

115TH CONGRESS  
2D SESSION

# S. 2680

To address the opioid crisis.

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IN THE SENATE OF THE UNITED STATES

APRIL 16, 2018

Mr. ALEXANDER (for himself and Mrs. MURRAY) introduced the following bill;  
which was read twice and referred to the Committee on Health, Edu-  
cation, Labor, and Pensions

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## A BILL

To address the opioid crisis.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Opioid Crisis Response Act of 2018”.

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

Sec. 1. Short title; table of contents.

TITLE I—REAUTHORIZATION OF CURES FUNDING

Sec. 101. State response to the opioid abuse crisis.

TITLE II—RESEARCH AND INNOVATION

Sec. 201. Advancing cutting-edge research.

Sec. 202. Pain research.

TITLE III—MEDICAL PRODUCTS AND CONTROLLED SUBSTANCES  
SAFETY

- Sec. 301. Clarifying FDA regulation of non-addictive pain products.
- Sec. 302. Clarifying FDA packaging authorities.
- Sec. 303. Strengthening FDA and CBP coordination and capacity.
- Sec. 304. Clarifying FDA post-market authorities.
- Sec. 305. First responder training.
- Sec. 306. Disposal of controlled substances of a deceased hospice patient by employees of a hospice program.
- Sec. 307. GAO study and report on hospice safe drug management.
- Sec. 308. Delivery of a controlled substance by a pharmacy to be administered by injection, implantation, or intrathecal pump.

TITLE IV—TREATMENT AND RECOVERY

- Sec. 401. Comprehensive opioid recovery centers.
- Sec. 402. Program to support coordination and continuation of care for drug overdose patients.
- Sec. 403. Alternatives to opioids.
- Sec. 404. Peer support technical assistance.
- Sec. 405. Medication-assisted treatment for recovery from addiction.
- Sec. 406. National recovery housing best practices.
- Sec. 407. Addressing economic and workforce impacts of the opioid crisis.
- Sec. 408. Youth prevention and recovery.
- Sec. 409. Plans of safe care.
- Sec. 410. Regulations relating to special registration for telemedicine.
- Sec. 411. National Health Service Corps behavioral and mental health professionals providing obligated service in schools and other community-based settings.
- Sec. 412. Loan repayment for substance use disorder treatment providers.
- Sec. 413. Improving treatment for pregnant and postpartum women.
- Sec. 414. Early interventions for pregnant women and infants.

TITLE V—PREVENTION

- Sec. 501. Study on prescribing limits.
- Sec. 502. Programs for health care workforce.
- Sec. 503. Education and awareness campaigns.
- Sec. 504. Enhanced controlled substance overdoses data collection, analysis, and dissemination.
- Sec. 505. Preventing overdoses of controlled substances.
- Sec. 506. CDC surveillance and data collection for child, youth, and adult trauma.
- Sec. 507. Reauthorization of NASPER.
- Sec. 508. Jessie's Law.
- Sec. 509. Development and dissemination of model training programs for substance use disorder patient records.
- Sec. 510. Communication with families during emergencies.
- Sec. 511. Prenatal and postnatal health.
- Sec. 512. Surveillance and education regarding infections associated with injection drug use and other risk factors.
- Sec. 513. Task force to develop best practices for trauma-informed identification, referral, and support.

Sec. 514. Grants to improve trauma support services and mental health care  
for children and youth in educational settings.

Sec. 515. National Child Traumatic Stress Initiative.

1 **TITLE I—REAUTHORIZATION OF**  
2 **CURES FUNDING**

3 **SEC. 101. STATE RESPONSE TO THE OPIOID ABUSE CRISIS.**

4 (a) IN GENERAL.—Section 1003 of the 21st Century  
5 Cures Act (Public Law 114–255) is amended—

6 (1) in subsection (a)—

7 (A) by striking “the authorization of ap-  
8 propriations under subsection (b) to carry out  
9 the grant program described in subsection (c)”  
10 and inserting “subsection (h) to carry out the  
11 grant program described in subsection (b)”;  
12 and

13 (B) by inserting after “and Indian tribes”  
14 after “States”;

15 (2) by striking subsection (b);

16 (3) by redesignating subsections (c) through (e)  
17 as subsections (b) through (d), respectively;

18 (4) by redesignating subsection (f) as sub-  
19 section (j);

20 (5) in subsection (b), as so redesignated—

21 (A) in paragraph (1)—

22 (i) in the paragraph heading, by in-  
23 sserting “AND INDIAN TRIBE” after  
24 “STATE”;

1 (ii) by striking “States for the pur-  
2 pose of addressing the opioid abuse crisis  
3 within such States” and inserting “States  
4 and Indian tribes for the purpose of ad-  
5 dressing the opioid abuse crisis within such  
6 States and Indian tribes”;

7 (iii) by inserting “or Indian tribes”  
8 after “preference to States”; and

9 (iv) by inserting before the period of  
10 the second sentence “or other Indian  
11 tribes, as applicable”; and

12 (B) in paragraph (2)—

13 (i) in the matter preceding subpara-  
14 graph (A), by striking “to a State”;

15 (ii) in subparagraph (A), by striking  
16 “State”;

17 (iii) in subparagraph (C), by inserting  
18 “preventing diversion of controlled sub-  
19 stances,” after “treatment programs,”;  
20 and

21 (iv) in subparagraph (E), by striking  
22 “as the State determines appropriate, re-  
23 lated to addressing the opioid abuse crisis  
24 within the State” and inserting “as the  
25 State or Indian tribe determines appro-

1            puate, related to addressing the opioid  
2            abuse crisis within the State, including di-  
3            recting resources in accordance with local  
4            needs related to substance use disorders”;

5            (6) in subsection (c), as so redesignated, by  
6            striking “subsection (c)” and inserting “subsection  
7            (b)”;

8            (7) in subsection (d), as so redesignated—

9            (A) in the matter preceding paragraph (1),  
10           by striking “the authorization of appropriations  
11           under subsection (b)” and inserting “subsection  
12           (h)”;

13           (B) in paragraph (1), by striking “sub-  
14           section (c)” and inserting “subsection (b)”;

15           (8) by inserting after subsection (d), as so re-  
16           designated, the following:

17           “(e) INDIAN TRIBES.—

18           “(1) DEFINITION.—For purposes of this sec-  
19           tion, the term ‘Indian tribe’ has the meaning given  
20           such term in section 4 of the Indian Self-Determina-  
21           tion and Education Assistance Act (25 U.S.C.  
22           5304).

23           “(2) APPROPRIATE MECHANISMS.—The Sec-  
24           retary, in consultation with Indian tribes, shall iden-  
25           tify and establish appropriate mechanisms for tribes

1 to demonstrate or report the information as required  
2 under subsections (b), (c), and (d).

3 “(f) REPORT TO CONGRESS.—Not later than 1 year  
4 after the date on which amounts are first awarded, after  
5 the date of enactment of the Opioid Crisis Response Act  
6 of 2018, pursuant to subsection (b), and annually there-  
7 after, the Secretary shall submit to the Committee on  
8 Health, Education, Labor, and Pensions of the Senate and  
9 the Committee on Energy and Commerce of the House  
10 of Representatives a report summarizing the information  
11 provided to the Secretary in reports made pursuant to  
12 subsection (c), including the purposes for which grant  
13 funds are awarded under this section and the activities  
14 of such grant recipients.

15 “(g) TECHNICAL ASSISTANCE.—The Secretary, in-  
16 cluding through the Tribal Training and Technical Assist-  
17 ance Center of the Substance Abuse and Mental Health  
18 Services Administration, shall provide State agencies and  
19 Indian tribes, as applicable, with technical assistance con-  
20 cerning grant application and submission procedures  
21 under this section, award management activities, and en-  
22 hancing outreach and direct support to rural and under-  
23 served communities and providers in addressing the opioid  
24 crisis.

1       “(h) AUTHORIZATION OF APPROPRIATIONS.—For  
2 purposes of carrying out the grant program under sub-  
3 section (b), there are authorized to be appropriated  
4 \$500,000,000 for each of fiscal years 2019 through 2021,  
5 to remain available until expended.

6       “(i) SET ASIDE.—Of the amounts made available for  
7 each fiscal year to award grants under subsection (b) for  
8 a fiscal year, 5 percent of such amount for such fiscal year  
9 shall be made available to Indian tribes, and up to 15 per-  
10 cent of such amount for such fiscal year may be set aside  
11 for States with the highest age-adjusted mortality rate as-  
12 sociated with opioid use disorders based on the ordinal  
13 ranking of States according to the age-adjusted overdose  
14 mortality rates of the Centers for Disease Control and  
15 Prevention.”.

16       (b) PREVIOUSLY APPROPRIATED AMOUNTS.—

17           (1) APPROPRIATION OF AMOUNTS REMAINING  
18 IN ACCOUNT.—Any unobligated amounts remaining,  
19 on the date of enactment of this Act, in the Account  
20 For the State Response to the Opioid Abuse Crisis  
21 established under section 1003(b) of the 21st Cen-  
22 tury Cures Act (Public Law 114–255) (as in effect  
23 on the day before the date of enactment of this Act)  
24 are hereby appropriated to the Secretary of Health  
25 and Human Services for purposes of carrying out

1 the grant program under subsection (b) of section  
 2 1003 of the 21st Century Cures Act (Public Law  
 3 114–255) (as redesignated by subsection (a)(3) of  
 4 this section).

5 (2) AVAILABLE UNTIL EXPENDED.—Amounts  
 6 appropriated under paragraph (1) of this subsection  
 7 or section 1003(b)(3) of the 21st Century Cures Act  
 8 (as in effect on the day before the date of enactment  
 9 of this Act) shall remain available until expended.

10 (c) CONFORMING AMENDMENT.—Section 1004(c) of  
 11 the 21st Century Cures Act (Public Law 114–255) is  
 12 amended by striking “, the FDA Innovation Account, or  
 13 the Account For the State Response to the Opioid Abuse  
 14 Crisis” and inserting “or the FDA Innovation Account”.

## 15 **TITLE II—RESEARCH AND** 16 **INNOVATION**

### 17 **SEC. 201. ADVANCING CUTTING-EDGE RESEARCH.**

18 Section 402(n)(1) of the Public Health Service Act  
 19 (42 U.S.C. 282(n)(1)) is amended—

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

21 (2) in subparagraph (B), by striking the period  
 22 and inserting “; or”; and

23 (3) by adding at the end the following:

24 “(C) high impact cutting-edge research  
 25 that fosters scientific creativity and increases

1 fundamental biological understanding leading to  
2 the prevention, diagnosis, or treatment of dis-  
3 eases and disorders, or research urgently re-  
4 quired to respond to a public health threat.”.

5 **SEC. 202. PAIN RESEARCH.**

6 Section 409J(b) of the Public Health Service Act (42  
7 U.S.C. 284q(b)) is amended—

8 (1) in paragraph (5)—

9 (A) in subparagraph (A), by striking “and  
10 treatment of pain and diseases and disorders  
11 associated with pain” and inserting “treatment,  
12 and management of pain and diseases and dis-  
13 orders associated with pain, including informa-  
14 tion on best practices for utilization of non-  
15 pharmacologic treatments, non-addictive med-  
16 ical products, and other drugs approved, or de-  
17 vices approved or cleared, by the Food and  
18 Drug Administration”;

19 (B) in subparagraph (B), by striking “on  
20 the symptoms and causes of pain;” and insert-  
21 ing the following: “on—

22 “(i) the symptoms and causes of pain;

23 “(ii) the diagnosis, prevention, treat-  
24 ment, and management of pain; and

1           “(iii) risk factors for, and early warn-  
2           ing signs of, substance use disorders; and”;  
3           (C) by striking subparagraphs (C) through  
4           (E) and inserting the following:

5           “(C) make recommendations to the Direc-  
6           tor of NIH—

7           “(i) to ensure that the activities of the  
8           National Institutes of Health and other  
9           Federal agencies are free of unnecessary  
10          duplication of effort;

11          “(ii) on how best to disseminate infor-  
12          mation on pain care; and

13          “(iii) on how to expand partnerships  
14          between public entities and private entities  
15          to expand collaborative, cross-cutting re-  
16          search.”;

17          (2) by redesignating paragraph (6) as para-  
18          graph (7); and

19          (3) by inserting after paragraph (5) the fol-  
20          lowing:

21          “(6) REPORT.—The Director of NIH shall en-  
22          sure that recommendations and actions taken by the  
23          Director with respect to the topics discussed at the  
24          meetings described in paragraph (4) are included in  
25          appropriate reports to Congress.”.

1 **TITLE III—MEDICAL PRODUCTS**  
2 **AND CONTROLLED SUB-**  
3 **STANCES SAFETY**

4 **SEC. 301. CLARIFYING FDA REGULATION OF NON-ADDICT-**  
5 **IVE PAIN PRODUCTS.**

6 (a) PUBLIC MEETINGS.—Not later than 1 year after  
7 the date of enactment of this Act, the Secretary of Health  
8 and Human Services (referred to in this section as the  
9 “Secretary”), acting through the Commissioner of Food  
10 and Drugs, shall hold not less than one public meeting  
11 to address the challenges and barriers of developing non-  
12 addictive medical products intended to treat pain or addic-  
13 tion, which may include—

14 (1) the manner by which the Secretary may in-  
15 corporate the risks of misuse and abuse of a con-  
16 trolled substance (as defined in section 102 of the  
17 Controlled Substances Act (21 U.S.C. 802) into the  
18 risk benefit assessment under section 505(e) of the  
19 Federal Food, Drug, and Cosmetic Act (21 U.S.C.  
20 355(e)), section 510(k) of such Act (21 U.S.C.  
21 360(k)), or section 515(e) of such Act (21 U.S.C.  
22 360e(c)), as applicable;

23 (2) the application of novel clinical trial designs  
24 (consistent with section 3021 of the 21st Century  
25 Cures Act (Public Law 114–255)), use of real world

1 evidence (consistent with section 505F of the Fed-  
2 eral Food, Drug, and Cosmetic Act (21 U.S.C.  
3 355g)), and use of patient experience data (con-  
4 sistent with section 569C of the Federal Food,  
5 Drug, and Cosmetic Act (21 U.S.C. 360bbb–8c)) for  
6 the development of non-addictive medical products  
7 intended to treat pain or addiction;

8 (3) the evidentiary standards and the develop-  
9 ment of opioid sparing data for inclusion in the la-  
10 beling of medical products; and

11 (4) the application of eligibility criteria under  
12 sections 506 and 515B of the Federal Food, Drug,  
13 and Cosmetic Act (21 U.S.C. 356, 360e–3) for non-  
14 addictive medical products intended to treat pain or  
15 addiction.

16 (b) GUIDANCE.—Not less than one year after the  
17 public meetings are conducted under subsection (a) the  
18 Secretary shall issue one or more final guidance docu-  
19 ments, or update existing guidance documents, to help ad-  
20 dress challenges to developing non-addictive medical prod-  
21 ucts to treat pain or addiction. Such guidance documents  
22 shall include information regarding—

23 (1) how the Food and Drug Administration  
24 may apply sections 506 and 515B of the Federal  
25 Food, Drug, and Cosmetic Act (21 U.S.C. 356,

1 360e–3) to non-addictive medical products intended  
2 to treat pain or addiction, including the cir-  
3 cumstances under which the Secretary—

4 (A) may apply the eligibility criteria under  
5 such sections 506 and 515B to non-opioid or  
6 non-addictive medical products intended to  
7 treat pain or addiction;

8 (B) considers the risk of addiction of con-  
9 trolled substances approved to treat pain when  
10 establishing unmet medical need; and

11 (C) considers pain, pain control, or pain  
12 management in assessing whether a disease or  
13 condition is a serious or life-threatening disease  
14 or condition;

15 (2) the methods by which sponsors may evalu-  
16 ate acute and chronic pain, endpoints for non-addictive  
17 medical products intended to treat pain, the  
18 manner in which endpoints and evaluations of effi-  
19 cacy will be applied across and within review divi-  
20 sions, taking into consideration the etiology of the  
21 underlying disease, and the manner in which spon-  
22 sors may use surrogate endpoints, intermediate  
23 endpoints, and real world evidence;

24 (3) the manner in which the Food and Drug  
25 Administration will assess evidence to support the

1 inclusion of opioid sparing data in the labeling of  
2 non-addictive medical products intended to treat  
3 pain, including—

4 (A) data collection methodologies, includ-  
5 ing the use of novel clinical trial designs (con-  
6 sistent with section 3021 of the 21st Century  
7 Cures Act (Public Law 114–255)), and real  
8 world evidence (consistent with section 505F of  
9 the Federal Food, Drug, and Cosmetic Act (21  
10 U.S.C. 355g)), as appropriate, to support prod-  
11 uct labeling;

12 (B) ethical considerations of exposing  
13 subjects to controlled substances in clinical  
14 trials to develop opioid sparing data and consid-  
15 erations on data collection methods that reduce  
16 harm, which may include the reduction of  
17 opioid use as a clinical benefit;

18 (C) endpoints, including primary, sec-  
19 ondary, and surrogate endpoints, to evaluate  
20 the reduction of opioid use;

21 (D) best practices for communication be-  
22 tween sponsors and the agency on the develop-  
23 ment of data collection methods, including the  
24 initiation of data collection; and

1 (E) the appropriate format to submit such  
2 data results to the Secretary; and

3 (4) the circumstances under which the Food  
4 and Drug Administration considers misuse and  
5 abuse of drugs in making determinations of safety  
6 under paragraphs (2) and (4) of subsection (d) of  
7 section 505 of the Federal Food, Drug, and Cos-  
8 metic Act (21 U.S.C. 355) and in finding that a  
9 drug is unsafe under paragraph (1) or (2) of sub-  
10 section (e) of such section.

11 (c) DEFINITIONS.—In this section—

12 (1) the term “medical product” means a drug  
13 (as defined in section 201(g)(1) of the Federal  
14 Food, Drug, and Cosmetic Act (21 U.S.C.  
15 321(g)(1))), biological product (as defined in section  
16 351(i) of the Public Health Service Act (42 U.S.C.  
17 262(i))), or device (as defined in section 201(h) of  
18 the Federal Food, Drug, and Cosmetic Act (21  
19 U.S.C. 321(h))); and

20 (2) the term “opioid sparing” means reducing,  
21 replacing, or avoiding the use of opioids or other  
22 controlled substances.

1 **SEC. 302. CLARIFYING FDA PACKAGING AUTHORITIES.**

2 Section 505–1(e) of the Federal Food, Drug, and  
3 Cosmetic Act (21 U.S.C. 355–1(e)) is amended by adding  
4 at the end the following:

5 “(4) **SERIOUS ADVERSE DRUG EXPERIENCE.**—

6 The Secretary may require a risk evaluation mitiga-  
7 tion strategy for a drug for which there is a serious  
8 risk of an adverse drug experience described in sub-  
9 paragraph (B) or (C) of subsection (b)(1), taking  
10 into consideration the factors described in subpara-  
11 graphs (C) and (D) of subsection (f)(2), which may  
12 include requiring that—

13 “(A) the drug be made available for dis-  
14 pensing to certain patients in unit dose pack-  
15 aging, packaging that provides a set duration,  
16 or other packaging system that the Secretary  
17 determines may help mitigate such serious risk;  
18 or

19 “(B) the drug be dispensed to certain pa-  
20 tients with a safe disposal packaging or safe  
21 disposal system for purposes of rendering un-  
22 used drugs non-retrievable (as defined in sec-  
23 tion 1300.05 of title 21, Code of Federal Regu-  
24 lations (or any successor regulation)) if the Sec-  
25 retary has determines that such safe disposal  
26 packaging or system may help mitigate such se-

1           rious risk and exists in sufficient quantities, in  
2           consultation with other relevant Federal agen-  
3           cies with authorities over drug packaging.”.

4 **SEC. 303. STRENGTHENING FDA AND CBP COORDINATION**  
5 **AND CAPACITY.**

6           (a) IN GENERAL.—The Secretary of Health and  
7 Human Services (referred to in this section as the “Sec-  
8 retary”), acting through the Commissioner of Food and  
9 Drugs, shall coordinate with the Secretary of Homeland  
10 Security to carry out activities related to customs and bor-  
11 der protection and response to illegal controlled substances  
12 and drug imports, including at sites of import (such as  
13 international mail facilities). Such Secretaries may carry  
14 out such activities through a memorandum of under-  
15 standing between the Food and Drug Administration and  
16 the United States Customs and Border Protection.

