



COLORADO
Office of Behavioral Health
Department of Human Services

Policy Analysis of State Legislation and Response to the Opioid Crisis

Fiscal Year 2018

Submitted September 12, 2017

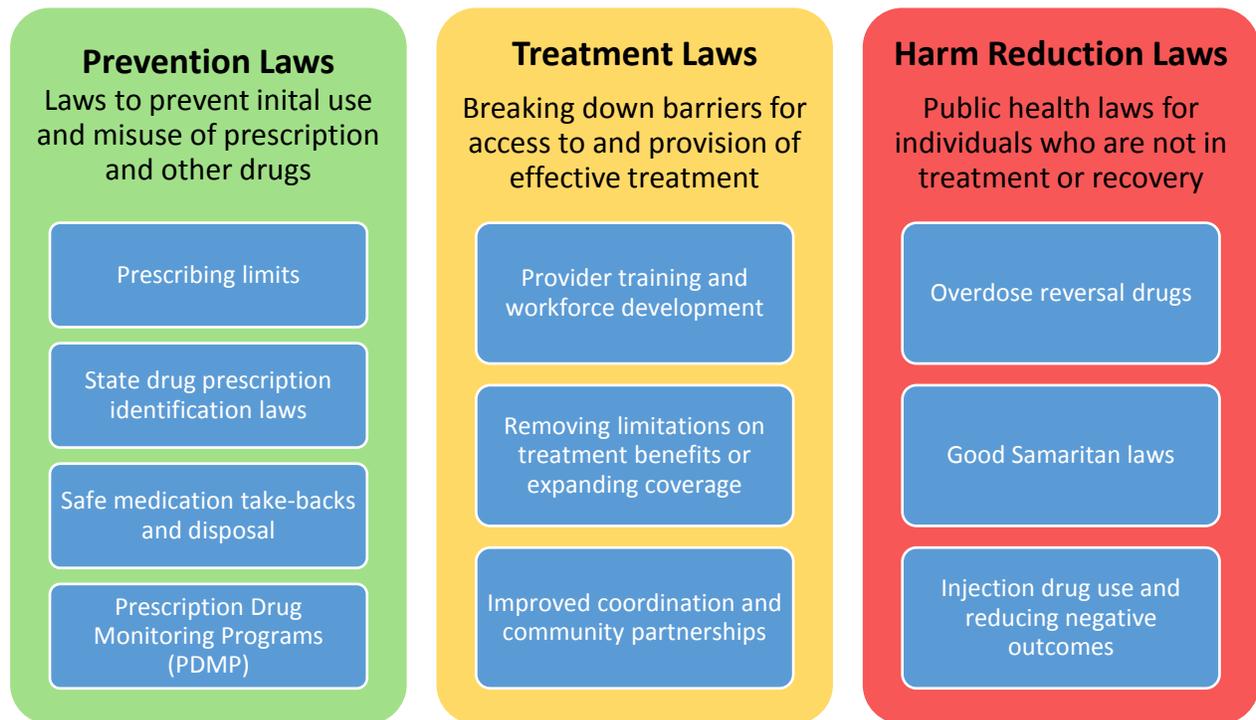
PREPARED FOR
The Opioid and Other Substance Use Disorders Interim Study Committee

PREPARED BY
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Introduction

Across the United States, the opioid crisis has gripped states and communities with increasing rates of opiate use disorder, overdose death, and need for prevention, treatment and recovery services. States have responded using multiple levers for change including legislation. This analysis outlines some of the types of legislation that have been proposed and passed in other states, case studies in success, and Colorado's progress.

This analysis is split into three categories: Prevention, Treatment, and Harm Reduction. These categories are based on opportunities to connect providers, individuals, and families to the resources they need to prevent initial use and misuse of prescription drugs and other substances; those with a substance use disorder to effective treatment; and those with substance use disorder who are not in treatment or recovery to public health and safety measures.



The Department of Human Services, Office of Behavioral Health and other referenced Departments are sharing this analysis as a source of information, not as an endorsement or recommendation of any specific policy.

Prevention Laws

The Colorado Heroin Strategy Group [report](#), published in April 2017, found that among more than 700 heroin users, the majority (70 percent) of respondents said that prescription pain killers played a role in their decision to use heroin. Many opioid-related state laws focus on preventing the misuse of prescription drugs by limiting the number of opioid prescriptions, increasing regulations for pharmacies and monitoring the number of prescriptions written and filled. The prevention laws outlined include:

- Prescribing limits
- State drug prescription identification laws
- Safe medication take-backs and disposal
- Prescription Drug Monitoring Programs (PDMP)

Opioids are any drug, synthetic, semi-synthetic, or natural opiate. This includes prescription medications such as OxyContin, Percocet, or Fentanyl or heroin. **Opiates** refer specifically to non-synthetic drugs derived from opium, such as heroin.

Prescribing limits

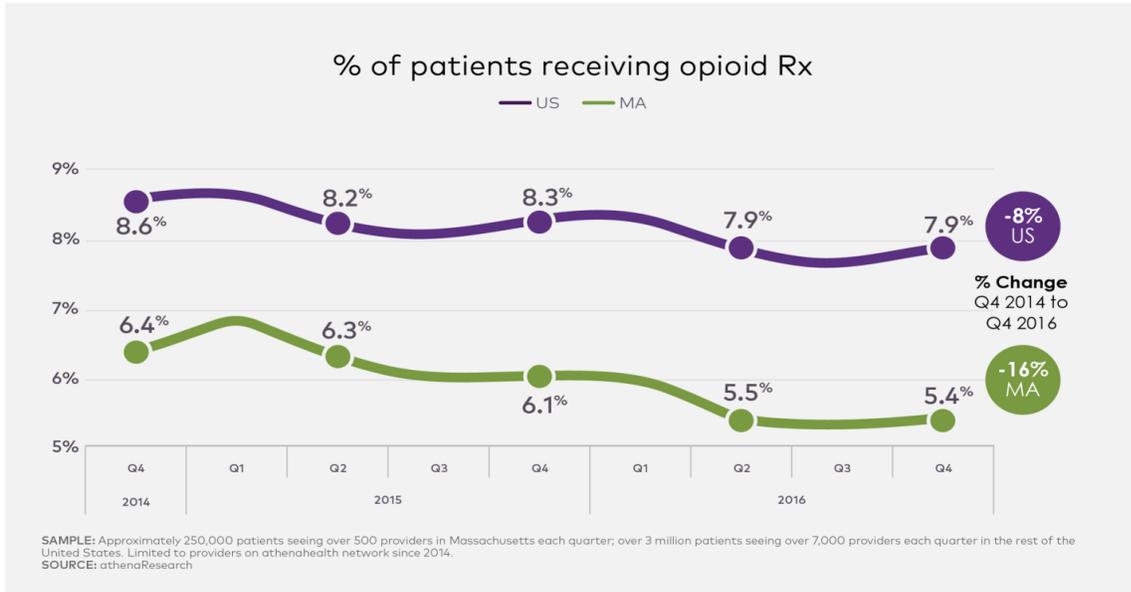
Many states have enacted laws that set time or dosage limits on the prescribing or dispensing of controlled substances. The time limit laws can apply to certain drugs, certain populations or certain situations. These limits apply to the whole state, not just the Medicaid agencies. Medicaid authorities, including the Colorado Department Health Care Financing and Policy, and commercial insurers have the authority to put in prescribing limits specific to their beneficiaries.

