Health District
OF NORTHERN LARIMER COUNTY

2/21/2020

STAFF: ALYSON WILLIAMS POLICY ANALYSIS

HB20-1085: PREVENTION OF SUBSTANCE USE DISORDERS

Concerning the prevention of substance use disorders.

Details

Bill Sponsors:	House – *Kennedy (D) and Herod (D)*
	Senate – *Winter (D) and Priola (R),* Donovan (D), Pettersen (D)
Committee:	House Health & Insurance
	House Appropriations
Bill History:	1/10/2020- Introduced
	2/19/2020- House Health & Insurance Refer Amended to House Appropriations
Next Action:	Hearing in House Appropriations
Fiscal Note:	2/14/2020[1]

Bill Summary

The bill addresses a variety of policy issues related to the general topic of substance use disorder (SUD) prevention. The bill:

- Requires coverage of nonpharmacological alternatives to opioids
- Prohibits carriers from limiting or excluding coverage of atypical opioids or non-opioid medications as alternatives to opioids
- Continues opioid prescribing limitation indefinitely
- Addresses continuing education requirements concerning opioid prescribing practices for physicians and physician assistants
- Allows the Department of Health Care Policy and Financing (HCPF) and health information organization network access to the Prescription Drug Monitoring Program (PDMP)
- Continues indefinitely the requirement that providers query the PDMP before a second fill of an opioid
- Requires each health care provider to query the program before prescribing a second fill for a benzodiazepine
- Appropriates money to address SUDs through local public health agencies, extend the operation of the SUD Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant program, develop and implement continuing education activities
- The Office of Behavioral Health (OBH), within the Department of Human Services (DHS), is to convene a collaborative concerning evidence-based prevention practices

Issue Summary

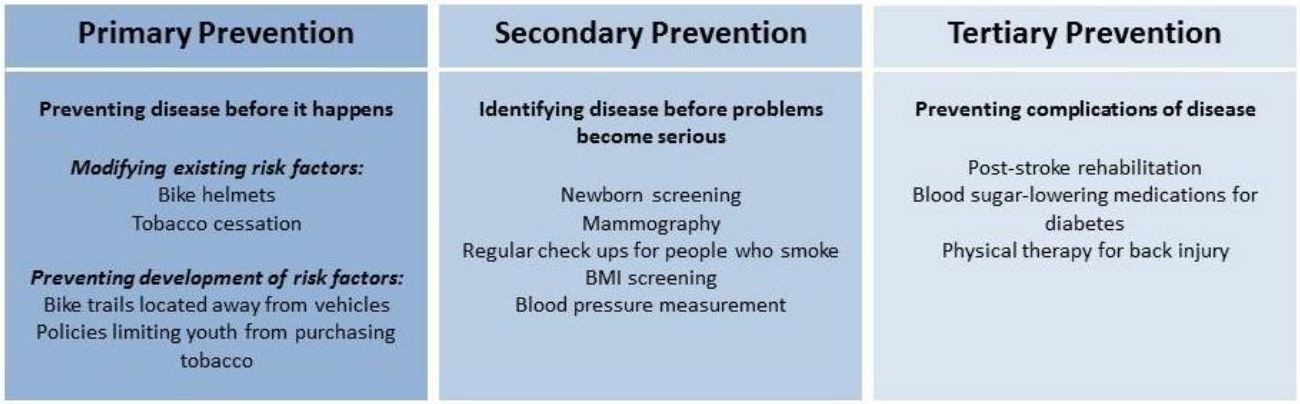
Levels of Prevention

Prevention encompasses a wide range of activities, which are distributed into three distinct categories: primary, secondary, and tertiary. Primary prevention aims to prevent injury or disease before it occurs by preventing exposure, altering behaviors, and increasing resistance to disease or injury.[2] Secondary prevention aims to reduce the impact of disease or injury that has occurred by early intervention, altering

[1] The fiscal note is based off the bill as introduced, not as it was amended by the House Health & Insurance Committee. The sections 'Bill Summary' and 'This Legislation' are both based off of the bill as amended in that committee.

