The Opioid Crisis:
Legislative Updates for Pain Physicians

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Colorado Pain Society Annual Meeting

April 14, 2019

Objectives

- Provide a brief update of current data on the scope of the opioid crisis in the U.S. and Colorado
- Describe current legislation in Colorado that is relevant to physicians and pain practices/patients
- Identify opportunities to implement practice level changes to impact the opioid crisis

What are the current data?

Drug Overdose Mortality

- In 2017, nearly 72,000 people died from drug overdoses in the United States
  - One every 10 minutes (6 more during this talk)
  - Nearly 2/3 of those deaths involved prescription drugs
  - Opioids (Rx or illicit) were involved in 75% of those deaths

CDC/MMWR Jan 13, 2012; 61(01):10-13.
Colorado Rx Abuse Task Force data
SAMSHA/NSDUH 2009 survey

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- Of these, 560 were opioid involved (Rx or illicit, combined)

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  - Opioids (Rx or illicit) were involved in 75% of those deaths
- In Colorado, there were 1,012 drug overdose deaths in 2016
- Of these, 560 were opioid involved (Rx or illicit, combined)
  - Rx opioid deaths rising again (329 in 2015, 300 in 2016, 373 in 2017)
  - Heroin deaths holding steady (160 in 2015, 228 in 2016, 224 in 2017)
  - Fentanyl deaths rising (41 in 2015, 49 in 2016, 81 in 2017)
  - Methadone deaths holding steady (34 in 2015, 56 in 2016, 58 in 2017)
- The problem knows no regional, gender, age, income, or other bounds: it is truly an epidemic (CDC: top four)

CDC/MMWR Jan 13, 2012; 61(01):10-13.
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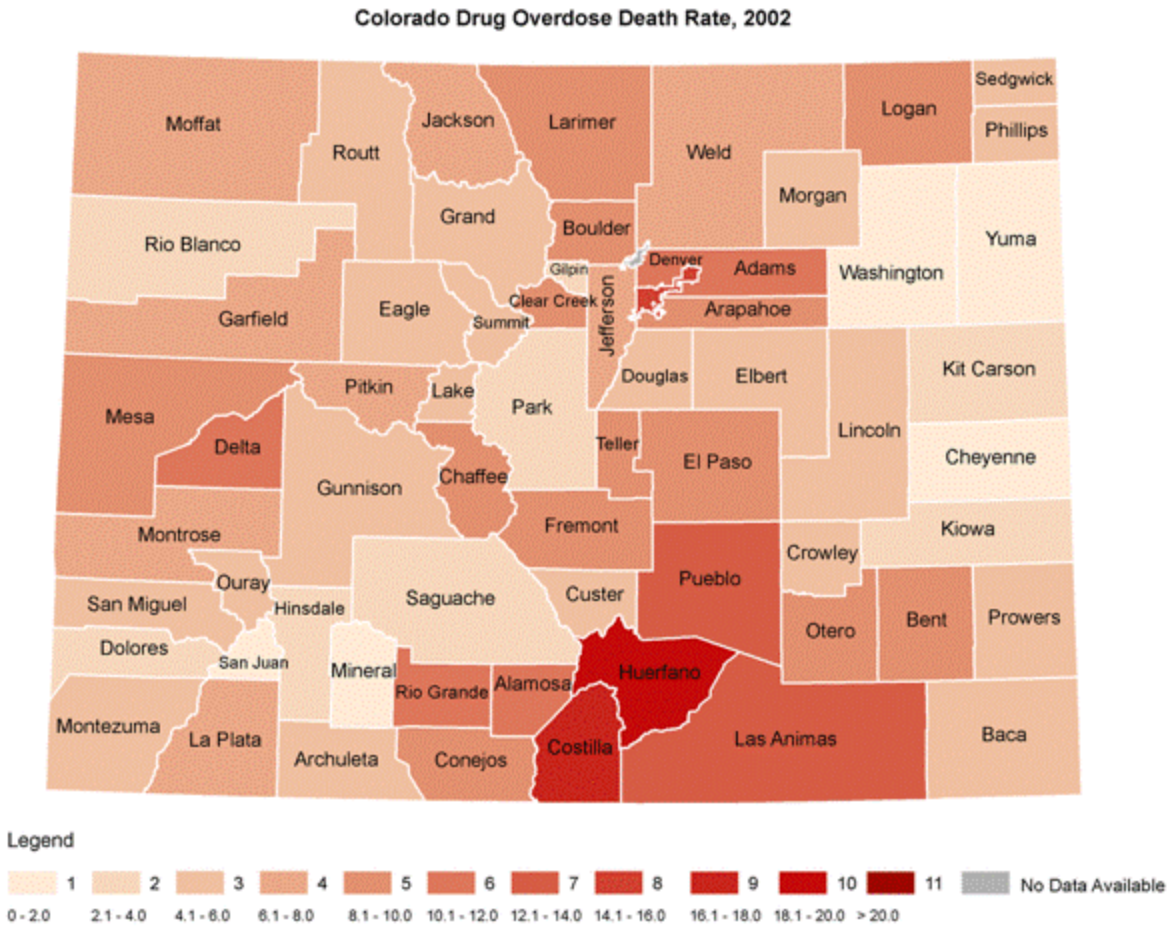
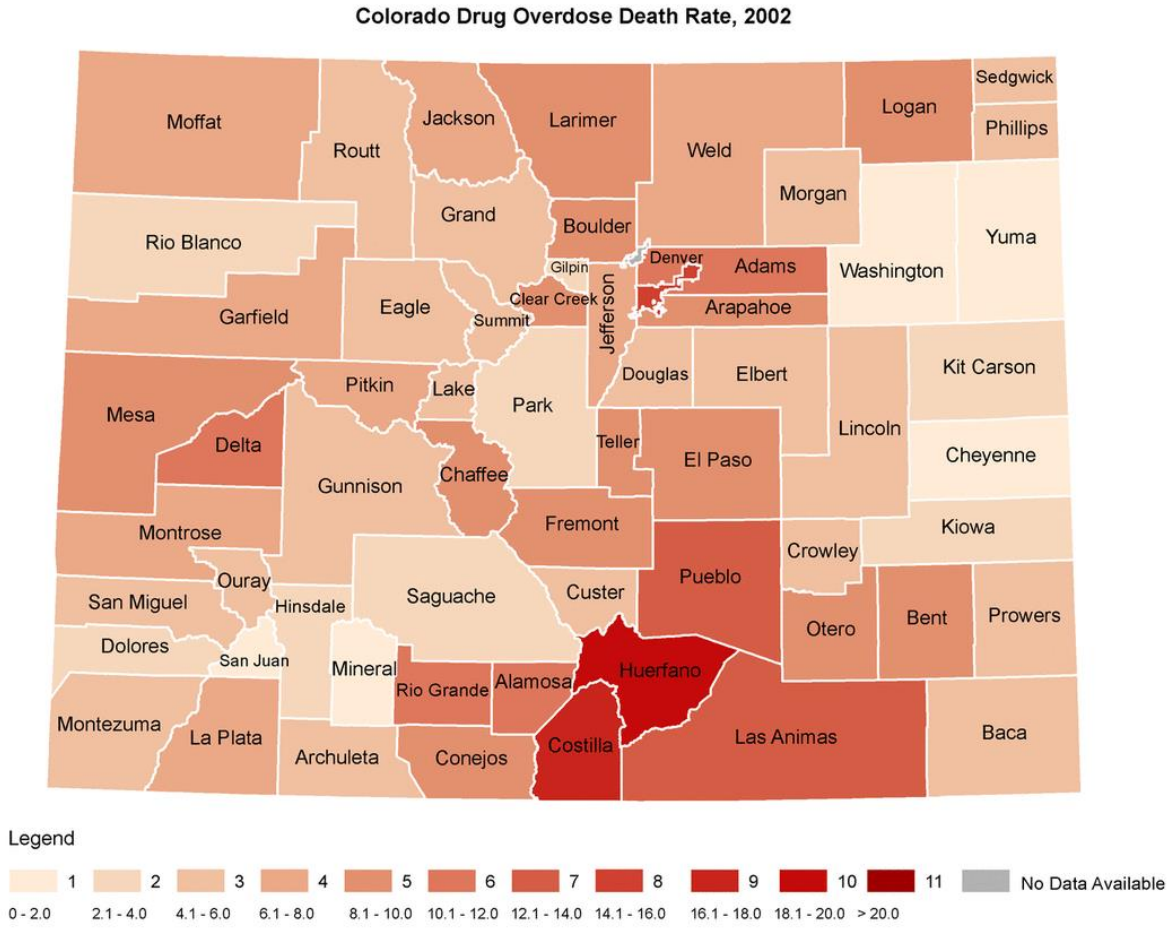
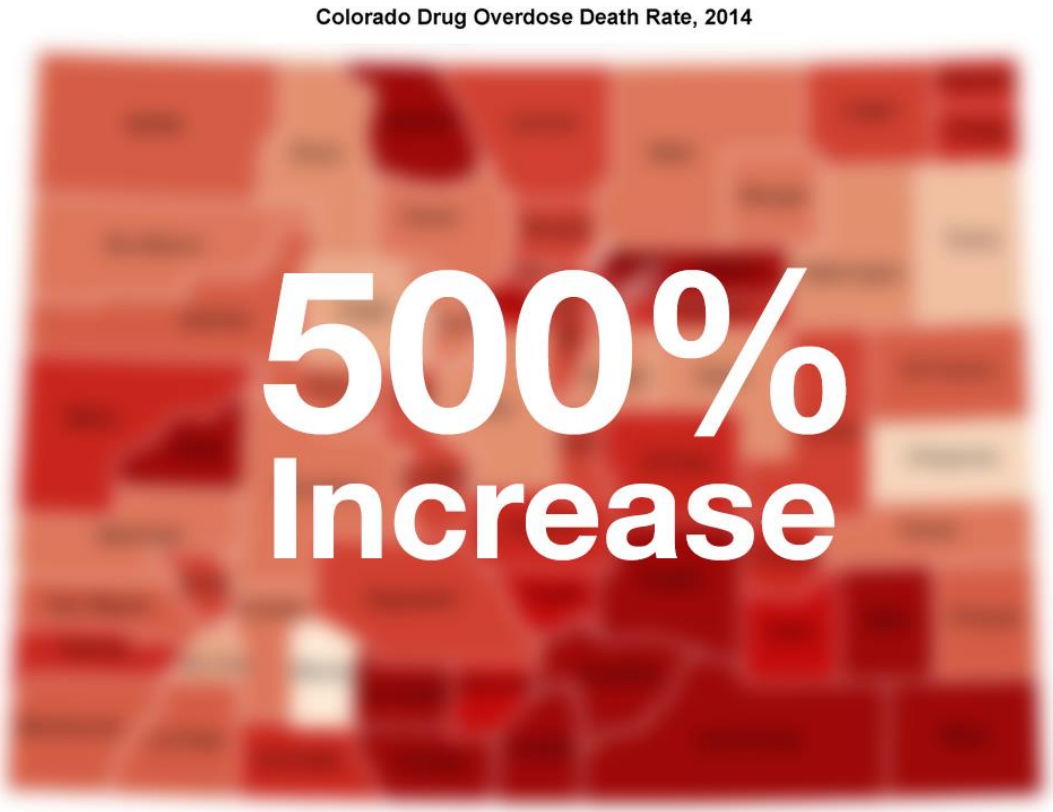
Drug Overdose Mortality in Colorado