17           (b) FDA IMPORT FACILITIES AND INSPECTION CA-  
18 PACITY.—In carrying out this section, the Secretary  
19 shall—

20           (1) in collaboration with the Secretary of  
21 Homeland Security and the Postmaster General of  
22 the United States Postal Service, provide that im-  
23 port facilities in which the Food and Drug Adminis-  
24 tration operates or carries out activities related to

1 drug imports within the international mail facilities  
2 include—

3 (A) facility upgrades and improved capac-  
4 ity in order to increase and improve inspection  
5 and detection capabilities, which may include,  
6 as the Secretary determines appropriate—

7 (i) improvements to facilities, such as  
8 upgrades or renovations, and support for  
9 the maintenance of existing import facili-  
10 ties and sites to improve coordination be-  
11 tween Federal agencies;

12 (ii) the construction of, or upgrades  
13 to, laboratory capacity for purposes of de-  
14 tection and testing of imported goods;

15 (iii) upgrades to the security of import  
16 facilities; and

17 (iv) innovative technology and equip-  
18 ment to facilitate improved and near-real-  
19 time information sharing between the Food  
20 and Drug Administration, the Department  
21 of Homeland Security, and the United  
22 States Postal Service; and

23 (B) provide import facilities in which the  
24 Food and Drug Administration operates or car-  
25 ries out activities related to drug imports within

1 the international mail facilities with innovative  
2 technology, including controlled substance de-  
3 tection and testing equipment and other appli-  
4 cable technology, and collaborate with United  
5 States Customs and Border Protection to share  
6 near-real-time information, including informa-  
7 tion about test results, as appropriate, provided  
8 that such technology is interoperable with tech-  
9 nology used by other relevant Federal agencies,  
10 including the United States Customs and Bor-  
11 der Protection, as applicable, and is used in the  
12 time and manner that the Secretary determines  
13 appropriate.

14 (c) REPORT.—Not later than 6 months after the date  
15 of enactment of this Act, the Secretary, in consultation  
16 with the Secretary of Homeland Security and the Post-  
17 master General of the United States Postal Service, shall  
18 report to the relevant committees of Congress on the im-  
19 plementation of this section, including a summary of  
20 progress made towards near-real-time information sharing  
21 and the interoperability of such technologies.

22 (d) AUTHORIZATION OF APPROPRIATIONS.—Out of  
23 amounts otherwise available to the Secretary, the Sec-  
24 retary may allocate such sums as may be necessary for  
25 purposes of carrying out this section.

1 **SEC. 304. CLARIFYING FDA POST-MARKET AUTHORITIES.**

2 Section 505–1(b)(1)(E) of the Federal Food, Drug,  
3 and Cosmetic Act (21 U.S.C. 355–1(b)(1)(E)) is amended  
4 by striking “of the drug” and inserting “of the drug,  
5 which may include reduced effectiveness that is not in ac-  
6 cordance with the labeling of such drug”.

7 **SEC. 305. FIRST RESPONDER TRAINING.**

8 Section 546 of the Public Health Service Act (42  
9 U.S.C. 290ee–1) is amended—

10 (1) in subsection (c)—

11 (A) in paragraph (2), by striking “and” at  
12 the end;

13 (B) in paragraph (3), by striking the pe-  
14 riod and inserting “; and”; and

15 (C) by adding at the end the following:

16 “(4) train and provide resources for first re-  
17 sponders and members of other key community sec-  
18 tors on safety around fentanyl and other dangerous  
19 illicit drugs to protect themselves from exposure to  
20 fentanyl and respond appropriately when exposure  
21 occurs.”;

22 (2) in subsection (d), by inserting “, and safety  
23 around fentanyl and other dangerous illicit drugs”  
24 before the period;

25 (3) in subsection (f)—

1 (A) in paragraph (3), by striking “and” at  
2 the end;

3 (B) in paragraph (4), by striking the pe-  
4 riod and inserting a semicolon; and

5 (C) by adding at the end the following:

6 “(5) the number of first responders and mem-  
7 bers of other key community sectors trained on safe-  
8 ty around fentanyl and other dangerous illicit  
9 drugs.”; and

10 (4) in subsection (g), by striking “\$12,000,000  
11 for each of fiscal years 2017 through 2021” and in-  
12 serting “\$36,000,000 for each of fiscal years 2019  
13 through 2023”.

14 **SEC. 306. DISPOSAL OF CONTROLLED SUBSTANCES OF A**  
15 **DECEASED HOSPICE PATIENT BY EMPLOY-**  
16 **EES OF A HOSPICE PROGRAM.**

17 (a) IN GENERAL.—Section 302(g) of the Controlled  
18 Substances Act (21 U.S.C. 822(g)) is amended by adding  
19 at the end the following:

20 “(5)(A) An employee of a qualified hospice program  
21 acting within the scope of employment may handle, in the  
22 place of residence of a hospice patient, any controlled sub-  
23 stance that was lawfully dispensed to the hospice patient,  
24 for the purpose of assisting in the disposal of the con-  
25 trolled substance after the hospice patient’s death.

1 “(B) In this paragraph:

2 “(i) The term ‘employee of a qualified hospice  
3 program’ means a physician, physician assistant, or  
4 nurse who—

5 “(I) is employed by, or is acting pursuant  
6 to arrangements made with, a qualified hospice  
7 program; and

8 “(II) is licensed or certified to perform  
9 such employment or acts in accordance with ap-  
10 plicable State law.

11 “(ii) The terms ‘hospice care’ and ‘hospice pro-  
12 gram’ have the meanings given those terms in sec-  
13 tion 1861(dd) of the Social Security Act (42 U.S.C.  
14 1395x(dd)).

15 “(iii) The term ‘hospice patient’ means an indi-  
16 vidual receiving hospice care.

17 “(iv) The term ‘qualified hospice program’  
18 means a hospice program that—

19 “(I) has written policies and procedures for  
20 employees of the hospice program to use assist-  
21 ing in the disposal of the controlled substances  
22 of a hospice patient after the hospice patient’s  
23 death;

24 “(II) at the time when the controlled sub-  
25 stances are first ordered—

1           “(aa) provides a copy of the written  
2 policies and procedures to the hospice pa-  
3 tient or hospice patient representative and  
4 the family of the hospice patient;

5           “(bb) discusses the policies and proce-  
6 dures with the hospice patient or hospice  
7 patient’s representative and the hospice  
8 patient’s family in a language and manner  
9 that such individuals understand to ensure  
10 that such individuals are informed regard-  
11 ing the safe disposal of controlled sub-  
12 stances; and

13           “(cc) documents in the clinical record  
14 of the hospice patient that the written poli-  
15 cies and procedures were provided and dis-  
16 cussed with the hospice patient or hospice  
17 patient’s representative; and

18           “(III) at the time when an employee of the  
19 hospice program assists in the disposal of con-  
20 trolled substances of a hospice patient, docu-  
21 ments in the clinical record of the hospice pa-  
22 tient a list of all controlled substances disposed  
23 of.

24           “(C) The Attorney General may, by regulation,  
25 include additional types of licensed medical profes-

1 sionals in the definition of the term ‘employee of a  
2 qualified hospice program’ under subparagraph  
3 (B).”.

4 (b) NO REGISTRATION REQUIRED.—Section 302(c)  
5 of the Controlled Substances Act (21 U.S.C. 822(c)) is  
6 amended by adding at the end the following:

7 “(4) An employee of a qualified hospice pro-  
8 gram for the purpose of assisting in the disposal of  
9 a controlled substance in accordance with subsection  
10 (g)(5).”.

11 (c) GUIDANCE.—The Attorney General may issue  
12 guidance to qualified hospice programs to assist the pro-  
13 grams in satisfying the requirements under paragraph (5)  
14 of section 302(g) of the Controlled Substances Act (21  
15 U.S.C. 822(g)), as added by subsection (a).

16 (d) STATE AND LOCAL AUTHORITY.—Nothing in this  
17 section or the amendments made by this section shall be  
18 construed to prevent a State or local government from im-  
19 posing additional controls or restrictions relating to the  
20 regulation of the disposal of controlled substances in hos-  
21 pice care or hospice programs.

22 **SEC. 307. GAO STUDY AND REPORT ON HOSPICE SAFE**  
23 **DRUG MANAGEMENT.**

24 (a) STUDY.—

1           (1) IN GENERAL.—The Comptroller General of  
2 the United States (in this section referred to as the  
3 “Comptroller General”) shall conduct a study on the  
4 requirements applicable to and challenges of hospice  
5 programs with regard to the management and dis-  
6 posal of controlled substances in the home of an in-  
7 dividual.

8           (2) CONTENTS.—In conducting the study under  
9 paragraph (1), the Comptroller General shall in-  
10 clude—

11                   (A) an overview of challenges encountered  
12 by hospice programs regarding the disposal of  
13 controlled substances, such as opioids, in a  
14 home setting, including any key changes in poli-  
15 cies, procedures, or best practices for the dis-  
16 posal of controlled substances over time; and

17                   (B) a description of Federal requirements,  
18 including requirements under the Medicare pro-  
19 gram, for hospice programs regarding the dis-  
20 posal of controlled substances in a home set-  
21 ting, and oversight of compliance with those re-  
22 quirements.

23           (b) REPORT.—Not later than 18 months after the  
24 date of enactment of this Act, the Comptroller General  
25 shall submit to Congress a report containing the results

1 of the study conducted under subsection (a), together with  
 2 recommendations, if any, for such legislation and adminis-  
 3 trative action as the Comptroller General determines ap-  
 4 propriate.

5 **SEC. 308. DELIVERY OF A CONTROLLED SUBSTANCE BY A**  
 6 **PHARMACY TO BE ADMINISTERED BY INJEC-**  
 7 **TION, IMPLANTATION, OR INTRATHECAL**  
 8 **PUMP.**

9 (a) IN GENERAL.—The Controlled Substances Act is  
 10 amended by inserting after section 309 (21 U.S.C. 829)  
 11 the following:

12 “DELIVERY OF A CONTROLLED SUBSTANCE BY A  
 13 PHARMACY TO AN ADMINISTERING PRACTITIONER

14 “SEC. 309A. (a) IN GENERAL.—Notwithstanding  
 15 section 102(10), a pharmacy may deliver a controlled sub-  
 16 stance to a practitioner in accordance with a prescription  
 17 that meets the requirements of this title and the regula-  
 18 tions issued by the Attorney General under this title, for  
 19 the purpose of administering of the controlled substance  
 20 by the practitioner if—

21 “(1) the controlled substance is delivered by the  
 22 pharmacy to the prescribing practitioner or the prac-  
 23 titioner administering the controlled substance, as  
 24 applicable, at the location listed on the practitioner’s  
 25 certificate of registration issued under this title;

1           “(2)(A) in the case of administering of the con-  
2           trolled substance for the purpose of maintenance or  
3           detoxification treatment under section 303(g)(2)—

4                   “(i) the practitioner who issued the pre-  
5                   scription is a qualifying practitioner authorized  
6                   under, and acting within the scope of that sec-  
7                   tion; and

8                   “(ii) the controlled substance is to be ad-  
9                   ministered by injection or implantation; or

10           “(B) in the case of administering of the con-  
11           trolled substance for a purpose other than mainte-  
12           nance or detoxification treatment, the controlled  
13           substance is to be administered by a practitioner  
14           through use of an intrathecal pump;

15           “(3) the pharmacy and the practitioner are au-  
16           thorized to conduct the activities specified in this  
17           section under the law of the State in which such ac-  
18           tivities take place;

19           “(4) the prescription is not issued to supply any  
20           practitioner with a stock of controlled substances for  
21           the purpose of general dispensing to patients;

22           “(5) except as provided in subsection (b), the  
23           controlled substance is to be administered only to  
24           the patient named on the prescription not later than

1 14 days after the date of receipt of the controlled  
2 substance by the practitioner; and

3 “(6) notwithstanding any exceptions under sec-  
4 tion 307, the prescribing practitioner, and the prac-  
5 titioner administering the controlled substance, as  
6 applicable, maintain complete and accurate records  
7 of all controlled substances delivered, received, ad-  
8 ministered, or otherwise disposed of under this sec-  
9 tion, including the persons to whom controlled sub-  
10 stances were delivered and such other information as  
11 may be required by regulations of the Attorney Gen-  
12 eral.

13 “(b) MODIFICATION OF NUMBER OF DAYS BEFORE  
14 WHICH CONTROLLED SUBSTANCE SHALL BE ADMINIS-  
15 TERED.—

16 “(1) INITIAL 2-YEAR PERIOD.—During the 2-  
17 year period beginning on the date of enactment of  
18 this section, the Attorney General, in coordination  
19 with the Secretary, may reduce the number of days  
20 described in subsection (a)(5) if the Attorney Gen-  
21 eral determines that such reduction will—

22 “(A) reduce the risk of diversion; or

23 “(B) protect the public health.

24 “(2) MODIFICATIONS AFTER SUBMISSION OF  
25 REPORT.—After the date on which the report de-

1 scribed in subsection (c) is submitted, the Attorney  
2 General, in coordination with the Secretary, may  
3 modify the number of days described in subsection  
4 (a)(5).

5 “(3) MINIMUM NUMBER OF DAYS.—Any modi-  
6 fication under this subsection shall be for a period  
7 of not less than 7 days.”.

8 (b) STUDY AND REPORT.—Not later than 2 years  
9 after the date of enactment of this section, the Comp-  
10 troller General of the United States shall conduct a study  
11 and submit to Congress a report on access to and potential  
12 diversion of controlled substances administered by injec-  
13 tion, implantation, or through the use of an intrathecal  
14 pump.

15 (c) TECHNICAL AND CONFORMING AMENDMENT.—  
16 The table of contents for the Comprehensive Drug Abuse  
17 Prevention and Control Act of 1970 is amended by insert-  
18 ing after the item relating to section 309 the following:

“Sec. 309A. Delivery of a controlled substance by a pharmacy to an admin-  
istering practitioner.”.

## 19 **TITLE IV—TREATMENT AND** 20 **RECOVERY**

### 21 **SEC. 401. COMPREHENSIVE OPIOID RECOVERY CENTERS.**

22 (a) IN GENERAL.—Part D of title V of the Public  
23 Health Service Act is amended by adding at the end the  
24 following new section:

1 **“SEC. 550. COMPREHENSIVE OPIOID RECOVERY CENTERS.**

2       “(a) IN GENERAL.—The Secretary, acting through  
3 the Assistant Secretary for Mental Health and Substance  
4 Use, shall award grants on a competitive basis to eligible  
5 entities to establish or operate a comprehensive opioid re-  
6 covery center (referred to in this section as a ‘Center’).  
7 A Center may be a single entity or an integrated delivery  
8 network.

9       “(b) GRANT PERIOD.—

10           “(1) IN GENERAL.—A grant awarded under  
11 subsection (a) shall be for a period not more than  
12 5 years.

13           “(2) RENEWAL.—A grant awarded under sub-  
14 section (a) may be renewed, on a competitive basis,  
15 for additional periods of time, as determined by the  
16 Secretary. In determining whether to renew a grant  
17 under this paragraph, the Secretary shall consider  
18 the data submitted under subsection (h).

19       “(c) MINIMUM NUMBER OF GRANTS.—The Secretary  
20 shall allocate the amounts made available under sub-  
21 section (j) such that not fewer than 10 grants may be  
22 awarded. Not more than one grant shall be made to enti-  
23 ties in a single State for any one period.

24       “(d) APPLICATION.—In order to be eligible for a  
25 grant under subsection (a), an entity shall submit an ap-  
26 plication to the Secretary at such time and in such manner

1 as the Secretary may require. Such application shall in-  
2 clude—

3           “(1) evidence that such entity carries out, or is  
4           capable of coordinating with other entities to carry  
5           out, the activities described in subsection (g); and

6           “(2) such other information as the Secretary  
7           may require.

8           “(e) PRIORITY.—In awarding grants under sub-  
9           section (a), the Secretary shall give priority to eligible enti-  
10          ties located in a State with an overdose mortality rate that  
11          is above the national overdose mortality rate, as deter-  
12          mined by the Director of the Centers for Disease Control  
13          and Prevention.

14          “(f) PREFERENCE.—In awarding grants under sub-  
15          section (a), the Secretary may give preference to eligible  
16          entities utilizing technology-enabled collaborative learning  
17          and capacity building models, including such models as de-  
18          fined in section 2 of the Expanding Capacity for Health  
19          Outcomes Act (Public Law 114–270; 130 Stat. 1395), to  
20          conduct the activities described in this section.

21          “(g) CENTER ACTIVITIES.—Each Center shall, at a  
22          minimum, carry out the following activities directly,  
23          through referral, or through contractual arrangements,  
24          which may include carrying out such activities through

1 technology-enabled collaborative learning and capacity  
2 building models described in subsection (f):

3 “(1) TREATMENT AND RECOVERY SERVICES.—

4 Each Center shall—

5 “(A) ensure that intake and evaluations  
6 meet the individualized clinical needs of pa-  
7 tients, including by offering assessments for  
8 services and care recommendations through  
9 independent, evidence-based verification proc-  
10 esses for reviewing patient placement in treat-  
11 ment settings;

12 “(B) provide the full continuum of treat-  
13 ment services, including—

14 “(i) all drugs approved by the Food  
15 and Drug Administration to treat sub-  
16 stance use disorders;

17 “(ii) medically supervised withdrawal  
18 management that includes patient evalua-  
19 tion, stabilization, and readiness for and  
20 entry into treatment;

21 “(iii) counseling provided by a pro-  
22 gram counselor or other certified profes-  
23 sional who is licensed and qualified by edu-  
24 cation, training, or experience to assess the  
25 psychological and sociological background

1 of patients, to contribute to the appro-  
2 priate treatment plan for the patient, and  
3 to monitor patient progress;

4 “(iv) treatment, as appropriate, for  
5 patients with co-occurring substance use  
6 and mental health disorders;

7 “(v) residential rehabilitation, and  
8 outpatient and intensive outpatient pro-  
9 grams;

10 “(vi) recovery housing;

11 “(vii) community-based and peer re-  
12 covery support services;

13 “(viii) job training, job placement as-  
14 sistance, and continuing education assist-  
15 ance to support reintegration into the  
16 workforce; and

17 “(ix) other best practices to provide  
18 the full continuum of treatment and serv-  
19 ices, as determined by the Secretary;

20 “(C) periodically conduct patient assess-  
21 ments to support sustained and clinically sig-  
22 nificant recovery, as defined by the Assistant  
23 Secretary for Mental Health and Substance  
24 Use;

1           “(D) administer an onsite pharmacy and  
2 provide toxicology services, for purposes of car-  
3 rying out this section; and

4           “(E) operate a secure, confidential, and  
5 interoperable electronic health information sys-  
6 tem.

7           “(2) OUTREACH.—Each Center shall carry out  
8 outreach activities to publicize the services offered  
9 through the Centers, which may include—

10           “(A) training and supervising outreach  
11 staff, as appropriate, to work with State and  
12 local health departments, health care providers,  
13 State and local education agencies, institutions  
14 of higher education, State and local workforce  
15 development boards, State and local community  
16 action agencies, public safety officials, first re-  
17 sponders, child welfare agencies, as appropriate,  
18 and other community partners and the public,  
19 including patients, to identify and respond to  
20 community needs, and ensuring that such enti-  
21 ties are aware of the services of the Center; and

22           “(B) disseminating and making publicly  
23 available, including through the internet, evi-  
24 dence-based resources that educate profes-  
25 sionals and the public on opioid use disorder

1           and other substance use disorders, including co-  
2           occurring substance use and mental health dis-  
3           orders.