[2] Institute for Work and Health (April 2015). *Primary, secondary, and tertiary prevention.* Retrieved from https://www.iwh.on.ca/what-researchers-mean-by/primary-secondary-and-tertiary-prevention

behaviors to prevent recurrence/re-injury, implementing programs to improve health, and preventing long-term problems. Finally, tertiary prevention aims to soften the impact of an ongoing injury or illness by helping people manage long-term issues that tend to be complex. The following graphic illustrates these three levels of prevention and some real world examples.[3]



Statewide Strategic Plan

The Colorado Department of Human Services (DHS), Office of Behavioral Health (OBH) in conjunction with the Colorado Health Institute (CHI), published *Colorado's Statewide Strategic Plan for Primary Prevention of Substance Abuse: 2019-2024*.[4] The plan's first objective is for the state to become a leader in prevention by creating public demand for prevention and funding it. Second, the state should have a prevention system that promotes tested and effective approaches. Third, the prevention workforce will be equipped to deliver high-quality prevention. Finally, an objective of the plan is for statewide prevention funders to align their resources and focus areas.

Alternatives to Opioids

In the 2017 Colorado Chapter of the American College of Emergency Physicians (COACEP) adopted a strategy known as Alternatives to Opioids (ALTO) to greater utilize non-opioids for pain management.[5] The ALTO strategy recommends the use of effective non-opioids and to use opioids as secondary treatment in the emergency department. Some of these alternatives include lidocaine, nitrous oxide, and nonsteroidal anti-inflammatory drugs (NSAIDs). Each non-opioid alternatives have their own risks, but when used for the pain conditions for which they are indicated, may be as effective as or more effective at reducing pain than opioids with a much lower risk of serious adverse effects. A recent study found the ibuprofen-acetaminophen combination was as effective as opioid-acetaminophen combinations in treating acute extremity pain in the emergency room.[6]

A federal report from the President's Commission found that federal and other payers' reimbursement policies create barriers to the adoption of non-opioid pain treatments.[7] In the Colorado Health First program, many NSAIDs are covered by the pharmacy benefit, with many not requiring prior authorizations.[5]

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[3] Office of Primary Prevention, Tennessee Department of Health (n.d.) *Office of Primary Prevention.* Retrieved from https://www.tn.gov/health/health-program-areas/office-of-primary-prevention.html

[4] OBH & CHI (March 2019). *Putting Prevention Science to Work: Colorado's Statewide Strategic Plan for Primary Prevention of Substance Abuse: 2019-2024.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/For%20Clearance%20II%20-%20Strategic%20Plan%20for%20Primary%20Prevention%20of%20Substance%20Abuse.pdf

[5] Colorado ACEP (2017). *2017 Opioid Prescribing & Treatment Guidelines.* Retrieved from https://cha.com/wp-content/uploads/2018/01/COACEP_Opioid_Guidelines-Final.pdf

[6] Chang AK, Bijur PE, Esses D, Barnaby DP, Baer J. Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department: A Randomized Clinical Trial. *JAMA*. 2017;318(17):1661–1667. doi:10.1001/jama.2017.16190

[7] The President's Commission on Combating Drug Addiction and the Opioid Crisis. (Nov. 2017). *Final Report.* Retrieved from https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

Some of these drugs are not for home-use outside of a health facility so are not included in preferred drug lists for insurance plans.

Nonpharmacological Alternatives

Physical therapy mostly focuses on helping to restore or maintain the ability to move and walk, while occupational therapists focus on improving ability to perform activities of daily living and work. Exercise therapy has been shown to reduce pain and improve function in chronic low back pain and in osteoarthritis of the knee and hip and improve symptoms, function, and wellbeing in fibromyalgia.[8] A presentation from the Colorado Chapter of the American Physical Therapist Association detailed the studies that have demonstrated that early access to physical therapy decreases opioid use while lowering costs.[9] Decreasing the out-of-pocket costs associated with accessing physical therapy addresses a potential hurdle to early entrance to the service. The presenter also noted that third-party utilization reviews can delay or prevent physical therapy care for the patient. In the Colorado Medicaid program, a prescription for physical therapy services is required and 48 hours of physical therapy are allowed in a 12-month period.[10] UnitedHealthcare began a pilot program in 2019 for enrollees in five states, which waives copays and deductibles for three physical therapy sessions for those with low back pain.[11]