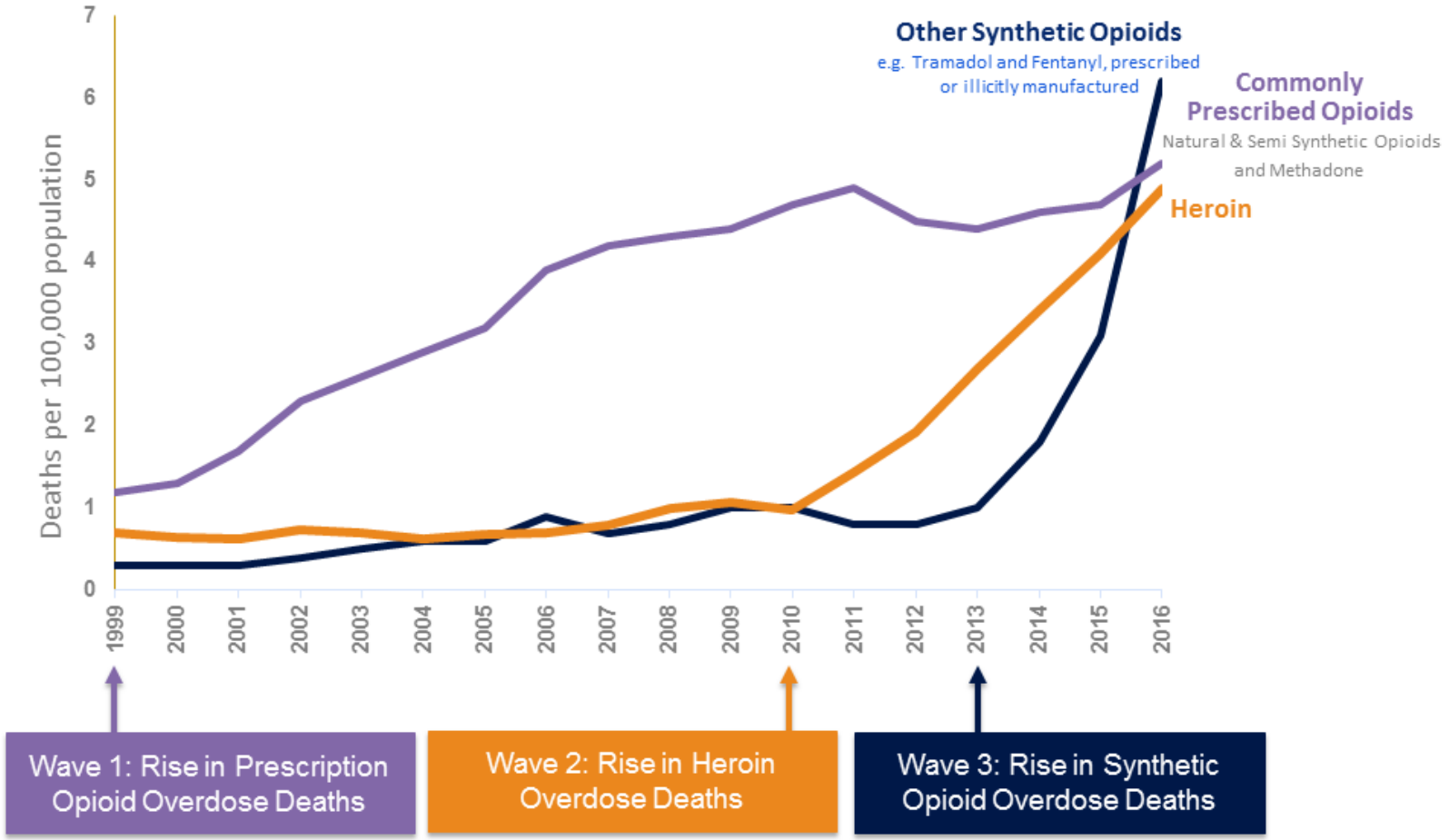
Drug Overdose Mortality in Colorado



Drug Overdose Mortality in Colorado



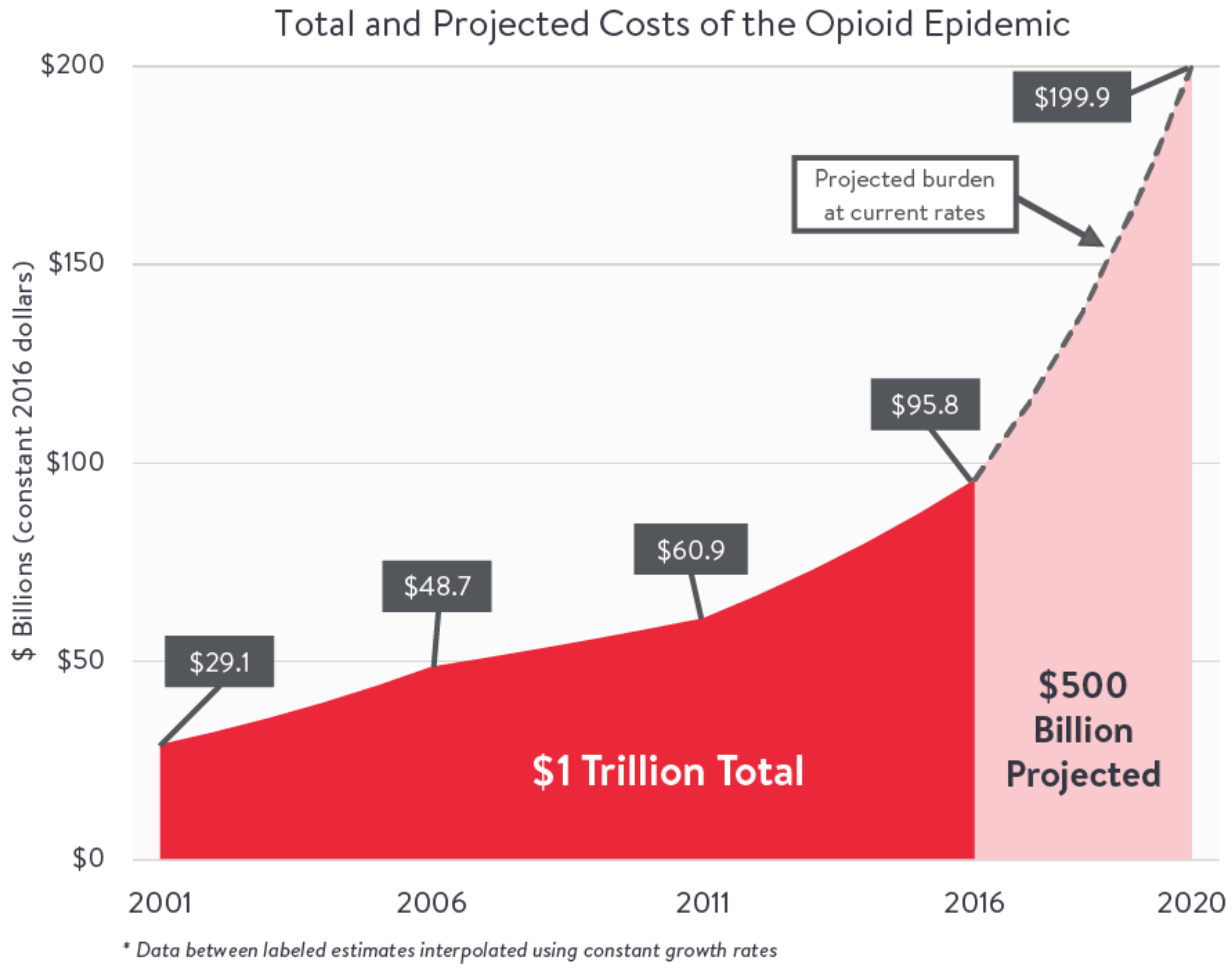
3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