States Involved

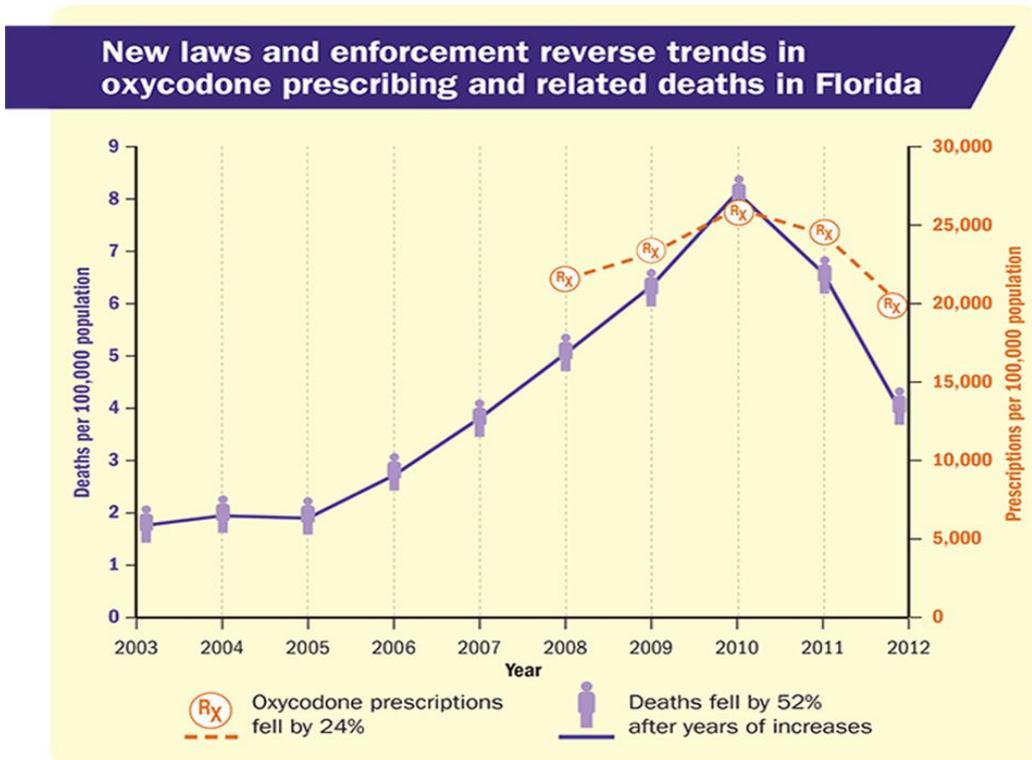
States began to make efforts in this arena in 2016, using both legislation and executive orders. At least 21 states have related legislation -- Alaska, Connecticut, Hawaii, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Utah, Vermont and Virginia -- while Arizona has an executive order. Some states have also enacted limits through Medicaid policy.

Most of the legislation limits first-time opioid prescriptions to seven days with exceptions such as for cancer and palliative care, according to the National Conference of State Legislatures. However, some legislation and Arizona's executive order direct other entities to establish limits. For example, Virginia's 2017 law directs the Boards of Dentistry and Medicine to adopt regulations for the prescribing of opioids and products containing buprenorphine. Oregon's law directs the Oregon Medical Board, Oregon State Board of Nursing, Oregon Board of Naturopathic Medicine and Oregon Board of Dentistry to provide licensees of boards with prescribing guidelines and recommendations.

Massachusetts [was the first](#) state to put prescribing limits legislation into place. By the end of 2016, the opioid prescribing rate in Massachusetts had [reached](#) its lowest level in two years, according to Athena Health. Massachusetts' prescribing limits went [into effect](#) March 14, 2016.



Source: [Athena Health](#)



SOURCE: Decline in Drug Overdose Deaths After State Policy Changes – Florida, 2010-2012. Morbidity and Mortality Weekly Report, July 1, 2014

Colorado Progress

The Department of Health Care Policy and Financing has followed the lead of the Governor's Task Force in reducing the misuse of prescription opioids. The Department [implemented a limit](#) on total daily morphine equivalents to 300 milligrams effective February 2016. Starting in 2014, the Department also had a policy that limited short-acting opioids to four per day, except for acute pain situations. Acute pain needs were addressed in an August 1, 2017, change. Recently, the Department of Health Care Policy and Financing announced that it is tightening [its policy](#) on prescribing and dispensing opioid pain medications to Health First Colorado (Colorado's Medicaid program) members. In effect since August 1, members who haven't had an opioid prescription in the past 12 months are limited to seven-day supplies of opioids and a total of 56 pills. The policy was developed following a Department analysis of claims data showing a growing number of Health First Colorado members who have not taken opioids before – or have not taken them for up to one year – go on to use opioids more frequently once they start. The new policy allows a seven-day supply to be filled initially and two additional seven-day refills. A fourth refill request will require providers to obtain prior authorization from the Department and may require a pain consult with a pain specialist.

The second phase of the new policy will reduce the daily Morphine Milligram Equivalents (MME) for members currently on a pain management regimen. Beginning October 1, 2017, the total daily limit of MME will decrease from 300 MME per day to 250 MME per day. Under the new policy, a prescription that puts the member above 250 MME per day will be rejected and require a prior authorization. In some circumstances, a consultation with the Department's pain management physician may be required. While the [Centers for Disease Control and Prevention recommends](#) that "Clinicians should use caution when prescribing opioids at any dosage...and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day," HCPF is moving gradually, not suddenly, toward this goal. Slowly reducing the MME requirements reduces the likelihood that patients will experience sudden changes to a long-term opioid prescription, which could lead to them seeking other sources of increased levels, such as heroin.

In addition to the HCPF policy, the Department of Regulatory Agencies, which houses the prescribing boards, provides uniform guidelines and resources for prescribers as part of their strategic plan. [The Policy for Prescribing and Dispensing Opioids](#) was adopted in 2014 after a year of intensive stakeholder engagement. The intent was to provide guidelines to improve prescriber habits, to improve health care outcomes, to provide uniform guidance to prescribers and practitioners, as well as to impact the overarching misuse and abuse problem in Colorado. The Department and the Boards have been engaging across the state since the summer of 2016 to further consider the new CDC guidelines and to modify the policy to reflect the best approaches for Colorado, including access to treatment, preventative treatment, and mental health components of the addiction problem.

State drug prescription identification laws

Most states have laws either mandating or allowing pharmacists to request identification before dispensing prescription drugs. Most of the states have at least one law mandating that pharmacist request identification generally or under special circumstances.

States Involved

The following 36 states have laws mandating or allowing pharmacists to check IDs before dispensing prescriptions.



Source: [Athena Health](#)

Most of the states [specify](#) the circumstances under which the requirement applies, although an ID is mandatory in some states. Some examples of enacted laws include:

- **Minnesota** and **Nevada** require identification for anyone purchasing controlled substances that are not covered by their plan.
- **Florida** requires identification if the pharmacist suspects non-medical use.
- **North Carolina and Oregon** allow a prescriber to ask for a form of identification as a precondition of filling a prescription or to refuse a prescription to a person without a valid ID.

Colorado Progress

Colorado is one of 14 states, plus the District of Columbia, without a law. No related bills have been introduced in recent legislative sessions.

Prescription Drug Monitoring

A Prescription Drug Monitoring Program (PDMP) is a state-based electronic database that tracks prescriptions for controlled substances including opioids like OxyContin, Percocet, and Vicodin. This allows health authorities to look for signs that patients may be abusing opioids or passing the drugs onto others.

States Involved

As of September 1, 2017, [all 50 states](#) have some form of a Prescription Drug Monitoring Program (PDMP) or a Prescription Monitoring Program (PMP). PDMPs and PMPs are generally housed within one of three state government agencies: a) Regulatory, b) Health and Human Services, or c) Law Enforcement. The programs contain information regarding prescribing and dispensing controlled substances. A central goal of many programs is to increase prescriber utilization to reduce misuse, abuse, and diversion of prescription drugs. Rules vary on when prescribers have to check them. Some states require that only certain providers check the database under certain circumstances, such as when they suspect opioid abuse or diversion.

According to the Colorado Department of Regulatory Agencies (DORA), there are eight evidence-based practices aimed at increasing prescriber utilization of PDMPs.