Acupuncture/acupressure are widely used for chronic pain despite mixed results in studies and uncertainty about mechanism of action. A meta-analysis of 29 randomized trials that compared acupuncture with "sham" acupuncture[12] showed a significant benefit for acupuncture for any of four conditions—chronic nonspecific musculoskeletal pain (e.g., low back pain, osteoarthritis, chronic headache, and shoulder pain). The researchers estimated that response rates for at least a 50 percent reduction in pain were 50 percent for real acupuncture, 42 percent for sham acupuncture, and 30 percent for no acupuncture.[13] The risks associated with acupuncture are very low as adverse effects are exceedingly uncommon. Acupuncture has been found to be cost-effective relative to usual care or no treatment in subjects with back pain.[14] Ohio's Medicaid program recently expanded its benefits to include 30 acupuncture and acupuncture plus electrotherapy visits a year for pain management by both acupuncturists and chiropractors.[15]

Opioid Prescribing

Nationally, the opioid prescribing rate has decreased from 81.3 percent in 2012 to 58.5 percent in 2017.[16] However, the average duration of opioid prescriptions has continued to increase, with an average of 28 days in 2017.[14] Although the prescribing amount, Morphine Milligram Equivalents (MME)[17], has decreased nationally in the past few years to 640 MME per capita, it is still substantially above the 180 MME per capita that was measured in 1999.[18]

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[8] Dowell, D., Haegerich, T., & Davis, R. B. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. *CDC*.

[9] Flynn, T. (2017). *Improved and Timely Access to Physical Therapy Decreases Opioid Use and Lowers Cost.* Retrieved from http://leg.colorado.gov/sites/default/files/apta._opioid_task_force_presentation_8.22.17.pdf .

[10] Centers for Medicare and Medicaid Services. (Feb. 9. 2018). *Colorado State Plan Amendment #17-0038*. Retrieved from https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-17-0038.pdf

[11] PT in Motion (June 24, 2019). *UnitedHealthcare Announces New Pilot Program to Increase Access to Physical Therapist Services as Result of Collaboration with APTA.* Retrieved from https://www.apta.org/PTinMotion/News/2019/06/24/UHCPilotAndStudy2019/

[12] Another term for placebo acupuncture, which is performed away from established acupuncture points.

[13] Vickers, A.J., Cronin, A.M., Maschino, A.C., et al. (2012). Acupuncture for chronic pain: individual patient data meta-analysis. *Arch Intern Med;* 172(19) 1444-53. doi: 10.1001/archinternmed.2012.3654.

[14] Furlan, A. D., Sandoval, J. A., Mailis-Gagnon, A., & Tunks, E. (2006). Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *174*(11), 1589–1594. http://doi.org/10.1503/cmaj.051528

[15] Schroeder, K. (Dec. 25, 2017). Ohioans with Medicaid can get acupuncture for pain next year. *Dayton Daily News.* Retrieved from https://www.daytondailynews.com/news/local/ohioans-with-medicaid-can-get-acupuncture-for-pain-next-year/x4Nimi4R8jIRksnsyPumKP/

[16] CDC (Aug. 2019). *Prescribing Practices.* Retrieved from https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html

[17] Morphine Milligram Equivalents is a value that is assigned to opioids to represent their relative potency to provide for the ease of comparison.

[18] Guy GP Jr., Zhang K, Bohm MK, et al.(July 2017). Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015. *MMWR Morb Mortal Wkly Rep 2017*;66:697–704. doi: http://dx.doi.org/10.15585/mmwr.mm6626a4

In 2017, the opioid prescribing rate in Colorado was 52.9 per 100 people, which has decreased from 73.5 prescriptions per 100 people in 2012.[19] State-specific research by the Colorado Department of Public Health and Environment (CDHPE) delineated that the number of opioid prescriptions per person increased with age.[20] One quarter of Coloradans have admitted to using pain medications in ways that were not prescribed by their provider.[21] Similarly, 29 percent of Coloradans have use pain medications that were not prescribed to them.[5] In Larimer County, the prescribing rate has dropped from 84.2 prescriptions per 100 people in 2012 to 52.7 prescriptions per 100 people in 2017.[17]

The Centers for Disease Control and Prevention (CDC) promulgated guidelines regarding the prescription of opioids in 2016.[22] The CDC recommended that when prescribing opioids for acute pain it should be sufficient to prescribe a quantity for three or less days, and rarely for more than seven. That should be adequate to address the expected duration of pain severe enough to require opioids while decreasing the risk of long-term use. Furthermore, the guidelines suggest that the use of a PDMP can ensure that the patient is not taking any other opioids or could have a negative interaction between two prescriptions.

HCPF has implemented rules for the Colorado Medicaid program that limited an initial opioid prescription to a 7-day supply and limited refills, with prior authorization required after four refills.[23] Additionally the department limited dosages of opioids to a certain threshold (200 MME per day) for pain management and anything above that MME requires prior authorization.