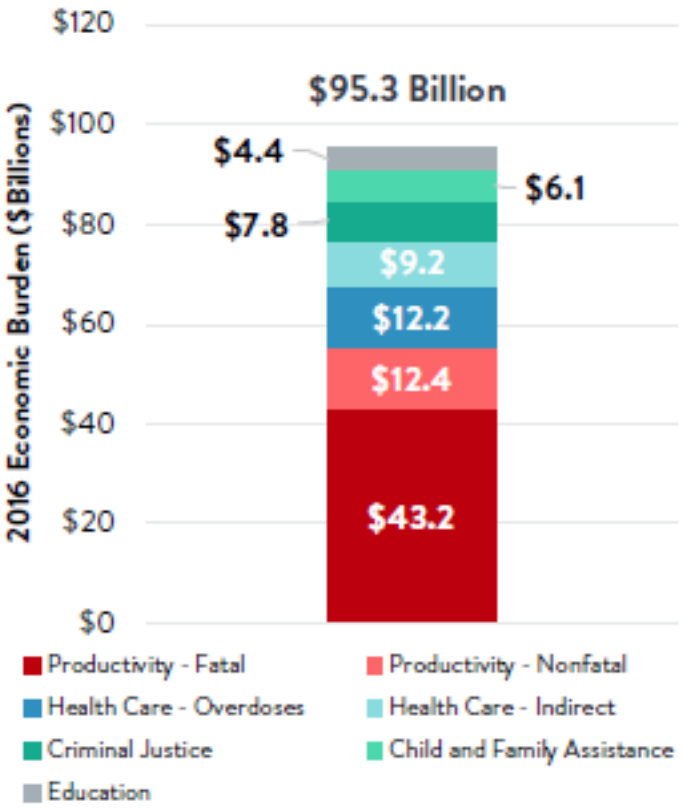
What has this cost us?

Costs of the Epidemic: Past and Projected



Altarum Research Institute. Economic Toll of Opioid Crisis in U.S. Exceeded $1 Trillion Since 2001. Feb 13, 2018. Viewed at: www.altarum.org/about/news-and-events/

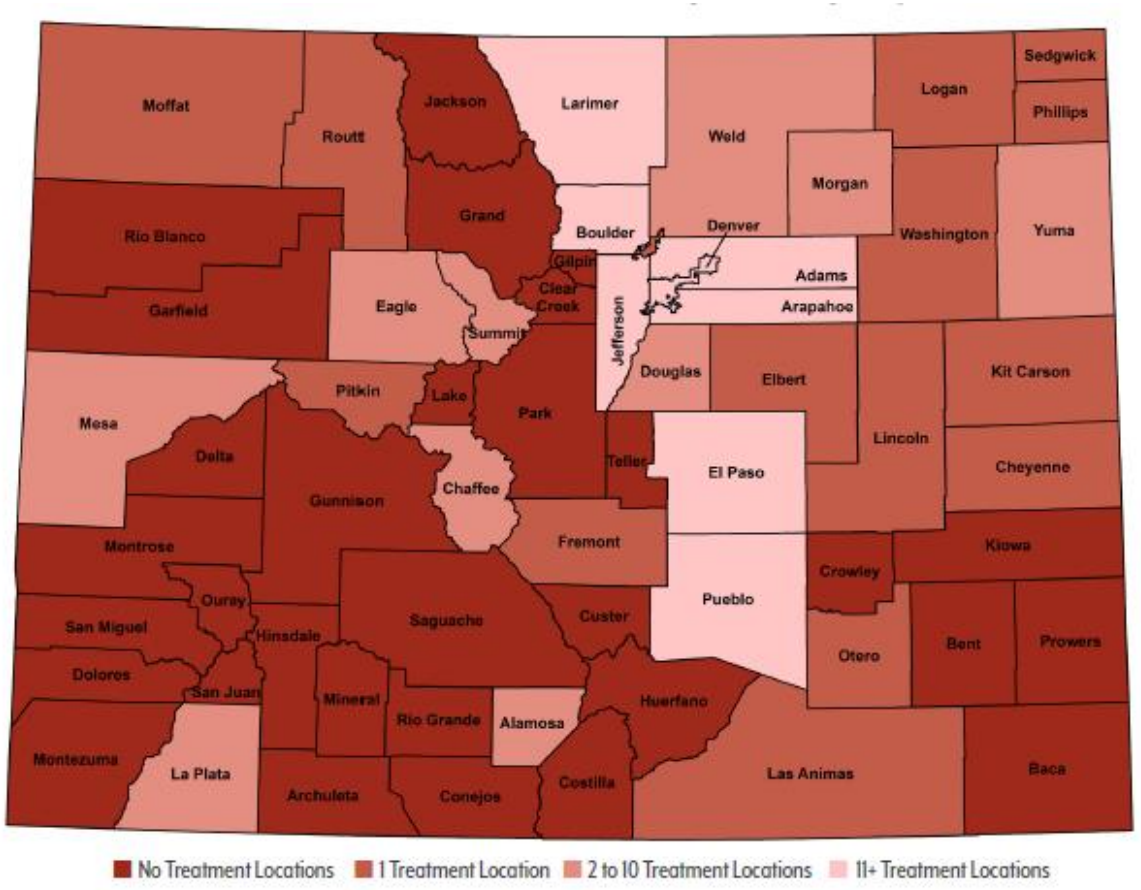
Societal Benefit of Eliminating Opioid Crisis



Rhyan, C. Altarum Research Brief, November 16, 2017. Accessed at: https://altarum.org/publications/the-potential-societal-benefit-of-eliminating-opioid-overdoses-deaths-and-substance-use-disorders

Substance Abuse Treatment Gap: 90%

Access to Medication Assisted Treatment (MAT) in Colorado: April 2017



University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus

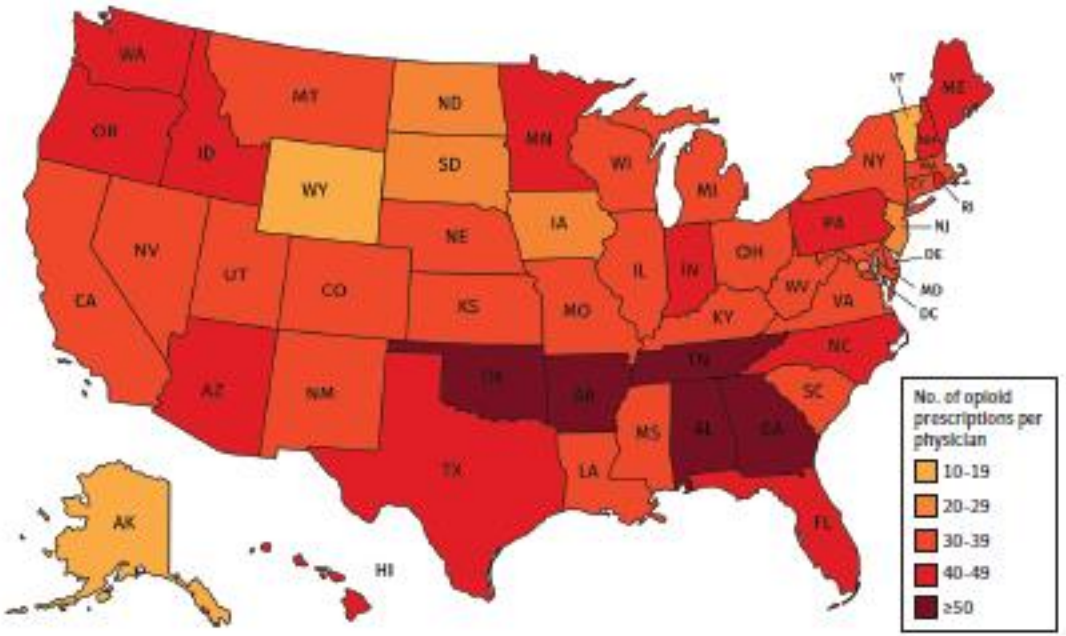
Colorado Health Institute. Miles Away from Help: The Opioid Epidemic and Medication-Assisted Treatment in Colorado. May 2017. Accessed at: www.coloradohealthinstitute.org

Office of the Governor

Opioid Prescribing Trends

Opioid Prescribing Rates in US: 2013-2015

Figure. Geographic Distribution of Opioid Prescriptions Written per Physician



Geographic distribution of opioid prescribing patterns from 2013 to 2015 across the United States based on the mean number of opioid prescriptions written per physician. These data include all physicians whose individual-level data were available.