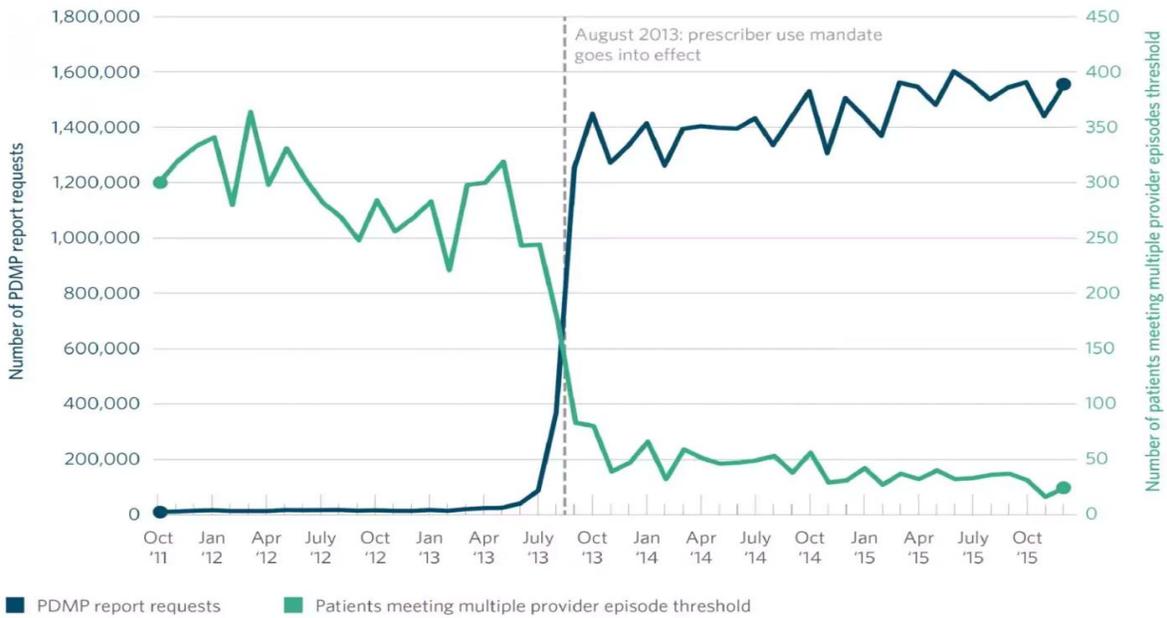
1. Prescriber use mandates (required participation by all prescribers).
2. Delegation (allowing prescribers to designate someone to access PDMP on their behalf).
3. Unsolicited reports (also known as prescriber reports, report cards, prescriber scorecards, or push notices and designed to proactively communicate prescribing activity).
4. Data timeliness (regularly uploading PDMP information).
5. Streamlined enrollment (simplifying access processes).
6. Educational and promotional initiatives (training, videos, and instructional materials).
7. Health information-technology integration (combining available clinical data).
8. Enhanced user interfaces (user-friendly technologies).

Currently, 64 percent of states utilize unsolicited reports/scorecards. According to the CDC, the [most useful PDMP features](#):

- Require providers to check a state PDMP before prescribing certain controlled substances
- Submit PDMP data in real time
- Use the data to understand the crisis
- Make the program easy to use and include integration into electronic health record systems

Mandating that providers use PDMPs has had a significant impact on opioid prescriptions. In New York, PDMP report requests increased from an average of 11,000 per month to 1.2 million per month in the six months after the mandate went into effect, [according to Pew](#). The below graph shows that as the PDMP prescriber mandate went into effect, the number of patients that are receiving the maximum amount of MMEs from multiple providers (meeting multiple provider episode threshold) dramatically decreases.

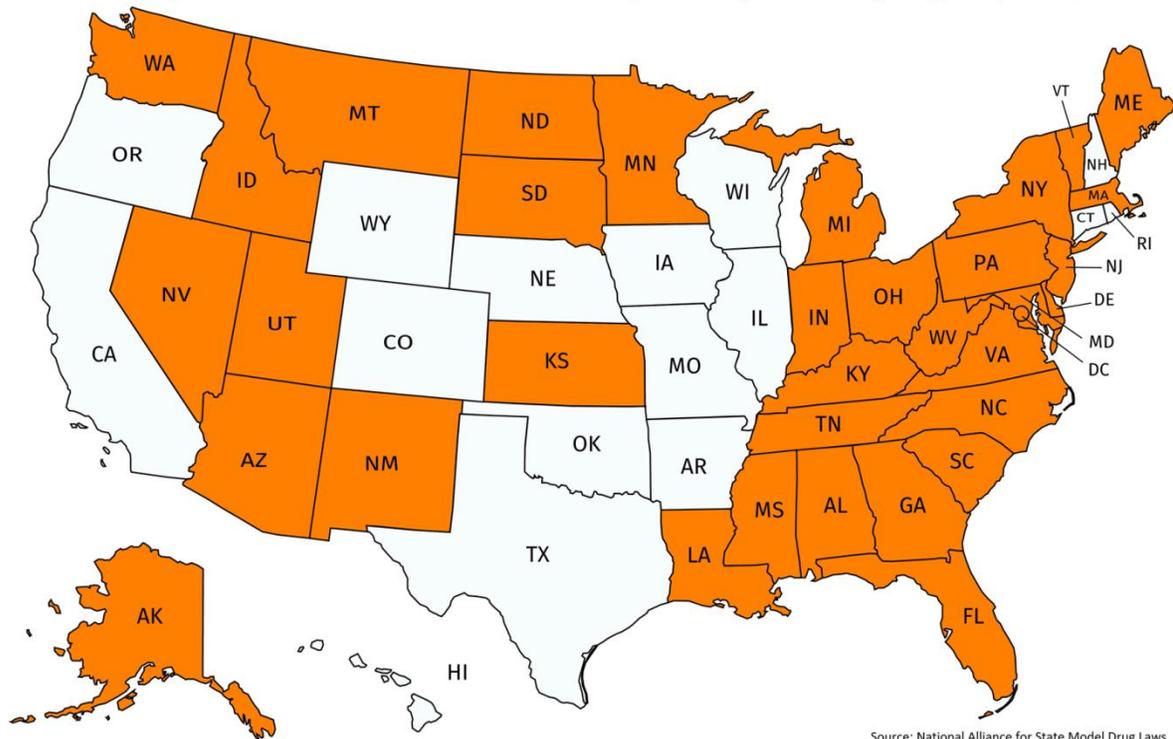
Multiple Provider Episodes and PDMP Requests in New York, October 2011 to October 2015



Source: [Pew Trust](#)

The Centers for Medicare and Medicaid Service (CMS) has identified Medicaid programs having access to their state’s PDMP as a national best practice to combat opioid misuse in the Medicaid population. National and state data show Medicaid clients are disproportionately impacted by substance use disorders and the opioid crisis. To date, 35 state Medicaid programs utilize their state’s PDMP to help identify clients who may be misusing prescription drugs.

Medicaid Programs with Access to their state's Prescription Drug Monitoring Program (PDMP)



Colorado Progress (See Appendix A for more information)

Registration into the Colorado PDMP, administered by the Department of Regulatory Agencies, is required for anyone registered with the Drug Enforcement Agency (DEA) to prescribe controlled substances, but participation in PDMP is not mandatory. As of January 2015, prescribers and pharmacists can assign up to three delegates on their health team who can also access the PDMP.

The Colorado General Assembly created the Colorado Electronic Prescription Drug Monitoring Program in 2005, with the passage of House Bill 05-1130. The purpose of the PDMP was to prevent prescription drug abuse by creating a database of all prescriptions for controlled substances that are filled in Colorado. The database allows prescribers to monitor patients' use of controlled substances, with the goal of mitigating the abuse of prescription drugs. The 2005 bill made implementation of the PDMP contingent upon receiving sufficient funding via gifts, grants, and donations. In 2007, the General Assembly passed Senate Bill 07-204, which authorized the Colorado Board of Pharmacy (Board) to supplement funding for the PDMP by charging all prescribers of controlled substances—i.e., dentists, nurses with prescriptive authority, optometrists, physicians, physician assistants, podiatrists, and veterinarians—a surcharge of up to \$7.50 per year. Prescribers pay the surcharge when renewing their licenses once every two years (in 2017, the cost was \$12).

Data points tracked by the PDMP include, at a minimum, the following information for each prescription:

- The date the prescription was dispensed;
- The name of the patient and the prescriber;
- The name and amount of the controlled substance;
- The method of payment (e.g., cash or health insurance); and
- The name of the dispensing pharmacy.

The law further authorizes the Board to collect any other data elements needed to determine whether a patient is visiting multiple prescribers or pharmacies, or both, to receive the same or similar medication.