In 2017, the Colorado Chapter of the American College of Emergency Physicians (COACEP) promulgated practice and policy recommendations regarding opioids.[5] One of the practice recommendations is the frequent consultation of the PDMP by emergency department (ED) physicians. The recommendations also suggest prescribing the lowest effective dose in the shortest appropriate duration and refusing to refill lost or stolen opioid prescriptions. In the policy section, COACEP recommends that the Colorado PDMP develop an automated query system that can be more readily integrated into electronic health records.

Benzodiazepines

More than 30 percent of overdoses involving opioids also involve benzodiazepines, a type of prescription commonly prescribed for anxiety or to help with insomnia.[24] Common benzodiazepines include Valium, Xanax, and Klonopin. The 2016 CDC opioid prescribing guidelines included a recommendation that providers avoid prescribing benzodiazepines and opioids concurrently whenever possible.[21] A study in North Carolina found that the overdose death rate in patients that had both medications was 10 times higher than those that only received opioids.[25] In 2017, 9.7 percent of patient prescription days in Colorado had overlapping opioid and benzodiazepine prescription use.[26]

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[19] Centers for Disease Control and Prevention. (July 31, 2017). *U.S. Prescribing Rate Maps.* Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[20] Colorado Department of Public Health and Environment (July 2017). *Colorado Prescription Drug Profile.* Retrieved from https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_Colorado%20Rx%20Drug%20Data%20Profile.pdf

[21] Colorado Chapter of the American College of Emergency Physicians (2017). *2017 Opioid Prescribing and Treatment Guidelines: Confronting the Opioid Epidemic in Colorado's Emergency Departments.* Retrieved from http://coacep.org/docs/COACEP_Opioid_Guidelines-Final.pdf

[22] Dowell D., Haegerich T.M., Chou R. (2016) *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016.* MMWR Recommendation Report; 65(No. RR-1):1–49.doi: http://dx.doi.org/10.15585/mmwr.rr6501e1

[23] HCPF (July 24, 2019) *Health First Colorado Initiatives Cut Opioid Use More than 50 Percent.* Retrieved from https://www.colorado.gov/pacific/hcpf/news/health-first-colorado-initiatives-cut-opioid-use-more-50-percent

[24] National Institute on Drug Abuse (NIDA) (March 2018). *Benzodiazepines and Opioids.* Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids

[25] Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality. *Pain Med Malden Mass*. 2016;17(1):85-98. doi:10.1111/pme.12907.

[26] Colorado Consortium for Prescription Drug Abuse Prevention (n.d.) *Consortium Dashboard.* Retrieved from https://public.tableau.com/profile/omni#!/vizhome/RXConsortiumdashboard/Readmefirst

Continuing Education

There are many different types of providers that can prescribe opioids; all must complete continuing education to be certified by their respective accreditation boards and/or to receive licensure from the state. At the state level, different boards govern the licensure of providers that may be registered with the Drug Enforcement Administration (DEA) to prescribe opioids. Each board has different requirements for the providers regarding CE. However, the specific topics to be covered through the continuing education is not currently mandated by law or regulation. Due to the passage of SB19-228, all licensed health care providers[27] must also complete at least four credit hours of substance use prevention training per licensing cycle.[28] Currently there are a variety of venues where these providers can receive training on effective pain management, appropriate opioid prescribing practices, and substance use disorders. National certification groups have their own requirements for CE to maintain professional certification.

As of 2017, more than 100,000 Colorado physicians had participated in training and/or education on topics such as opioid misuse, prescribing practices, substance use treatment and other related issues.[29] The Colorado School of Public Health and the Colorado Consortium for Prescription Drug Abuse Prevention have previously partnered to develop and implement three online CE modules on the topic of prescribing practices for physicians, dentists, pharmacists, nurses and veterinarians.[30] The Provider Education Work Group of the Consortium has created live CE for prescribers on topics ranging from safe prescribing to MAT in primary care; as of 2017 these events had been delivered seven times to more than 300 providers.[31] COPIC, a company that provides medical liability insurance to health professionals, allows insured providers to earn points to decrease their premium by attending their in-person and online education seminars, which include programs on opioid prescribing and pain management.[32]

Prescription Drug Monitoring Program (PDMP)