Patel et al, JAMA 2017 (online Oct 5)

Opioid Prescribing Trends: 2014-2017

Characteristics of Opioid Prescriptions Dispensed, Colorado

Characteristics	2014	2015	2016	2017
Number of Prescriptions Dispensed	4,039,048	4,310,254	4,159,575	3,765,253
Number of Unique Patients	1,085,551	1,131,781	1,102,297	1,027,685
Number of Unique Prescribers	25,011	24,784	28,063	27,676
Number of Unique Pharmacies	941	839	1,039	1,097

Excludes buprenorphine drugs commonly used to treat opioid use disorder
In 2014 NPI was used to identify unique prescribers and pharmacies as DEA numbers were not available until 2015
Data Source: Colorado Prescription Drug Monitoring Program, Colorado Department of Regulatory Agencies Analysis
by: Colorado Department of Public Health and Environment, 2018

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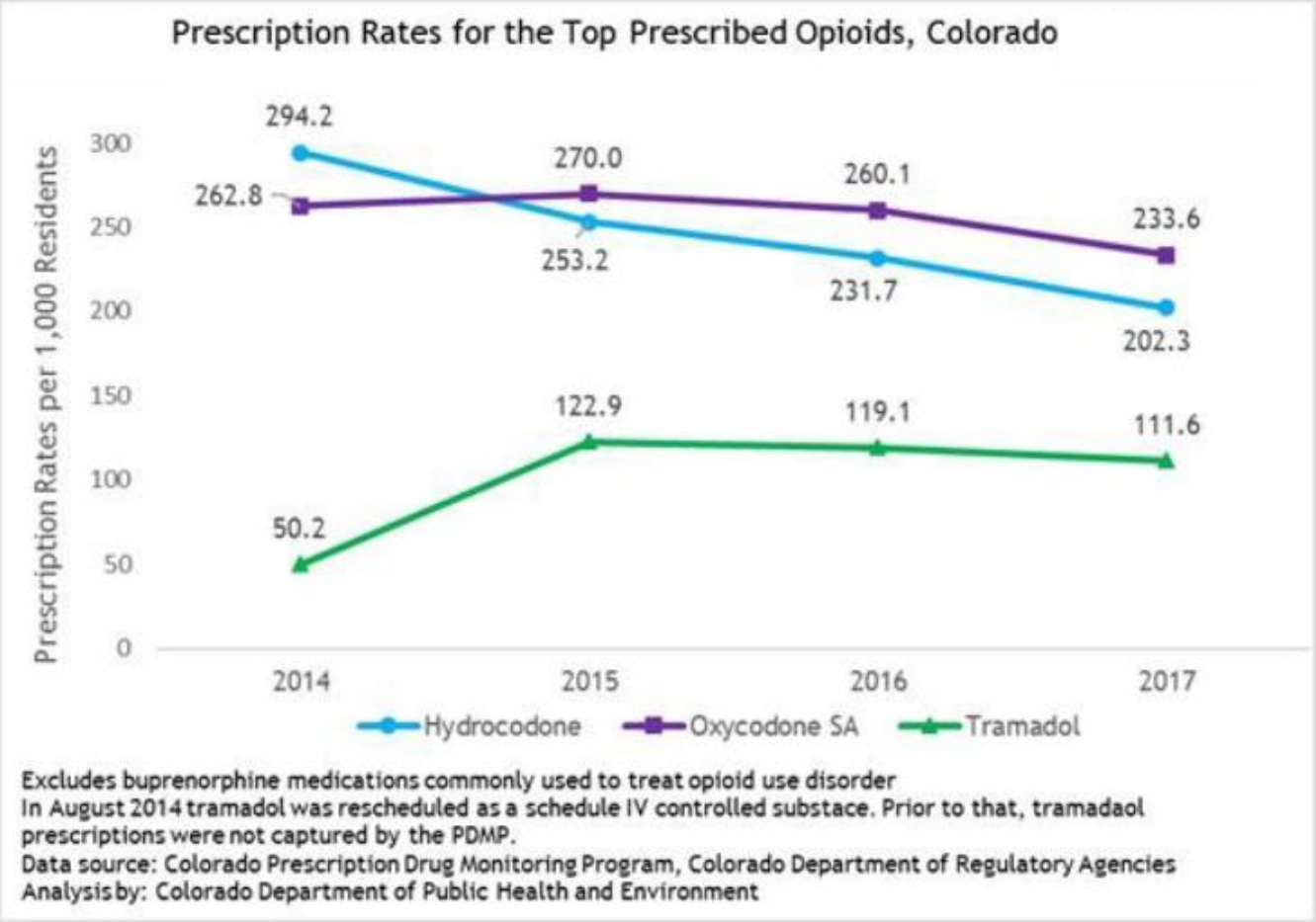


Opioid Prescribing Trends: 2014-2017

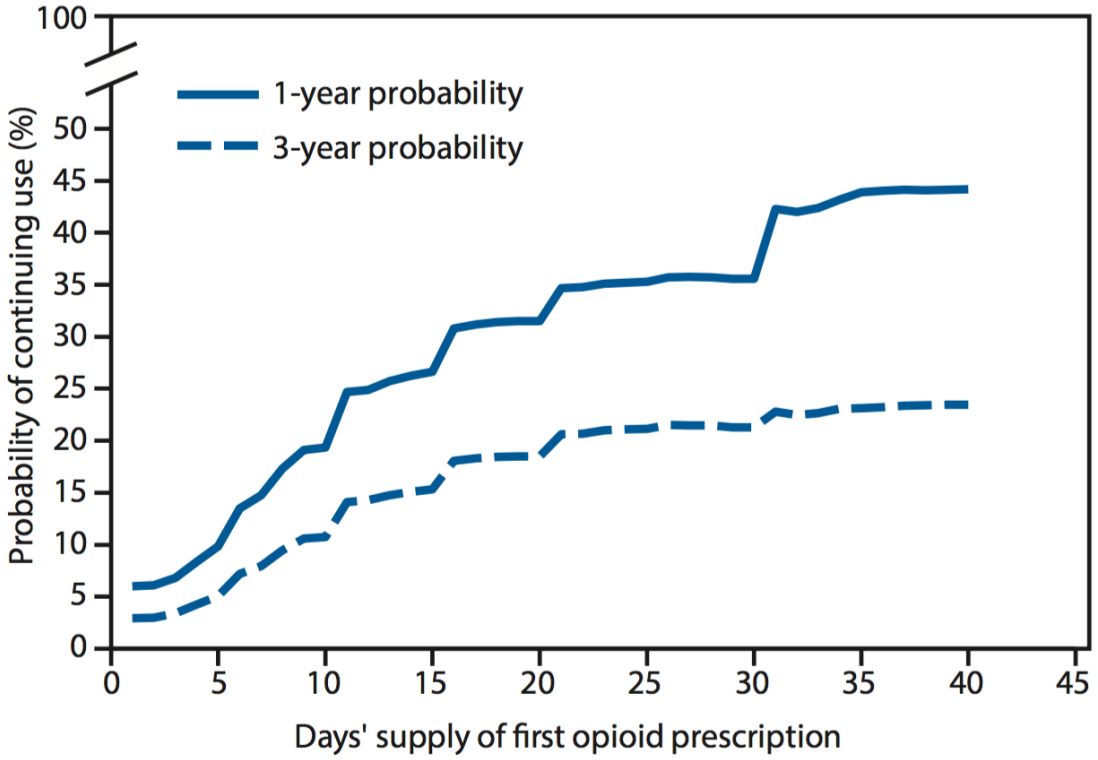
High Risk Prescribing Practices and Patient Behaviors, Colorado

Indicators	2014	2015	2016	2017	2014-2017 % change
Patients receiving more than 90 MME (%)	10.3	8.9	8.7	8.2	20.5
Patients with MPE's (rate/100,000 residents)	170.1	124.0	93.6	68.0	60.0
Patients prescribed LA/ER opioids who were opioid-naïve (%)	18.2	17.6	15.8	15.1	17.3
Patient prescription days with overlapping opioid prescriptions (%)	22.3	21.5	21.4	20.5	7.8
Patient prescriptions days with overlapping opioid and benzodiazepine prescriptions (%)	12.1	11.6	11.2	9.9	18.0

Schedule II-IV Controlled Substances
Excludes Buprenorphine drugs commonly used for treatment
Annual percentages are based on average of quarterly percentages
Data Source: Vital Statistics Program, CDPHE and the Colorado Prescription Drug Monitoring Program, DORA
Data Analysis by: CDPHE, 2018

Probability of Continued Opioid Use by Days Supply of First Opioid Rx: 2006-2015

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



CDC MMWR: IQVIA Rx Panel data, 2005-2015.