Access to the PDMP is set by § 12-42.5-404, C.R.S. This includes:

- Regulatory boards in the Department of Regulatory Agencies may obtain, but not directly, access the PDMP with a valid court order or subpoena in connection with a bona fide investigation.
- Law enforcement officers may obtain, but not directly access, the PDMP with a valid court order or subpoena in connection with a bona fide investigation.
- Prescribing practitioners and pharmacists in Colorado and those in other states treating Colorado patients through the PMPi Inter-Connect as established by the National Association of Boards of Pharmacy.
- Patients may request their own data.
- Research agreements so long as they do not reveal the identity of a specific patient, prescriber, or dispenser.

Since the original passage, there have been modifications to the PDMP based on administrative and legislative changes, including changes that align with evidence-based practices listed in a [Pew Charitable Trusts study on PDMPs](#). Two recent updates to the PDMP have been passed.

- **HB14-1283** achieved many improvements including amending the PDMP statute to require mandatory registration by all pharmacists and DEA-registered prescribers; to provide the Colorado Department of Public Health and Environment (CDPHE) the ability to collect PDMP data for population-level analysis, expanding the State's ability to study the effectiveness of the PDMP through statistical analysis; allowed prescribers and pharmacists to designate up to three delegates to access the PDMP upon authorization; allowed for unsolicited reports to prescribers and pharmacists that inform on the number of patients being prescribed controlled substances by multiple

prescribers and at multiple pharmacies over set periods of time, thereby reducing potential patient misuse, abuse, and diversion of controlled substances; and created the PDMP Task Force under the authority of the Executive Director of the Department of Regulatory Agencies. The Executive Director requested the formal assistance of the Colorado Consortium for Prescription Drug Abuse and Misuse to serve as this task force.

- **SB17-146**, which clarified access for prescribers and pharmacists for improved clinical decision-making, aligned PDMP with best practices in other states, and allowing utilization to check drug-drug interactions improving patient care, as well as clarifying the ability for veterinarians to check the PDMP for the pet owner.

The executive director of DORA tasked the PDMP Task Force with the examination and analysis of the PDMP and to provide recommendations. Such requests for examination have included:

- Examine issues, opportunities, and weaknesses of the program, including how personal information is secured in the program and whether inclusion of personal identifying information in the program and access to that information is necessary;
- Make recommendations on ways to make the program a more effective tool for practitioners and pharmacists in order to reduce prescription drug abuse in this state;
- Determine what specific steps can we take to integrate the PDMP into Colorado's two health information exchanges and electronic health records;
- Research and inform alternative methods to measure effectiveness; and
- Provide recommendations regarding alternative outreach (in addition to unsolicited reports/push notices) such as score cards.

PDMP Efficacy and Utilization

As depicted from the table below, in addition to gradually increasing utilization of the PDMP by prescribers over time, the number of push notices, or notifications sent to prescribers and pharmacies when their patient obtains prescriptions from multiple sources and in potentially harmful quantities, gradually decreased each time a higher threshold was set as determined by the prescriber boards and the Pharmacy Board.

While the original push notice threshold was set in October 2014, the Pharmacy Board continues to monitor the effectiveness of push notices and set a new (higher) threshold in September 2016.

This suggests a change in prescriber behavior by using the PDMP as an informative public health tool to ultimately reduce the incidents of doctor shopping. Also as depicted in the table below, prescriber behavior was also influenced through even higher PDMP utilization rates by

way of the PDMP’s integration into the University of Colorado emergency room health record system in January 2017.

This allowed prescribers to more easily access the PDMP by logging into their own emergency room computer system as opposed to having to log into two, separate computer systems to obtain relevant health record information regarding a patient presenting to an emergency room. In addition, a similar utilization rate pattern was observed with pharmacists when the PDMP was integrated into all Colorado-based Kroger-owned pharmacies in February 2016.

Finally, as illustrated in the table, while the total number of controlled substance prescriptions dispensed in Colorado fluctuated over time, a general trending decrease in prescriptions dispensed was observed since January 2014. This is particularly striking considering Colorado’s population continues to increase and certain drugs (for example, tramadol and carisoprodol) have been reclassified as controlled substances and as such, count toward the total number of controlled substances dispensed since 2014.

PDMP Utilization Rates (by percentages) and Push Notices (by number)

	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
Prescriber %	23	25	23	26	15	65	104	82	73	90	95	93	72
Registered pharmacist %	63	67	64	71	43	61	42	66	60	61	60	62	49
Push Notices	175	1011 ***	718 **	518 **	738	549	492	699	522	774	679	604	n/a

** Pharmacist only - Patient Specific Queries/Prescriptions Dispensed

*** Due to higher threshold as voted upon by prescriber boards and pharmacy board.

The Colorado Department of Health Care Policy and Financing (HCPF) is committed to using every tool available to help members at risk of opioid addiction or substance misuse. Access to the PDMP is not available currently to the state Medicaid agency. While HCPF can track opioid prescriptions that are paid for through Medicaid, it does not have information on Medicaid members who are cash paying for such prescriptions or getting them through a third party, which could be a red flag for potential opioid misuse.

Safe medication take-backs and disposal

Disposing of unused controlled substances prevents the sale, theft, or misuse of these medications by the prescription holder or others. There are two primary methods for safe disposal: drop boxes and take-back events. Drop boxes provide a secure, non-retrievable location to dispose of unwanted medications at a DEA regulated location. Safe take-back events can be held at any community location as long as law enforcement is present.

States Involved

Many states [have](#) year-round drug take-back programs that use on-site drug disposal boxes or a mail-back program, or they have local medication take-back events at different sites throughout the year. The take-back programs are facilitated by a variety of entities, including police departments, municipal buildings and pharmacies, and regulated by the DEA.

Many executive orders and state legislation has focused on the promotion of these federally regulated safe disposal sites and events across districts, counties, state agencies, and private community partners such as pharmacists and health care systems. The following are examples of programs that are working to establish statewide solutions for safe drug disposal.

- [Arkansas Take Back](#): “There was just 146 pounds of prescription medications collected at the first Operation Medicine Cabinet in Benton back in the spring of 2009, but the program and education to the public continued growth. Dustin McDaniel and both Arkansas districts of the U.S. Attorney’s Office launched an ongoing educational program to encourage everyone to “Monitor, Secure and Dispose” of their prescription medications. In May 2016, the DEA announced that 893,498 pounds of prescription medications were collected in all 50 states, with 25,289 pounds collected from Arkansas.
- [Oregon Drug Take-Back and Disposal](#): Following promotion of the September 2015 Take-Back Day by the Oregon Health Authority, “8,934 pounds (4.5 tons) were removed from circulation that day, averting both possible misuse/abuse by humans and contamination of water resources.”
- [Indiana Bitter Pill](#): The state of Indiana, through a cross-departmental partnership and a Prescription Drug Abuse Prevention Task Force, manages a website and campaign, which includes safe take-back locations as well as information on state policy, how to find treatment, prescriber resources, and prevention information.