The Colorado PDMP was first authorized by law in 2005 and was enhanced by law in 2014 to the program that is currently running.[33] Practitioners and pharmacists, even in other states, can query information on Colorado patients.[34] Pharmacies must upload prescription data during every business day for medications that are classified as Schedule II-V. Physicians are not required to query the PDMP, unless it is prior to prescribing a refill for an opioid, except in certain circumstances.[35] A study found that comprehensive use mandates that require use of the PDMP were associated with a 9.2 percent reduction in the probability of overlapping opioid prescriptions, a 6.6 percent reduction in the probability of having 3 or more opioid prescribers, and an 8 percent reduction in the probability of having overlapping opioid and benzodiazepine prescriptions.[36]

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[27] Licensed health care providers include: physicians, physician assistants, podiatrists, dentists, advance practice nurses with prescriptive authority, optometrists, and veterinarians.

[28] C.R.S.§12-30-114

[29] Colorado Medical Society. (Sept. 2017). *Colorado leads opioid prevention.* Retrieved from http://www.cms.org/communications/colorado-leads-opioid-prevention.

[30] Colorado School of Public Health, Center for Health, Work & Environment (n.d.). *Preventing Prescription Drug Abuse.* Retrieved from http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CHWE/training/Online/Pages/RxAbuse.aspx.

[31] Valuck, R. (July 10 2017). *Presentation to the Colorado General Assembly Opioid and Other Substance Use Disorders Interim Study Committee* [PowerPoint slides]. Retrieved from http://leg.colorado.gov/sites/default/files/colorado_consortium_presentation_for_interim_study_committee_-_july_10_2017.pdf

[32] COPIC (2017). *COPIC Education Catalog.* Retrieved from https://www.callcopic.com/resources/Documents/FINAL_CourseCatalog_04-17.pdf.

[33] Colorado Department of Regulatory Agencies (2014). *Colorado's Prescription Drug Monitoring Program- 2014 and Beyond* [Presentation]. Retrieved from https://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2014/august_2014/gassen.pdf

[34] Colorado Department of Regulatory Agencies (2018). *About Program.* Retrieved from https://www.colorado.gov/pacific/dora-pdmp/about-program

[35] C.R.S.§ 12-280-404

[36] Bao, Y., Wen, K., Johnson, P., Jeng, P.J., Meisel, Z.F., & Schackman, B.R. (Oct. 2018). Assessing the Impact of State Policies for Prescription Drug Monitoring Programs on High-Risk Opioid Prescriptions. *Health Affairs 37*(10). Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0512

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

The SBIRT approach consists of three components: screening, brief intervention, and referral to treatment. In this process the provider screens the patient to determine the severity of the substance use and appropriate level of treatment, a brief intervention to assess the patient's insight into their substance use as well as their motivation for behavior change, and ends with referral to treatment for those patients that have been identified as needing more attentive care.[37] Colorado received funding from the federal government through the Substance Abuse and Mental Health Services Administration (SAMHSA) for ten years, from 2006-2016, with the intent of integrating SBIRT into the routine delivery of health care.[38]

This Legislation

Coverage for Nonpharmacological Alternatives to Opioids

Health benefit plans, except supplemental policies, must provide coverage for nonpharmacological treatment as an alternative to opioids.

The required coverage must include, at the lowest cost sharing tier, a minimum of 6 physical therapy, 6 occupational therapy, 6 chiropractic, and 6 acupuncture visits. The coverage cannot require prior authorization for nonpharmacological treatments as opioid alternatives. At the time of a person's initial visit for treatment, the professional shall notify the carrier that the person has started treatment.

Non-Opioid or Atypical Opioid Coverage

An insurance carrier cannot limit or exclude coverage under a plan for a FDA-approved non-opioid or atypical opioid that has the same indication as an opioid and is prescribed by a provider as an alternative to an opioid. The carrier cannot mandate that the person undergo step therapy for the non-opioid or atypical opioid or require prior authorization. Additionally, the bill requires the carrier to make the prescribed non-opioid or atypical opioid available under the plan's lowest cost-sharing tier of the plan's formulary that is applicable to alternative covered opioid. The bill defines "non-opioid or an atypical opioid" as analgesics with far fewer fatality rates than pure opioid agonists as specified by rule of the Commissioner of Insurance.

