

Colorado General Assembly
Interim Study Committee on Opioid and Other Substance Use Disorders
Stakeholder Task Force

Notes: Policy Proposal Review 8/30/17 and 8/31/17

Stakeholders were invited to submit ideas for improving practice and policy in Colorado that would have a positive impact on addressing the opioid crisis and other substance use disorders.

The ideas were submit by form and the ideas presented in the submissions were compiled into these categories:

1. Clinical Practice, which encompassed these areas
 - Prescription Drug Monitoring Program
 - Provider Education
 - Screening, Brief Intervention, and referral to Treatment
 - Patient and Public Education
 - Other Clinical Practices (i.e. number of opioids prescribed, days per prescription of opioids)
2. Safe Disposal of prescribed opioids
3. Law Enforcement
4. Harm Reduction
5. Workforce
6. Payment Reform
7. Treatment and recovery Support
8. Funding Coalition Work
9. Other items

The two Stakeholder Task Force sessions allowed for a review and discussion of the general areas of recommended policy considerations and for additional ideas to be shared and discussed.

This process helped to narrow the focus of policy considerations.

Below are general notes from the two sessions, one held on August 30th and the second on August 21st.

The compilation of proposed practice and policy recommendations is available online at:

https://leg.colorado.gov/sites/default/files/policy_proposals_-_aug._30.pdf

Session 1: August 30, 2017, 2:00 p.m. – 5:00 p.m.

This session focused on proposed policy considerations related to clinical practices, safe disposal and law enforcement with attention to distinguishing recommendations that fall within state government authority and those within federal authority.

Clinical Practices

See the compilation policy proposals for details about each of the following

Colorado Prescription Drug Monitoring Program (PDMP)

- Consider expand to all psychoactive drugs
- Consider notification of contraindicated drugs
- With the PDMP integration into Electronic Health Records (EHRs), are there any HIPAA concern?
 - Usually part of the same hospital system, so not a concern
 - E-prescribing makes it easier to not overprescribe and decreases fraud
 - E-Scripts barrier--can only be used during business hours
- Concern was expressed about PDMP limitations between states. There is a new PDMP vendor that serves 41 states and they are working on interconnectivity
 - Q: How many EHRs exist? Is the underlying data system the same? Cost is a big concern.

Provider Education

- Look at breath/broader range of educational opportunities.
- There appears to be agreement about limiting opioid prescribing
- Q: Could there be a “push notification” about prescribing habits?
 - The Colorado Department of Public Health and Environment just received a grant from CDC to pilot a “report card” for prescriber to educate them about their prescribing habits. There is coordination with the Colorado Department of Regulatory Affairs; one challenge is identifying the provider’s specialty
 - **REQUEST: Rep. Petterson asked for more information about report card**
- The Office of Behavioral Health is also pilot testing integrating PDMP and EHR; challenge is sustainability since funding runs out August 2019
- Discussion about coroners: There is potentially underreporting of opioid related deaths. This is due to a number of factors, including no requirement for consistent reporting on opioids as a cause of death, and the lack of medical examiners in smaller counties. Larger Colorado counties have medical examiners, but smaller counties have a coroner limits. It could be useful to mandate PDMP check by coroners, especially those with a medical examiner.

SBIRT

- The proposals submitted focused on the importance of screening pregnant women for substance use.

Patient/Public awareness & education

- There is currently a statewide prescription drug public awareness campaign *Take Meds Seriously* which promotes the message of Safe Use, Safe Storage, Safe Disposal, of prescription medications, especially opioid drugs. Ongoing funding is needed to maintain and expand this campaign.
- There is a need to provide education materials for patients about prescribed opioids in office of prescribers.

Safe Disposal

- The State Legislature allocated funds to establish the Colorado Medication Take Back Program, which official launched in early 2017. The goals of the program is to have at least one permanent Take Back location in every county in Colorado by June 2018.
- A media campaign called *Take Meds Back* was launched in early and mid-2017, and there is still work to do to inform the public about the Take Back locations.
- A hospice representative commented about the need for enforcement around educating families about disposal options at time of death. Very often, there are unused prescribed opioids and no information provided to the family members about proper disposal
- Although concerns have been expressed by chain pharmacies about liability for implementing their own Take Back programs, specifically for disposing of the unused medications, the state-sponsored Medication Take Back Program pays for the collection boxes participants liability coverage)
- There is the issue of long-term sustainability of the Colorado Medication Take Back Program, especially as it begins to expand to more locations across the state. The number of locations and the potential for increased amount of household medication collected will result in additional costs for disposal efforts.
- At this time, there does not appear to be a need for any policy enactment related to Colorado's safe disposal activities, which is being coordinated through the Safe Disposal work group of the Colorado Consortium for Prescription Drug Abuse Prevention.