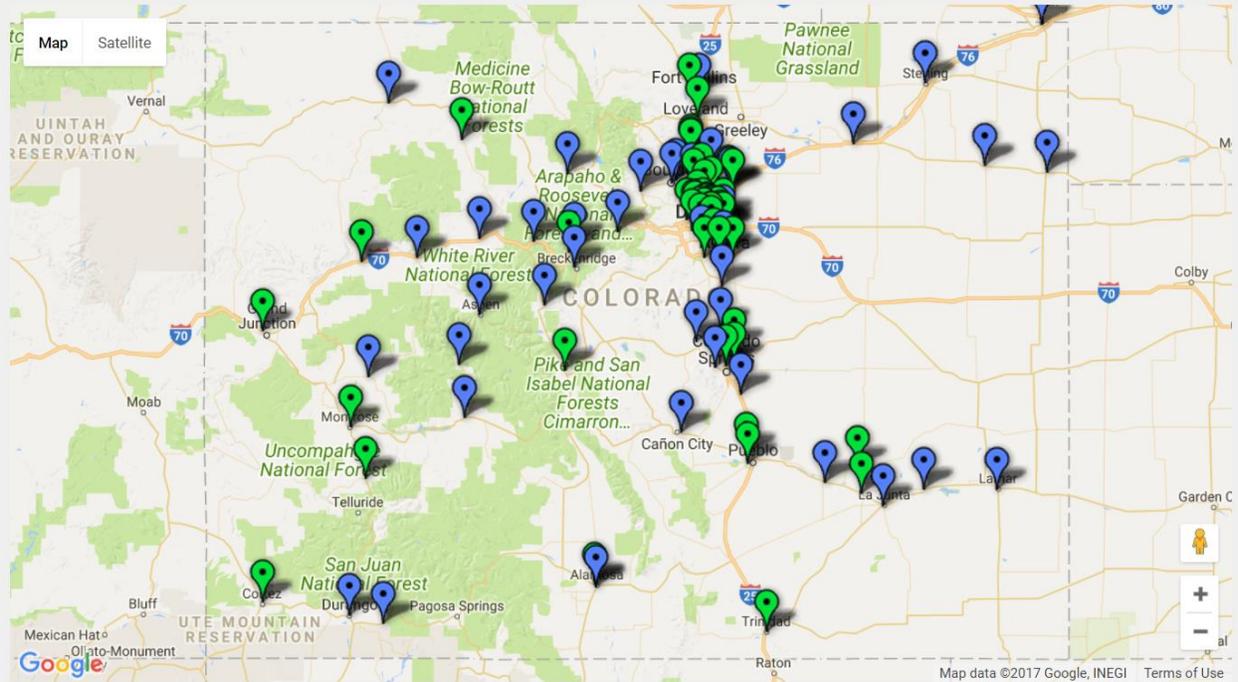
Colorado Progress

In January 2017, the Colorado Department of Public Health and Environment (CDPHE) established a permanent household [medication take-back program](#), adding more than 42 drop-off locations in two dozen counties across the state. CDPHE has set a goal of at least one take-back location in each county by 2017.

The Colorado Consortium for Prescription Drug Abuse Prevention (Consortium), created by Gov. John Hickenlooper in the fall of 2013, has disposal as one its key goals. A Safe Disposal Work Group within the Consortium is charged with expanding the CDPHE Medication Take-Back Program and promoting Colorado’s disposal activities nationally.

Medication Take Back locations map

[Back to Medication Take-Back program](#)



Source: <https://www.colorado.gov/pacific/cdphe/medication-take-back-locations-map>

Treatment Laws

For individuals seeking treatment for opiate use disorder, barriers such as long wait times, high cost, geographic location, and a limited workforce can be seemingly insurmountable. Timely access to effective treatment programs is an essential component to combating the opioid crisis. States have worked to increase access to evidence-based treatment by increasing the workforce and number of provider locations and decreasing cost and reimbursement barriers and expanding the type of services provided. This policy analysis focuses on laws that address:

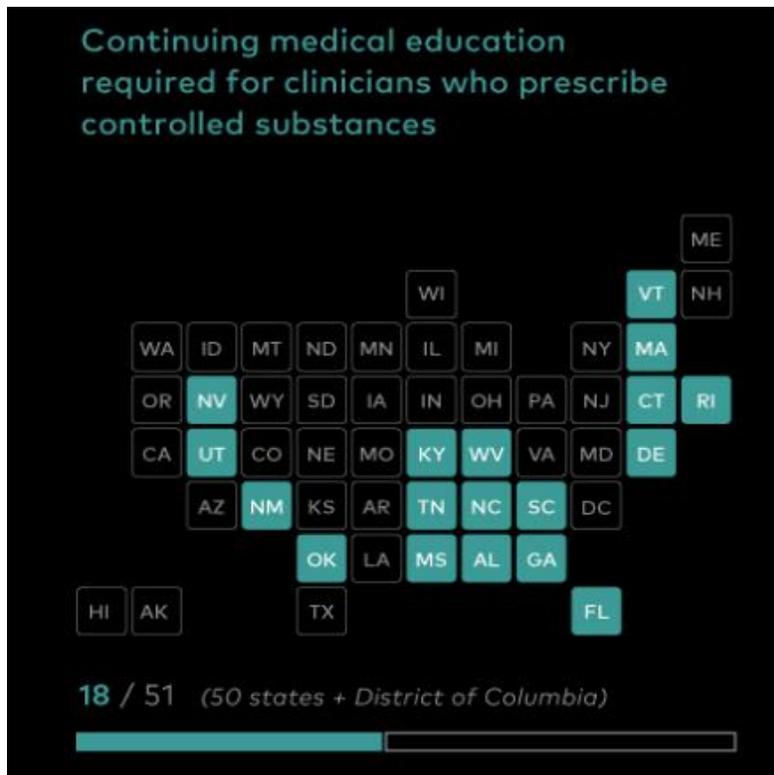
- Provider training and development
- Expanding access to treatment

Provider training and workforce development

Mandating provider training or workforce development for primary care providers, substance use treatment providers or other prescribers (i.e. dentists, veterinarians, etc.) through legislation is a tactic some states have used to better prepare our existing workforce to serve individuals abusing opioids.

States Involved

The following 18 states have enacted legislation related to provider training on opioids:



Source: [Athena Health](#)

These laws typically require certain providers to have training or continuing education in prescribing controlled substances, opioid misuse and abuse, and/or require training or education in pain management. As with the other categories, variation exists among states.

In [Kentucky](#), the Board of Pharmacy set prescribing limits on buprenorphine, which limit or prohibit the concurrent prescribing of buprenorphine and other controlled substances and require that a provider consult with an a Board Certified Addictionologist for any concurrent prescribing or prescriptions lasting more than 12 months. The Board also requires regular visits with a physician, drug screens, and pill counts to prevent diversion. [North Carolina](#) requires that physicians must register with the state Department of Health and Human Services and provide written documentation of their plan to refer any patient prescribed buprenorphine to substance use treatment.

Many of the limitations on buprenorphine prescribing are set by federal policies, including the education requirements and the number of patients in a prescriber can manage over time. SAMHSA [funds](#) continuing medical education courses on prescribing opioids for chronic pain. The courses are developed by local and state health organizations nationwide.

Colorado Progress

Colorado does not have any continuing education requirements for physicians, according to the Colorado Medical Board. However, some continuing education opportunities are or have been available in Colorado, including continuing education on opioids.

In 2012, the Colorado School of Public Health [launched](#) a two-hour online course called “The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management.” The course is accredited by the University of Colorado School of Medicine for awarding continuing medical education credits.

The Department of Health Care Policy and Financing (HCPF) [completed](#) two years of Chronic Pain Disease Management Programs, which connected pain management specialists throughout the country with primary care providers across Colorado who were managing the care of Medicaid members suffering from chronic pain.

HCPF also offered the Buprenorphine Telehealth Program starting in 2016, which connected primary care providers licensed to prescribe buprenorphine combination products, such as Suboxone, with specialists to gain greater insights and experience with treating clients with opioid addiction.

Another way telemedicine is helping fight the opioid crisis in Colorado is through the Agency for Healthcare Research and Quality (AHRQ), which in 2016 [launched](#) a three-year, approximately \$12 million effort to train rural health care providers in medication-assisted treatment (MAT) therapy.

In Colorado, the AHRQ is expanding access to MAT across 24 counties across the eastern and southern parts of the state. Primary care practices will receive comprehensive training and support for the delivery of MAT in their rural practices.

Additionally, although no continuing education is required at the state level, hospitals may require continuing education.

Access to Treatment Laws

States have identified multiple avenues to increase access to substance use disorder treatment services. These laws often focus on improving timeliness of access, increasing access locations, collaborations across agencies to improve referrals, collaborations across agencies to improve benefit management and administration of programs, and increasing funds for SUD treatment through grants, federal dollars, and state funds.

States Involved

Access to inpatient treatment has been a challenge for all states, based on the federal Centers for Medicare and Medicaid Services' limitation on this benefit. While inpatient treatment is not standard for all individuals seeking treatment for substance use disorder, the American Society of Addiction Medicine (ASAM) criteria used to determine need for treatment modality includes a bio-social assessment looking at an individual's biomedical and intoxication/withdrawal state, readiness to change, cognitive and emotional complications such as co-occurring mental illness, level of use and relapse, and living environment. For those who meet the criteria for inpatient treatment, paying for treatment can be a barrier even for those with insurance coverage. Many states have made changes to their insurance requirements or requested a waiver from this limitation from CMS.