Carrier Contracts with Physical Therapists, Occupational Therapists & Acupuncturists

A carrier that has a contract with a physical therapist, occupational therapist, or acupuncturist cannot:

- Prohibit the provider from providing a covered person information on the amount of their financial responsibility for the services
- Penalize the provider for disclosing the covered person's financial responsibility or providing a more affordable alternative
- Require the provider to charge or collect a copayment that exceeds the total charges submitted

If the Commissioner of Insurance determines that a carrier has not complied with these requirements, they shall institute a corrective action plan or use any of their enforcement powers to obtain compliance.

Opioid/Benzodiazepine Prescribing Limits

The current limitations on opioid prescribing that were enacted with the passage of SB18-022 are continued in perpetuity instead of being repealed on September 1, 2021. This change is for all affected prescribers, including: dentists, physicians, physician assistants, advanced practice nurses with prescriptive authority, optometrists, podiatrists, and veterinarians. In addition, the bill requires prescribers to query the PDMP before a second fill of a benzodiazepine prescription. The Executive Director of the Department of Regulatory Agencies (DORA) is to promulgate rulemaking that limits the supply of a benzodiazepine that may be prescribed to a patient who has not had such a prescription in the last 12 months by that prescriber.

[37] Substance Abuse and Mental Health Services Administration (2017). *About SBIRT.* Retrieved from https://www.samhsa.gov/sbirt/about.

[38] SBIRT Colorado (n.d.). *Why SBIRT?.* Retrieved from https://www.integration.samhsa.gov/clinical-practice/SBIRT_Colorado_WhySBIRT.pdf.

Continuing Education for Physicians & Physician Assistants

The bill repeals a current section of statute that states that physicians and PAs that are applying for re-licensure cannot be required to attend and complete CE programs. The State Medical Board, in consultation withthe Center for Research into Substance Use Disorder Prevention, Treatment, and Recovery Support Strategies (the Center), is to promulgate rules to establish competency-based standards for continuing medical education for physicians and physician assistants concerning opioid prescribing practices. The Medical Board is to require completion of these continuing education requirements for licensure renewal.

Prescription Drug Monitoring Program

The Prescription Drug Monitoring Program (PDMP) currently tracks specific information regarding prescriptions for controlled substances. The bill allows for rulemaking by the Pharmacy Board to allow for other prescription drugs to be included in the tracking of information. Beginning January 1, 2021, the PDMP must include the name of the person paying for the prescription. Other than the $25 fee[39] that is collected from prescribers of controlled substances in conjunction of license renewal fees, the Pharmacy Board shall not charge a fee or assessment for registering or maintaining an account with the PDMP or accessing the PDMP. By January 1, 2021, the Pharmacy Board must require each pharmacist, pharmacist's designee, or prescription drug outlet to enter each prescription dispensed in Colorado or to an address in Colorado, including prescriptions not paid for by a third-party into the PDMP daily.

The bill clarifies that a death investigation, not just an autopsy, of an individual is a valid reason for a medical examiner or coroner to query the PDMP. Additionally, it allows HCPF to query the PDMP in order to conduct care coordination and utilization review regarding Medicaid recipients as long as the use is consistent with HIPAA.

The bill requires practitioners or their designee to query the PDMP before prescribing a second fill for a benzodiazepine unless the medication is prescribed to treat a patient in hospice, a seizure or seizure disorder, alcohol withdrawal, or a neurological emergency event (including a post-traumatic brain injury). The current requirement for practitioners or their designee to query the PDMP before prescribing a second fill for an opioid is continued in perpetuity instead of being repealed on September 1, 2021.

Rules must be promulgated by the Pharmacy Board to designate additional controlled substances and other prescription drugs that have the potential for abuse or an adverse drug interaction with a controlled substance to be tracked through the PDMP.

By January 1, 2021, the Pharmacy Board is to provide a means of sharing prescription information with the health information organization network to work collaboratively with the state health information exchanges. Use of the information is subject to privacy and security protections in state law and HIPAA.

Funding Local Efforts

The bill continues in perpetuity the appropriation of $2 million to the Department of Public Health and Environment (CDPHE) to address SUDs through public health interventions and to work with community partners, including county/district public health agencies, to address SUD priorities throughout the state.[40]

SBIRT Grant Program

The bill extends the SBIRT Grant Program administered by HCPF through the 2023-2024 state fiscal year and requires the General Assembly to appropriate $500,000 each fiscal year from the Marijuana Tax Cash Fund.

[39] C.R.S.§12-280-405

[40] Funding was originally provided in SB19-228.