Law Enforcement

- One major area of concern for law enforcement professionals is connecting the need for medication assisted treatment services for individuals who come into the jails with an opioid use disorder and continuity of care when they are released from jail.
- In regard to drug overdoses, there are now 140 law enforcement departments that carry Narcan, the nasal-spray version of Naloxone, which is used to reverse an opioid overdose.
- Although the Colorado Office of the Attorney General has purchased large quantities of Narcan for distribution to law enforcement personnel in counties with the highest rates of drug overdose deaths, there are additional law enforcement departments requesting Narcan and do not have funding in their budgets.

Additional Considerations

Data

- The need for better data collection was discussed, particularly what are the sources of data. There is a need for a data warehouse, ie: what drug is being prescribed the most.
- Build data surveillance into recommendations, other states have had success with this.
REQUEST for Cristen Bates at the Office of Behavioral Health to provide the committee with information about data sources

Prevention

- The Office of Behavioral Health received federal funds to conduct a state prevention needs assessment. The contractor for this work is the Colorado Health Institute and the results of the needs assessment are expected in July 2018. At that time, a review of those results may have some policy considerations.
- How do we help children of addicted parents? *Illuminate Colorado* is a non-profit organization that is doing some strategic planning around this issue. Also, there are some new federal funds that will support implementation of the CRAFT & Celebrating Families programs through the contracted Behavioral Health Managed Services Organizations. MSOs-training to occur 9/24 & 9/25
- A representative from Colorado Association of Physical Therapists highlighted that PT for addressing and managing pain is a prevention method

Alternatives to Pain Management

- Consider expand funding for alternative therapies such as acupuncture, physical therapy and yoga. Some of these alternatives may already be covered.
- What is meant by acute pain?
 - Some states have day limit for acute pain; some have MME limit (Q: who is setting those standards? A: Medical societies). This could be a statute change. "Acute" could be addressed with medical societies.
- Fifth vital sign discussion-culture shift now, educating patients and providers; one unintended consequence has been that a patient's pain is not being addressed; suggestion to disconnect payment from pain.
- On the other hand, how do we avoid drastically cutting patients off their opioid?
 - There needs to be consideration for those with severe chronic pain.

General Comments

- Many proposals contained the word "encourage", which is not a firm lever for policy action.
- Comment about recent Center for Disease Control study about the decrease in opioid prescription is not the cause of increased heroin use, but is contributing to the increase in heroin use.

- Comment about primary care providers' struggle with what to do with patients substance use disorders to assist in connecting them with treatment services; suggestion for a hotline for providers
- The recently received State Targeted response to the Opioid Crisis grant will increase capacity at state funded crisis center: Crisis hotline # 844-293-TALK
- CeDAR, a treatment center, is increasing insurance contracts. Pre-authorization can take hours to days. Suggestion to create a similar law to the Emergency Medical Treatment and labor Act (EMTALA) to meet emergency substance use disorders treatment need.
- Suggestion to create Safe Haven for providers who work with individuals with substance use disorders.

Session 2: August 31, 2017, 2:00 p.m. – 5:00 p.m.

This session focused on proposed policy considerations related to harm reduction, payment reform, treatment and recovery services, and funding coalitions work with attention to distinguishing recommendations that fall within state government authority and those within federal authority.