4           “(h) DATA REPORTING AND PROGRAM OVER-  
5 SIGHT.—With respect to a grant awarded under sub-  
6 section (a), not later than 90 days after the end of the  
7 first year of the grant period, and annually thereafter for  
8 the duration of the grant period (including the duration  
9 of any renewal period for such grant), the entity shall sub-  
10 mit data, as appropriate, to the Secretary regarding—

11           “(1) the programs and activities funded by the  
12 grant;

13           “(2) health outcomes of the population of indi-  
14 viduals with a substance use disorder who received  
15 services from the Center, evaluated by an inde-  
16 pendent program evaluator through the use of out-  
17 comes measures, as determined by the Secretary;

18           “(3) the retention rate of program participants;  
19 and

20           “(4) any other information that the Secretary  
21 may require for the purpose of ensuring that the  
22 Center is complying with all the requirements of the  
23 grant, including providing the full continuum of  
24 services described in subsection (g)(1)(B).

1       “(i) PRIVACY.—The provisions of this section, includ-  
2 ing with respect to data reporting and program oversight,  
3 shall be subject to all applicable Federal and State privacy  
4 laws.

5       “(j) AUTHORIZATION OF APPROPRIATIONS.—There  
6 is authorized to be appropriated \$10,000,000 for each of  
7 fiscal years 2019 through 2023 for purposes of carrying  
8 out this section.”.

9       (b) REPORTS TO CONGRESS.—

10           (1) PRELIMINARY REPORT.—Not later than 3  
11 years after the date of the enactment of this Act, the  
12 Secretary of Health and Human Services shall sub-  
13 mit to Congress a preliminary report that analyzes  
14 data submitted under section 550(h) of the Public  
15 Health Service Act, as added by subsection (a).

16           (2) FINAL REPORT.—Not later than 2 years  
17 after submitting the preliminary report required  
18 under paragraph (1), the Secretary of Health and  
19 Human Services shall submit to Congress a final re-  
20 port that includes—

21                   (A) an evaluation of the effectiveness of  
22 the comprehensive services provided by the Cen-  
23 ters established or operated pursuant to section  
24 550 of the Public Health Service Act, as added  
25 by subsection (a), on health outcomes of the

1 population of individuals with substance use  
2 disorder who receive services from the Center,  
3 which shall include an evaluation of the effec-  
4 tiveness of services for treatment and recovery  
5 support and to reduce relapse, recidivism, and  
6 overdose; and

7 (B) recommendations, as appropriate, re-  
8 garding ways to improve Federal programs re-  
9 lated to substance use disorders, which may in-  
10 clude dissemination of best practices for the  
11 treatment of substance use disorders to health  
12 care professionals.

13 **SEC. 402. PROGRAM TO SUPPORT COORDINATION AND**  
14 **CONTINUATION OF CARE FOR DRUG OVER-**  
15 **DOSE PATIENTS.**

16 (a) IN GENERAL.—The Secretary of Health and  
17 Human Services (referred to in this section as the “Sec-  
18 retary”) shall identify or facilitate the development of best  
19 practices for—

20 (1) emergency treatment of known or suspected  
21 drug overdose;

22 (2) coordination and continuation of care and  
23 treatment, including, as appropriate, through refer-  
24 rals, of individuals after an opioid overdose; and

1           (3) the provision of overdose reversal medica-  
2           tion, as appropriate.

3           (b) GRANT ESTABLISHMENT AND PARTICIPATION.—

4           (1) IN GENERAL.—The Secretary shall award  
5           grants on a competitive basis to eligible entities to  
6           support implementation of voluntary programs for  
7           care and treatment of individuals after an opioid  
8           overdose, as appropriate, which may include imple-  
9           mentation of the best practices described in sub-  
10          section (a).

11          (2) ELIGIBLE ENTITY.—In this section, the  
12          term “eligible entity” means an entity that offers  
13          treatment or other services for individuals in re-  
14          sponse to, or following, drug overdoses or a drug  
15          overdose.

16          (3) APPLICATION.—An eligible entity desiring a  
17          grant under this section, in consultation with the  
18          principal agency of a State in which such entity of-  
19          fers treatment or other services that is responsible  
20          for carrying out the block grant for prevention and  
21          treatment of substance abuse under subpart II of  
22          part B of title XIX of the Public Health Service Act  
23          (42 U.S.C. 300x–21 et seq.), shall submit an appli-  
24          cation to the Secretary, at such time and in such

1 manner as the Secretary may require, that in-  
2 cludes—

3 (A) evidence that such eligible entity car-  
4 ries out, or is capable of coordinating with  
5 other entities to carry out, the activities de-  
6 scribed in paragraph (4); and

7 (B) such additional information as the Sec-  
8 retary may require.

9 (4) USE OF GRANT FUNDS.—An eligible entity  
10 awarded a grant under this section shall use such  
11 grant funds to—

12 (A) hire or utilize recovery coaches to help  
13 support recovery, including by—

14 (i) connecting patients to a continuum  
15 of care services, such as—

16 (I) treatment and recovery sup-  
17 port programs;

18 (II) programs that provide non-  
19 clinical recovery support services;

20 (III) peer support networks;

21 (IV) recovery community organi-  
22 zations;

23 (V) health care providers, includ-  
24 ing physicians and other providers of  
25 behavioral health and primary care;

1 (VI) educational and vocational  
2 schools;

3 (VII) employers;

4 (VIII) housing services; and

5 (IX) child welfare agencies;

6 (ii) providing education on overdose  
7 prevention to patients; and

8 (iii) providing other services the Sec-  
9 retary determines necessary to help ensure  
10 continued connection with recovery support  
11 services;

12 (B) establish policies and procedures that  
13 address the provision of overdose reversal medi-  
14 cation, the administration of all drugs approved  
15 by the Food and Drug Administration to treat  
16 substance use disorder, and subsequent continu-  
17 ation of, or referral to, evidence-based treat-  
18 ment for patients with a substance use disorder  
19 who have experienced a non-fatal drug over-  
20 dose, in order to prevent relapse, and reduce re-  
21 cidivism and future overdose;

22 (C) develop or implement best practices for  
23 treating non-fatal drug overdoses, including,  
24 with respect to care coordination and integrated  
25 care models, for long term treatment and recov-

1           ery options for individuals with a substance use  
2           disorder who have experienced a non-fatal drug  
3           overdose; and

4                   (D) establish integrated models of care for  
5           individuals who have experienced a non-fatal  
6           drug overdose which may include patient as-  
7           sessment, follow up, and transportation to and  
8           from treatment facilities.

9           (5) ADDITIONAL PERMISSIBLE USES.—In addi-  
10          tion to the uses described in paragraph (4), a grant  
11          awarded under this section may be used, directly or  
12          through contractual arrangements, to provide—

13                   (A) all drugs approved by the Food and  
14          Drug Administration to treat substance use dis-  
15          orders, pursuant to Federal and State law;

16                   (B) withdrawal and detoxification services  
17          that include patient evaluation, stabilization,  
18          and preparation for treatment of substance use  
19          disorder, including treatment described in sub-  
20          paragraph (A), as appropriate; or

21                   (C) mental health services provided by a  
22          program counselor, social worker, therapist, or  
23          other certified professional who is licensed and  
24          qualified by education, training, or experience  
25          to assess the psychosocial background of pa-

1           tients, to contribute to the appropriate treat-  
2           ment plan for patients with substance use dis-  
3           order, and to monitor patient progress.

4           (6) PREFERENCE.—In awarding grants under  
5           this section, the Secretary shall give preference to el-  
6           igible entities that meet any or all of the following  
7           criteria:

8                   (A) The eligible entity is a critical access  
9                   hospital (as defined in section 1861(mm)(1) of  
10                  the Social Security Act (42 U.S.C.  
11                  1395x(mm)(1))), a low volume hospital (as de-  
12                  fined in section 1886(d)(12)(C)(i) of such Act  
13                  (42 U.S.C. 1395ww(d)(12)(C)(i))), or a sole  
14                  community hospital (as defined in section  
15                  1886(d)(5)(D)(iii) of such Act (42 U.S.C.  
16                  1395ww(d)(5)(D)(iii))).

17                  (B) The eligible entity is located in a State  
18                  with an overdose mortality rate that is above  
19                  the national overdose mortality rate, as deter-  
20                  mined by the Director of the Centers for Dis-  
21                  ease Control and Prevention.

22                  (C) The eligible entity demonstrates that  
23                  recovery coaches will be placed in both health  
24                  care settings and community settings.

1           (7) PERIOD OF GRANT.—A grant awarded to an  
2 eligible entity under this section shall be for a period  
3 of not more than 5 years.

4           (c) DEFINITION.—In this section, the term “recovery  
5 coach” means an individual—

6           (1) with knowledge of, or experience with, re-  
7 covery from a substance use disorder; and

8           (2) who has completed training from, and is de-  
9 termined to be in good standing by, a recovery serv-  
10 ices organization capable of conducting such training  
11 and making such determination.

12          (d) REPORTING REQUIREMENTS.—

13           (1) REPORTS BY GRANTEEES.—Each eligible en-  
14 tity awarded a grant under this section shall submit  
15 to the Secretary an annual report for each year for  
16 which the entity has received such grant that in-  
17 cludes information on—

18           (A) the number of individuals treated by  
19 the entity for non-fatal overdoses, including the  
20 number of non-fatal overdoses where overdose  
21 reversal medication was administered;

22           (B) the number of individuals administered  
23 medication-assisted treatment by the entity;

24           (C) the number of individuals referred by  
25 the entity to other treatment facilities after a

1 non-fatal overdose, the types of such other fa-  
2 cilities, and the number of such individuals ad-  
3 mitted to such other facilities pursuant to such  
4 referrals; and

5 (D) the frequency and number of patients  
6 with reoccurrences, including readmissions for  
7 non-fatal overdoses and evidence of relapse re-  
8 lated to substance abuse disorder.

9 (2) REPORT BY SECRETARY.—Not later than 5  
10 years after the date of enactment of this Act, the  
11 Secretary shall submit to Congress a report that in-  
12 cludes an evaluation of the effectiveness of the grant  
13 program carried out under this section with respect  
14 to long term health outcomes of the population of in-  
15 dividuals who have experienced a drug overdose, the  
16 percentage of patients treated or referred to treat-  
17 ment by grantees, and the frequency and number of  
18 patients who experienced relapse, were readmitted  
19 for treatment, or experienced another overdose.

20 (e) PRIVACY.—The requirements of this section, in-  
21 cluding with respect to data reporting and program over-  
22 sight, shall be subject to all applicable Federal and State  
23 privacy laws.

24 (f) AUTHORIZATION OF APPROPRIATIONS.—There is  
25 authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years  
2 2019 through 2023.

3 **SEC. 403. ALTERNATIVES TO OPIOIDS.**

4 (a) IN GENERAL.—The Secretary of Health and  
5 Human Services shall, directly or through grants to, or  
6 contracts with, public and private entities, provide tech-  
7 nical assistance to hospitals and other acute care settings  
8 on alternatives to opioids for pain management. The tech-  
9 nical assistance provided shall be for the purpose of—

10 (1) utilizing information from acute care pro-  
11 viders including emergency departments and other  
12 providers that have successfully implemented alter-  
13 natives to opioids programs, promoting non-opioid  
14 protocols and medications while appropriately lim-  
15 iting the use of opioids;

16 (2) identifying or facilitating the development of  
17 best practices on the use of alternatives to opioids,  
18 which may include pain-management strategies that  
19 involve non-addictive medical products, non-pharma-  
20 cologic treatments, and technologies or techniques to  
21 identify patients at-risk for opioid use disorder;

22 (3) identifying or facilitating the development of  
23 best practices on the use of alternatives to opioids  
24 that target common painful conditions and include

1 certain patient populations, such as geriatric pa-  
2 tients, pregnant women, and children;

3 (4) disseminating information on the use of al-  
4 ternatives to opioids to providers in acute care set-  
5 tings, which may include emergency departments,  
6 outpatient clinics, critical access hospitals, and Fed-  
7 erally qualified health centers; and

8 (5) collecting data and reporting on health out-  
9 comes associated with the use of alternatives to  
10 opioids.

11 (b) **AUTHORIZATION OF APPROPRIATIONS.**—There is  
12 authorized to be appropriated to carry out this section  
13 such sums as may be necessary for each of fiscal years  
14 2019 through 2023.

15 **SEC. 404. PEER SUPPORT TECHNICAL ASSISTANCE.**

16 (a) **TECHNICAL ASSISTANCE FOR PEER SUPPORT**  
17 **SERVICES.**—The Secretary of Health and Human Services  
18 (referred to in this section as the “Secretary”), acting  
19 through the Assistant Secretary for Mental Health and  
20 Substance Abuse, shall provide technical assistance and  
21 support to organizations providing peer support services  
22 related to substance use disorder, including technical as-  
23 sistance and support related to—

24 (1) training on identifying—

25 (A) signs of substance use disorder;

1 (B) resources to assist individuals with a  
2 substance use disorder, or resources for families  
3 of an individual with a substance use disorder;  
4 and

5 (C) best practices for the delivery of recov-  
6 ery support services;

7 (2) the provision of translation services, inter-  
8 pretation, or other such services for clients with lim-  
9 ited English speaking proficiency;

10 (3) capacity building; and

11 (4) evaluation and improvement, as necessary,  
12 of the effectiveness of such peer support services.

13 (b) BEST PRACTICES.—The Secretary shall periodi-  
14 cally issue best practices related to peer support services  
15 for use by organizations that provide peer support serv-  
16 ices.

17 (c) AUTHORIZATION OF APPROPRIATIONS.—There is  
18 authorized to be appropriated to carry out this section  
19 such sums as may be necessary for each of fiscal years  
20 2019 through 2023.

21 **SEC. 405. MEDICATION-ASSISTED TREATMENT FOR RECOV-**  
22 **ERY FROM ADDICTION.**

23 (a) REPEAL OF REQUIREMENT TO UPDATE REGULA-  
24 TIONS.—Section 303 of the Comprehensive Addiction and

1 Recovery Act of 2016 (Public Law 114–198; 130 Stat.  
2 720) is amended by striking subsection (c).

3 (b) CODIFICATION OF EXPANSION OF MAXIMUM  
4 NUMBER OF PATIENTS FOR MEDICATION-ASSISTED  
5 TREATMENT.—Section 303(g)(2)(B)(iii)(II) of the Con-  
6 trolled Substances Act (21 U.S.C. (g)(2)(B)(iii)(II)) is  
7 amended by striking “100” each place it appears and in-  
8 serting “275”.

9 **SEC. 406. NATIONAL RECOVERY HOUSING BEST PRACTICES.**  
10

11 (a) BEST PRACTICES.—The Secretary of Health and  
12 Human Services (referred to in this section as the “Sec-  
13 retary”), in consultation with the Secretary for Housing  
14 and Urban Development, patients with a history of opioid  
15 use disorder, and other stakeholders, which may include  
16 State accrediting entities and reputable providers of, and  
17 analysts of, recovery housing services, shall identify or fa-  
18 cilitate the development of best practices, which may in-  
19 clude model laws for implementing suggested minimum  
20 standards, for operating recovery housing.

21 (b) DISSEMINATION.—The Secretary shall dissemi-  
22 nate the best practices identified or developed under sub-  
23 section (a) to—

1           (1) State agencies, which may include the provi-  
2           sion of technical assistance to State agencies seeking  
3           to adopt or implement such best practices;

4           (2) recovery housing entities; and

5           (3) the public, as appropriate.

6           (c) REQUIREMENTS.—In identifying or facilitating  
7           the development of best practices under subsection (a), the  
8           Secretary, in consultation with appropriate stakeholders,  
9           shall consider how recovery housing is able to (including  
10          by improving access and adherence to treatment) support  
11          recovery and prevent relapse, recidivism, or overdose, in-  
12          cluding overdose death.

13          (d) RULE OF CONSTRUCTION.—Nothing in this sec-  
14          tion shall be construed to provide the Secretary with the  
15          ability to require States to adhere to minimum standards  
16          in the State oversight of recovery housing.

17          (e) DEFINITION.—In this section, the term “recovery  
18          housing” means a shared living environment free from al-  
19          cohol and illicit drug use and centered on peer support  
20          and connection to services that promote sustained recovery  
21          from substance use disorders.

22       **SEC. 407. ADDRESSING ECONOMIC AND WORKFORCE IM-**  
23       **PACTS OF THE OPIOID CRISIS.**

24          (a) DEFINITIONS.—Except as otherwise expressly  
25          provided, in this section:

1           (1) EDUCATION PROVIDER.—The term “edu-  
2 cation provider” means—

3           (A) an institution of higher education, as  
4 defined in section 101 of the Higher Education  
5 Act of 1965 (20 U.S.C. 1001); or

6           (B) a postsecondary vocational institution,  
7 as defined in section 102(e) of such Act (20  
8 U.S.C. 1002(e)).

9           (2) ELIGIBLE ENTITY.—The term “eligible enti-  
10 ty” means—

11           (A) a State workforce agency;

12           (B) a State board;

13           (C) an outlying area, as defined in section  
14 3 of the Workforce Innovation and Opportunity  
15 Act (29 U.S.C. 3102); or

16           (D) a Tribal entity.

17           (3) LOCAL AREA; LOCAL BOARD; ONE-STOP OP-  
18 ERATOR.—The terms “local area”, “local board”,  
19 and “one-stop operator” have the meanings given  
20 such terms in section 3 of the Workforce Innovation  
21 and Opportunity Act (29 U.S.C. 3102).

22           (4) LOCAL ENTITY.—The term “local entity”  
23 means a local board or one-stop operator.

24           (5) PARTICIPATING PARTNERSHIP.—The term  
25 “participating partnership” means a partnership es-

1        established under subsection (e)(1) by a local entity  
2        receiving a subgrant under subsection (d).

3            (6) PROGRAM PARTICIPANT.—The term “pro-  
4        gram participant” means an individual who—

5            (A) is a member of a population of workers  
6        described in subsection (e)(2) that is served by  
7        a participating partnership through the pilot  
8        program under this section; and

9            (B) enrolls with the applicable partici-  
10        pating partnership to receive any of the services  
11        described in subsection (e)(3).

12          (7) SECRETARY.—The term “Secretary” means  
13        the Secretary of Labor.

14          (8) STATE BOARD.—The term “State board”  
15        has the meaning given the term in section 3 of the  
16        Workforce Innovation and Opportunity Act (29  
17        U.S.C. 3102).

18          (9) STATE WORKFORCE AGENCY.—The term  
19        “State workforce agency” means the lead State  
20        agency with responsibility for the administration of  
21        a program under chapter 2 or 3 of subtitle B of title  
22        I of the Workforce Innovation and Opportunity Act  
23        (29 U.S.C. 3161 et seq., 3171 et seq.).

24          (10) SUBSTANCE USE DISORDER.—The term  
25        “substance use disorder” means such a disorder

1 within the meaning of title V of the Public Health  
2 Service Act (42 U.S.C. 290aa et seq.).

3 (11) SUPPORTIVE SERVICES.—The term “sup-  
4 portive services” has the meaning given such term in  
5 section 3 of the Workforce Innovation and Oppor-  
6 tunity Act (29 U.S.C. 3102).

7 (12) TREATMENT PROVIDER.—The term “treat-  
8 ment provider”—

9 (A) means a health care provider that of-  
10 fers services for treating substance use dis-  
11 orders and is licensed in accordance with appli-  
12 cable State law to provide such services;

13 (B) accepts health insurance for such serv-  
14 ices, including coverage under title XIX of the  
15 Social Security Act (42 U.S.C. 1396 et seq.);  
16 and

17 (C) may include—

18 (i) a nonprofit provider of peer recov-  
19 ery support services, as defined by the  
20 State involved in regulation or guidance;

21 (ii) a community health care provider;

22 or

23 (iii) a Federally qualified health cen-  
24 ter (as defined in section 1861(aa) of the  
25 Social Security Act (42 U.S.C. 1395x)).

1           (13) TRIBAL ENTITY.—The term “Tribal enti-  
2           ty” includes any Indian tribe, tribal organization,  
3           Indian-controlled organization serving Indians, Na-  
4           tive Hawaiian organization, or Alaska Native entity,  
5           as such terms are defined or used in section 166 of  
6           the Workforce Innovation and Opportunity Act (29  
7           U.S.C. 3221).

8           (b) PILOT PROGRAM AND GRANTS AUTHORIZED.—

9           (1) IN GENERAL.—The Secretary, in consulta-  
10          tion with the Secretary of Health and Human Serv-  
11          ices, shall carry out a pilot program to address eco-  
12          nomic and workforce impacts associated with a high  
13          rate of a substance use disorder. In carrying out the  
14          pilot program, the Secretary shall make grants, on  
15          a competitive basis, to eligible entities to enable such  
16          entities to make subgrants to local boards and one-  
17          stop operators to address the economic and work-  
18          force impacts associated with a high rate of a sub-  
19          stance use disorder.