The funds are to be used for expanded training and technical assistance in order to monitor fidelity to the SBIRT model through qualitative and quantitative data collection and analysis.

Continuing Education

The Center must develop and implement continuing education activities that include best practices for prescribing benzodiazepines as well as the potential harm of inappropriately limiting opioid prescriptions to chronic pain patients. For all the continuing education activities developed by the Center for prescribers, there should be an emphasis on physicians, physician assistants, nurses, and dentists that serve underserved populations. For state fiscal years 2020-2021 through 2024-2025, the General Assembly is to annually appropriate $250,000 from the Marijuana Tax Cash Fund.

Colorado Substance Use Disorders Prevention Collaborative

OBH is to convene and administer a "Colorado Substance Use Disorders Prevention Collaborative" that includes institutions of higher education, nonprofit agencies, and state agencies in order to gather feedback concerning evidence-based prevention practices. The mission of the collaborative is to:

- Coordinate with and assist state agencies and communities to strengthen the prevention infrastructure and implement a strategic plan for primary prevention of SUDs for state fiscal years 2020-2021 through 2023-2024
- Advance the use of tested and effective prevention programs through education, outreach, advocacy and technical assistance, with an emphasis on addressing the needs of underserved populations
- Direct efforts to raise public awareness of cost savings of prevention
- Provide direct training and technical assistance to communities regarding tested and effective primary prevention programs
- Pursue local and state policy changes that enhance the use of tested and effective primary prevention programs
- Advise state agencies and communities regarding new and innovative primary prevention programs
- Support funding efforts in order to align funding and services and communicate with communities about funding strategies
- Work with key state and community stakeholders to establish a minimum standard for primary prevention programs
- Work with prevention specialists and existing training agencies to provide and support training to strengthen the prevention workforce

OBH and the collaborative are to establish community-based prevention coalitions and delivery systems to reduce substance misuse, implement effective primary prevention programs, and coordinate to provide prevention science training and continuing education to prevention specialists.

To implement the collaborative the General Assembly is to appropriate funds from the Marijuana Tax Cash Fund for state fiscal years 2020-2021 through 2023-2024. By September 1, 2021, every September 1 through 2024, OBH is to report its progress to the General Assembly. This section about the collaborative is repealed on September 30, 2024.

Reasons to Support

Supporters assert that reducing prescribing will also reduce the quantity of drugs available for misuse and abuse. Creating this limit will reduce the chance that the development an opioid use disorder will develop in opioid naïve patients. Additionally, it decreases the possibility that excess opioid pills fall into the hands of someone other than the intended patient. This bill protects the availability of these opioid products for those who have chronic illness or cancer, which is a usual trepidation for consumers.

Supporters

- Colorado Academy of Family Physicians
- Colorado Association of Local Public Health Officials (CALPHO)
- Colorado Behavioral Healthcare Council (CBHC)
- Colorado Chapter, American College of Emergency Physicians
- Colorado Community Health Network
- Colorado Coroners' Association
- Colorado Cross-Disability Coalition
- Colorado Dental Association
- Colorado Medical Society
- Colorado Occupational Therapist Association
- Colorado Providers Association (COPA)
- Colorado Rural Health Center
- Denver Health
- Emergent Biosolutions
- Mental Health Colorado
- Quality Health Network

Reasons to Oppose

Opponents may say that this infringes on the business practices of health plans to ensure that their members are provided with appropriate, affordable, and quality care. Some may say that requiring specific benefit coverage for private plans in state statute interferes with the carrier's ability to complete its mission and goals effectively.

Some believe that policies that aggressively limit prescription opioid prescribing could drive people to turn to illicit drugs and injection opioids, such as heroin. Some assert that this policy could force patients to live with inadequately treated pain. This inadequately treated pain could lead to other physical and behavioral health issues for the patient. A CDC analysis found that chronic pain may be an important contributor to suicide.[41] Other opponents may assert that this is an intrusion into the provider-patient relationship and the practice of medicine.

Opponents

- Any opposition has not been made public at the time of publication.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.

[41] Petrosky E, Harpaz R, Fowler KA, et al. (2018) Chronic Pain Among Suicide Decedents, 2003 to 2014: Findings From the National Violent Death Reporting System. *Ann Intern Med*.169:448–455. doi: https://doi.org/10.7326/M18-0830 Retrieved from https://annals.org/aim/fullarticle/2702061/chronic-pain-among-suicide-decedents-2003-2014-findings-from-national