Interim Study Committee Regarding Opioid and Other Substance Use Disorders in Colorado

Stakeholder Response Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Donald Stader, MD
Email address:	donald.stader@gmail.com
If submitting on behalf of an organization, provide organization name*:	Colorado ACEP
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: - Identification of drug seeking behavior - Increase of PDMP usage via a user friendly "push system" - Increased coordination of care - Decrease in utilization of opioids	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. Funding from implementation of Emergency Department Information Exchange (EDIE) across Colorado Emergency Departments	
2. Legislature works with health insurers to assure that non-narcotic pain control options are covered by insurers (examples include lidoderm patches)	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Laws should be changed to allow syringe exchange programs in all communities, with or without county health board approval.	
2. Legislation should be passed to allow emergency departments to participate as syringe exchange and access centers, especially in rural areas where syringe exchange programs are unavailable or financially not feasible	
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE	

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

TO: Task Force to Assist the Interim Study Committee on Opioid and Other Substance Use Disorders

THROUGH: José Esquibel, Director, Office of Community Engagement, Colorado Department of Law
Rob Valuck PhD, RPh, Coordinating Center Director, Colorado Consortium for Prescription Drug Abuse Prevention

FROM: Daniel Shodell, MD, MPH, Deputy Director, Disease Control and Environmental Epidemiology Division, Colorado Department of Public Health and Environment

DATE: September 7, 2017

SUBJECT: Syringe Services Programs

This memo is intended to provide background information on syringe services programs (SSPs) for members of the Task Force. As defined by the United States Department of Health and Human Services, SSPs include provision of sterile needles, syringes, other drug preparation equipment, and disposal services in a setting that provides comprehensive services or referral to services related to substance used disorder. In Colorado, Senate Bill 10-189 authorized clean syringe exchange programs (SEPs). For current purposes, SSP and SEP can be used interchangeably, although SSPs refer to a broader range of services including SEPs.

The Colorado Department of Public Health and Environment (CDPHE) manages SSP support through its Disease Control and Environmental Epidemiology Division (DCEED), since injection drug use is a factor in HIV infections and a major driver of hepatitis C virus (HCV) infections. Access to sterile needles and clean drug injection materials is a proven intervention for disease control. This is an increasingly important intervention in the context of the opioid crisis and ongoing increases of HCV infection within a relatively young age group, most likely driven directly by injection drug use.

Across Colorado there are currently eight counties that have adopted SEP, with a total of ten access points. While not enough data points exist to establish a stable trend over time, CDPHE observations indicate that most sites have extremely rapid growth in the first year of service, with slower but still substantial growth as programs mature. Perhaps most importantly, there is no program in the state that has seen syringe exchange volume either level off or decline. Growth in demand appears to be continual so far. Overall, CDPHE is projecting that syringe exchange volume will increase approximately 50% between Colorado state fiscal years 2016 and 2017.

Unmet need is apparent, as demonstrated by not only these ongoing increases in volume but also complete absence of SSPs in a number of counties that are heavily impacted by the opioid crisis. Also missing from the current SSP approach is the capability to reach the scale and saturation of access needed for early engagement with people who have recently started injection drug use. This is critical because individuals who are just starting to inject drugs have increased risk of HCV infection, and are among the least likely to seek out SSPs.

The policy environment is favorable for addressing unmet need. Key interventions to effectively address unmet need include additional resource allocation and expanded efforts to engage key stakeholders (including law enforcement) in harm reduction planning discussions.

For additional background, please see the attached determination of need document that CDPHE submitted to the United States Centers for Disease Control and Prevention (CDC); CDC has provided their concurrence with this document.

For more information: Daniel.Shodell@state.co.us 303-692-2363

Attachment: CDPHE Determination of Need

Attachment: CDPHE Determination of Need

REQUEST FOR DETERMINATION OF NEED

Requesting jurisdiction: ***Colorado*** *(Colorado Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division)*

Geographic area for which the determination is requested: State-wide

We are submitting evidence for consultation with CDC to demonstrate our jurisdiction is **at risk for** significant increases in viral hepatitis (VH) and/or HIV infections due to injection drug use (IDU). With the increased flexibility made possible through this determination, the Colorado Department of Health and Environment (CDPHE) will be better positioned to address the growing public health crisis around injection behaviors.