20          (2) GRANT AMOUNTS.—The Secretary shall  
21          make each such grant in an amount that is not less  
22          than \$500,000, and not more than \$5,000,000, for  
23          a fiscal year.

24          (c) GRANT APPLICATIONS.—

1           (1) IN GENERAL.—An eligible entity applying  
2 for a grant under this section shall submit an appli-  
3 cation to the Secretary at such time and in such  
4 form and manner as the Secretary may reasonably  
5 require, including the information described in this  
6 subsection.

7           (2) SIGNIFICANT IMPACT ON COMMUNITY BY  
8 OPIOID ABUSE AND SUBSTANCE USE DISORDER-RE-  
9 LATED PROBLEMS.—

10           (A) DEMONSTRATION.—An eligible entity  
11 shall include in the application information that  
12 demonstrates significant impact on the commu-  
13 nity by problems related to opioid abuse or an-  
14 other substance use disorder, by—

15           (i) identifying the communities, re-  
16 gions, or local areas that will be served  
17 through the grant (each referred to in this  
18 section as a “service area”); and

19           (ii) showing, for each such service  
20 area, an increase equal to or greater than  
21 the national increase in such problems, be-  
22 tween—

23           (I) 1999; and

24           (II) 2016 or the latest year for  
25 which data are available.

1 (B) INFORMATION.—In making the show-  
2 ing described in subparagraph (A)(ii), the eligi-  
3 ble entity may use information including data  
4 on—

5 (i) the incidence or prevalence of  
6 opioid abuse and other substance use dis-  
7 orders;

8 (ii) the per capita drug overdose mor-  
9 tality rate, as determined by the Director  
10 of the Centers for Disease Control and  
11 Prevention;

12 (iii) the rate of non-fatal hospitaliza-  
13 tions related to opioid abuse or another  
14 substance use disorder; or

15 (iv) the number of arrests or convic-  
16 tions, or a relevant law enforcement sta-  
17 tistic, that reasonably shows an increase in  
18 opioid abuse or another substance use dis-  
19 order.

20 (C) SUPPORT FOR STATE STRATEGY.—The  
21 eligible entity shall also include in the applica-  
22 tion information describing how the proposed  
23 services and activities support the State’s strat-  
24 egy for addressing problems described in sub-

1 paragraph (A) in specific regions or across the  
2 State, outlying area, or Tribal entity.

3 (3) ECONOMIC AND EMPLOYMENT CONDITIONS  
4 DEMONSTRATE ADDITIONAL FEDERAL SUPPORT  
5 NEEDED.—

6 (A) DEMONSTRATION.—An eligible entity  
7 shall include in the application information that  
8 demonstrates that a high rate of a substance  
9 use disorder has caused, or is coincident to, an  
10 economic or employment downturn in the serv-  
11 ice area.

12 (B) INFORMATION.—In making the dem-  
13 onstration described in subparagraph (A), the  
14 eligible entity may use information including—

15 (i) documentation of any layoff, an-  
16 nounced future layoff, legacy industry de-  
17 cline, decrease in an employment or labor  
18 market participation rate, or economic im-  
19 pact, whether or not the result described in  
20 this clause is overtly related to a high rate  
21 of a substance use disorder;

22 (ii) documentation showing decreased  
23 economic activity related to, caused by, or  
24 contributing to a high rate of a substance  
25 use disorder, including a description of

1           how the service area has been impacted, or  
2           will be impacted, by such a decrease;

3           (iii) in particular, information on eco-  
4           nomic indicators, labor market analyses,  
5           information from public announcements,  
6           and demographic and industry data;

7           (iv) information on rapid response ac-  
8           tivities (as defined in section 3 of the  
9           Workforce Innovation and Opportunity Act  
10          (29 U.S.C. 3102)) that have been or will  
11          be conducted, including demographic data  
12          gathered by employer or worker surveys or  
13          through other methods;

14          (v) data or documentation, beyond an-  
15          ecdotal evidence, showing that employers  
16          face challenges filling job vacancies due to  
17          a lack of skilled workers able to pass a  
18          drug test; or

19          (vi) any additional relevant data or in-  
20          formation on the economy, workforce, or  
21          another aspect of the service area to sup-  
22          port the application.

23           (4) WORKFORCE SHORTAGE RELATED TO  
24           TREATMENT WORKFORCE.—

1 (A) IN GENERAL.—An eligible entity may  
2 include in the application a demonstration of  
3 the workforce shortage in a professional area to  
4 be addressed under the grant. Such professional  
5 areas may include—

6 (i) substance use disorder treatment  
7 and related services;

8 (ii) non-opioid pain therapy and pain  
9 management services; or

10 (iii) mental health care treatment  
11 services.

12 (B) INFORMATION TO BE INCLUDED.—An  
13 eligible entity demonstrating a workforce short-  
14 age under subparagraph (A) shall demonstrate  
15 the workforce shortage through information  
16 that may include—

17 (i) the distance between—

18 (I) communities affected by  
19 opioid abuse or another substance use  
20 disorder; and

21 (II) facilities or professionals of-  
22 fering services in the professional  
23 area;

24 (ii) the maximum capacity of facilities  
25 or professionals to serve individuals in an

1 affected community, or increases in arrests  
2 related to opioid abuse or another sub-  
3 stance use disorder, overdose deaths, or  
4 nonfatal overdose emergencies in the com-  
5 munity; or

6 (iii) other information that can dem-  
7 onstrate such a shortage.

8 (d) SUBGRANT AUTHORIZATION AND APPLICATION  
9 PROCESS.—

10 (1) SUBGRANTS AUTHORIZED.—

11 (A) IN GENERAL.—An eligible entity re-  
12 ceiving a grant under subsection (b)—

13 (i) may use not more than 5 percent  
14 of the grant funds for the administrative  
15 costs of carrying out the grant; and

16 (ii) shall use the remaining grant  
17 funds to make subgrants to local entities  
18 in the area served by the eligible entity to  
19 carry out the services and activities de-  
20 scribed in subsection (e).

21 (B) GEOGRAPHIC DISTRIBUTION.—In mak-  
22 ing subgrants under this subsection, an eligible  
23 entity shall ensure, to the extent practicable,  
24 the equitable geographic distribution (such as

1 urban and rural distribution) of areas receiving  
2 subgrant funds.

3 (2) SUBGRANT APPLICATION.—

4 (A) IN GENERAL.—A local entity desiring  
5 to receive a subgrant under this subsection shall  
6 submit an application at such time and in such  
7 and manner as the eligible entity may reason-  
8 ably require, including the information de-  
9 scribed in this paragraph.

10 (B) CONTENTS.—Each application de-  
11 scribed in subparagraph (A) shall include an  
12 analysis of the estimated performance of the  
13 local entity in carrying out the proposed serv-  
14 ices and activities under the subgrant that—

15 (i) uses primary indicators of per-  
16 formance described in section  
17 116(c)(1)(A)(i) of the Workforce Innova-  
18 tion and Opportunity Act (29 U.S.C.  
19 3141(c)(1)(A)(i)), to assess estimated ef-  
20 fectiveness of the proposed services and ac-  
21 tivities, including the estimated number of  
22 individuals with a substance use disorder  
23 who may be served by the proposed serv-  
24 ices and activities;

1                   (ii) analyzes the record of the local  
2                   entity in serving individuals with a barrier  
3                   to employment; and

4                   (iii) analyzes the ability of the local  
5                   entity to establish the partnership de-  
6                   scribed in subsection (e)(1).

7                   (C) ANALYSIS.—The analysis described in  
8                   subparagraph (B) may include or utilize—

9                   (i) data from the National Center for  
10                  Health Statistics of the Centers for Dis-  
11                  ease Control and Prevention;

12                  (ii) data from the Center for Behav-  
13                  ioral Health Statistics and Quality of the  
14                  Substance Abuse and Mental Health Serv-  
15                  ices Administration;

16                  (iii) State vital statistics;

17                  (iv) municipal police department  
18                  records;

19                  (v) reports from local coroners; or

20                  (vi) other relevant data.

21                  (e) SUBGRANT SERVICES AND ACTIVITIES.—

22                   (1) FORMATION OF PARTNERSHIP.—

23                   (A) IN GENERAL.—Each local entity that  
24                   receives a subgrant under subsection (d) shall  
25                   form a partnership, established through a writ-

1           ten contract or other agreement, with members  
2           described in subparagraph (B), and shall carry  
3           out the services and activities described in this  
4           subsection through the partnership.

5           (B) MEMBERS OF THE PARTNERSHIP.—A  
6           partnership described in subparagraph (A) shall  
7           include 1 or more of the following:

8                   (i) The eligible entity.

9                   (ii) A treatment provider.

10                   (iii) An employer or industry organi-  
11                   zation.

12                   (iv) An education provider.

13                   (v) A justice or law enforcement orga-  
14                   nization.

15                   (vi) A faith-based or community-based  
16                   organization.

17                   (vii) Other State or local agencies.

18                   (viii) Other organizations, as deter-  
19                   mined to be necessary by the local entity.

20           (2) SELECTION OF POPULATION TO BE  
21           SERVED.—A participating partnership shall elect to  
22           provide services and activities under the subgrant to  
23           one or both of the following populations of workers:

24                   (A) Workers, including dislocated workers,  
25                   new entrants in the workforce, or incumbent

1 workers (employed or underemployed), who are  
2 directly or indirectly affected by a high rate of  
3 a substance use disorder and each of whom is—

4 (i) an individual who voluntarily con-  
5 firms that the individual, or a friend or  
6 family member of the individual, has a his-  
7 tory of opioid abuse or another substance  
8 use disorder; or

9 (ii) an individual who works or resides  
10 in a community substantially impacted by  
11 a high rate of a substance use disorder or  
12 can otherwise demonstrate job loss as a re-  
13 sult of a high rate of a substance use dis-  
14 order.

15 (B) Workers, including dislocated workers,  
16 new entrants in the workforce, or incumbent  
17 workers (employed or underemployed), who—

18 (i) seek to transition to professions  
19 that support individuals struggling with a  
20 substance use disorder or at risk for devel-  
21 oping such disorder, such as professions  
22 that provide—

23 (I) substance use disorder treat-  
24 ment and related services;

1 (II) peer recovery support serv-  
2 ices described in subsection  
3 (a)(12)(C)(i);

4 (III) non-opioid pain therapy and  
5 pain management services; or

6 (IV) mental health care; and

7 (ii) need new or upgraded skills to  
8 better serve such a population of strug-  
9 gling or at-risk individuals.

10 (3) SERVICES AND ACTIVITIES.—Each partici-  
11 pating partnership shall use funds available through  
12 a subgrant under this subsection to carry out 1 or  
13 more of the following:

14 (A) ENGAGING EMPLOYERS.—Engaging  
15 with employers to—

16 (i) learn about the skill and hiring re-  
17 quirements of employers;

18 (ii) learn about the support needed by  
19 employers to hire and retain program par-  
20 ticipants, and other individuals with a sub-  
21 stance use disorder, and the support need-  
22 ed by such employers to obtain their com-  
23 mitment to testing creative solutions to  
24 employing program participants and such  
25 individuals;

1 (iii) connect employers and workers to  
2 on-the-job or customized training programs  
3 before or after layoff to help facilitate re-  
4 employment;

5 (iv) connect employers with an edu-  
6 cation provider to develop classroom in-  
7 struction to complement on-the-job learn-  
8 ing for program participants and such in-  
9 dividuals;

10 (v) help employers develop the cur-  
11 riculum design of a work-based learning  
12 program for program participants and  
13 such individuals; or

14 (vi) help employers employ program  
15 participants or such individuals engaging  
16 in a work-based learning program for a  
17 transitional period before hiring such a  
18 program participant or individual for full-  
19 time employment of not less than 30 hours  
20 a week.

21 (B) SCREENING SERVICES.—Providing  
22 screening services, which may include—

23 (i) using an evidence-based screening  
24 method to screen each individual seeking  
25 participation in the pilot program to deter-

1 mine whether the individual has a sub-  
2 stance use disorder;

3 (ii) conducting an assessment of each  
4 such individual to determine the services  
5 needed for such individual to obtain or re-  
6 tain employment, including an assessment  
7 of strengths and general work readiness;  
8 and

9 (iii) accepting walk-ins or referrals  
10 from employers, labor organizations, or  
11 other entities recommending individuals to  
12 participate in such program.

13 (C) INDIVIDUAL TREATMENT AND EM-  
14 PLOYMENT PLAN.—Developing an individual  
15 treatment and employment plan for each pro-  
16 gram participant, which shall include providing  
17 a case manager to work with each participant  
18 to develop the plan, which may include—

19 (i) identifying employment and career  
20 goals;

21 (ii) exploring career pathways that  
22 lead to in-demand industries and sectors as  
23 determined by the State board and the  
24 head of the State workforce agency;

- 1 (iii) setting appropriate achievement  
2 objectives to attain the employment and  
3 career goals identified under clause (i); or  
4 (iv) developing the appropriate com-  
5 bination of services to enable the partici-  
6 pant to achieve the employment and career  
7 goals.

8 (D) OUTPATIENT TREATMENT AND RECOV-  
9 ERY CARE.—In the case of a participating part-  
10 nership serving program participants described  
11 in paragraph (2)(A)(i) with a substance use dis-  
12 order, providing individualized and group out-  
13 patient treatment and recovery services for such  
14 program participants that are offered during  
15 the day and evening, and on weekends. Such  
16 treatment and recovery services—

17 (i) shall be based on a model that uti-  
18 lizes combined behavioral interventions and  
19 other evidence-based or evidence-informed  
20 interventions; and

21 (ii) may include additional services  
22 such as—

23 (I) health, mental health, addic-  
24 tion, or other forms of outpatient  
25 treatment that may impact a sub-

1                   stance use disorder and co-occurring  
2                   conditions;

3                   (II) drug testing for a current  
4                   substance use disorder prior to enroll-  
5                   ment in career or training services or  
6                   prior to employment;

7                   (III) linkages to community serv-  
8                   ices, including services offered by  
9                   partner organizations designed to sup-  
10                  port program participants; and

11                  (IV) referrals to health care, in-  
12                  cluding referrals to substance use dis-  
13                  order treatment and mental health  
14                  services.

15                  (E) SUPPORTIVE SERVICES.—Providing  
16                  supportive services, which shall include services  
17                  such as—

18                  (i) coordinated wraparound services to  
19                  provide maximum support for program  
20                  participants to ensure that the program  
21                  participants maintain employment and re-  
22                  covery for not less than 12 months, as ap-  
23                  propriate;

24                  (ii) assistance in establishing eligi-  
25                  bility for assistance under Federal, State,

1 and local programs providing health serv-  
2 ices, mental health services, housing serv-  
3 ices, transportation services, or social serv-  
4 ices;

5 (iii) peer recovery support services de-  
6 scribed in subsection (a)(12)(C)(i);

7 (iv) networking and mentorship op-  
8 portunities; or

9 (v) any supportive services determined  
10 necessary by the local entity.

11 (F) CAREER AND JOB TRAINING SERV-  
12 ICES.—Offering career services and training  
13 services, and related services, concurrently or  
14 sequentially with the services provided under  
15 subparagraphs (B) through (E). Such services  
16 shall include the following:

17 (i) Services provided to program par-  
18 ticipants who are in a pre-employment  
19 stage of the program. Such services may  
20 include—

21 (I) initial education and skills as-  
22 sessments;

23 (II) traditional classroom train-  
24 ing funded through individual training  
25 accounts under chapter 3 of subtitle B

1 of title I of the Workforce Innovation  
2 and Opportunity Act (29 U.S.C. 3171  
3 et seq.);

4 (III) services to promote employ-  
5 ability skills such as punctuality, per-  
6 sonal maintenance skills, and profes-  
7 sional conduct;

8 (IV) in-depth interviewing and  
9 evaluation to identify employment bar-  
10 riers and to develop individual em-  
11 ployment plans;

12 (V) career planning that in-  
13 cludes—

14 (aa) career pathways leading  
15 to in-demand, high-wage jobs;  
16 and

17 (bb) job coaching, job  
18 matching, and job placement  
19 services;

20 (VI) provision of payments and  
21 fees for employment and training-re-  
22 lated applications, tests, and certifi-  
23 cations; or

24 (VII) any other appropriate ca-  
25 reer service or training service de-

1                   scribed in section 134(c) of the Work-  
2                   force Innovation and Opportunity Act  
3                   (29 U.S.C. 3174(c)).

4                   (ii) Services provided to program par-  
5                   ticipants during their first 6 months of  
6                   employment to ensure job retention, which  
7                   may include—

8                   (I) case management and support  
9                   services, including a continuation of  
10                  the services described in clause (i);

11                  (II) a continuation of skills train-  
12                  ing, and career and technical edu-  
13                  cation, described in clause (i) that is  
14                  conducted in collaboration with the  
15                  employers of such participants;

16                  (III) mentorship services and job  
17                  retention support for such partici-  
18                  pants; or

19                  (IV) targeted training for man-  
20                  agers and workers working with such  
21                  participants (such as mentors), and  
22                  human resource representatives in the  
23                  business in which such participants  
24                  are employed.

1 (iii) Services to assist program partici-  
2 pants in maintaining employment for not  
3 less than 12 months, as appropriate.

4 (G) PROVEN AND PROMISING PRAC-  
5 TICES.—Leading efforts in the service area to  
6 identify and promote proven and promising  
7 strategies and initiatives for meeting the needs  
8 of employers and program participants.

9 (4) LIMITATIONS.—A participating partnership  
10 may not use—

11 (A) more than 5 percent of the funds re-  
12 ceived under a subgrant under subsection (d)  
13 for the administrative costs of the partnership;

14 (B) more than 10 percent of the funds re-  
15 ceived under such subgrant for the provision of  
16 treatment and recovery services, as described in  
17 paragraph (3)(D); or

18 (C) more than 10 percent of the funds re-  
19 ceived under such subgrant for the provision of  
20 supportive services described in paragraph  
21 (3)(E) to program participants.

22 (f) PERFORMANCE ACCOUNTABILITY.—

23 (1) REPORTS.—The Secretary shall establish  
24 quarterly reporting requirements for recipients of  
25 grants and subgrants under this section that, to the

1 extent practicable, are based on the performance ac-  
2 countability system under section 116 of the Work-  
3 force Innovation and Opportunity Act (29 U.S.C.  
4 3141), including the indicators described in sub-  
5 section (c)(1)(A)(i) of such section and the require-  
6 ments for local area performance reports under sub-  
7 section (d) of such section.

8 (2) EVALUATIONS.—

9 (A) AUTHORITY TO ENTER INTO AGREE-  
10 MENTS.—The Secretary shall ensure that an  
11 independent evaluation is conducted on the pilot  
12 program carried out under this section to deter-  
13 mine the impact of the program on employment  
14 of individuals with substance use disorders. The  
15 Secretary shall enter into an agreement with el-  
16 igible entities receiving grants under this sec-  
17 tion to pay for all or part of such evaluation.

18 (B) METHODOLOGIES TO BE USED.—The  
19 independent evaluation required under this  
20 paragraph shall use experimental designs using  
21 random assignment or, when random assign-  
22 ment is not feasible, other reliable, evidence-  
23 based research methodologies that allow for the  
24 strongest possible causal inferences.

25 (g) FUNDING.—

1           (1) COVERED FISCAL YEAR.—In this sub-  
2           section, the term “covered fiscal year” means any of  
3           fiscal years 2018 through 2023.

4           (2) USING FUNDING FOR NATIONAL DIS-  
5           LOCATED WORKER GRANTS.—Subject to paragraph  
6           (4) and notwithstanding section 132(a)(2)(A) and  
7           subtitle D of the Workforce Innovation and Oppor-  
8           tunity Act (29 U.S.C. 3172(a)(2)(A), 3221 et seq.)  
9           or any other provision of law, the Secretary may use,  
10          to carry out the pilot program under this section for  
11          a covered fiscal year—

12                   (A) funds made available to carry out sec-  
13                   tion 170 of such Act (29 U.S.C. 3225) for that  
14                   fiscal year;

15                   (B) funds made available to carry out sec-  
16                   tion 170 of such Act that remain available for  
17                   that fiscal year; and

18                   (C) funds that remain available under sec-  
19                   tion 172(f) of such Act (29 U.S.C. 3227(f)).