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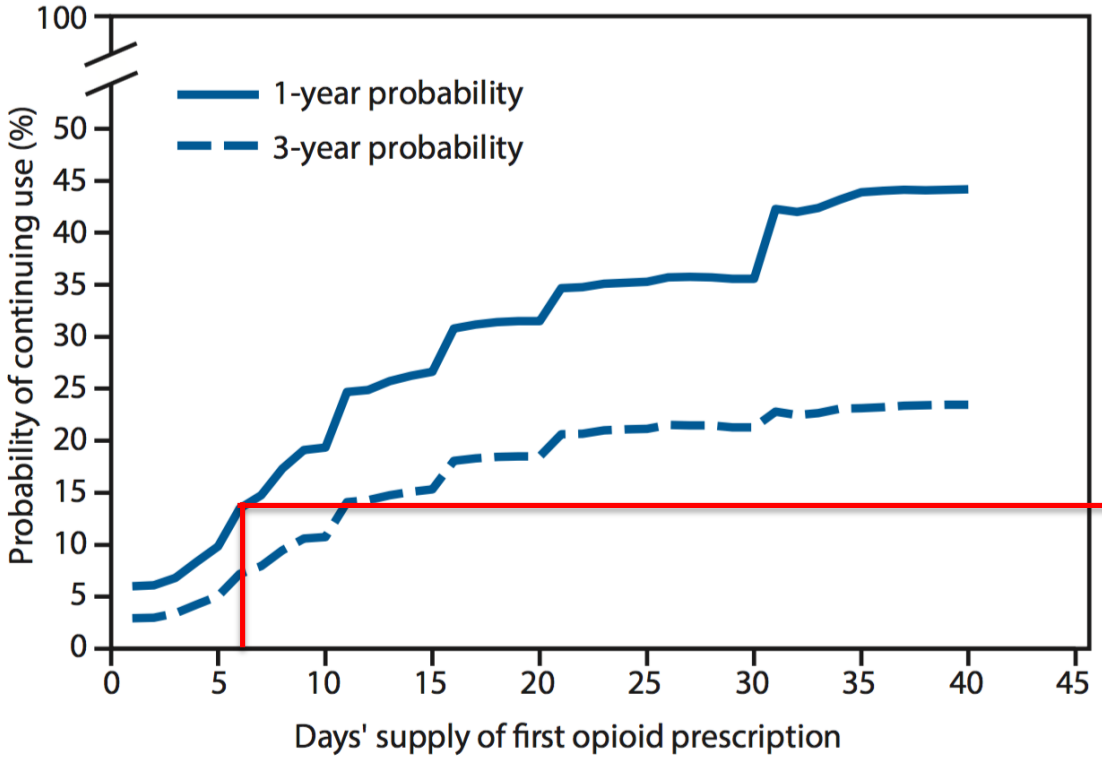

7 days supply: 14% 1-year persistence; 7% 3-year persistence

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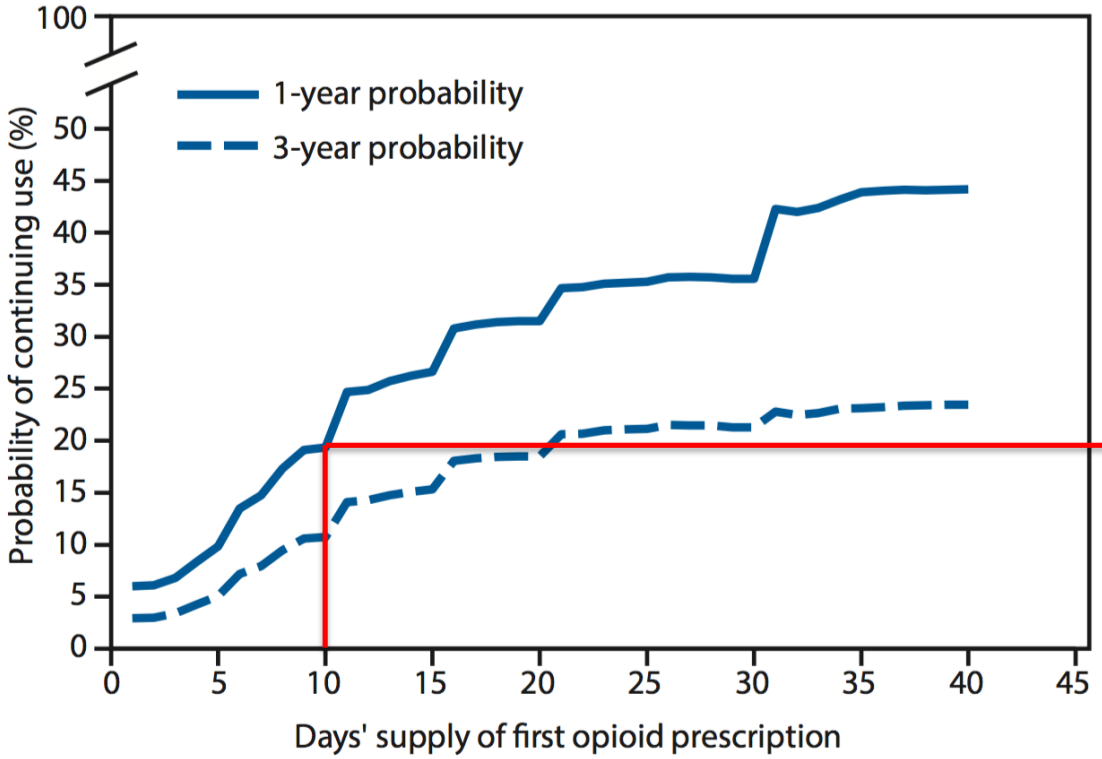
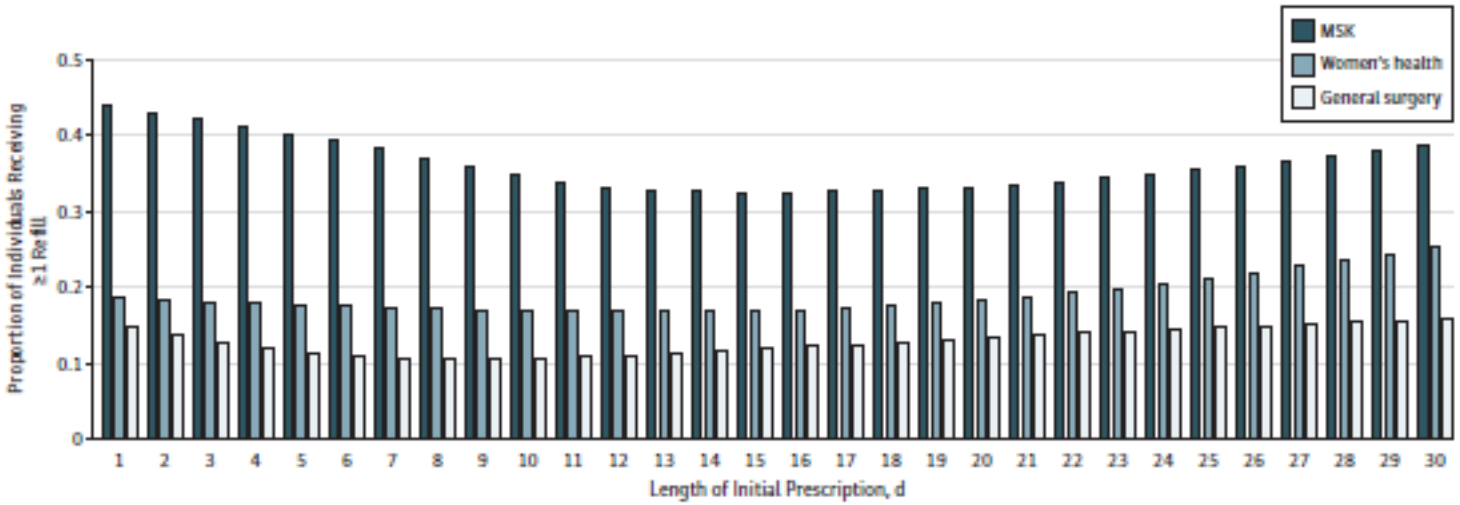


10 days supply: 20% 1-year persistence, 10% 3-year persistence

CDC MMWR: IQVIA Rx Panel data, 2005-2015.