As shown in part 1 below, current data reflect higher baseline rates of substance abuse in Colorado when compared to national U.S. data, as well as ongoing increases. While indicators specific to IDU are not readily available, we have identified proxy indicators that show similarly high levels of concern around IDU and potential for explosive spread of VH and/or HIV in Colorado.

In this context, Colorado has already developed a coordinated, statewide, multi-disciplinary approach to preventing and addressing substance abuse. The state legislature created the Substance Abuse Trend and Response Task Force (referred to as the Task Force), which is chaired by the state Attorney General and includes representation from state agencies responsible for public health, public safety, and publicly-funded substance treatment services. As a result of Colorado's participation in the National Governor's Association Policy Academy on prescription drug abuse, these same state agencies and the governor's office created the Colorado Consortium for Prescription Drug Abuse Prevention (referred to as the Consortium). The Consortium became a subcommittee under the Task Force and was charged with implementing the governor's Colorado Plan to Reduce Prescription Drug Abuse. In recognition of the rise in heroin deaths and the connection between prescription opioid and heroin use disorders, the Task Force recently added a Heroin Response Work Group under the Consortium. CDPHE co-chairs the new Heroin Response Work Group.

This request for determination of need has been developed in collaboration with the Colorado Department of Human Services (as the SAMHSA designated single state agency for substance abuse services) and across divisions within CDPHE. The CDPHE co-chair for the Heroin Response Work Group is the Director of the Violence Injury Prevention - Mental Health Promotion Branch, which is responsible for CDPHE activities related to primary prevention of prescription drug misuse and youth initiation of marijuana use. Branch leadership and staff work closely with other members of the Consortium and assisted with this request. The CDPHE STI/HIV/VH Branch is responsible for CDPHE activities related to syringe services programs (SSP). County-level SSP are legal in Colorado.

Data in the table below indicate that Colorado is at high risk of increases in VH and/or HIV infections due to IDU. Because Colorado has invested in state-level coordination, we have existing platforms that can be leveraged to further define and monitor the risk we are facing, design interventions, and successfully execute implementation.

PART 1: Data Sources

Outcomes	**Data source**	**Geographic area**	**Assessment period beginning year and number or rate**	**Assessment period ending year and number or rate**	**Percent increase during the assessment period**
Injection drug use among substance abuse treatment admissions	Colorado Department of Human Services[1]	State of Colorado	Calendar year 2008 Rate of 2.7	Calendar year 2015 Rate of 7.2	+167%
Heroin-related arrests	Rocky Mountain High Intensity Drug Trafficking Area[2]	State of Colorado	Calendar year 2010 77 heroin related arrests	Calendar year 2015 251 heroin related arrests	+226%
Heroin Seizures	Rocky Mountain High Intensity Drug Trafficking Area[3]	State of Colorado	Calendar year 2010 11.96 pounds	Calendar year 2015 206.68 pounds	+1628%
Heroin related hospital discharges ages 18-25	Hospital Discharge Dataset, Colorado Hospital Association[4]	State of Colorado	Calendar year 2010 Rate of 2.2	Calendar year 2013 Rate of 9.1	+314%
Heroin related hospital discharges ages 26-64	Hospital Discharge Dataset, Colorado Hospital Association[5]	State of Colorado	Calendar year 2010 Rate of 1.4	Calendar year 2013 Rate of 2.7	+93%
Injection drug use among hospital discharges (estimated using range of published methodologies)	Hospital Discharge Dataset, Colorado Hospital Association[6]	State of Colorado	Calendar year 2010 Number: A) 1,101 B) 595 C) 442	Calendar year 2014 Number: A) 1,919 B) 871 C) 685	A) +74% [7] B) +46% [8] C) +55% [9]
Deaths from overdose	Colorado Health Institute[10]	State of Colorado	Calendar year 2001 Rate of 9.7	Calendar year 2014 Rate of 16.3	+68%
Deaths from heroin overdose	Colorado Department of Public Health and Environment[11]	State of Colorado	Calendar year 2010 Rate of 0.9	Calendar year 2014 Rate of 2.8	+211%
Neonatal abstinence syndrome	Colorado Department of Public Health and Environment[12]	State of Colorado	Calendar year 2010 Rate of 199.0	Calendar year 2013 Rate of 375.4	+89%