20          (3) AVAILABILITY OF FUNDS.—Funds appro-  
21          priated under section 136(e) of such Act (29 U.S.C.  
22          3181(e)) and made available to carry out section  
23          170 of such Act for a fiscal year shall remain avail-  
24          able for use under paragraph (2) for a subsequent  
25          fiscal year until expended.

1           (4) LIMITATION.—The Secretary may not use  
 2           more than \$100,000,000 of the funds described in  
 3           paragraph (2) for any covered fiscal year under this  
 4           section.

5 **SEC. 408. YOUTH PREVENTION AND RECOVERY.**

6           (a) SUBSTANCE ABUSE TREATMENT SERVICES FOR  
 7 CHILDREN, ADOLESCENTS, AND YOUNG ADULTS.—Sec-  
 8 tion 514 of the Public Health Service Act (42 U.S.C.  
 9 290bb-7) is amended—

10           (1) in the section heading, by striking “**CHIL-**  
 11 **DREN AND ADOLESCENTS**” and inserting “**CHIL-**  
 12 **DREN, ADOLESCENTS, AND YOUNG ADULTS**”;

13           (2) in subsection (a)(2), by striking “children,  
 14 including” and inserting “children, adolescents, and  
 15 young adults, including”; and

16           (3) by striking “children and adolescents” each  
 17 place it appears and inserting “children, adolescents,  
 18 and young adults”.

19           (b) YOUTH PREVENTION AND RECOVERY INITIA-  
 20 TIVE.—

21           (1) DEFINITIONS.—In this subsection:

22           (A) ELIGIBLE ENTITY.—The term “eligible  
 23 entity” means—

24           (i) a local educational agency that is  
 25 seeking to establish or expand substance

1 use prevention and recovery support serv-  
2 ices at one or more high schools;

3 (ii) an institution of higher education;

4 (iii) a recovery program at an institu-  
5 tion of higher education;

6 (iv) a local board or one-stop oper-  
7 ator; or

8 (v) a nonprofit organization, excluding  
9 a school.

10 (B) HIGH SCHOOL.—The term “high  
11 school” has the meaning given such term in  
12 section 8101 of the Elementary and Secondary  
13 Education Act of 1965 (20 U.S.C. 7801).

14 (C) INSTITUTION OF HIGHER EDU-  
15 CATION.—The term “institution of higher edu-  
16 cation” has the meaning given such term in  
17 section 101 of the Higher Education Act of  
18 1965 (20 U.S.C. 1001) and includes a “post-  
19 secondary vocational institution” as defined in  
20 section 102(c) of such Act (20 U.S.C. 1002(c)).

21 (D) LOCAL EDUCATION AGENCY.—The  
22 term “local educational agency” has the mean-  
23 ing given the term in section 8101 of the Ele-  
24 mentary and Secondary Education Act of 1965.

1           (E) LOCAL BOARD; ONE-STOP OPER-  
2           ATOR.—The terms “local board” and “one-stop  
3           operator” have the meanings given such terms  
4           in section 3 of the Workforce Innovation and  
5           Opportunity Act (29 U.S.C. 3102).

6           (F) RECOVERY PROGRAM.—The term “re-  
7           covery program” means a program—

8                   (i) to help children, adolescents, or  
9                   young adults who are recovering from sub-  
10                  stance use disorders to initiate, stabilize,  
11                  and maintain healthy and productive lives  
12                  in the community; and

13                   (ii) that includes peer-to-peer support  
14                  delivered by individuals with lived experi-  
15                  ence in recovery, and communal activities  
16                  to build recovery skills and supportive so-  
17                  cial networks.

18           (G) SECRETARY.—The term “Secretary”  
19           means the Secretary of Health and Human  
20           Services, except as otherwise specified.

21           (2) BEST PRACTICES.—The Secretary, in con-  
22           sultation with the Secretary of Education, shall—

23                   (A) identify or facilitate the development of  
24                   evidence-based best practices for prevention of  
25                   substance misuse and abuse by children, adoles-

1 cents, and young adults, for appropriate recov-  
2 ery support services, and for appropriate use of  
3 medication-assisted treatment for such individ-  
4 uals, if applicable;

5 (B) disseminate such best practices to local  
6 educational agencies, institutions of higher edu-  
7 cation, recovery programs at institutions of  
8 higher education, local boards, one-stop opera-  
9 tors, and nonprofit organizations, as appro-  
10 priate;

11 (C) conduct a rigorous, independent eval-  
12 uation of each grant funded under this sub-  
13 section, particularly its impact on the indicators  
14 described in paragraph (5)(B); and

15 (D) provide technical assistance for grant-  
16 ees under this subsection.

17 (3) GRANTS AUTHORIZED.—The Secretary, in  
18 consultation with the Secretary of Education, shall  
19 award 3-year grants, on a competitive basis, to eligi-  
20 ble entities to enable such entities, in coordination  
21 with State agencies responsible for carrying out sub-  
22 stance use disorder prevention and treatment pro-  
23 grams, to carry out evidence-based or promising pro-  
24 grams for—

1 (A) prevention of substance abuse and mis-  
2 use by children, adolescents, and young adults;

3 (B) recovery support services for children,  
4 adolescents, and young adults, which may in-  
5 clude counseling, job training, linkages to com-  
6 munity-based services, family support groups,  
7 and recovery coaching; and

8 (C) treatment or referrals for treatment of  
9 substance use disorders, as appropriate.

10 (4) APPLICATION.—To be eligible for a grant  
11 under this subsection, an entity shall submit to the  
12 Secretary an application at such time, in such man-  
13 ner, and containing such information as the Sec-  
14 retary may require. Such application shall include—

15 (A) a description of the impact of sub-  
16 stance use disorders on children, adolescents,  
17 and young adults enrolled in the local edu-  
18 cational agency, one-stop operator, local board,  
19 or institution of higher education;

20 (B) a description of how the eligible entity  
21 has solicited input from faculty, teachers, staff,  
22 families, students, and experts in substance use  
23 prevention and treatment in developing such  
24 application;

1 (C) how the eligible entity plans to use  
2 grant funds for evidence-based or promising ac-  
3 tivities, in accordance with this subsection to  
4 prevent, provide recovery support for, and treat  
5 substance use disorders amongst such individ-  
6 uals;

7 (D) an assurance that the eligible entity  
8 will participate in the evaluation described in  
9 paragraph (2)(C); and

10 (E) a description of how the eligible entity  
11 will collaborate with local service providers, in-  
12 cluding substance use disorder treatment pro-  
13 grams, providers of mental health services, and  
14 primary care providers, in carrying out the  
15 grant program.

16 (5) REPORT.—Each eligible entity awarded a  
17 grant under this section shall submit to the appro-  
18 priate committees of Congress, a report at such time  
19 and in such manner as the Secretary may require.  
20 Such report shall include—

21 (A) a description of how the eligible entity  
22 used grant funds, in accordance with this sub-  
23 section, including the number of children, ado-  
24 lescents, and young adults reached through pro-  
25 gramming; and

1 (B) a description of how the grant pro-  
2 gram has made an impact on—

3 (i) indicators of student success, in-  
4 cluding student well-being and academic  
5 achievement; and

6 (ii) substance use disorders amongst  
7 children, adolescents, and young adults, in-  
8 cluding the number of overdoses and  
9 deaths amongst children, adolescents, and  
10 young adults during the grant period.

11 (6) AUTHORIZATION OF APPROPRIATIONS.—

12 There is authorized to be appropriated, such sums  
13 as may be necessary to carry out this subsection.

14 **SEC. 409. PLANS OF SAFE CARE.**

15 (a) IN GENERAL.—Section 105(a) of the Child Abuse  
16 Prevention and Treatment Act (42 U.S.C. 5106(a)) is  
17 amended by adding at the end the following:

18 “(7) GRANTS TO STATES TO IMPROVE AND CO-  
19 ORDINATE THEIR RESPONSE TO ENSURE THE SAFE-  
20 TY, PERMANENCY, AND WELL-BEING OF INFANTS  
21 AFFECTED BY SUBSTANCE USE.—

22 “(A) PROGRAM AUTHORIZED.—The Sec-  
23 retary shall make grants to States for the pur-  
24 pose of assisting child welfare agencies, social  
25 services agencies, substance use disorder treat-

1           ment agencies, public health and mental health  
2           agencies, and maternal and child health agen-  
3           cies to facilitate collaboration in developing, up-  
4           dating, and implementing plans of safe care de-  
5           scribed in section 106(b)(2)(B)(iii).

6           “(B) DISTRIBUTION OF FUNDS.—

7           “(i) RESERVATIONS.—Of the amounts  
8           appropriated under subparagraph (H), the  
9           Secretary shall reserve—

10           “(I) no more than 3 percent for  
11           the purposes described in subpara-  
12           graph (G); and

13           “(II) up to 3 percent for grants  
14           to Indian Tribes and tribal organiza-  
15           tions for purposes consistent with this  
16           section, as the Secretary determines  
17           appropriate.

18           “(ii) ALLOTMENTS TO STATES AND  
19           TERRITORIES.—The Secretary shall allot  
20           the amount appropriated under subpara-  
21           graph (H) that remains after application  
22           of clause (i) on a competitive basis to  
23           States that apply for such a grant.

24           “(iii) SELECTION CRITERIA.—The  
25           Secretary shall allot funds to States that

1 demonstrate a strong need for such funds,  
2 and a strong commitment to using such  
3 funds, to meet the purposes described in  
4 subparagraph (A) in accordance with sub-  
5 paragraph (D).

6 “(C) APPLICATION.—A State desiring a  
7 grant under this paragraph shall submit an ap-  
8 plication to the Secretary at such time and in  
9 such manner as the Secretary may require.  
10 Such application shall include—

11 “(i) a description of—

12 “(I) the impact of substance use  
13 disorder in such State, including with  
14 respect to the substance or class of  
15 substances with the highest incidence  
16 of abuse in the previous year in such  
17 State, including—

18 “(aa) the prevalence of sub-  
19 stance use disorder in such State;

20 “(bb) the aggregate rate of  
21 births in the State of infants af-  
22 fected by substance abuse or  
23 withdrawal symptoms or a fetal  
24 alcohol spectrum disorder (as de-  
25 termined by hospitals, insurance

1 claims, claims submitted to the  
2 State Medicaid program, or other  
3 records), if available and to the  
4 extent practicable; and

5 “(cc) the number of infants  
6 identified, for whom a plan of  
7 safe care was developed, and for  
8 whom a referral was made for  
9 appropriate services, as reported  
10 under section 106(d)(18);

11 “(II) the challenges the State  
12 faces in developing and implementing  
13 plans of safe care in accordance with  
14 section 106(b)(2)(B)(iii);

15 “(III) the State’s lead agency for  
16 the grant program and how that agen-  
17 cy will coordinate with relevant State  
18 entities and programs, including the  
19 child welfare agency, the substance  
20 use disorder treatment agency, the  
21 public health and mental health agen-  
22 cies, programs funded by the Residen-  
23 tial Treatment for Pregnant and  
24 Postpartum Women grant program of  
25 the Substance Abuse and Mental

1 Health Services Administration under  
2 section 508 of the Public Health Serv-  
3 ice Act (42 U.S.C. 290bb-1), the  
4 State Medicaid program, the State  
5 agency administering the block grant  
6 program under title V of the Social  
7 Security Act (42 U.S.C. 701 et seq.),  
8 the State agency administering the  
9 programs funded under part C of the  
10 Individuals with Disabilities Edu-  
11 cation Act (20 U.S.C. 1431 et seq.),  
12 the maternal, infant, and early child-  
13 hood home visiting program under  
14 section 511 of the Social Security Act  
15 (42 U.S.C. 711), the State judicial  
16 system, and other agencies, as deter-  
17 mined by the Secretary;

18 “(IV) how the State will monitor  
19 local implementation of plans of safe  
20 care, in accordance with section  
21 106(b)(2)(B)(iii)(II);

22 “(V) how the State meets the re-  
23 quirements of section 1927 of the  
24 Public Health Service Act (42 U.S.C.  
25 300x-27);

1           “(VI) how the State plans to uti-  
2           lize funding authorized under part E  
3           of title IV of the Social Security Act  
4           (42 U.S.C. 670 et seq.) to assist in  
5           carrying out any plan of safe care, in-  
6           cluding such funding authorized under  
7           section 471(e) of such Act (as in ef-  
8           fect on October 1, 2018) for mental  
9           health and substance abuse prevention  
10          and treatment services and in-home  
11          parent skill-based programs and fund-  
12          ing authorized under such section  
13          472(j) (as in effect on October 1,  
14          2018) for children with a parent in a  
15          licensed residential family-based treat-  
16          ment facility for substance abuse; and  
17          “(VII) an assessment of the  
18          treatment and other services and pro-  
19          grams available in the State, to effec-  
20          tively carry out any plan of safe care  
21          developed, including identification of  
22          needed treatment, and other services  
23          and programs to ensure the wellbeing  
24          of young children and their families  
25          affected by substance use disorder,

1           such as programs carried out under  
2           part C of the Individuals with Disabil-  
3           ities Education Act and comprehen-  
4           sive early childhood development serv-  
5           ices and programs such as Head Start  
6           programs;

7           “(ii) a description of how the State  
8           plans to use funds for activities described  
9           in subparagraph (D) for the purposes of  
10          ensuring State compliance with require-  
11          ments under clauses (ii) and (iii) of section  
12          106(b)(2)(B); and

13          “(iii) an assurance that the State  
14          will—

15                 “(I) comply with this Act and  
16                 parts B and E of title IV of the Social  
17                 Security Act (42 U.S.C. 621 et seq.,  
18                 670 et seq.); and

19                 “(II) comply with requirements  
20                 to refer a child identified as sub-  
21                 stance-exposed to early intervention  
22                 services as required pursuant to a  
23                 grant under part C of the Individuals  
24                 with Disabilities Education Act (20  
25                 U.S.C. 1431 et seq.).

1           “(D) USES OF FUNDS.—Funds awarded to  
2 a State under this paragraph may be used for  
3 the following activities, which may be carried  
4 out by the State directly, or through grants or  
5 subgrants, contracts, or cooperative agreements:

6           “(i) Improving State and local sys-  
7 tems with respect to the development and  
8 implementation of plans of safe care,  
9 which—

10           “(I) shall include parent and  
11 caregiver engagement, as required  
12 under section 106(b)(2)(B)(iii)(I), re-  
13 garding available treatment and serv-  
14 ice options, which may include re-  
15 sources available for pregnant,  
16 perinatal, and postnatal women; and

17           “(II) may include activities such  
18 as—

19           “(aa) developing policies,  
20 procedures, or protocols for the  
21 administration of evidence-based  
22 and validated screening tools for  
23 infants who may be affected by  
24 substance use withdrawal symp-  
25 toms or a fetal alcohol spectrum

1 disorder and pregnant, perinatal,  
2 and postnatal women whose in-  
3 fants may be affected by sub-  
4 stance use withdrawal symptoms  
5 or a fetal alcohol spectrum dis-  
6 order;

7 “(bb) improving assessments  
8 used to determine the needs of  
9 the infant and family;

10 “(cc) improving ongoing  
11 case management services; and

12 “(dd) improving access to  
13 treatment services, which may be  
14 prior to the pregnant woman’s  
15 delivery date.

16 “(ii) Developing policies, procedures,  
17 or protocols in consultation and coordina-  
18 tion with health professionals, public and  
19 private health facilities, and substance use  
20 disorder treatment agencies to ensure  
21 that—

22 “(I) appropriate notification to  
23 child protective services is made in a  
24 timely manner;

1                   “(II) a plan of safe care is in  
2                   place, where needed, before the infant  
3                   is discharged from the birth or health  
4                   care facility; and

5                   “(III) such health and related  
6                   agency professionals are trained on  
7                   how to follow such protocols and are  
8                   aware of the supports that may be  
9                   provided under a plan of safe care.

10                  “(iii) Training health professionals  
11                  and health system leaders, child welfare  
12                  workers, substance use disorder treatment  
13                  agencies, and other related professionals  
14                  such as home visiting agency staff and law  
15                  enforcement in relevant topics including—

16                         “(I) State mandatory reporting  
17                         laws and the referral and notification  
18                         process;

19                         “(II) the co-occurrence of preg-  
20                         nancy and substance use disorder;

21                         “(III) the clinical guidance about  
22                         treating substance use disorder in  
23                         pregnant and postpartum women;

24                         “(IV) appropriate screening and  
25                         interventions for infants affected by

1 substance use disorder, withdrawal  
2 symptoms, or a fetal alcohol spectrum  
3 disorder and the requirements under  
4 section 106(b)(2)(B)(iii); and

5 “(V) appropriate strategies to ad-  
6 dress the mental health needs of the  
7 parent and child together.

8 “(iv) Establishing partnerships, agree-  
9 ments, or memoranda of understanding be-  
10 tween the lead agency and health profes-  
11 sionals, health facilities, child welfare pro-  
12 fessionals, substance use disorder and  
13 mental health disorder treatment pro-  
14 grams, early childhood education pro-  
15 grams, and maternal and child health and  
16 early intervention professionals, including  
17 home visiting providers, peer-to-peer recov-  
18 ery programs such as parent mentoring  
19 programs, and housing agencies to facili-  
20 tate the implementation of, and compliance  
21 with section 106(b)(2) and clause (ii) of  
22 this subparagraph, in areas which may in-  
23 clude—

24 “(I) developing a comprehensive,  
25 multi-disciplinary assessment and

1 intervention process for infants and  
2 their families who are affected by sub-  
3 stance use disorder, withdrawal symp-  
4 toms, or a fetal alcohol spectrum dis-  
5 order, that includes meaningful en-  
6 gagement with and takes into account  
7 the unique needs of each family and  
8 addresses differences between legal,  
9 medically supervised substance use,  
10 and substance use disorder;

11 “(II) ensuring that treatment ap-  
12 proaches for serving infants, pregnant  
13 women, and perinatal and postnatal  
14 women whose infants may be affected  
15 by substance use, withdrawal symp-  
16 toms, or a fetal alcohol spectrum dis-  
17 order, are designed to, where appro-  
18 priate, keep infants with their moth-  
19 ers during both inpatient and out-  
20 patient treatment; and

21 “(III) increasing access to evi-  
22 dence-based medication-assisted treat-  
23 ment approved by the Food and Drug  
24 Administration, behavioral therapy,  
25 and counseling services for the treat-

1                   ment of substance use disorders, as  
2                   appropriate.

3                   “(v) Developing and updating systems  
4                   of technology for improved data collection  
5                   and        monitoring        under        section  
6                   106(b)(2)(B)(iii), including existing elec-  
7                   tronic medical records, to measure the out-  
8                   comes achieved through the plans of safe  
9                   care, including monitoring systems to meet  
10                  the requirements of this Act and submis-  
11                  sion of performance measures.

12                  “(E) REPORTING.—Each State that re-  
13                  ceives funds under this paragraph, for each  
14                  year such funds are received, shall submit a re-  
15                  port to the Secretary, disaggregated by geo-  
16                  graphic location, economic status, and major  
17                  racial and ethnic groups, except that such  
18                  disaggregation shall not be required if the re-  
19                  sults would reveal personally identifiable infor-  
20                  mation, on the following:

21                  “(i) The number of the infants identi-  
22                  fied under section 106(b)(2)(B)(ii) who ex-  
23                  perienced removal due to parental sub-  
24                  stance use concerns who are reunified with

1 parents, and the length of time between  
2 such removal and reunification.

3 “(ii) The number of the infants iden-  
4 tified under section 106(b)(2)(B)(ii) who  
5 experienced substantiated reports of child  
6 abuse or neglect and received differential  
7 response while in the care of their birth  
8 parents or within 1 year after a reunifica-  
9 tion has occurred.

10 “(iii) The number of the infants iden-  
11 tified under section 106(b)(2)(B)(ii) who  
12 experienced a return to out-of-home care  
13 within one year after reunification.