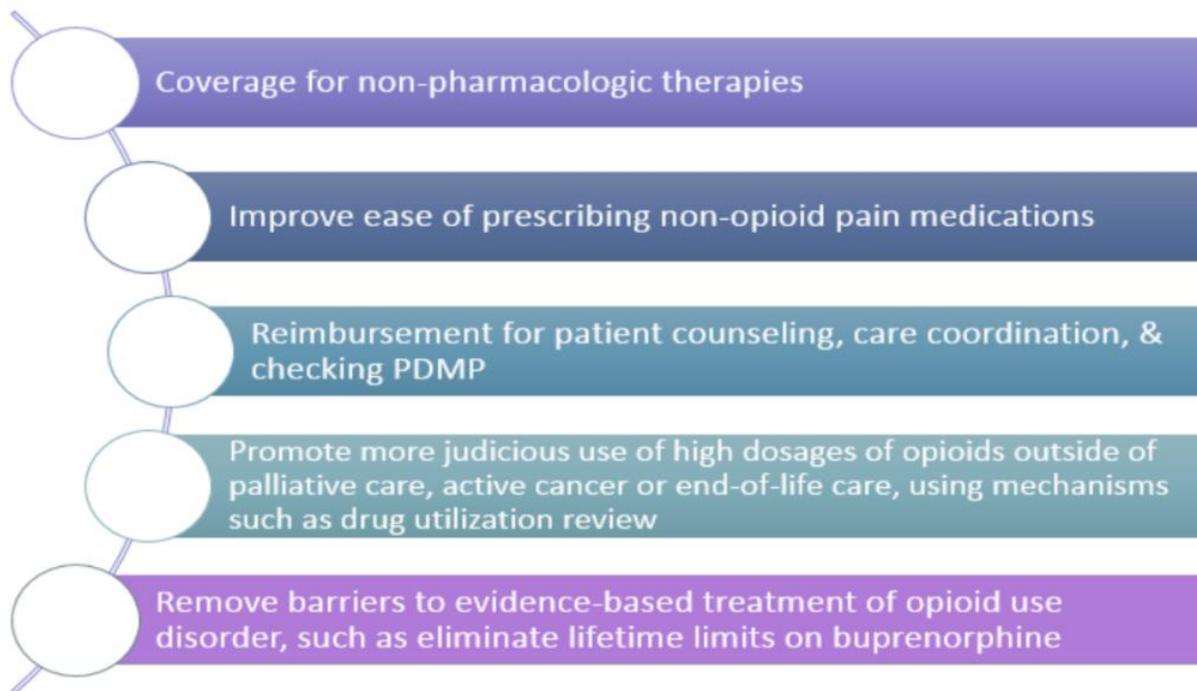
Expanding coverage through public and private payers

"New York's [new addiction treatment law](#), for example, requires insurers to give people seeking treatment immediate access to care and to cover at least 14 days of continuous [inpatient] treatment before requiring authorization from providers. It also requires health care providers to use objective, state-approved criteria to determine what level of care a patient needs." The removal of the pre-authorization does not pertain to prescribing medication for substance use treatment.

In New Hampshire, the city of Manchester has created "[Safe Stations](#)," fire departments that open their doors to individuals seeking treatment. "Every fire station in Manchester, NH, is a designated safe haven for people struggling with addiction who want to enter treatment and begin their path to recovery. Available 24 hours a day, seven days a week, any person can go to any fire station in the city, speak with the firefighters on duty, and immediately get connected to treatment support and services. Developed and implemented without any new funding, Safe Stations has connected 1,326 people to treatment between May 4, 2016 and March 4, 2017." Partners include a treatment network and a recovery network. The recovery services include recovery coaches that provide peer navigation services and assist individuals and families in accessing treatment services.

During the 2017 State Opioid Workshop, hosted by federal health agencies including CMS, Centers for Disease Control and Prevention (CDC), and the Substance Abuse Mental Health Services Administration (SAMHSA), the CDC presented on how to implement their recommendations to reduce opioid prescribing, including the slide below:

Insurer Interventions



Source: Jan Losby, PhD, MSW, Dissemination and Implementation of CDC’s Guideline for Prescribing for Chronic Pain Opioids for Chronic Pain. Division of Unintentional Injury Prevention Centers for Disease Control and Prevention State Opioid Workshop August 8, 2017.

In 2015, [Rand created a set of recommendations](#), highlighting that increasing barriers to substance use treatment through insurance requirements reduces access. Specifically, they identified the following policies reduce access to treatment:

- prior authorization;
- copayments; and
- counseling requirements.

Access to Medication Assisted Treatment (MAT)

In the 2017 legislative session in Indiana, the state passed [HB 1541 Addiction Treatment Teams](#), which “adds a definition of ‘medication assisted treatment.’ Specifies: (1) providers that must be included as part of; and (2) services that must be provided by; an addiction treatment team.

[The legislation] establishes reimbursement for addiction treatment teams from health and addiction forensic treatment services grants. [The legislation] allows addiction treatment teams to provide services in temporary locations and mobile units in specified conditions.” This law will expand the services that are provided as a part of standard MAT in the state and the types of location that can receive reimbursement.

Colorado Progress

Colorado’s legislators added new state funding for MAT in 2017. Senate Bill 17-74 taps the Marijuana Tax Cash Fund to train more MAT providers in Pueblo and Routt counties. The program will be administered by the University of Colorado College of Nursing.

Regarding partnerships with law enforcement and emergency services, Colorado has created some strong program partnerships, including naloxone training and purchasing of naloxone for EMS and police and the Law Enforcement Assisted Diversion (LEAD) program funded out of Senate Bill 17-207. This program identifies individuals with a substance use disorder through contact with law enforcement and creates pathways to treatment as an alternative to sentencing.

House Bill 17-1351 requires the Department to prepare a written report (due November 1, 2017) relating to residential and inpatient substance use disorder treatment options under the Medicaid program, the cost of treatment and the potential impact on other state and county programs and services if residential and inpatient treatment options were effective.

In 2016, the state Legislature passed Senate Bill 16-202, which allocated funds for the State’s system of Managed Service Organizations (MSO) to conduct a community needs assessment of substance use disorder (SUD) needs in our state, develop regional and local community action plans, and begin filling out the SUD services continuum. To assess community need, the Keystone Policy Center (Keystone) participated in dozens of interviews, held 10 statewide meetings, and conducted hundreds of surveys with key stakeholders to solicit feedback on the current gaps in SUD services in Colorado. Following the feedback from stakeholders outlined in the report, each MSO completed their regional action plans.

In 2017, funds were used to fill out service gaps based on community feedback and collaboration. During the 2017 session, additional substance use treatment funding was allocated to the MSOs to implement community-initiated projects to fill gaps in the service continuum as experienced by local community members. Projects ranged across the full continuum of SUD services, and included such things as:

- Supporting and expanding residential treatment services;
- Expanding access to withdrawal management services;

- Increasing access to outpatient, school, and cross-system services;
- Targeting opioid services and initiatives; and
- Promoting and expanding access to recovery services

The MSOs are continuously working with their local stakeholders to maximize the initiatives, track progress, and collect outcomes measures for the state.

Harm Reduction Laws

For those individuals with opiate use disorder that are not in treatment or recovery, harm reduction legislation can reduce negative outcomes such as overdose and overdose death, the spread of communicable diseases such as HIV/AIDS and Hepatitis C, and create relationships between those actively using drugs and community outreach workers that can connect them to additional resources when they are ready, such as behavioral health treatment. Harm reduction laws specific to opioid abuse and injection drug use include laws related to:

- Overdose reversal drugs such as naloxone
- Good Samaritan laws for reporting an overdose
- Harm reduction for injection drug users

Overdose Reversal Drugs

Opioid overdose is reversible through the timely administration of the medication naloxone (brand name Narcan) and, where needed, the provision of other emergency care. In response to the unprecedented increase in preventable overdose deaths, all 50 states and the District of Columbia have now modified their laws to increase access to naloxone, the standard first-line treatment for opioid overdose. However, the drug is too often not available when needed and state laws can be an impediment too in that they generally only allow a prescription for naloxone.

States Involved

New Mexico [became](#) the first state to enact legislation to increase access to naloxone in 2001, and today every state has [enacted](#) a law to broaden access to naloxone. All states have removed some legal barriers to the seeking of emergency medical care and the timely administration of naloxone. The first improves the availability of naloxone, typically by permitting it to be prescribed to people other than the person at risk of overdose or otherwise removing the need for a person to see a prescriber before obtaining the medication. See [the table here](#) for specifics of each state's law.