PART 2: Summary of Evidence

The data in part 1 reflect a significant risk situation in Colorado, based on assessment of nine variables related to substance abuse and IDU. Taken together, these data suggest an increasing trend in unsafe injection practices that may lead to increases in VH and HIV infections. Colorado's substance abuse rates are higher than national U.S. rates, and there are significant, ongoing increases in substance abuse overall. This is reflected both in indicators for general drug abuse, as well as indicators that more closely approximate IDU behavior specifically.

General variables that demonstrate substance abuse in Colorado include the following:

- Death from overdose (fatal acute drug poisoning rates): The Colorado rate of drug overdose deaths climbed to 16.3 per 100,000 residents in 2014, an increase of 68% from 2002 when the rate was 9.7 per 100,000 residents. Colorado's 2014 rate was higher than the national average of 14.7 drug-related deaths per 100,000. Twelve Colorado counties have drug overdose death rates of more than 20 per 100,000 residents, [13] meaning they are among the highest in the nation. These counties are geographically distributed throughout the State, and the majority are classified as rural or frontier.
- Past Month Illicit Drug Use: Colorado is second highest in the nation for percentage of the population using illicit drugs (other than marijuana) in the past month among 18+ years old; and sixth in the nation among 18-25 year olds.[14]
- Neonatal abstinence syndrome: In 2013 the rate of opiate-related symptoms was 375 (44 cases reported among 65,004 live births), an increase of 89% from 2010 when the rate was 199 (132 cases of NAS reported among 66,346 live births).

Specific variables that demonstrate IDU in Colorado include the following:

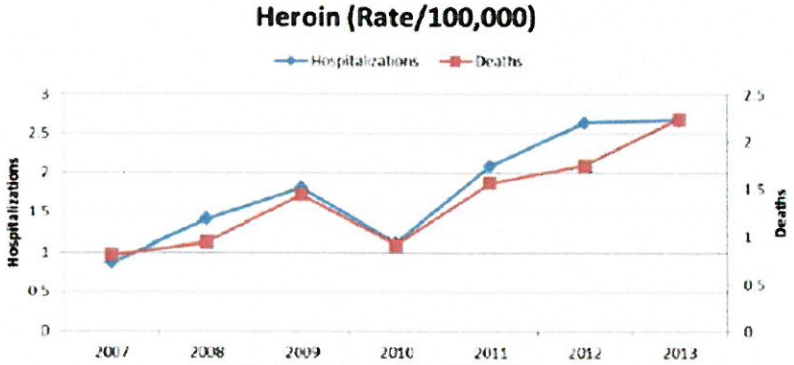
- Injection drug use among treatment admissions (any drug) to licensed providers and programs: Increased to 8,249 in 2015, an increase of 131% from 3,563 in 2008. When considered as a proportion of all treatment admissions the increase is 167%: in 2008, 2.7% of admissions were for IDU (3,563 out of 129,765 total admissions) and in 2015, 7.2% of admissions were for IDU (8,249 out of 113,783 total admissions).
- Heroin-related arrests and heroin seizures: Between 2010 and 2015, arrests for heroin increased by 226% and heroin seizure (by weight) increased to more than 200 pounds from 12, an increase of more than 1,600%. Discussions with criminal justice and law enforcement counterparts revealed no new policing initiatives that would explain these increases (seizures resulting from multi-jurisdictional actions were excluded from analysis).
- Heroin-related hospital discharges: Among 26-64 year olds in Colorado, the rate of hospital discharges reached a rate of 2.7 in 2013, an increase of 93% from 1.4 in 2010. The increase was even higher among 18-25 year olds: in 2013 the rate reached 9.1, from 2.2 in 2010. This increase of 314% among the younger age group may be a major consideration in estimating potential increases in injection initiation.
- Death from heroin overdose: The overall rate of death in Colorado that was attributed to heroin overdose was 2.8 per 100,000 residents in 2014, an increase of 211% from 0.9 in 2010. Figure 1 shows heroin-related hospitalizations and deaths.