14 “(F) SECRETARY’S REPORT TO CON-  
15 GRESS.—The Secretary shall submit an annual  
16 report to the Committee on Health, Education,  
17 Labor, and Pensions and the Committee on Ap-  
18 propriations of the Senate and the Committee  
19 on Education and the Workforce and the Com-  
20 mittee on Appropriations of the House of Rep-  
21 resentatives that includes the information de-  
22 scribed in subparagraph (E) and recommenda-  
23 tions or observations on the challenges, suc-  
24 cesses, and lessons derived from implementation  
25 of the grant program.

1           “(G) RESERVATION OF FUNDS.—The Sec-  
2           retary shall use the amount reserved under sub-  
3           paragraph (B)(i)(I) for the purposes of—

4                   “(i) providing technical assistance, in-  
5                   cluding programs of in-depth technical as-  
6                   sistance, to additional States, territories,  
7                   and Indian tribes in accordance with the  
8                   substance-exposed infant initiative devel-  
9                   oped by the National Center on Substance  
10                  Abuse and Child Welfare;

11                  “(ii) issuing guidance on the require-  
12                  ments of this Act with respect to infants  
13                  born with and identified as being affected  
14                  by substance use or withdrawal symptoms  
15                  or fetal alcohol spectrum disorder, as de-  
16                  scribed in clauses (ii) and (iii) of section  
17                  106(b)(2)(B), including by—

18                           “(I) clarifying key terms; and

19                           “(II) disseminating best practices  
20                           on implementation of plans of safe  
21                           care, on such topics as differential re-  
22                           sponse, collaboration and coordina-  
23                           tion, and identification and delivery of  
24                           services, for different populations;

1                   “(iii) supporting State efforts to de-  
2                   velop information technology systems to  
3                   manage plans of safe care; and

4                   “(iv) preparing the Secretary’s report  
5                   to Congress described in subparagraph  
6                   (F).

7                   “(H) AUTHORIZATION OF APPROPRIA-  
8                   TIONS.—To carry out the program under this  
9                   paragraph, there are authorized to be appro-  
10                  priated \$60,000,000 for each of fiscal years  
11                  2019 through 2023.”.

12                  (b) DEFINITION.—Section 3 of the Child Abuse Pre-  
13                  vention and Treatment Act (42 U.S.C. 5101 note) is  
14                  amended—

15                   (1) in paragraph (7), by striking “; and” and  
16                   inserting a semicolon;

17                   (2) by redesignating paragraph (8) as para-  
18                   graph (9); and

19                   (3) by inserting after paragraph (7) the fol-  
20                   lowing:

21                   “(8) the term ‘substance use disorder’ means  
22                   the abuse of alcohol or other drugs; and”.

1 **SEC. 410. REGULATIONS RELATING TO SPECIAL REGISTRA-**  
2 **TION FOR TELEMEDICINE.**

3 Section 311(h) of the Controlled Substances Act (21  
4 U.S.C. 831(h)) is amended by striking paragraph (2) and  
5 inserting the following:

6 “(2) REGULATIONS.—

7 “(A) IN GENERAL.—Not later than 1 year  
8 after the date of enactment of the Opioid Crisis  
9 Response Act of 2018, in consultation with the  
10 Secretary, and in accordance with the procedure  
11 described in subparagraph (B), the Attorney  
12 General shall promulgate final regulations  
13 specifying—

14 “(i) the limited circumstances in  
15 which a special registration under this sub-  
16 section may be issued; and

17 “(ii) the procedure for obtaining a  
18 special registration under this subsection.

19 “(B) PROCEDURE.—In promulgating final  
20 regulations under subparagraph (A), the Attor-  
21 ney General shall—

22 “(i) issue a notice of proposed rule-  
23 making that includes a copy of the pro-  
24 posed regulations;

1 “(ii) provide a period of not less than  
2 60 days for comments on the proposed reg-  
3 ulations;

4 “(iii) finalize the proposed regulation  
5 not later than 6 months after the close of  
6 the comment period; and

7 “(iv) publish the final regulations not  
8 later than 30 days before the effective date  
9 of the final regulations.”.

10 **SEC. 411. NATIONAL HEALTH SERVICE CORPS BEHAVIORAL**  
11 **AND MENTAL HEALTH PROFESSIONALS PRO-**  
12 **VIDING OBLIGATED SERVICE IN SCHOOLS**  
13 **AND OTHER COMMUNITY-BASED SETTINGS.**

14 Subpart III of part D of title III of the Public Health  
15 Service Act (42 U.S.C. 254*l* et seq.) is amended by adding  
16 at the end the following:

17 **“SEC. 338N. BEHAVIORAL AND MENTAL HEALTH PROFES-**  
18 **SIONALS PROVIDING OBLIGATED SERVICE IN**  
19 **SCHOOLS AND OTHER COMMUNITY-BASED**  
20 **SETTINGS.**

21 “(a) SCHOOLS AND COMMUNITY-BASED SETTINGS.—  
22 An entity to which a Corps member is assigned under sec-  
23 tion 333 may direct such Corps member to provide service  
24 as a behavioral and mental health professional at a school

1 or other community-based setting located in a health pro-  
 2 fessional shortage area.

3 “(b) OBLIGATED SERVICE.—

4 “(1) IN GENERAL.—Any service described in  
 5 subsection (a) that a Corps member provides may  
 6 count towards such Corps member’s completion of  
 7 any obligated service requirements under the Schol-  
 8 arship Program or the Loan Repayment Program,  
 9 subject to any limitation imposed under paragraph  
 10 (2).

11 “(2) LIMITATION.—The Secretary may impose  
 12 a limitation on the number of hours of service de-  
 13 scribed in subsection (a) that a Corps member may  
 14 credit towards completing obligated service require-  
 15 ments, provided that the limitation allows a member  
 16 to credit service described in subsection (a) for not  
 17 less than 50 percent of the total hours required to  
 18 complete such obligated service requirements.

19 “(c) RULE OF CONSTRUCTION.—The authorization  
 20 under subsection (a) shall be notwithstanding any other  
 21 provision of this subpart or subpart II.”.

22 **SEC. 412. LOAN REPAYMENT FOR SUBSTANCE USE DIS-**  
 23 **ORDER TREATMENT PROVIDERS.**

24 (a) LOAN REPAYMENT FOR SUBSTANCE USE TREAT-  
 25 MENT PROVIDERS.—The Secretary of Health and Human

1 Services (referred to in this section as the “Secretary”)  
2 shall enter into contracts under section 338B of the Public  
3 Health Service Act (42 U.S.C. 254l–1) with eligible health  
4 professionals providing substance use disorder treatment  
5 services in substance use disorder treatment facilities, as  
6 defined by the Secretary.

7 (b) PROVISION OF SUBSTANCE USE DISORDER  
8 TREATMENT.—In carrying out the activities described in  
9 subsection (a)—

10 (1) such facilities shall be located in mental  
11 health professional shortage areas designated under  
12 section 332 of the Public Health Service Act (42  
13 U.S.C. 254e);

14 (2) section 331(a)(3)(D) of such Act (42 U.S.C.  
15 254d(a)(3)(D)) shall be applied as if the term “pri-  
16 mary health services” includes health services re-  
17 garding substance use disorder treatment;

18 (3) section 331(a)(3)(E)(i) of such Act (42  
19 U.S.C. 254d(a)(3)(E)(i)) shall be applied as if the  
20 term “behavioral and mental health professionals”  
21 includes masters level, licensed substance use dis-  
22 order treatment counselors; and

23 (4) such professionals and facilities shall pro-  
24 vide—

1 (A) counseling by a program counselor or  
2 other certified professional who is licensed and  
3 qualified by education, training, or experience  
4 to assess the psychological and sociological  
5 background of patients, to contribute to the ap-  
6 propriate treatment plan for the patient, and to  
7 monitor progress; and

8 (B) all drugs approved by the Food and  
9 Drug Administration to treat substance use dis-  
10 orders.

11 (c) AUTHORIZATION OF APPROPRIATIONS.—There is  
12 authorized to be appropriated to carry out this section,  
13 \$25,000,000 for each of fiscal years 2019 through 2023.

14 **SEC. 413. IMPROVING TREATMENT FOR PREGNANT AND**  
15 **POSTPARTUM WOMEN.**

16 (a) REPORT.—

17 (1) IN GENERAL.—Not later than 60 days after  
18 the date of enactment of this Act, the Secretary of  
19 Health and Human Services (referred to in this sub-  
20 section as the “Secretary”) shall submit to the ap-  
21 propriate committees of Congress and make avail-  
22 able to the public on the internet website of the De-  
23 partment of Health and Human Services a report  
24 regarding the implementation of the recommenda-  
25 tions in the strategy relating to prenatal opioid use,

1 including neonatal abstinence syndrome, developed  
2 pursuant to section 2 of the Protecting Our Infants  
3 Act of 2015 (Public Law 114–91). Such report shall  
4 include—

5 (A) an update on the implementation of  
6 the recommendations in the strategy, including  
7 information regarding the agencies involved in  
8 the implementation; and

9 (B) information on additional funding or  
10 authority the Secretary requires, if any, to im-  
11 plement the strategy, which may include au-  
12 thorities needed to coordinate implementation  
13 of such strategy across the Department of  
14 Health and Human Services.

15 (2) PERIODIC UPDATES.—The Secretary shall  
16 periodically update the report under paragraph (1).

17 (b) RESIDENTIAL TREATMENT PROGRAMS FOR  
18 PREGNANT AND POSTPARTUM WOMEN.—Section 508(s)  
19 of the Public Health Service Act (42 U.S.C. 290bb–1(s))  
20 is amended by striking “\$16,900,000 for each of fiscal  
21 years 2017 through 2021” and inserting “\$29,931,000 for  
22 each of fiscal years 2019 through 2023”.

1 **SEC. 414. EARLY INTERVENTIONS FOR PREGNANT WOMEN**  
2 **AND INFANTS.**

3 (a) DEVELOPMENT OF EDUCATIONAL MATERIALS BY  
4 CENTER FOR SUBSTANCE ABUSE PREVENTION.—Section  
5 515(b) of the Public Health Service Act (42 U.S.C.  
6 290bb–21(b)) is amended—

7 (1) in paragraph (13), by striking “and” at the  
8 end;

9 (2) in paragraph (14), by striking the period at  
10 the end and inserting “; and”; and

11 (3) by adding at the end the following:

12 “(15) in cooperation with relevant stakeholders  
13 and the Director of the Centers for Disease Control  
14 and Prevention, develop educational materials for  
15 clinicians to use with pregnant women for shared de-  
16 cisionmaking regarding pain management during  
17 pregnancy.”.

18 (b) GUIDELINES AND RECOMMENDATIONS BY CEN-  
19 TER FOR SUBSTANCE ABUSE TREATMENT.—Section  
20 507(b) of the Public Health Service Act (42 U.S.C.  
21 290bb(b)) is amended—

22 (1) in paragraph (13), by striking “and” at the  
23 end;

24 (2) in paragraph (14), by striking the period at  
25 the end and inserting a semicolon; and

26 (3) by adding at the end the following:

1           “(15) in cooperation with the Secretary, imple-  
 2           ment and disseminate, as appropriate, the rec-  
 3           ommendations in the report entitled ‘Protecting Our  
 4           Infants Act: Final Strategy’ issued by the Depart-  
 5           ment of Health and Human Services in 2017; and”.

6           (c) SUPPORT OF PARTNERSHIPS BY CENTER FOR  
 7           SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the  
 8           Public Health Service Act (42 U.S.C. 290bb(b)), as  
 9           amended by subsection (b), is further amended by adding  
 10          at the end the following:

11           “(16) in cooperation with relevant stakeholders,  
 12           support public-private partnerships to assist with  
 13           education about, and support with respect to, sub-  
 14           stance use disorder for pregnant women and health  
 15           care providers who treat pregnant women and ba-  
 16           bies.”.

## 17           **TITLE V—PREVENTION**

### 18           **SEC. 501. STUDY ON PRESCRIBING LIMITS.**

19           Not later than 2 years after the date of enactment  
 20           of this Act, the Secretary of Health and Human Services,  
 21           in consultation with the Attorney General, shall submit to  
 22           the Committee on Health, Education, Labor, and Pen-  
 23           sions of the Senate and the Committee on Energy and  
 24           Commerce of the House of Representatives a report on  
 25           the impact of Federal and State laws and regulations that

1 limit the length, quantity, or dosage of opioid prescrip-  
2 tions. Such report shall address—

3 (1) the impact of such limits on—

4 (A) the incidence and prevalence of over-  
5 dose related to prescription opioids;

6 (B) the incidence and prevalence of over-  
7 dose related to illicit opioids;

8 (C) the prevalence of opioid use disorders;  
9 and

10 (D) medically appropriate use of, and ac-  
11 cess to, opioids, including any impact on travel  
12 expenses and pain management outcomes for  
13 patients, whether such limits are associated  
14 with significantly higher rates of negative  
15 health outcomes, including suicide, and whether  
16 the impact of such limits differs based on clin-  
17 ical indication for which opioids are prescribed;

18 (2) whether such limits lead to a significant in-  
19 crease in burden for prescribers of opioids or pre-  
20 scribers of treatments for opioid use disorder, in-  
21 cluding any impact on patient access to treatment,  
22 and whether any such burden is mitigated by any  
23 factors such as electronic prescribing; and

24 (3) the impact of such limits on diversion or  
25 misuse of any controlled substance in schedule II,

1 III, or IV of section 202(c) of the Controlled Sub-  
2 stances Act (21 U.S.C. 812(c)).

3 **SEC. 502. PROGRAMS FOR HEALTH CARE WORKFORCE.**

4 (a) PROGRAM FOR EDUCATION AND TRAINING IN  
5 PAIN CARE.—Section 759 of the Public Health Service  
6 Act (42 U.S.C. 294i) is amended—

7 (1) in subsection (a), by inserting “nonprofit”  
8 after “private”;

9 (2) in subsection (b)—

10 (A) in the matter preceding paragraph (1),  
11 by striking “award may be made under sub-  
12 section (a) only if the applicant for the award  
13 agrees that the program carried out with the  
14 award will include” and inserting “entity receiv-  
15 ing an award under this section shall develop a  
16 comprehensive education and training plan that  
17 includes”;

18 (B) in paragraph (1)—

19 (i) by inserting “preventing,” after  
20 “diagnosing,”; and

21 (ii) by inserting “non-addictive med-  
22 ical products and non-pharmacologic treat-  
23 ments and” after “including”;

24 (C) in paragraph (2)—

1 (i) by inserting “Federal, State, and  
2 local” after “applicable”; and

3 (ii) by striking “the degree to which”  
4 and all that follows through “effective pain  
5 care” and inserting “opioids”;

6 (D) in paragraph (3), by inserting “and,  
7 as appropriate, non-pharmacotherapy” before  
8 the semicolon;

9 (E) in paragraph (4)—

10 (i) by inserting “any” before “cul-  
11 tural”; and

12 (ii) by striking “; and” and inserting  
13 “;”;

14 (F) in paragraph (5), by striking “provi-  
15 sion of pain care.” and inserting “scientific  
16 basis of pain and the provision of pain care, in-  
17 cluding through non-addictive medical products  
18 and non-pharmacologic treatments; and”;

19 (G) by adding at the end the following:

20 “(6) the dangers of opioid abuse, detection of  
21 early warning signs of opioid use disorders, and safe  
22 disposal options for prescription medications, includ-  
23 ing such options provided by law enforcement, or  
24 other innovative deactivation mechanisms.”;

1 (3) in subsection (d), by inserting “prevention,”  
2 after “diagnosis,”; and

3 (4) in subsection (e), by striking “2010 through  
4 2012” and inserting “2019 through 2023”.

5 (b) MENTAL AND BEHAVIORAL HEALTH EDUCATION  
6 AND TRAINING PROGRAM.—Section 756(a) of the Public  
7 Health Service Act (42 U.S.C. 294e–1(a)) is amended—

8 (1) in paragraph (1), by inserting “, trauma,”  
9 after “focus on child and adolescent mental health”;  
10 and

11 (2) in paragraphs (2) and (3), by inserting  
12 “trauma-informed care and” before “substance use  
13 disorder prevention and treatment services”.

14 **SEC. 503. EDUCATION AND AWARENESS CAMPAIGNS.**

15 Section 102 of the Comprehensive Addiction and Re-  
16 covery Act of 2016 (Public Law 114–198) is amended—

17 (1) by amending subsection (a) to read as fol-  
18 lows:

19 “(a) IN GENERAL.—The Secretary of Health and  
20 Human Services, acting through the Director of the Cen-  
21 ters for Disease Control and Prevention and in coordina-  
22 tion with the heads of other departments and agencies,  
23 shall advance education and awareness regarding the risks  
24 related to misuse and abuse of opioids, as appropriate,  
25 which may include developing or improving existing pro-

1 grams, conducting activities, and awarding grants that ad-  
2 vance the education and awareness of—

3 “(1) the public, including patients and con-  
4 sumers;

5 “(2) patients, consumers, and other appropriate  
6 members of the public, regarding such risks related  
7 to unused opioids and the dispensing options under  
8 section 309(f) of the Controlled Substances Act, as  
9 applicable;

10 “(3) providers, which may include—

11 “(A) providing for continuing education on  
12 appropriate prescribing practices;

13 “(B) education related to applicable State  
14 or local prescriber limit laws, information on  
15 the use of non-addictive or non-opioid alter-  
16 natives for pain management, and the use of  
17 overdose reversal drugs, as appropriate;

18 “(C) disseminating and improving the use  
19 of evidence-based opioid prescribing guidelines  
20 across relevant health care settings, as appro-  
21 priate, and updating guidelines as necessary;

22 “(D) implementing strategies, such as best  
23 practices, to encourage and facilitate the use of  
24 prescriber guidelines, in accordance with State  
25 and local law; and

1           “(E) disseminating information to pro-  
2           viders about prescribing options for controlled  
3           substances, including such options under sec-  
4           tion 309(f) of the Controlled Substances Act, as  
5           applicable; and

6           “(4) other appropriate entities.”; and

7           (2) in subsection (b)—

8           (A) by striking “opioid abuse” each place  
9           such term appears and inserting “opioid misuse  
10           and abuse”; and

11           (B) in paragraph (2), by striking “safe dis-  
12           posal of prescription medications and other”  
13           and inserting “non-addictive or non-opioid  
14           treatment options, safe disposal options for pre-  
15           scription medications, and other applicable”.

16 **SEC. 504. ENHANCED CONTROLLED SUBSTANCE**  
17 **OVERDOSES DATA COLLECTION, ANALYSIS,**  
18 **AND DISSEMINATION.**

19           Part J of title III of the Public Health Service Act  
20           is amended by inserting after section 392 (42 U.S.C.  
21           280b-1) the following:

1 **“SEC. 392A. ENHANCED CONTROLLED SUBSTANCE**  
2 **OVERDOSES DATA COLLECTION, ANALYSIS,**  
3 **AND DISSEMINATION.**

4 “(a) IN GENERAL.—The Director of the Centers for  
5 Disease Control and Prevention, using the authority pro-  
6 vided to the Director under section 392, may—

7 “(1) to the extent practicable, carry out and ex-  
8 pand any controlled substance overdose data collec-  
9 tion, analysis, and dissemination activity described  
10 in subsection (b);

11 “(2) provide training and technical assistance  
12 to States, localities, and Indian tribes for the pur-  
13 pose of carrying out any such activity; and

14 “(3) award grants to States, localities, and In-  
15 dian tribes for the purpose of carrying out any such  
16 activity.

17 “(b) CONTROLLED SUBSTANCE OVERDOSE DATA  
18 COLLECTION AND ANALYSIS ACTIVITIES.—A controlled  
19 substance overdose data collection, analysis, and dissemi-  
20 nation activity described in this subsection is any of the  
21 following activities:

22 “(1) Improving the timeliness of reporting ag-  
23 gregate data to the public, including data on fatal  
24 and nonfatal controlled substance overdoses.

25 “(2) Enhancing the comprehensiveness of con-  
26 trolled substance overdose data by collecting infor-

1       mation on such overdoses from appropriate sources  
2       such as toxicology reports, death scene investiga-  
3       tions, and emergency department services.

4               “(3) Modernizing the system for coding causes  
5       of death related to controlled substance overdoses to  
6       use an electronic-based system.