Opioid Refill Rates by Length of First Rx

Figure 2. Modeled Proportion of Individuals Requiring Opioid Pain Medication Refill by Length of Initial Prescription by Procedure Group



Adjusted proportion of individuals requiring repeated opioid prescription after procedure by duration of initial prescription. Risk was adjusted for age, sex, race/ethnicity, socioeconomic status, and postoperative complications. The modified Charlson Comorbidity Index was used to adjust for comorbidities. MSK indicates musculoskeletal.

Scully et al, JAMA Surg. 2017 (online Sept 27)

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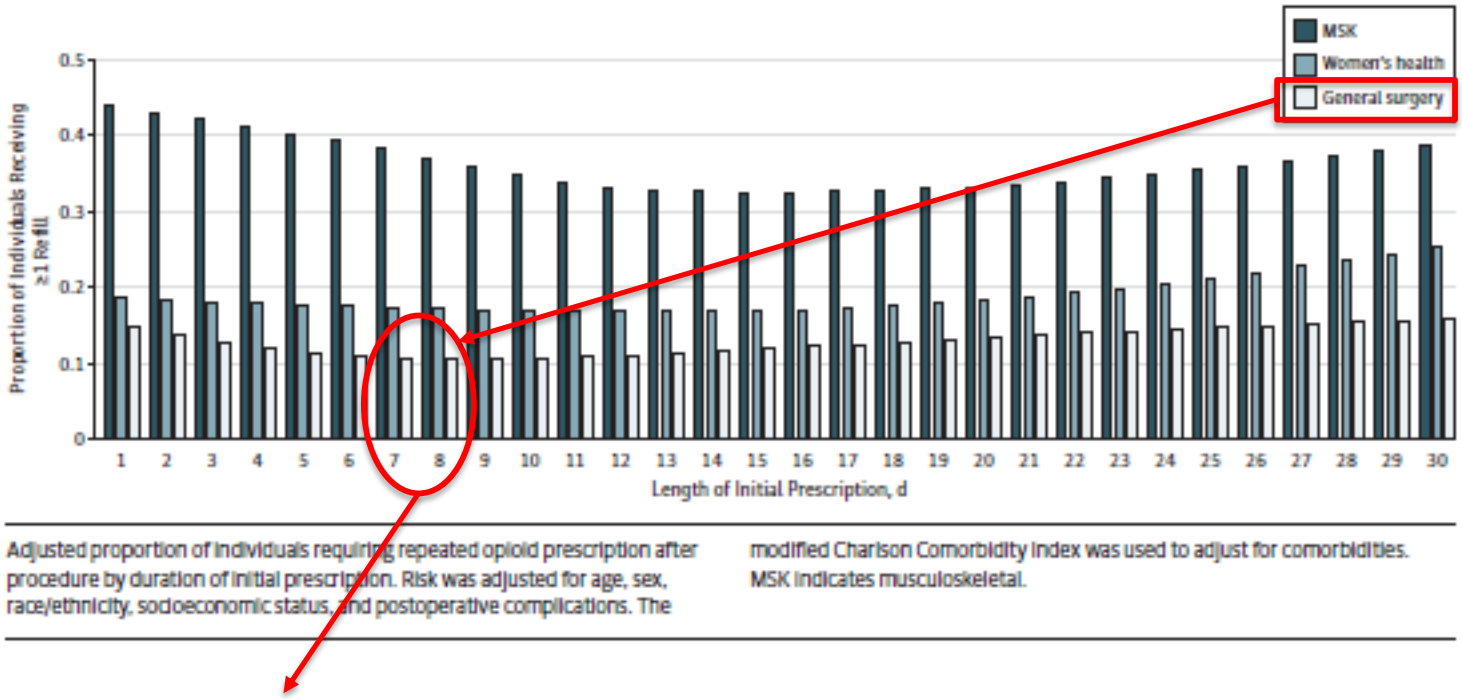

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Optimization point: 7-8 days

Scully et al, JAMA Surg. 2017 (online Sept 27)

What are the Feds doing?

Recent Federal Legislation

- House Energy & Commerce committee held hearings over the last winter/spring, drafted a package of 56 opioid bills, combined into HR-6 (SUPPORT for Patients and Communities)
- Timeline:
  - In June, HR-6 passed House by vote of 396-14
  - On Sept 17, Opioid Crisis Response Act passed Senate 99-1
  - On Sept 27, cleared Conference Committee
  - On Oct 24, President Trump signed into law
- Topics range from treatment access, to workforce development, to incentives for development of non opioid medications, to safe disposal, to fentanyl interdiction (etc.)
- For details: https://energycommerce.house.gov/opioids/
- President has pledged ~$13 Billion to opioid crisis over the next two fiscal years (10X prior funding; still 1/10 of HIV/AIDS)

How the SUPPORT for Patients and Communities Act will Help Combat the Opioid Crisis:

Treatment and Recovery

- Improve and expand access to treatment and recovery services
- Provide incentives for enhanced care, coordination, and innovation
- Establish comprehensive opioid recovery centers

Prevention

- Encourage non-addictive opioid alternatives to treat pain
- Improve data to identify and help at-risk patients and families
- Address high prescribing rates while enhancing prescription drug monitoring programs

Protecting Communities

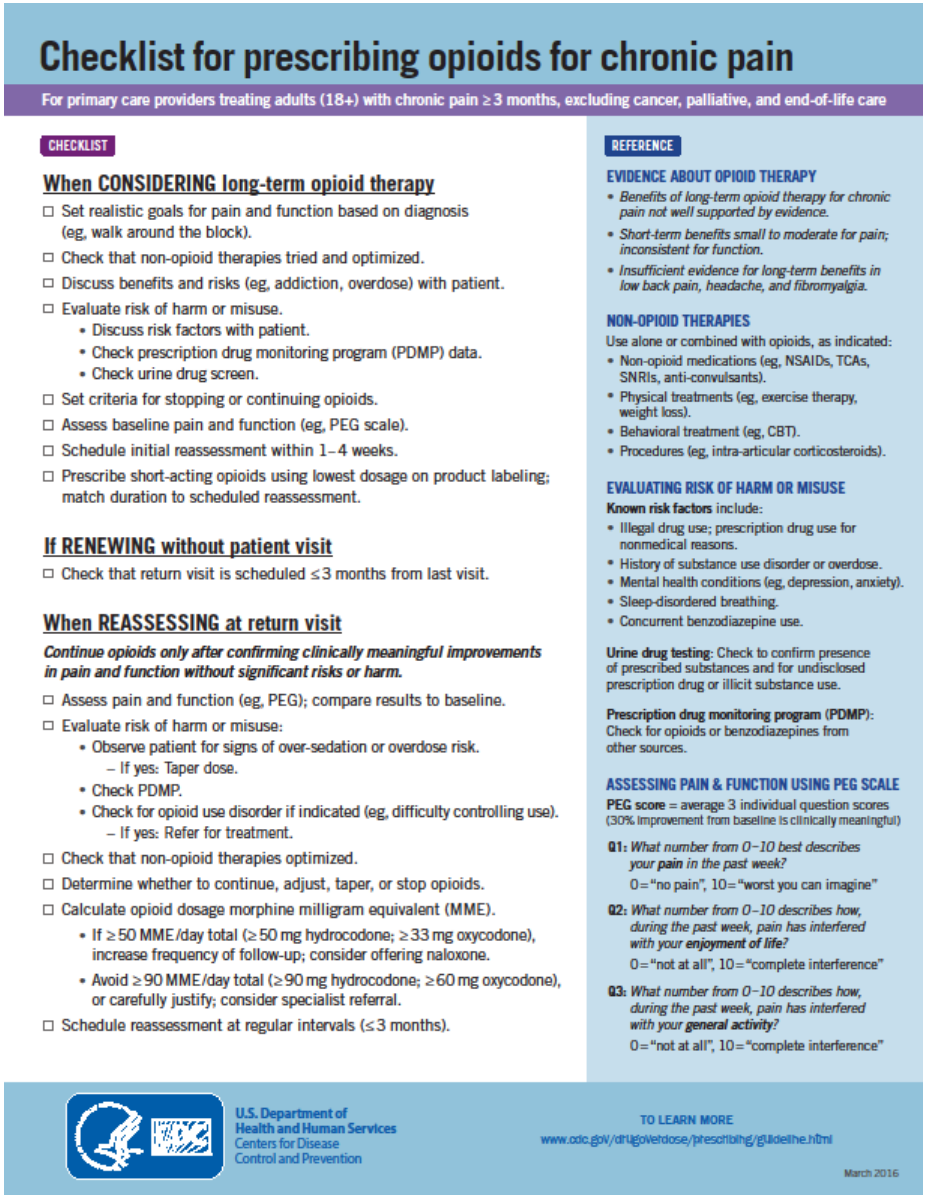
- Give law enforcement tools to get dangerous drugs out of our communities
- Better intercept illicit opioids at international mail facilities
- Improve access to federal resources for local communities

Fighting Fentanyl

- Better tackle ever-changing synthetic drugs
- Crack down on foreign shipments of illicit drugs
- Provide grants for local communities to combat fentanyl

Also contained in HR-6: President's "Safe Prescribing Plan", which states: "Within 5 years, 95% of prescriptions must follow best practice guidelines, or provider will not be eligible for federal payments" (Medicare/Medicaid)

So, if you don't know the CDC Guideline, you probably should...



Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016

What is the State doing?

First Regular Session | 71st General Assembly
Colorado General Assembly

Visit & Learn | Find My Legislator | Watch & Listen

Apply

INTERIM SCHEDULE BILLS LAWS LEGISLATORS COMMITTEES INITIATIVES BUDGET AUDITS PUBLICATIONS AGENCIES

INTERIM COMMITTEE INTERIM COMMITTEE

Opioid and Other Substance Use Disorders Interim Study Committee

Committee Audio Share

VIEW BY SESSION 2017 Regular Session

SUBJECTS: Health Care & Health Insurance, Human Services

The study committee must review data and statistics on the scope of the substance use disorder problem in Colorado; compile an overview of the current resources available to Coloradoans; review the availability of medication-assisted treatment options and whether pharmacists can prescribe those medications; examine what other states and countries are doing to address substance use disorders; identify the gaps in prevention, intervention, harm reduction, treatment, and recovery resources; and identify possible legislative options to address these gaps.

Committee Documents | Task Force and Committee Schedule | Task Force Documents | Authorization Letter

COMMITTEE INFORMATION

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Senator
Jack Tate


Representative
James D. Wilson

- Committee met in the summer and fall of 2017, drafted 6 bills, 5 passed:
  - Prevention/Education
  - Clinical Practice Improvement
  - ~~Harm Reduction~~
  - Workforce Development
  - Treatment (Inpatient/Residential)
  - Payment Reform (MAT, prior auth)
- Committee met in 2018, referred 5 bills to Legislative Council, which killed 3 of them (Prevention, Treatment and Harm Reduction), passed 2 (Criminal Justice and Recovery)

SB18-022: Clinical Practice for Opioid Prescribing

- Limits initial opioid Rx to 7 days with an option to allow for one 7 day refill with exceptions
- Requires prescribers to check the Prescription Drug Monitoring Program (PDMP) prior to prescribing the 2nd fill with exceptions
- Prescribers include: Physicians, dentists, PAs, advanced practice nurses, optometrists, podiatrists and veterinarians

Examples of Exceptions to SB18-022

- Chronic pain lasting longer > 90 days
- Cancer and cancer-associated pain
- Hospice Care or Palliative Care
- Post-surgical pain lasting > 14 days
- Treatment during a natural disaster

Signed May 21, 2018 into law

2018 Opioid Interim Committee Bills

Treatment for Opioid and Other SUDs	HB 1287	Esgar, Wilson Petterson, Priola	Introduced 3/28/19
Substance Use Disorders Recovery	HB 1009	Kennedy, Singer, Pettersen, Priola	Interim Bill Passed Legislative Council
Harm Reduction SUDs	HB 227	Pettersen, Gonzales Kennedy, Herod	Introduced 4/1/19
Prevention of Opioid and Other Substance Use	SB 228	Winter, Moreno Buentello, Singer	Introduced 4/1/19
SUD Treatment in Criminal Justice System	SB 008	Pettersen, Priola Kennedy, Singer	Interim Bill Passed Legislative Council

2019 Additional Opioid Bills Introduced

Expand MAT Pilot Program	SB 001	Garcia Buentello
Electronic Prescribing Controlled Substances	SB 079	Todd, Priola Esgar, Landgraf

-> SIGNED INTO LAW EARLIER THIS WEEK (APRIL 8, 2019)

SB19-079: Electronic Prescribing of Controlled Substances (EPCS)

"Concerning a requirement that certain practitioners prescribe controlled substances electronically"

SESSION: 2019 Regular Session

SUBJECT: Health Care & Health Insurance

BILL SUMMARY

Sections 1 to 14 of the bill require podiatrists, physicians, physician assistants, advanced practice nurses, and optometrists, starting July 1, 2021, and dentists and practitioners serving rural communities or in a solo practice, starting July 1, 2023, to prescribe schedule II, III, or IV controlled substances only via a prescription that is electronically transmitted to a pharmacy unless a specified exception applies. Prescribers are required to indicate on license renewal questionnaires whether they have complied with the electronic prescribing requirement.

Section 15 specifies that pharmacists need not verify the applicability of an exception to electronic prescribing when they receive an order for a controlled substance in writing, orally, or via facsimile transmission and may fill the order if otherwise valid under the law.

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SB19-079: Changes to Medical Practice Act

SECTION 7. In Colorado Revised Statutes, add 12-36-117.9 as follows:

EXCEPT AS PROVIDED IN SUBSECTION (1)(b) OF THIS SECTION, ON OR AFTER JULY 1, 2021, A PHYSICIAN OR PHYSICIAN ASSISTANT SHALL PRESCRIBE A CONTROLLED SUBSTANCE THAT IS INCLUDED IN SCHEDULE II, III, OR IV, ONLY BY ELECTRONIC PRESCRIPTION TRANSMITTED TO A PHARMACY UNLESS:

(I) AT THE TIME OF ISSUING THE PRESCRIPTION, ELECTRONIC PRESCRIBING IS NOT AVAILABLE DUE TO A TEMPORARY TECHNOLOGICAL OR ELECTRICAL FAILURE;

(II) THE PRESCRIPTION IS TO BE DISPENSED AT A PHARMACY THAT IS LOCATED OUTSIDE OF THIS STATE;

(III) THE PRESCRIBING PHYSICIAN OR PHYSICIAN ASSISTANT IS DISPENSING THE CONTROLLED SUBSTANCE TO THE PATIENT;

(IV) THE PRESCRIPTION INCLUDES ONE OR MORE ELEMENTS THAT ARE NOT SUPPORTED BY THE MOST RECENT VERSION OF THE NCPDP SCRIP STANDARD;

SB19-079: Changes to Medical Practice Act

(V) THE FDA OR DEA REQUIRES THE PRESCRIPTION FOR THE PARTICULAR CONTROLLED SUBSTANCE TO CONTAIN ONE OR MORE ELEMENTS THAT CANNOT BE SATISFIED WITH ELECTRONIC PRESCRIBING;

(VI) THE PRESCRIPTION IS NOT SPECIFIC TO A PATIENT AND ALLOWS DISPENSING OF THE PRESCRIBED CONTROLLED SUBSTANCE:

(A) PURSUANT TO A STANDING ORDER, APPROVED PROTOCOL OF DRUG THERAPY, OR COLLABORATIVE DRUG MANAGEMENT OR COMPREHENSIVE MEDICATION MANAGEMENT PLAN;

(B) IN RESPONSE TO A PUBLIC HEALTH EMERGENCY; OR

(C) UNDER OTHER CIRCUMSTANCES THAT PERMIT THE PHYSICIAN OR PHYSICIAN ASSISTANT TO ISSUE A PRESCRIPTION THAT IS NOT PATIENT-SPECIFIC;

(VII) THE PRESCRIPTION IS FOR A CONTROLLED SUBSTANCE UNDER A RESEARCH PROTOCOL;

SB19-079: Changes to Medical Practice Act

(VIII) THE PHYSICIAN OR PHYSICIAN ASSISTANT WRITES TWENTY-FOUR OR FEWER PRESCRIPTIONS FOR CONTROLLED SUBSTANCES PER YEAR;

(IX) THE PHYSICIAN OR PHYSICIAN ASSISTANT IS PRESCRIBING A CONTROLLED SUBSTANCE TO BE ADMINISTERED TO A PATIENT IN A HOSPITAL, NURSING CARE FACILITY, HOSPICE FACILITY, DIALYSIS CLINIC, ASSISTED LIVING RESIDENCE, OR LICENSED HOSPICE HOME CARE OR TO A PERSON WHO IS IN THE CUSTODY OF THE DEPARTMENT OF CORRECTIONS;

(X) THE PHYSICIAN OR PHYSICIAN ASSISTANT REASONABLY DETERMINES THAT THE PATIENT WOULD BE UNABLE TO OBTAIN THE CONTROLLED SUBSTANCE PRESCRIBED ELECTRONICALLY [N A TIMELY MANNER AND THAT THE DELAY WOULD ADVERSELY AFFECT THE PATIENT'S MEDICAL CONDITION; OR

(XI) THE PHYSICIAN OR PHYSICIAN ASSISTANT DEMONSTRATES ECONOMIC HARDSHIP IN ACCORDANCE WITH RULES ADOPTED BY THE BOARD PURSUANT TO SUBSECTION (2)(b) OF THIS SECTION.

SB19-079: Changes to Medical Practice Act

(b) A PHYSICIAN OR PHYSICIAN ASSISTANT PRACTICING IN A RURAL AREA OF THE STATE OR IN A PRACTICE CONSISTING OF ONLY ONE PHYSICIAN OR PHYSICIAN ASSISTANT SHALL COMPLY WITH THIS SUBSECTION (1) ON OR AFTER JULY 1, 2023.