Note that while heroin-specific data do not indicate the route of administration, approximately 65% of heroin administration was via injection in 2014.[1]

- IDU-related hospitalization: Combinations of ICD-9 codes can be used to estimate drug-related hospitalizations, and more specifically injection drug-related hospitalizations. Various methodologies have been published, and CDPHE chose three algorithms to replicate, using different combinations of ICD-9 codes for skin or soft tissue infections, endocarditis, drug abuse and drug poisoning diagnoses.[7-8-9] The results show Colorado occurrences of hospital discharges for infection related to injection drug use, ages 18-65, between 2010 and 2014. While the different methodologies generate different absolute numbers based on our Colorado data, the trends over time all reflect increases, with the methodology from Tookes et al. [7] showing an increase to 1,919 in 2014, from 1,101 in 2010 (74% increase); the methodology from Takahashi et al.[8] showing an increase to 871 in 2014, from 595 in 2010 (46% increase); and the methodology from Heinzerling et al.[9] showing an increase to 685 in 2014, from 442 in 2010 (55% increase).

In addition to data shown in part 1, Colorado has been tracking potential "leading edge" signals for increases of VH or HIV associated with IDU. One illustrative example comes from a rural county, where the seat (and largest city), population 9,464, reported three acute cases of hepatitis C associated with the injection of heroin in 2015. This follows a period from 2007 through 2014 during which no cases of acute HCV were reported. No new screening or health care mobilization activities have been documented that may have transiently increased reporting. Investigation of this possible cluster did not generate any additional outbreak signals, but such occurrences may reflect that Colorado is experiencing real and present risk for VH and/or HIV due to IDU.

Figure 1. Heroin-related hospitalizations and deaths.



Heroin Deaths and Hospitalizations.
Source: Colorado Department of Public Health and Environment

Indicators for overall drug abuse trends, as well as indicators designed to act as close proxies for IDU specifically, suggest that Colorado is experiencing significant risk for spread of viral hepatitis and HIV. All of the indicators examined show high rates and significant increase over time, with particularly concerning data related to IDU behavior among a younger cohort of Coloradans. Colorado has a functional platform for coordination and implementation of syringe services programs, and increased attention and resources for these programs will be critical in mitigating risk and preventing rapid increases in VH and HIV.

REFERENCES

[1] From Rebecca S. Helfand, Ph.D., Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) presentation on Colorado Drug Trends, August 7, 2015. Attributed source: Drug/Alcohol Coordinated Data System (DACODS), Office of Behavioral Health (OBH) Colorado Department of Human Services (CDHS).
[2] 2010-2014 data from Rocky Mountain High Intensity Drug Trafficking Area Presentation "Colorado Heroin"; 2015 data from personal communication May 2016, Kevin Wong, Intelligence Analyst Rocky Mountain High Intensity Drug Trafficking Area
[3] 2010-2014 data from Rocky Mountain High Intensity Drug Trafficking Area Presentation "Colorado Heroin"; 2015 data from personal communication May 2016, Kevin Wong, Intelligence Analyst Rocky Mountain High Intensity Drug Trafficking Area
[4] Hospital Discharge Dataset, Colorado Hospital Association; Rates calculated by Colorado Department of Public Health and Environment, May 2016.
[5] Hospital Discharge Dataset, Colorado Hospital Association; Rates calculated by Colorado Department of Public Health and Environment, May 2016.
[6] Data from Colorado Hospital Association analyzed by Kirk Bol MSPH, Manager, Vital Statistics Program, Colorado Department of Public Health and Environment. May 2016.
[7] Tookes H, Diaz C, Li H, Doblecki-Lewis S. A Cost Analysis of Hospitalizations for Infections Related to Injection Drug Use at a County Safety-Net Hospital in Miami, Florida. 2015. PLoS ONE, 10(6):e0129360
[8] Takahashi TA, Maciejewski ML, Bradley K. US Hospitalizations and Costs for Illicit Drug Users with Soft Tissue Infections. 2009. Journal of Behavioral Health Services & Research. 37(4): 508-518
[9] Heinzerling KG, Etzioni DA, Hurley B, Holtom P, Bluthenthal RN, Asch SM. Hospital Utilization for Injection Drug Use-Related Soft Tissue Infections in Urban versus Rural Counties in California. 2006. Journal of Urban Health. 83(2):176-81
[10] Colorado Health Institute. Colorado County Drug Overdose Death Rate. http://coloradohealthinstitute.org/key-issues/detail/community-health/colorado-county-drug-overdose-death-rate. Accessed May 8, 2016
[11] Data from Colorado County Coroners analyzed by Barbara Gabella, MSPH Senior Scientist in Injury Epidemiology Violence and Injury Prevention - Mental Health Promotion Branch, Colorado Department of Public Health and Environment. May 2016.
[12] Data from Colorado Hospital Association analyzed by Margaret F. Ruttenber, MSPH, Physical Scientist Research Scientist Program Director, Colorado Responds to Children with Special Needs (CRCSN), Colorado Department of Public Health and Environment. May 2016.
[13] Colorado Health Institute. Colorado County Drug Overdose Death Rate. http://coloradohealthinstitute.org/key-issues/detail/community-health/colorado-county-drug-overdose-death-rate Accessed May 19, 2016.
[14] SAMHSA. 2013-2014 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia). http://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf Accessed May 26, 2016.