"The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths," [published](#) by the National Bureau of Economic Research, found that adoption of a naloxone access law is associated with a 9 to 11 percent decrease in the opioid-related deaths.

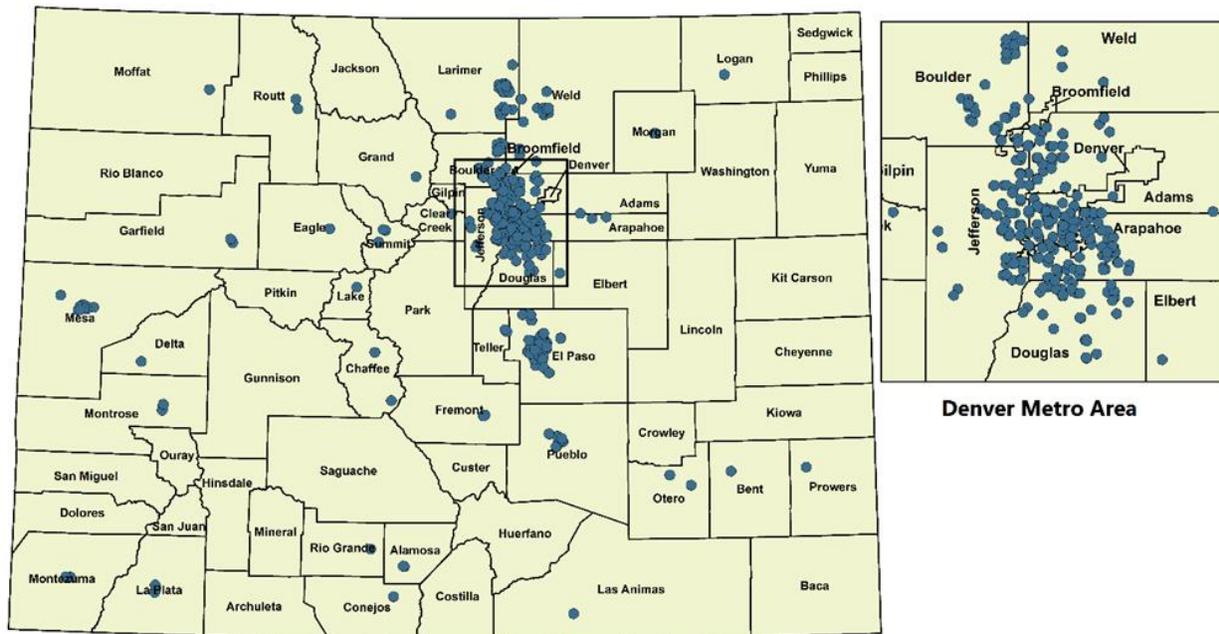
Colorado Progress

Colorado passed Senate Bill 13-014 in the 2013 legislative session, allowing third-party prescribing of opiate antagonists such as naloxone. It provides criminal and civil immunity for

prescribers and dispensers of opiate antagonists and those who act in good faith to administer opiate antagonists in the event of an overdose.

Senate Bill 15-053, passed in 2015, expands statewide access to naloxone. It allows the chief medical officer of the Colorado Department of Public Health and Environment (CDPHE) to issue standing orders for naloxone to be dispensed by pharmacies and harm reduction organization employees and volunteers. The standing order for a naloxone prescription means individuals can access naloxone through a pharmacist without an individual prescription. Naloxone is covered by most commercial insurance plans and Colorado Medicaid. Colorado Attorney General Cynthia Coffman launched the Naloxone for Life Initiative in 2016. The initiative uses funds from settlements with pharmaceutical companies to purchase 2,500 dual dose Narcan rescue kits that were supplied to law enforcement and first responders in 17 counties with high rates of overdose deaths. Ten trainings on Narcan use were held in six regions across the state. As of July 2017, officers in 140 law enforcement departments carry naloxone.

Pharmacies that have standing orders to prescribe Naloxone; Colorado and Denver Metro



Source: [Stop the Clock Colorado](#)

Good Samaritan Laws for Reporting an Overdose

In an overdose emergency, calling for first responders and fast administration of overdose reversal medications (naloxone) can save lives. [Good Samaritan laws](#) protect individuals at the scene of an overdose from “arrest, charge or prosecution for certain controlled substance possession and paraphernalia offenses when a person who is either experiencing an opioid-related overdose or observing one calls 911 for assistance or seeks medical attention. State laws are also increasingly providing immunity from violations of pretrial, probation or parole conditions and violations of protection or restraining order.” These laws address circumstances in which an individual might delay or refuse to call for help in a life-threatening emergency due to fear of arrest and prosecution. They also protect a person acting in good faith to assist a person in a life-threatening emergency, including the administration of naloxone.

States Involved

Forty states and the District of Columbia have enacted some form of a Good Samaritan or 911 drug immunity law.

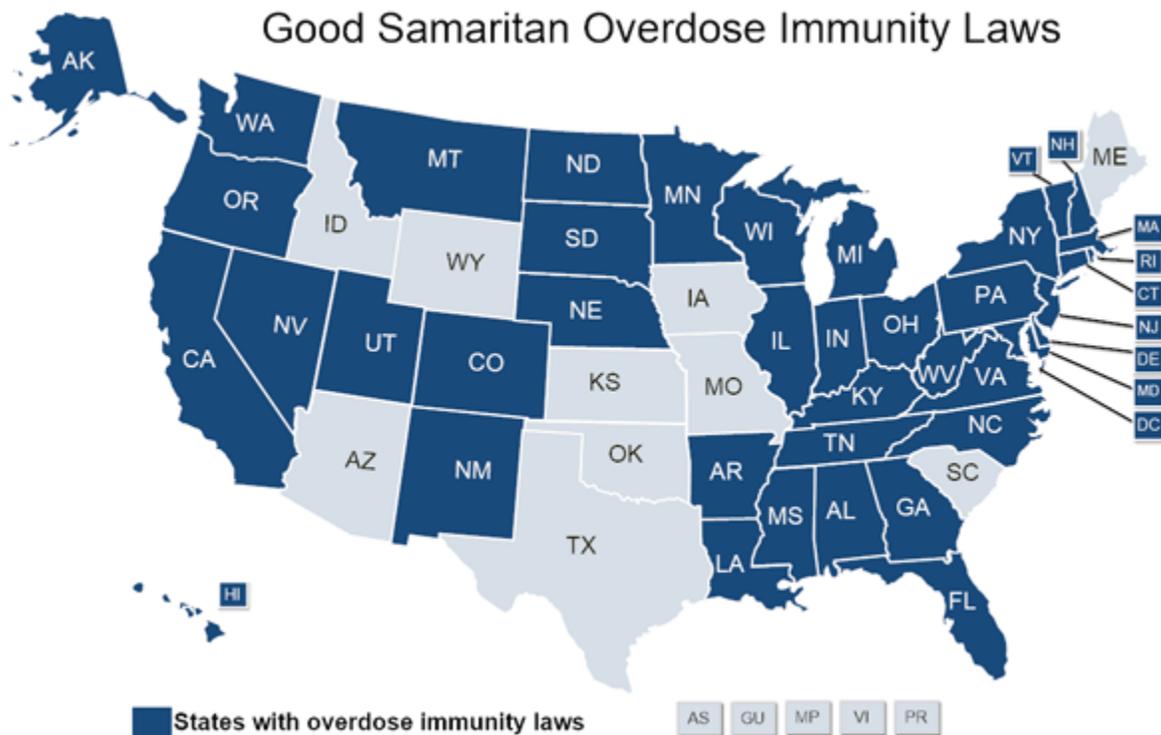


Image Source: [National Conference of State Legislature](#) June 5, 2017

Colorado Progress

Colorado legislators have [passed two bills](#) that protect people who report an overdose. Passed in 2012, Senate Bill 12-20 provides legal protection from drug charges for those who call 911 for help. The law also protects persons suffering an opioid overdose from being arrested or

prosecuted. HB16-1390, passed in 2016, updates SB12-20. The law extends protections to underage Coloradans.

