to hepatitis C treatment medications (DAAs): Medicaid	American Association for the Study of Liver Diseases and Infectious Diseases Society of America, 2017	HCV guidance: Recommendations for testing, managing and treating h epatitis C
	Centers for Medicare and Medicaid Services, 2015	Medicaid drug rebate program notice: Assuring Medicaid beneficiaries access to hepatitis C (HCV) drugs
Access to hepatitis C treatment medications (DAAs): State employees and state retirees	American Association for the Study of Liver Diseases and Infectious Diseases Society of America, 2017	HCV guidance: Recommendations for testing, managing and treating hepatitis C
	Centers for Medicare and Medicaid Services, 2015	Medicaid drug rebate program notice: Assuring Medicaid beneficiaries access to hepatitis C (HCV) drugs
HIV screening, particularly for people at high risk, including injection drug users (consistent with USPSTF recommendation)	U.S. Preventive Services Task Force, 2016	Final Recommendation Statement Human Immunodeficiency Virus (HIV) Infection: Screening

Table 10. **Motor vehicle injury due to alcohol-impaired driving**

Evidence-based policy, program or practice	Evidence sources	
	Organization and year	Report, guideline or evidence registry
Housing First programs	What Works for Health, County Health Rankings and Roadmaps, 2016	Housing First
Publicized sobriety checkpoint programs	Community Guide, CDC, 2012	Motor vehicle injury- Alcohol-impaired driving: Publicized sobriety checkpoint programs
Ignition interlocks	Community Guide, CDC, 2006	Motor vehicle injury- Alcohol-impaired driving: Ignition interlocks
	Prevention Status Reports, CDC, 2016	Ignition interlock law
0.08% Blood Alcohol Concentration (BAC) laws	Community Guide, CDC, 2000	Motor vehicle injury- Alcohol-impaired driving: 0.08% Blood Alcohol Concentration Laws
Lower BAC for younger drivers	Community Guide, CDC, 2000	Motor vehicle injury- Alcohol-impaired driving: Lower BAC laws for young or inexperienced drivers