7               “(4) Using data to help identify risk factors as-  
8       sociated with controlled substance overdoses, includ-  
9       ing the delivery of certain health care services.

10              “(5) Supporting entities involved in reporting  
11       information on controlled substance overdoses, such  
12       as coroners and medical examiners, to improve accu-  
13       rate testing and reporting of causes and contributing  
14       factors of such overdoses, and analysis of various  
15       opioid analogues to controlled substances overdoses.

16              “(6) Working to enable and encourage the ac-  
17       cess, exchange, and use of data regarding controlled  
18       substances overdoses among data sources and enti-  
19       ties.

20              “(c) CONTROLLED SUBSTANCE DEFINED.—In this  
21       section, the term ‘controlled substance’ has the meaning  
22       given that term in section 102 of the Controlled Sub-  
23       stances Act.”.

1 **SEC. 505. PREVENTING OVERDOSES OF CONTROLLED SUB-**  
2 **STANCES.**

3 Part J of title III of the Public Health Service Act  
4 (42 U.S.C. 280b et seq.), as amended by section 504, is  
5 further amended by inserting after section 392A the fol-  
6 lowing:

7 **“SEC. 392B. PREVENTING OVERDOSES OF CONTROLLED**  
8 **SUBSTANCES.**

9 “(a) PREVENTION ACTIVITIES.—

10 “(1) IN GENERAL.—The Director of the Cen-  
11 ters for Disease Control and Prevention (referred to  
12 in this section as the ‘Director’), using the authority  
13 provided to the Director under section 392, may—

14 “(A) to the extent practicable, carry out  
15 and expand any prevention activity described in  
16 paragraph (2);

17 “(B) provide training and technical assist-  
18 ance to States, localities, and Indian tribes to  
19 carrying out any such activity; and

20 “(C) award grants to States, localities, and  
21 tribes for the purpose of carrying out any such  
22 activity.

23 “(2) PREVENTION ACTIVITIES.—A prevention  
24 activity described in this paragraph is an activity to  
25 improve the efficiency and use of a new or currently  
26 operating prescription drug monitoring program—

1           “(A) encouraging all authorized users (as  
2 specified by the State or other entity) to reg-  
3 ister with and use the program;

4           “(B) enabling such users to access any  
5 data updates in as close to real-time as prac-  
6 ticable;

7           “(C) providing for a mechanism for the  
8 program to notify authorized users of any po-  
9 tential misuse or abuse of controlled substances  
10 and any detection of inappropriate prescribing  
11 practices relating to such substances;

12           “(D) encouraging the analysis of prescrip-  
13 tion drug monitoring data for purposes of pro-  
14 viding de-identified, aggregate reports based on  
15 such analysis to State public health agencies,  
16 State licensing boards, and other appropriate  
17 State agencies, as permitted under applicable  
18 Federal and State law and the policies of the  
19 prescription drug monitoring program and not  
20 containing any protected health information, to  
21 prevent inappropriate prescribing, drug diver-  
22 sion, or abuse and misuse of controlled sub-  
23 stances, and to facilitate better coordination  
24 among agencies;

1           “(E) enhancing interoperability between  
2           the program and any health information tech-  
3           nology (including certified health information  
4           technology), including by integrating program  
5           data into such technology;

6           “(F) updating program capabilities to re-  
7           spond to technological innovation for purposes  
8           of appropriately addressing the occurrence and  
9           evolution of controlled substance overdoses; and

10           “(G) facilitating and encouraging data ex-  
11           change between the program and the prescrip-  
12           tion drug monitoring programs of other States.

13           “(b) ADDITIONAL GRANTS.—The Director may  
14           award grants to States, localities, and Indian tribes—

15           “(1) to carry out innovative projects for grant-  
16           ees to rapidly respond to controlled substance mis-  
17           use, abuse, and overdoses, including changes in pat-  
18           terns of controlled substance use; and

19           “(2) for any other evidence-based activity for  
20           preventing controlled substance misuse, abuse, and  
21           overdoses as the Director determines appropriate.

22           “(c) RESEARCH.—The Director may conduct studies  
23           and evaluations to address substance use disorders, in-  
24           cluding preventing substance use disorders or other re-  
25           lated topics the Director determines appropriate.

1       “(d) PUBLIC AND PRESCRIBER EDUCATION.—Pursu-  
2 ant to section 102 of the Comprehensive Addiction and  
3 Recovery Act of 2016, the Director may advance the edu-  
4 cation and awareness of prescribers and the public regard-  
5 ing the risk of abuse of prescription opioids.

6       “(e) CONTROLLED SUBSTANCE DEFINED.—In this  
7 section, the term ‘controlled substance’ has the meaning  
8 given that term in section 102 of the Controlled Sub-  
9 stances Act.

10       “(f) AUTHORIZATION OF APPROPRIATIONS.—For  
11 purposes of carrying out this section, section 392A of this  
12 Act, and section 102 of the Comprehensive Addiction and  
13 Recovery Act of 2016, there is authorized to be appro-  
14 priated \$486,000,000 for each of fiscal years 2019  
15 through 2024.”.

16 **SEC. 506. CDC SURVEILLANCE AND DATA COLLECTION FOR**  
17 **CHILD, YOUTH, AND ADULT TRAUMA.**

18       (a) DATA COLLECTION.—The Director of the Centers  
19 for Disease Control and Prevention (referred to in this  
20 section as the “Director”) may, in cooperation with the  
21 States, collect and report data on adverse childhood expe-  
22 riences through the Behavioral Risk Factor Surveillance  
23 System, the Youth Risk Behavior Surveillance System,  
24 and other relevant public health surveys or questionnaires.

1 (b) TIMING.—The collection of data under subsection  
2 (a) may occur in fiscal year 2019 and every 2 years there-  
3 after.

4 (c) DATA FROM TRIBAL AND RURAL AREAS.—The  
5 Director shall encourage each State that participates in  
6 collecting and reporting data under subsection (a) to col-  
7 lect and report data from tribal and rural areas within  
8 such State, in order to generate a statistically reliable rep-  
9 resentation of such areas.

10 (d) AUTHORIZATION OF APPROPRIATIONS.—To carry  
11 out this section, there are authorized to be appropriated  
12 such sums as may be necessary for the period of fiscal  
13 years 2019 through 2021.

14 **SEC. 507. REAUTHORIZATION OF NASPER.**

15 Section 3990 of the Public Health Service Act (42  
16 U.S.C. 280g–3) is amended—

17 (1) in subsection (a)—

18 (A) in paragraph (1), in the matter pre-  
19 ceding subparagraph (A), by striking “Adminis-  
20 trator of the Substance Abuse and Mental  
21 Health Services Administration and Director of  
22 the Centers for Disease Control and Preven-  
23 tion” and inserting “Director of the Centers for  
24 Disease Control and Prevention and the Assist-

1 ant Secretary for Mental Health and Substance  
2 Use Disorders”; and

3 (B) by adding at the end the following:

4 “(4) STATES AND LOCAL GOVERNMENTS.—

5 “(A) IN GENERAL.—In the case of a State  
6 that does not have a prescription drug moni-  
7 toring program, a county or other unit of local  
8 government within the State that has a pre-  
9 scription drug monitoring program shall be  
10 treated as a State for purposes of this section,  
11 including for purposes of eligibility for grants  
12 under paragraph (1).

13 “(B) PLAN FOR INTEROPERABILITY.—For  
14 purposes of meeting the interoperability re-  
15 quirements under subsection (c)(3), a county or  
16 other unit of local government shall submit a  
17 plan outlining the methods such county or unit  
18 of local government will use to ensure the capa-  
19 bility of data sharing with other counties and  
20 units of local government within the State and  
21 with other States, as applicable.”;

22 (2) in subsection (c)—

23 (A) in paragraph (1)(A)(iii)—

1 (i) by inserting “as such standards  
2 become available,” after “interoperability  
3 standards,”; and

4 (ii) by striking “generated or identi-  
5 fied by the Secretary or his or her des-  
6 ignee” and inserting “recognized by the  
7 Office of the National Coordinator for  
8 Health Information Technology”; and

9 (B) in paragraph (3)(A), by inserting “in-  
10 cluding electronic health records,” after “tech-  
11 nology systems,”;

12 (3) in subsection (d)(1), by striking “not later  
13 than 1 week after the date of such dispensing” and  
14 inserting “in as close to real time as practicable”;

15 (4) in subsection (f)(1)(D), by striking “med-  
16 icaid” and inserting “Medicaid”;

17 (5) in subsection (i), by inserting “, in collabo-  
18 ration with the National Coordinator for Health In-  
19 formation Technology and the Director of the Na-  
20 tional Institute of Standards and Technology,” after  
21 “The Secretary”; and

22 (6) in subsection (n), by striking “2021” and  
23 inserting “2026”.

24 **SEC. 508. JESSIE’S LAW.**

25 (a) BEST PRACTICES.—

1           (1) IN GENERAL.—Not later than 1 year after  
2           the date of enactment of this Act, the Secretary of  
3           Health and Human Services (referred to in this sec-  
4           tion as the “Secretary”), in consultation with appro-  
5           priate stakeholders, including a patient with a his-  
6           tory of opioid use disorder, an expert in electronic  
7           health records, an expert in the confidentiality of pa-  
8           tient health information and records, and a health  
9           care provider, shall identify or facilitate the develop-  
10          ment of best practices regarding—

11                   (A) the circumstances under which infor-  
12                   mation that a patient has provided to a health  
13                   care provider regarding such patient’s history of  
14                   opioid use disorder should, only at the patient’s  
15                   request, be prominently displayed in the med-  
16                   ical records (including electronic health records)  
17                   of such patient;

18                   (B) what constitutes the patient’s request  
19                   for the purpose described in subparagraph (A);  
20                   and

21                   (C) the process and methods by which the  
22                   information should be so displayed.

23           (2) DISSEMINATION.—The Secretary shall dis-  
24          seminate the best practices developed under para-

1 graph (1) to health care providers and State agen-  
2 cies.

3 (b) REQUIREMENTS.—In identifying or facilitating  
4 the development of best practices under subsection (a), as  
5 applicable, the Secretary, in consultation with appropriate  
6 stakeholders, shall consider the following:

7 (1) The potential for addiction relapse or over-  
8 dose, including overdose death, when opioid medica-  
9 tions are prescribed to a patient recovering from  
10 opioid use disorder.

11 (2) The benefits of displaying information  
12 about a patient’s opioid use disorder history in a  
13 manner similar to other potentially lethal medical  
14 concerns, including drug allergies and contraindica-  
15 tions.

16 (3) The importance of prominently displaying  
17 information about a patient’s opioid use disorder  
18 when a physician or medical professional is pre-  
19 scribing medication, including methods for avoiding  
20 alert fatigue in providers.

21 (4) The importance of a variety of appropriate  
22 medical professionals, including physicians, nurses,  
23 and pharmacists, having access to information de-  
24 scribed in this section when prescribing or dis-

1        pensing opioid medication, consistent with Federal  
2        and State laws and regulations.

3           (5) The importance of protecting patient pri-  
4        vacy, including the requirements related to consent  
5        for disclosure of substance use disorder information  
6        under all applicable laws and regulations.

7           (6) All applicable Federal and State laws and  
8        regulations.

9        **SEC. 509. DEVELOPMENT AND DISSEMINATION OF MODEL**  
10                   **TRAINING PROGRAMS FOR SUBSTANCE USE**  
11                   **DISORDER PATIENT RECORDS.**

12        (a) INITIAL PROGRAMS AND MATERIALS.—Not later  
13        than 1 year after the date of the enactment of this Act,  
14        the Secretary of Health and Human Services (referred to  
15        in this section as the “Secretary”), in consultation with  
16        appropriate experts, shall identify the following model pro-  
17        grams and materials (or if no such programs or materials  
18        exist, recognize private or public entities to develop and  
19        disseminate such programs and materials):

20           (1) Model programs and materials for training  
21        health care providers (including physicians, emer-  
22        gency medical personnel, psychiatrists, psychologists,  
23        counselors, therapists, nurse practitioners, physician  
24        assistants, behavioral health facilities and clinics,  
25        care managers, and hospitals, including individuals

1 such as general counsels or regulatory compliance  
2 staff who are responsible for establishing provider  
3 privacy policies) concerning the permitted uses and  
4 disclosures, consistent with the standards and regu-  
5 lations governing the privacy and security of sub-  
6 stance use disorder patient records promulgated by  
7 the Secretary under section 543 of the Public  
8 Health Service Act (42 U.S.C. 290dd-2) for the  
9 confidentiality of patient records.

10 (2) Model programs and materials for training  
11 patients and their families regarding their rights to  
12 protect and obtain information under the standards  
13 and regulations described in paragraph (1).

14 (b) REQUIREMENTS.—The model programs and ma-  
15 terials described in paragraphs (1) and (2) of subsection  
16 (a) shall address circumstances under which disclosure of  
17 substance use disorder patient records is needed to—

18 (1) facilitate communication between substance  
19 use disorder treatment providers and other health  
20 care providers to promote and provide the best pos-  
21 sible integrated care;

22 (2) avoid inappropriate prescribing that can  
23 lead to dangerous drug interactions, overdose, or re-  
24 lapse; and

1           (3) notify and involve families and caregivers  
2 when individuals experience an overdose.

3           (c) PERIODIC UPDATES.—The Secretary shall—

4           (1) periodically review and update the model  
5 program and materials identified or developed under  
6 subsection (a); and

7           (2) disseminate such updated programs and  
8 materials to the individuals described in subsection  
9 (a)(1).

10          (d) INPUT OF CERTAIN ENTITIES.—In identifying,  
11 reviewing, or updating the model programs and materials  
12 under this section, the Secretary shall solicit the input of  
13 relevant stakeholders.

14          (e) AUTHORIZATION OF APPROPRIATIONS.—There is  
15 authorized to be appropriated to carry out this section,  
16 such sums as may be necessary for each of fiscal years  
17 2019 through 2023.

18 **SEC. 510. COMMUNICATION WITH FAMILIES DURING EMER-**  
19 **GENCIES.**

20          (a) PROMOTING AWARENESS OF AUTHORIZED DIS-  
21 CLOSURES DURING EMERGENCIES.—The Secretary of  
22 Health and Human Services shall annually notify health  
23 care providers regarding permitted disclosures during  
24 emergencies, including overdoses, of certain health infor-

1 mation to families and caregivers under Federal health  
2 care privacy laws and regulations.

3 (b) USE OF MATERIAL.—For the purposes of car-  
4 rying out subsection (a), the Secretary of Health and  
5 Human Services may use material produced under section  
6 509 of this Act or under section 11004 of the 21st Cen-  
7 tury Cures Act (42 U.S.C. 1320d–2 note).

8 **SEC. 511. PRENATAL AND POSTNATAL HEALTH.**

9 Section 317L of the Public Health Service Act (42  
10 U.S.C. 247b–13) is amended—

11 (1) in subsection (a)—

12 (A) by amending paragraph (1) to read as  
13 follows:

14 “(1) to collect, analyze, and make available data  
15 on prenatal smoking, alcohol and substance abuse  
16 and misuse, including—

17 “(A) data on—

18 “(i) the incidence, prevalence, and im-  
19 plications of such activities; and

20 “(ii) the incidence and prevalence of  
21 implications and outcomes, including neo-  
22 natal abstinence syndrome and other out-  
23 comes associated with such activities; and

24 “(B) to inform such analysis, additional in-  
25 formation or data on family health history,

1 medication exposures during pregnancy, demo-  
2 graphic information, such as race, ethnicity, ge-  
3 ographic location, and family history, and other  
4 relevant information, as appropriate;”;

5 (B) in paragraph (2)—

6 (i) by striking “prevention of” and in-  
7 serting “prevention and long-term out-  
8 comes associated with”; and

9 (ii) by striking “illegal drug use” and  
10 inserting “substance abuse and misuse”;

11 (C) in paragraph (3), by striking “and ces-  
12 sation programs; and” and inserting “, treat-  
13 ment, and cessation programs;”;

14 (D) in paragraph (4), by striking “illegal  
15 drug use.” and inserting “substance abuse and  
16 misuse; and”; and

17 (E) by adding at the end the following:

18 “(5) to issue public reports on the analysis of  
19 data described in paragraph (1), including analysis  
20 of—

21 “(A) long-term outcomes of children af-  
22 fected by neonatal abstinence syndrome;

23 “(B) health outcomes associated with pre-  
24 natal smoking, alcohol, and substance abuse  
25 and misuse; and

1           “(C) relevant studies, evaluations, or infor-  
2           mation the Secretary determines to be appro-  
3           priate.”;

4           (2) in subsection (b), by inserting “tribal enti-  
5           ties,” after “local governments,”;

6           (3) by redesignating subsection (c) as sub-  
7           section (d);

8           (4) by inserting after subsection (b) the fol-  
9           lowing:

10          “(c) COORDINATING ACTIVITIES.—To carry out this  
11 section, the Secretary may—

12           “(1) provide technical and consultative assist-  
13           ance to entities receiving grants under subsection  
14           (b);

15           “(2) ensure a pathway for data sharing between  
16           States, tribal entities, and the Centers for Disease  
17           Control and Prevention;

18           “(3) ensure data collection under this section is  
19           consistent with applicable State, Federal, and Tribal  
20           privacy laws; and

21           “(4) coordinate with the National Coordinator  
22           for Health Information Technology, as appropriate,  
23           to assist States and tribes in implementing systems  
24           that use standards recognized by such National Co-  
25           ordinator, as such recognized standards are avail-

1 able, in order to facilitate interoperability between  
2 such systems and health information technology sys-  
3 tems, including certified health information tech-  
4 nology.”; and

5 (5) in subsection (d), as so redesignated, by  
6 striking “2001 through 2005” and inserting “2019  
7 through 2023”.

8 **SEC. 512. SURVEILLANCE AND EDUCATION REGARDING IN-**  
9 **FECTIONS ASSOCIATED WITH INJECTION**  
10 **DRUG USE AND OTHER RISK FACTORS.**

11 Section 317N of the Public Health Service Act (42  
12 U.S.C. 247b–15) is amended—

13 (1) by amending the section heading to read as  
14 follows: “**SURVEILLANCE AND EDUCATION RE-**  
15 **GARDING INFECTIONS ASSOCIATED WITH IN-**  
16 **JECTION DRUG USE AND OTHER RISK FAC-**  
17 **TORS**”;

18 (2) in subsection (a)—

19 (A) in the matter preceding paragraph (1),  
20 by inserting “activities” before the colon;

21 (B) in paragraph (1)—

22 (i) by inserting “or maintaining” after  
23 “implementing”;

24 (ii) by striking “hepatitis C virus in-  
25 fection (in this section referred to as ‘HCV

1 infection’))” and inserting “infections com-  
2 monly associated with injection drug use,  
3 including viral hepatitis and human im-  
4 munodeficiency virus,”; and

5 (iii) by striking “such infection” and  
6 all that follows through the period at the  
7 end and inserting “such infections, which  
8 may include the reporting of cases of such  
9 infections.”;

10 (C) in paragraph (2), by striking “HCV  
11 infection” and all that follows through the pe-  
12 riod at the end and inserting “infections as a  
13 result of injection drug use, receiving blood  
14 transfusions prior to July 1992, or other risk  
15 factors.”;

16 (D) in paragraphs (4) and (5), by striking  
17 “HCV infection” each place such term appears  
18 and inserting “infections described in para-  
19 graph (1)”;

20 (E) in paragraph (5), by striking “pedia-  
21 tricians and other primary care physicians, and  
22 obstetricians and gynecologists” and inserting  
23 “substance use disorder treatment providers,  
24 pediatricians, other primary care providers, and  
25 obstetrician-gynecologists”;

1 (3) in subsection (b)—

2 (A) by striking “directly and” and insert-  
3 ing “directly or”; and

4 (B) by striking “hepatitis C,” and all that  
5 follows through the period at the end and in-  
6 serting “infections described in subsection  
7 (a)(1).”;

8 (4) by redesignating subsection (c) as sub-  
9 section (d);

10 (5) by inserting after subsection (b) the fol-  
11 lowing:

12 “(c) DEFINITION.—In this section, the term ‘injec-  
13 tion drug use’ means—

14 “(1) intravenous administration of a substance  
15 in schedule I of section 202(c) of the Controlled  
16 Substances Act;

17 “(2) intravenous administration of a substance  
18 in schedule II, III, IV, or V of section 202(c) of the  
19 Controlled Substances Act that has not been ap-  
20 proved for intravenous use under section 505 of the  
21 Federal Food, Drug and Cosmetic Act or section  
22 351 of the Public Health Service Act; or

23 “(3) intravenous administration of a substance  
24 in schedule II, III, IV, or V of section 202(c) of the

1 Controlled Substances Act that has not been pre-  
 2 scribed to the person using the substance.”; and

3 (6) in subsection (d), as so redesignated, by  
 4 striking “such sums as may be necessary for each of  
 5 the fiscal years 2001 through 2005” and inserting  
 6 “\$40,000,000 for each of fiscal years 2019 through  
 7 2023”.