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Zach Lynkiewicz
Email address:	zach.lynkiewicz@state.co.us
If submitting on behalf of an organization, provide organization name*:	Colorado Department of Health Care Policy & Financing

PROBLEM OR ISSUE

National and state data show Medicaid clients are disproportionally impacted by substance use disorders and the opioid crisis. The Department of Health Care Policy and Financing (the Department) is committed to using every tool available to help members at risk of opioid addiction or substance misuse.

The Centers for Medicare and Medicaid Service (CMS) has identified Medicaid programs having access to their state's prescription drug monitoring program (PDMP) as a national best practice to combat opioid misuse in the Medicaid population. To date, 35 other state Medicaid programs utilize their state's PDMP to help identify clients who may be misusing prescription drugs.

While the Department 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. Paying cash for opioids is often a red flag for potential opioid misuse.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)

HCPF should be granted access to Medicaid-specific data from the PDMP with the goal of identifying Medicaid members who may benefit from improved care coordination or substance abuse treatment services.

Once a member has been identified as cash paying for opioids, the Department would utilize its Regional Care Coordination Organizations (RCCOs) to reach out to the member's care team to better understand the member's situation. The RCCO would work with the member's medical care team to determine how and whether the member should be contacted to see if he or she would be interested in voluntary substance use disorder services.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Tonya Wheeler, CPFS, CACIII
Email address:	tonyawheeler@advocatesforrecovery.org
If submitting on behalf of an organization, provide organization name*:	Advocates for Recovery Colorado

PROBLEM OR ISSUE

The only state funding source at present are funds from SB16-202, and while this is a great advancement in funding for recovery support services, we need to be mindful of the needs of people before, during and after formal treatment services, and for those who aren't able to access formal treatment services.

There are few opportunities for a Recovery Community Organization (RCO), like Advocates for Recovery Colorado, to obtain funding to provide peer recovery support services out in the community.

Grassroots, non-profit organizations that are peer-led & peer-run represent the "authentic voice of the recovery community", and when these RCOs are stand alone organizations they ar often left out of funding systems due to not being attached to a formal SUD treatment agency. The work that these RCOs do is a critical addition of services and support for people who need them, especially during early recovery in their home community.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. We need to better practice a recovery oriented system of care in Colorado by supporting recovery in the community, and not only when a person is involved with a formal treatment agency.

2. Substance Use Disorder treatment programs should refer people who are leaving treatment to a recovery Community Organization in their home community, if available, to connect with and maintain support from others in long-term recovery from addiction.

3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)

1. Additional funding is needed for SB16-202 for all parts of the continuum of care, and should be supported by the interim committee

2. Create the ability for non-profit Recovery Community Organizations (RCO) who have have a 501c3 designation, to be able to bill Medicaid for recovery support services that are provided ir the community instead of only in formal treatment programs.