Harm Reduction

- One proposed idea is supporting over the counter access to Naloxone, rather than Naloxone being available only by prescription. This is an issue to be considered by the federal government.
- In the state, there needs to be a requirement that inmates of county and municipal jails who have an opioid use disorder leave jail with Naloxone, preferable the nasal-spray form called Narcan.
- What should incarceration facilities provide to people leaving the system?
 - Response: medication-Assisted Treatment induction, benefits through Medicaid, education and distribution of Naloxone.
- Another consideration is a requirement for co-prescribing Naloxone/Narcan with any opioid prescription with a certain MME dose.
- Require a Naloxone brochure with opioid prescription.
- It was mentioned that Dr. Ingrid Bingswagner at the University of Colorado/Department of medicine is conducting or has conducted a study about barriers to prescribing naloxone and fear about liability [This may be a reference to Binswagner, e.al., "Overdose Education and Naloxone for Patients Prescribed Opioids in Primary Care: A Qualitative Study of Primary Care Staff," [J Gen Intern Med.](#) 2015 Dec;30(12):1837-44. doi: 10.1007/s11606-015-3394-3.
 - **REQUEST:** The Committee would like to see this study.
- Under Medicaid, there is a barrier to obtaining Narcan, the nasal spray version of Naloxone. Medicaid will pay for the spray adapter to Naloxone versus the nasal spray kit (Narcan). This is a cost issue for Medicaid; however, pharmacies tend to not carry the adapters. The implications is that people on Medicaid who want Narcan do not end up with it.

- There is also a question about how to create sustainability for access to Naloxone? Cost can be an issue, some states created a voucher program to offset the cost of Naloxone and Narcan to individuals.
- Another harm reduction strategy is Supervised Injection Facilities, which have run successful in other countries and is starting to be implemented in other cities across the U.S. This idea is being discussed among business leaders and City and County of Denver officials with staff of the Harm Reduction Action Center. Legislative action is required to make a change to Colorado nuisance law related to drugs in order to allow local communities to implement Safe Injection Facilities. The evidence for these facilities indicates a reduction in HIV/AIDS and Hepatitis and prevents overdose deaths as well as increases access to medical care and substance use disorder treatment.

Workforce

- There are a number of ideas proposed with regard to workforce, including incentives to increase the number of providers in various fields, especially for to attract these professionals to rural areas.
- It was commented that there is a shortage of internship opportunities, especially in rural communities.
- In the field of substance use disorders treatment, there is an identified barrier with the requirement that addiction counselors need a bachelor's degree. The background check restrictions can also be a barrier for those with lived experience who are interested in entering the field of SUD treatment.

Payment Reform

- One identified barrier is a prior authorization requirement for Naltrexone/Vivitrol, one of the FDA approved medication for medication assisted treatment.
- In addition, the requirement through Medicaid of the upfront purchase of a large quantity of Naltrexone is problematic because of the high upfront cost to providers and the slow reimbursement by the state.
- There is a need to look into enforcement of Federal parity among private insurance providers to determine if they are indeed paying for SUD treatment
- There is a challenge with buy in by providers to provide medication assisted treatment is a challenge.
- There is broad support for utilizing the SB16-202 framework and adding funds to this framework, concerning increased access to substance use disorder services through designated regional managed service organizations and additional funds would help expand this program. There is broad consensus that the enactment of SB16-202 has been very successful.

Treatment and Recovery

- There is a need for medical detox option in Colorado.

- Q: What is medical detox? There is an opportunity to educate the Committee about levels of detox. How many medical detox facilities are in Colorado? What are the payment options?
 - SB16-202 helped fund anew facility in Aurora called New Day Resource Center
- Recent federal funding to Colorado will be used to expand medication assisted treatment.
- There is a need to ensure that people who are receiving medication-assisted treatment who are placed in jail don't lose access to their medications. What's not clear is whether this practice is a local jail policy, a state regulation, or a state law. This needs to be looked in to.
- There is a lack of treatment programs for pregnant women and those who have new born children inpatient treatment. There is a need to increase access to treatment for women postpartum and allow those on Medicaid to elect the benefit after they have left the hospital following the birth of their child.
- Q: Why isn't Suboxone used in hospitals? A: Limited training, those that are waived can't work 24 hours/day, lack of education among providers; surgery patients have unique risk
- There are inpatient treatment programs available but in some cases not all beds are filled because of insufficient payment and/or lack of staff.
- Q: How many inpatient treatment facilities does Colorado have, especially those with empty beds?
 - **REQUEST from Senator Jahn: Provide the Committee with occupancy numbers/data**
 - Staff of the Office of Behavioral Health will be getting occupancy reports from contracted managed Care Organizations
- To address substance use disorders at a younger age, there is a recommendation to increase funding for school- based health centers to provide screening services and treatment.
- In regard to recovery services, there is a need to look beyond the treatment and recovery services and to consider the necessary community support with regard to housing, employment and education.
- Q: What laws create barriers for those to get treatment instead of going to jail?
- Q: How do we get providers to comply with standards?
 - Response: There are physician champions at Denver Health, doc-to-doc education