(2) THE BOARD SHALL ADOPT RULES:

(a) DEFINING WHAT CONSTITUTES A TEMPORARY TECHNOLOGICAL OR ELECTRICAL FAILURE FOR PURPOSES OF SUBSECTION (1)(a)(I) OF THIS SECTION; AND

(b) DEFINING ECONOMIC HARDSHIP FOR PURPOSES OF SUBSECTION (1)(a)(XI) OF THIS SECTION AND ESTABLISHING:

(I) THE PROCESS FOR A PHYSICIAN OR PHYSICIAN ASSISTANT TO DEMONSTRATE ECONOMIC HARDSHIP, INCLUDING INFORMATION REQUIRED TO BE SUBMITTED; AND

(II) THE PERIOD DURING WHICH THE ECONOMIC HARDSHIP EXCEPTION IS EFFECTIVE, WHICH PERIOD SHALL NOT EXCEED 1 YEAR;

SB19-079: Changes to Medical Practice Act

(3) (a) THIS SECTION DOES NOT:

(I) CREATE A PRIVATE RIGHT OF ACTION;

(II) SERVE AS THE BASIS OF A CAUSE OF ACTION; OR

(III) ESTABLISH A STANDARD OF CARE.

(b) A VIOLATION OF THIS SECTION DOES NOT CONSTITUTE NEGLIGENCE PER SE OR CONTRIBUTORY NEGLIGENCE PER SE.

(4) As USED IN THIS SECTION, "RURAL AREA" MEANS A COUNTY LOCATED IN A NONMETROPOLITAN AREA IN THE STATE THAT:

(a) HAS NO MUNICIPALITY WITHIN ITS TERRITORIAL BOUNDARIES WITH FIFTY THOUSAND OR MORE PERMANENT RESIDENTS BASED UPON THE MOST RECENT POPULATION ESTIMATES PUBLISHED BY THE UNITED STATES CENSUS BUREAU; OR

(b) SATISFIES ALTERNATE CRITERIA FOR THE DESIGNATION OF A RURAL AREA AS MAY BE PROMULGATED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET.

SB19-228: Substance Use Disorder Prevention Measures

Bill Sponsors: Winter/Moreno (S), Singer/Buentello (H)

- Support continuation of Consortium activities
  - Public Awareness, Provider Education
- Funding for a variety of prevention activities
  - At-risk youth grant programs
  - Targeting pregnant/postpartum women for screening and intervention
  - Increased funding for local public health agencies (LPHAs)
- Continuing education for substance use disorder training for healthcare providers
- Require opioids for outpatient use to carry specific warning label

Introduced April 1, passed Senate Health and Human Services Committee April 11 (3-1 vote), referred to Senate Appropriations

What can you do?

First Regular Session | 72nd General assembly

Colorado General Assembly

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https://leg.colorado.gov/find-my-legislator

Practice Level Strategies to Prevent Misuse

- Laws, Regs, Guidelines, Incentives: be aware of best practices, requirements (both carrots and sticks)
- Minimize opioid exposure as much as possible
- Patient Education: safe use, storage, *and* disposal
- Screen for Use Disorders, talk about treatment
- Participate in the larger effort (local or state level)
  - Colorado Pain Society, CMS, local medical societies
  - Colorado's CURE: specialty specific, state level guidelines
  - Join Consortium: www.corxconsortium.org (or call us or go online for free patient education materials)

Thank You!

Email: robert.valuck@ucdenver.edu
Website: www.corxconsortium.org
Phone: 303-724-2890

Pocket Slides on Other 2018 Opioid Legislation

HB 1003: Opioid Misuse Prevention Bill

- Continues Interim Study Committee thru July 1 2020
- Develop report on recovery & recovery residences
- Continuing education for providers and law enforcement
- Funding for School Based Health Centers
- Grant for training on Screening, Brief Intervention, and Referral to Treatment program (SBIRT) for women of child-birthing age

Signed May 21, 2018 into law

SB 24: Expand Access Behavioral Health Care Providers

Expands the **Colorado Health Service Corps** (CHSC) program with $2.5 million (marijuana tax cash fund) for a loan repayment program for behavioral health providers who have addiction-specific training and are willing to commit 2 years of service in a “behavioral health care provider shortage area”

Signed May 21, 2018 into law

Eligible Healthcare Providers for SB 24

- LAC, CAC, LPC, LCSW, LMFT
- Licensed psychologists
- PAs with specific training in SUDs, advanced practice nurses, and MDs certified or trained in addiction medicine, pain management, or psychiatry
- Candidates for licensure as an addiction counselor, professional counselor, clinical social worker, marriage and family therapist, or psychologist

Program Detail	CHSC - Substance Use Disorder	NHSC
Provider Application Cycle	Application for SUD ONLY open Jan 1 - Jan 31st 2019; Regular CHSC application (including SUD) Open March 1 -31st 2019. Application open every September and March as usual	2019 application open now - Feb 21 2019; varies yearly
Primary Contact for Interested Providers	PCO: Rachel Carmen, rachel.carmen@state.co.us	HRSA: Evan Krasomil, ekrasomil@hrsa.gov
Site Approval Application Cycle	Continually open	Varies yearly, typically late spring or early summer.
Primary Contact for Site Approvals	Natalie Kwofie, nataliekwofie@state.co.us	Natalie Kwofie, nataliekwofie@state.co.us
Website	https://www.colorado.gov/pacific/cdphe/colorado-health-service-corps	https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program.html
Shortage Criteria	State Health Professional Shortage Area	Federal Health Professional Shortage Area

HB 1136: Substance Use Disorder Treatment

- Adds residential and inpatient treatment and medical detox as a Medicaid benefit, if federal approval is authorized
- Managed Service Organizations (MSOs) shall reprioritize MJ tax money for inpatient residential treatment

Signed June 6, 2018 into law

HB 1007: SUD Payment & Coverage

- Prohibits commercial health plans from penalizing physicians for low ratings from patients as a result of pain management
- Authorizes pharmacists, within existing scope of practice requirements, to inject naltrexone
- Reduces copays for physical therapy, acupuncture, and chiropractic alternatives to narcotics
- Changes Prior Authorization for Medication Assisted Treatment (MAT)

Signed May 21, 2018 into law

HB 1007: What are the Changes to MAT?

- Commercial Plans must include MAT in definition of urgent services
- Allows providers to stock short term doses of Buprenorphine (5 days max), and requires the health plan to pay for it
- Directs the Medical Services Board to streamline and simplify prior authorization of MAT among the Behavioral Health Organizations and Regional Accountability Entities

SB 18-40: Substance Use Harm Reduction (Did Not Pass)

- Would have authorized a supervised injection facility pilot program in Denver County
- Would have authorized hospitals to administer syringe access programs
- Would have authorized schools to create policies concerning possession and use of an opioid antagonist in case of student overdose

Killed in Senate State Affairs Committee – Feb 14, 2018

Pocket Slides on Other 2019 Opioid Legislation

SB 1: Expand MAT Pilot Program

Sponsors: Garcia (S), Buentello (R)

- Continue and expand SB17-074, to train and coach NPs and PAs for MAT services in Pueblo and Routt Counties
- Expand to the San Luis Valley and two additional counties in which a need is demonstrated

On March 8 passed Senate Appropriations 10-0 with amendments. On March 22, Passed House Committee on Public Health Care and Human Services and heard in House Appropriations April 9.

SB 008: SUD Treatment in Criminal Justice

Bill Sponsors: Pettersen/Priola (S), Kennedy/Singer (H)

- Requires counties that accept JBBS funding to create protocol around MAT in jail or prison and provides funding
- Funding for Harm Reduction Grant programming
- Simplify sealing drug charges and study alternatives to incarceration

Introduced on January 4, and passed Senate Judiciary 5-0 with amendments and referred to Committee on Finance.

HB 1009: SUD Recovery

Bill Sponsors: Kennedy/Singer (H), Pettersen, Priola (S)

- Expand housing vouchers for people with SUD ($4.3million for 5 yrs)
- Addresses licensing for recovery houses by CDPHE
- Create opioid settlement fund for $ from litigation

Introduced on January 4 and passed House Public Health Care & Human Services 8-3 with amendments on March 6; referred to Appropriations.

HB 1287: Treatment for Opioids and SUDS

Bill Sponsors: Esgar/Wilson (H), Pettersen/Priola (S)

- Implement centralized web-based behavioral health tracking system for treatment capacity
- Implement care navigation through Office of Behavioral Health
- Expand treatment for rural and underserved areas

Introduced on March 28 to House Health and Insurance Committee to be heard on April 16.

SB 227: Harm Reduction Substance Use Disorders

Bill Sponsors: Pettersen/Gonzales(S), Kennedy/Herod (H)

- Creates a naloxone bulk purchase fund
- Specifies hospitals can provide syringe access
- Expands medication take back to include sharps
- Requires naloxone where AED is available
- Explicitly specifies school districts can carry naloxone
- Does not include safe infection facility (SIF) language

Introduced on April 1, passed Senate Health and Human Services Committee April 11, moved to Senate Appropriations