8 **SEC. 513. TASK FORCE TO DEVELOP BEST PRACTICES FOR**  
 9 **TRAUMA-INFORMED IDENTIFICATION, RE-**  
 10 **FERRAL, AND SUPPORT.**

11 (a) **ESTABLISHMENT.**—There is established a task  
 12 force, to be known as the Interagency Task Force on  
 13 Trauma-Informed Care (in this section referred to as the  
 14 “task force”) that shall identify, evaluate, and make rec-  
 15 ommendations regarding best practices with respect to  
 16 children and youth, and their families as appropriate, who  
 17 have experienced or are at risk of experiencing trauma.

18 (b) **MEMBERSHIP.**—

19 (1) **COMPOSITION.**—The task force shall be  
 20 composed of the heads of the following Federal de-  
 21 partments and agencies, or their designees:

22 (A) The Centers for Medicare & Medicaid  
 23 Services.

24 (B) The Substance Abuse and Mental  
 25 Health Services Administration.

1 (C) The Agency for Healthcare Research  
2 and Quality.

3 (D) The Centers for Disease Control and  
4 Prevention.

5 (E) The Indian Health Service.

6 (F) The Department of Veterans Affairs.

7 (G) The National Institutes of Health.

8 (H) The Food and Drug Administration.

9 (I) The Health Resources and Services Ad-  
10 ministration.

11 (J) The Department of Defense.

12 (K) The Office of Minority Health.

13 (L) The Administration for Children and  
14 Families.

15 (M) The Office of the Assistant Secretary  
16 for Planning and Evaluation.

17 (N) The Office for Civil Rights at the De-  
18 partment of Health and Human Services.

19 (O) The Office of Juvenile Justice and De-  
20 linquency Prevention of the Department of Jus-  
21 tice.

22 (P) The Office of Community Oriented Po-  
23 licing Services of the Department of Justice.

24 (Q) The Office on Violence Against  
25 Women of the Department of Justice.

1 (R) The National Center for Education  
2 Evaluation and Regional Assistance of the De-  
3 partment of Education.

4 (S) The National Center for Special Edu-  
5 cation Research of the Institute of Education  
6 Science.

7 (T) The Office of Elementary and Sec-  
8 ondary Education of the Department of Edu-  
9 cation.

10 (U) The Office for Civil Rights at the De-  
11 partment of Education.

12 (V) The Office of Special Education and  
13 the Rehabilitative Services of the Department  
14 of Education.

15 (W) the Bureau of Indian Affairs of the  
16 Department of the Interior.

17 (X) The Veterans Health Administration  
18 of the Department of Veterans Affairs.

19 (Y) The Office of Special Needs Assistance  
20 Programs of the Department of Housing and  
21 Urban Development.

22 (Z) The Office of Head Start of the Ad-  
23 ministration for Children and Families.

24 (AA) The Children's Bureau of the Admin-  
25 istration for Children and Families.

1 (BB) The Bureau of Indian Education of  
2 the Department of the Interior.

3 (CC) Such other Federal agencies as the  
4 Secretaries determine to be appropriate.

5 (2) DATE OF APPOINTMENTS.—The heads of  
6 Federal departments and agencies shall appoint the  
7 corresponding members of the task force not later  
8 than 6 months after the date of enactment of this  
9 Act.

10 (3) CHAIRPERSON.—The task force shall be  
11 chaired by the Assistant Secretary for Mental  
12 Health and Substance Use.

13 (c) TASK FORCE DUTIES.—The task force shall—

14 (1) solicit input from stakeholders, including  
15 frontline service providers, educators, mental health  
16 professionals, researchers, experts in infant, child,  
17 and youth trauma, child welfare professionals, and  
18 the public, in order to inform the activities under  
19 paragraph (2); and

20 (2) identify, evaluate, make recommendations,  
21 and update such recommendations not less than an-  
22 nually, to the general public, the Secretary of Edu-  
23 cation, the Secretary of Health and Human Services,  
24 the Secretary of Labor, the Secretary of the Inte-

1       rior, the Attorney General, and other relevant cabi-  
2       net Secretaries, and Congress regarding—

3               (A) a set of evidence-based, evidence-in-  
4               formed, and promising best practices with re-  
5               spect to—

6                       (i) the identification of infants, chil-  
7                       dren and youth, and their families as ap-  
8                       propriate, who have experienced or are at  
9                       risk of experiencing trauma; and

10                      (ii) the expeditious referral to and im-  
11                      plementation of trauma-informed practices  
12                      and supports that prevent and mitigate the  
13                      effects of trauma;

14               (B) a national strategy on how the task  
15               force and member agencies will collaborate,  
16               prioritize options for, and implement a coordi-  
17               nated approach which may include data sharing  
18               and the awarding of grants that support chil-  
19               dren and their families as appropriate, who  
20               have experienced or are at risk of experiencing  
21               trauma; and

22               (C) existing Federal authorities at the De-  
23               partment of Education, Department of Health  
24               and Human Services, Department of Justice,  
25               Department of Labor, Department of Interior,

1 and other relevant agencies, and specific Fed-  
2 eral grant programs to disseminate best prac-  
3 tices on, provide training in, or deliver services  
4 through, trauma-informed practices, and dis-  
5 seminate such information—

6 (i) in writing to relevant program of-  
7 fices at such agencies to encourage grant  
8 applicants in writing to use such funds,  
9 where appropriate, for trauma-informed  
10 practices; and

11 (ii) to the general public through the  
12 internet website of the task force.

13 (d) BEST PRACTICES.—In identifying, evaluating,  
14 and recommending the set of best practices under sub-  
15 section (c), the task force shall—

16 (1) include guidelines for providing professional  
17 development for front-line services providers, includ-  
18 ing school personnel, providers from child- or youth-  
19 serving organizations, primary and behavioral health  
20 care providers, child welfare and social services pro-  
21 viders, family and juvenile court judges and attor-  
22 neys, health care providers, individuals who are  
23 mandatory reporters of child abuse or neglect,  
24 trained nonclinical providers (including peer mentors  
25 and clergy), and first responders, in—

1 (A) understanding and identifying early  
2 signs and risk factors of trauma in children and  
3 youth, and their families as appropriate, includ-  
4 ing through screening processes;

5 (B) providing practices to prevent and  
6 mitigate the impact of trauma, including by fos-  
7 tering safe and stable environments and rela-  
8 tionships; and

9 (C) developing and implementing proce-  
10 dures or systems that—

11 (i) are designed to quickly refer in-  
12 fants, children, youth, and their families as  
13 appropriate, who have experienced or are  
14 at risk of experiencing trauma to the ap-  
15 propriate trauma-informed screening and  
16 support, including treatment appropriate  
17 to the age of the child, and to ensure such  
18 infants, children, youth, and family mem-  
19 bers receive such support;

20 (ii) utilize and develop partnerships  
21 with local social services organizations,  
22 such as organizations serving youth, and  
23 clinical mental health or health care service  
24 providers with expertise in providing sup-  
25 port services (including trauma-informed

1 and evidence-based treatment appropriate  
2 to the age of the child) aimed at pre-  
3 venting or mitigating the effects of trau-  
4 ma;

5 (iii) educate children and youth to—

6 (I) understand and identify the  
7 signs, effects, or symptoms of trauma;

8 and

9 (II) build the resilience and cop-  
10 ing skills to mitigate the effects of ex-  
11 perienceing trauma;

12 (iv) promote and support multi-  
13 generational practices that assist parents,  
14 foster parents, and kinship and other care-  
15 givers in accessing resources related to,  
16 and developing environments conducive to,  
17 the prevention and mitigation of trauma;  
18 and

19 (v) collect and utilize data from  
20 screenings, referrals, or the provision of  
21 services and supports, conducted in the  
22 covered settings, to evaluate and improve  
23 processes for trauma-informed support and  
24 outcomes that are culturally sensitive, lin-

1                   guistically appropriate, and specific to age  
2                   ranges and sex, as applicable; and

3                   (2) recommend best practices that are designed  
4                   to avoid unwarranted custody loss or criminal pen-  
5                   alties for parents or guardians in connection with in-  
6                   fants, children, and youth who have experienced or  
7                   are at risk of experiencing trauma.

8                   (e) OPERATING PLAN.—Not later than 1 year after  
9                   the date of enactment of this Act, the task force shall hold  
10                  the first meeting. Not later than 2 years after such date  
11                  of enactment, the task force shall submit to the Secretary  
12                  of Education, Secretary of Health and Human Services,  
13                  Secretary of Labor, Secretary of the Interior, the Attorney  
14                  General, and Congress an operating plan for carrying out  
15                  the activities of the task force described in paragraphs (2)  
16                  and (3) of subsection (c). Such operating plan shall in-  
17                  clude—

18                  (1) a list of specific activities that the task  
19                  force plans to carry out for purposes of carrying out  
20                  duties described in subsection (c)(2), which may in-  
21                  clude public engagement;

22                  (2) a plan for carrying out the activities under  
23                  paragraphs (2) and (3) of subsection (c);

24                  (3) a list of members of the task force and  
25                  other individuals who are not members of the task

1 force that may be consulted to carry out such activi-  
2 ties;

3 (4) an explanation of Federal agency involve-  
4 ment and coordination needed to carry out such ac-  
5 tivities, including any statutory or regulatory bar-  
6 riers to such coordination;

7 (5) a budget for carrying out such activities;  
8 and

9 (6) other information that the task force deter-  
10 mines appropriate.

11 (f) FINAL REPORT.—Not later than 3 years after the  
12 date of the first meeting of the task force, the task force  
13 shall submit to the general public, Secretary of Education,  
14 Secretary of Health and Human Services, Secretary of  
15 Labor, Secretary of the Interior, the Attorney General,  
16 and other relevant cabinet Secretaries, and Congress, a  
17 final report containing all of the findings and rec-  
18 ommendations required under this section.

19 (g) AUTHORIZATION OF APPROPRIATIONS.—To carry  
20 out this section, there are authorized to be appropriated  
21 such sums as may be necessary for each of fiscal years  
22 2019 through 2022.

23 (h) SUNSET.—The task force shall on the date that  
24 is 60 days after the submission of the final report under  
25 subsection (f), but not later than September 30, 2022.

1 **SEC. 514. GRANTS TO IMPROVE TRAUMA SUPPORT SERV-**  
2 **ICES AND MENTAL HEALTH CARE FOR CHIL-**  
3 **DREN AND YOUTH IN EDUCATIONAL SET-**  
4 **TINGS.**

5 (a) GRANTS, CONTRACTS, AND COOPERATIVE  
6 AGREEMENTS AUTHORIZED.—The Secretary, in coordina-  
7 tion with the Director of Substance Abuse and Mental  
8 Health Services Administration, is authorized to award  
9 grants to, or enter into contracts or cooperative agree-  
10 ments with, State educational agencies, local educational  
11 agencies, Head Start agencies (including Early Head  
12 Start agencies), State or local agencies that administer  
13 public preschool programs, Indian tribes or their tribal  
14 educational agencies, a school operated by the Bureau of  
15 Indian Education, a Regional Corporation (as defined in  
16 section 3 of the Alaska Native Claims Settlement Act (43  
17 U.S.C. 1602)), or a Native Hawaiian educational organi-  
18 zation (as defined in section 6207 of the Elementary and  
19 Secondary Education Act of 1965 (20 U.S.C. 7517)), for  
20 the purpose of increasing student access to evidence-based  
21 trauma support services and mental health care by devel-  
22 oping innovative initiatives, activities, or programs to link  
23 local school systems with local trauma-informed support  
24 and mental health systems, including those under the In-  
25 dian Health Service.

1 (b) DURATION.—With respect to a grant, contract,  
2 or cooperative agreement awarded or entered into under  
3 this section, the period during which payments under such  
4 grant, contract or agreement are made to the recipient  
5 may not exceed 4 years.

6 (c) USE OF FUNDS.—An entity that receives a grant,  
7 contract, or cooperative agreement under this section shall  
8 use amounts made available through such grant, contract,  
9 or cooperative agreement for evidence-based or promising  
10 activities, which shall include any of the following:

11 (1) Collaborative efforts between school-based  
12 service systems and trauma-informed support and  
13 mental health service systems to provide, develop, or  
14 improve prevention, screening, referral, and treat-  
15 ment services to students, such as by providing uni-  
16 versal trauma screenings to identify students in need  
17 of specialized support.

18 (2) To implement multi-tiered positive behav-  
19 ioral interventions and supports, or other trauma-in-  
20 formed models of support.

21 (3) To provide professional development to  
22 teachers, teacher assistants, school leaders, special-  
23 ized instructional support personnel, and mental  
24 health professionals that—

1 (A) fosters safe and stable learning envi-  
2 ronments that prevent and mitigate the effects  
3 of trauma, including through social and emo-  
4 tional learning;

5 (B) improves school capacity to identify,  
6 refer, and provide services to students in need  
7 of trauma support or behavioral health services;  
8 or

9 (C) reflects the best practices developed by  
10 the Interagency Task Force on Trauma-In-  
11 formed Care established under section 513.

12 (4) Engaging families and communities in ef-  
13 forts to increase awareness of child and youth trau-  
14 ma, which may include sharing best practices with  
15 law enforcement regarding trauma-informed care  
16 and working with mental health professionals to pro-  
17 vide interventions, as well as longer term coordi-  
18 nated care within the community for children and  
19 youth who have experienced trauma and their fami-  
20 lies.

21 (5) To provide technical assistance to school  
22 systems and mental health agencies.

23 (6) To evaluate the effectiveness of the program  
24 carried out under this section in increasing student

1 access to evidence-based trauma support services  
2 and mental health care.

3 (d) APPLICATIONS.—To be eligible to receive a grant,  
4 contract, or cooperative agreement under this section, an  
5 entity described in subsection (a) shall submit an applica-  
6 tion to the Secretary at such time, in such manner, and  
7 containing such information as the Secretary may reason-  
8 ably require, which shall include the following:

9 (1) A description of the program to be funded  
10 under the grant, contract, or cooperative agreement,  
11 including how such program will increase access to  
12 evidence-based trauma support services and mental  
13 health care for students, and, as applicable, the fam-  
14 ilies of the students.

15 (2) A description of how the program will pro-  
16 vide linguistically appropriate and culturally com-  
17 petent services.

18 (3) A description of how the program will sup-  
19 port students and the school in improving the school  
20 climate in order to support an environment condu-  
21 cive to learning.

22 (4) An assurance that—

23 (A) persons providing services under the  
24 grant, contract, or cooperative agreement are  
25 adequately trained to provide such services; and

1 (B) teachers, school leaders, administra-  
2 tors, specialized instructional support personnel,  
3 representatives of local Indian tribes as appro-  
4 priate, other school personnel, and parents or  
5 guardians of students participating in services  
6 under this section will be engaged and involved  
7 in the design and implementation of the serv-  
8 ices.

9 (5) A description of how the applicant will sup-  
10 port and integrate existing school-based services  
11 with the program in order to provide mental health  
12 services for students, as appropriate.

13 (e) INTERAGENCY AGREEMENTS.—

14 (1) DESIGNATION OF LEAD AGENCY.—A recipi-  
15 ent of a grant, contract, or cooperative agreement  
16 under this section shall designate a lead agency to  
17 direct the establishment of an interagency agreement  
18 among local educational agencies, juvenile justice au-  
19 thorities, mental health agencies, child welfare agen-  
20 cies, and other relevant entities in the State, in col-  
21 laboration with local entities, such as Indian tribes.

22 (2) CONTENTS.—The interagency agreement  
23 shall ensure the provision of the services described  
24 in subsection (c), specifying with respect to each  
25 agency, authority, or entity—

1 (A) the financial responsibility for the serv-  
2 ices;

3 (B) the conditions and terms of responsi-  
4 bility for the services, including quality, ac-  
5 countability, and coordination of the services;  
6 and

7 (C) the conditions and terms of reimburse-  
8 ment among the agencies, authorities, or enti-  
9 ties that are parties to the interagency agree-  
10 ment, including procedures for dispute resolu-  
11 tion.

12 (f) EVALUATION.—The Secretary shall reserve not to  
13 exceed 3 percent of the funds made available under sub-  
14 section (l) for each fiscal year to—

15 (1) conduct a rigorous, independent evaluation  
16 of the activities funded under this section; and

17 (2) disseminate and promote the utilization of  
18 evidence-based practices regarding trauma support  
19 services and mental health care.

20 (g) DISTRIBUTION OF AWARDS.—The Secretary shall  
21 ensure that grants, contracts, and cooperative agreements  
22 awarded or entered into under this section are equitably  
23 distributed among the geographical regions of the United  
24 States and among tribal, urban, suburban, and rural pop-  
25 ulations.

1 (h) RULE OF CONSTRUCTION.—Nothing in this sec-  
2 tion shall be construed—

3 (1) to prohibit an entity involved with a pro-  
4 gram carried out under this section from reporting  
5 a crime that is committed by a student to appro-  
6 priate authorities; or

7 (2) to prevent Federal, State, and tribal law en-  
8 forcement and judicial authorities from exercising  
9 their responsibilities with regard to the application  
10 of Federal, tribal, and State law to crimes com-  
11 mitted by a student.

12 (i) SUPPLEMENT, NOT SUPPLANT.—Any services  
13 provided through programs carried out under this section  
14 shall supplement, and not supplant, existing mental health  
15 services, including any special education and related serv-  
16 ices provided under the Individuals with Disabilities Edu-  
17 cation Act.

18 (j) CONSULTATION WITH INDIAN TRIBES.—In car-  
19 rying out subsection (a), the Secretary shall, in a timely  
20 manner, meaningfully consult, engage, and cooperate with  
21 Indian tribes and their representatives to ensure notice of  
22 eligibility.

23 (k) DEFINITIONS.—In this section:

24 (1) ELEMENTARY OR SECONDARY SCHOOL.—

25 The term “elementary or secondary school” means a

1 public elementary and secondary school as such term  
2 is defined in section 8101 of the Elementary and  
3 Secondary Education Act of 1965 (20 U.S.C. 7801).

4 (2) EVIDENCE-BASED.—The term “evidence-  
5 based” has the meaning given such term in section  
6 8101(21)(A)(i) of the Elementary and Secondary  
7 Education Act of 1965 (20 U.S.C. 7801(21)(A)(i)).

8 (3) SCHOOL LEADER.—The term “school lead-  
9 er” has the meaning given such term in section  
10 8101 of the Elementary and Secondary Education  
11 Act of 1965 (20 U.S.C. 7801).

12 (4) SECRETARY.—The term “Secretary” means  
13 the Secretary of Education.

14 (5) SPECIALIZED INSTRUCTIONAL SUPPORT  
15 PERSONNEL.—The term “specialized instructional  
16 support personnel” has the meaning given such term  
17 in 8101 of the Elementary and Secondary Education  
18 Act of 1965 (20 U.S.C. 7801).

19 (l) AUTHORIZATION OF APPROPRIATIONS.—There is  
20 authorized to be appropriated to carry out this section,  
21 such sums as may be necessary for each of fiscal years  
22 2019 through 2023.

1 **SEC. 515. NATIONAL CHILD TRAUMATIC STRESS INITIA-**  
2 **TIVE.**

3 Section 582(j) of the Public Health Service Act (42  
4 U.S.C. 290hh-1(j)) is amended by striking “\$46,887,000  
5 for each of fiscal years 2018 through 2022” and inserting  
6 “\$53,887,000 for each of fiscal years 2019 through  
7 2023”.

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