According to the Colorado Department of Public Health and Environment; “the Third Party Naloxone law (C.R.S. §18-1-712) allows for a person other than a health care provider or health care facility who acts in good faith to administer an opiate antagonist to another person whom the person believes to be suffering an opiate-related drug overdose. The individual who administers naloxone shall be immune from criminal prosecution for such an act.”

Injection Drug Use and Preventing Negative Outcomes

Many states have created legal protections for harm reduction services that improve health outcomes for injection drug users, reduce the incidence of HIV/AIDS and Hepatitis C, and improve public safety. Syringe exchange programs provide clean syringes to injection drug users to prevent the likelihood of sharing needles. These are supported through legislation that exempts the providers of clean syringes from drug paraphernalia laws. Safe injection facilities (SIFs) provide a safe place for people to use injection drugs in a sterile environment managed by medical staff who can respond to medical emergencies including overdoses. These facilities require laws to exempt them from aiding and abetting a crime and civil forfeiture. Syringe exchange programs and SIFs often also include behavioral health services and case workers available to anyone who is ready to move into treatment.

States Involved

At least 20 states [have laws](#) explicitly allowing needle exchange programs. Four states, including Colorado, passed bills in the 2015 legislative session. Two more, Florida and Utah, passed legislation in 2016. “The general consensus in the public health community is that needle exchange programs contribute to harm reduction in preventing the spread of infectious diseases,” according to the Council of State Governments.

[New York](#), [Maryland](#), and [Massachusetts](#) have introduced legislation and [California](#) passed a bill to permit safe injection facilities with bipartisan support. [King County, Washington](#), health officials have approved support for two safe injection facilities for the Seattle metro area. The [Drug Policy Alliance](#) overview of the safe injection facilities states “the evidence is conclusive that [safe injection facilities] reduce HIV and hepatitis transmission risks, prevent overdose deaths, reduce public injections, reduce discarded syringes, and increase the number of people who enter drug treatment. Similar facilities in other countries “provide sterile injection equipment, information about reducing the harms of drugs, health care, treatment referrals, and access to medical staff. Some offer counseling, hygienic amenities, and other services.”

According to the Colorado Harm Reduction Center, “As of August 2017, five states are pushing forward with statewide legislation to make exemptions for a SIF, primarily for the property on which the SIF will be located. State and City support for this initiative will be crucial for the success of this lifesaving opportunity. A SIF would significantly impact rates of public injection, reduce acquisition of HIV/viral hepatitis, reduction of skin tissue infections, decreases overdoses, and would serve to help connect our marginalized citizens to evidence-based health care and support.”

Colorado Progress

The Colorado Harm Reduction Action Center (HRAC) and other state public health providers support harm reduction services through safe syringe programs, which are legislatively supported by [two statutes](#): “Syringe Exchange Programs C.R. S. §25-1-520 allows local jurisdictions to approve the operations of syringe exchange programs. Participants, volunteers and staff are exempt from the provisions of paraphernalia laws, C.R.S. §18-18-425 to 18-18-430, when they associated with an approved syringe exchange program created pursuant to this law. Drug Paraphernalia Law Exemption, C.R.S. §18-18-430.5 states that syringe exchange program participants are exempt from drug paraphernalia laws, C.R.S. §18-18-425 through 18-18-430.”

HRAC is also currently working with the City and County of Denver to create a safe injection facility. According to HRAC, “in Colorado, there is a fatal overdose every nine hours and 24 minutes. 174 people died of overdose just in the City and County of Denver in 2016. At least 20 died outside, in an alley, in a park, or in a business bathroom. Supervised injection facilities, commonly known as SIFs, bridge the gap between people who inject drugs and public health interventions that are proven to reduce the spread of HIV and viral hepatitis and also prevent fatal overdoses. In fact, of 102 SIFs currently operating around the globe, in 63 cities in 9 countries, and not one has reported a single fatal overdose on its premises.” (HRAC, direct communication).

Appendix A: DORA Efforts Related to Prescription Drug Abuse and Misuse

The Department of Regulatory Agencies (DORA) has taken multiple approaches to impact the issue of prescription drug abuse and misuse, focusing on the need to change prescriber behavior in an effort to reduce prescription drug abuse in Colorado.

- These efforts were formally launched in 2013, in conjunction with the Colorado Plan to Reduce Prescription Drug Abuse issued by the Governor, with a Quad-Regulator Boards conference convened by the prescriber boards of Nursing, Medical, Dental and Pharmacy. After a period of public stakeholder meetings, the Policy for Prescribing and Dispensing Opioids was adopted in 2014.
- In addition, DORA has maintained active participation in the Consortium on Reducing Prescription Drug Abuse, continued educational outreach efforts to prescribers and pharmacists, and has spearheaded two, separate legislative bills (in 2014 and 2017) to enhance the Prescription Drug Monitoring Program (PDMP) and to increase its utilization.
- In 2014, an administrative change was made to increase controlled substance dispensing reporting from bi-weekly to daily, thereby providing up-to-date PDMP patient data for prescribers and pharmacists.
- In the fall of 2015, DORA was awarded a Harold Rogers Prescription Drug Monitoring Program Practitioner and Research Partnerships grant. This \$750,000 three-year grant allows a primary investigator to investigate three integrations of the PDMP into five major Colorado hospital emergency departments. In the first phase, PDMP access was integrated into hospital EHRs as part of the typical provider workflow. In the second phase, prescribers in these hospitals were provided systematic decision support in the interpretation of integrated PDMP data using a risk assessment tool added to the integration process. In the final phase, integrated PDMP access will be mandated into prescribers' workflow when considering therapy. DORA and PDMP staff are continuing to work closely with the primary investigator and the UC Health School of Medicine to implement each aspect of the grant directives. In the course of the three-year study, it is expected that key information about the manner in which an integrated PDMP system is accessed and considered in a patient's care will be studied and evaluated.
- In 2016, the PDMP created a five-minute informational video that teaches a potential delegate and his or her corresponding overseeing prescriber or pharmacist how to register and begin to access the PDMP. As the number of delegates rises, this video provides an excellent informational source for increased ease-of-use and comfort level with the PDMP. To go along with this, the PDMP launched a PDMP website in 2016. The PDMP site is designed to provide both consumers and healthcare professionals with the tools they need to access PDMP information, drug misuse and abuse resources, and up-to-date news and documentation for providers and pharmacists.

As noted in the PDMP section, the Executive Director of DORA tasked the PDMP Task Force, pursuant to 12-42.5-408.5 for the examination and analysis of prescription drug monitoring program and for the task force to provide recommendations to the Executive Director.

Outcomes from the work of the PDMP Task Force have included:

- Recommendations to inform the effectiveness and utilization of the PDMP to include: a metric that is the ratio of the number of patient-specific queries made against the PDMP system compared to the total number of prescriptions that were dispensed in the same time period in the state. Patient-specific queries are defined as queries made only to access patient PDMP data, and not, for example, passwords or username resets (utilization Rate = # of total Patient-Specific queries / # of total CS prescriptions dispensed); and utilization Rate = # of Patient-Specific queries by Providers / # of total CS prescriptions dispensed because the foregoing metric is specific to Colorado providers, it offers a keen insight into their use of the PDMP system.
- Moving forward with the Kroger, Co. integration. The PDMP was made available to the Apriss Gateway integration process in September, and the King Soopers and City Market pharmacists began to use the rapid access integration program in February of 2016. The integration proved to be immediately successful, resulting in a marked increase in PDMP utilization among pharmacists, and no issues involving a “slowdown” occurred.
- Recommendations for best practices to carefully stratify the organizations mentioned above to determine those most likely to provide the highest level of return to the patients of Colorado from an integration process. Such stratification would include the consideration of the current state of the technology available at the facility, while taking into account the ability to connect successfully to the Colorado PDMP vendor and to continue to facilitate the work of CORHIO and QHN by assisting the stratification of possible sites to determine the best possible outcomes for an integration project for both HIE organizations.
- Focus by the PDMP Work Group to explore access options that, according to CDPHE and the HIE representatives, could lead to an HIE integrated into an EHR system. Once such an integration of the HIE occurs into the prescriber’s EHR, a “single-sign-on” could be achieved. This would be a very important first step in prescriber access.