3.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
The process of recovery is highly personal and occurs via many pathways. Some RCOs, again lik Advocates for Recovery Colorado, support all pathways to recovery. Some of the pathways ma include clinical treatment, medications, faith-based approaches, secular approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continua growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery. There will be money saved when people are connected with Recovery Community Organizations to remain involved with the recovery community. There are four major dimensions that support a life in recovery: • Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being • Home—having a stable and safe place to live • Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society • Community—having relationships and social networks that provide support, friendship, love, and hope Recovery Community Organizations can help coordinate a person's four major dimensions to support life in long-term recovery from addiction. However, if these recovery community organizations/centers are not supported with funding then their chances of remaining open and active in communities may be deteriorated.

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

Olberding, Gina

From: Bethany Pace-Danley <BPace-Danley@peerassist.org>
Sent: Friday, September 1, 2017 1:05 PM
To: Jose.Esquibel@coag.gov
Cc: leg@corxconsortium.org
Subject: Follow Up Re: SBIRT and Women of Childbearing Age/during Pregnancy
Attachments: Omni WOCBA Topic Summary Final.pdf

Hello José,

As we discussed yesterday, we have collected information for you regarding the role of SBIRT and women of childbearing age and during pregnancy. Because this is not a separate proposal I have not used the formal document; this is to support the SBIRT proposal that Peer Assistance previously submitted.

1. The attached document describes a study that included 2,373 women who were able to get pregnant and reported using alcohol or drugs. 41% (976) of the women were at risk for a substance-exposed pregnancy because they were not using contraception or using an unreliable form of contraception that is unreliable: 57% for an alcohol exposed pregnancy and 48% for a cannabis exposed pregnancy. Alcohol, cannabis and other drug use during pregnancy can result in a range of reversible and irreversible effects on the offspring.
2. ACOG Committee Opinion: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice: https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Alcohol-Abuse-and-Other-Substance-Use-Disorders-Ethical-Issues-in-Obstetric-and-Gynecologic-Practice
3. ACOG Committee Opinion: At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications: https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/At-Risk-Drinking-and-Alcohol-Dependence-Obstetric-and-Gynecologic-Implications
4. Ideally, if SBIRT is utilized routinely in women of childbearing age during the interconception, prenatal and postpartum time periods it will increase identification of women who use or misuse alcohol or drugs before they are pregnant and early during pregnancy when harm can be minimized. Routine SBIRT also normalizes conversations about alcohol and drug use, increases patient-provider trust, and increases the likelihood that women with more severe substance use disorders will receive help before she has a substance-exposed pregnancy.
5. Many women receive most of their healthcare from women's health providers (MDs and advanced practice nurses including midwives) so it makes sense to make SBIRT routine in those settings.
6. Some work (but no published research that I am aware of yet) indicates that women may benefit more from SBIRT than men.
7. Pregnant women typically want to ensure healthy outcomes for their baby- even when they are struggling with a severe substance use problem. This is an ideal time to help women change substance use and can benefit entire family units.

Best,
Bethany

Bethany C. Pace-Danley, BSW, MA
Program Manager, SBIRT in Colorado
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Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	
Email address:	
If submitting on behalf of an organization, provide organization name*:	Eugene S. Farley, Jr. Health Policy Center

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders:

The Farley Center works on behavioral health and primary care integration, community-based prevention, workforce, and payment reform. The challenges inherent to the opioid crisis touch on all of these focus areas and needed solutions exist across a spectrum from prevention to treatment.

With regard to treatment, behavioral health and primary care integration is critical to meet the needs of patients with substance use disorders. Medication Assisted Treatment (MAT) for opioid use disorder combines psychosocial treatment with medication; for primary care medical homes to be able to provide these services, there needs to be an adequate workforce of behavioral health clinicians to hire and payment that sustainably reimburses their work.

With regard to prevention, in addition to shorter-term strategies such as limits on opioid prescribing, it is important to recognize the value of long-term strategies such as evidence-based youth programs known to prevent substance use disorders.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Create public awareness campaigns on dangers of opioid misuse and stigma reduction around substance use disorders.

2. Integrate the Prescription Drug Monitoring Program into electronic health record systems and optimize automatic alerts to prescribers on concerning patterns of use.

3. Provide education to primary care practices on how to implement MAT including information on necessary training and how to bill for services.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)

1. Eliminate any insurance coverage limits for MAT and mandate insurance coverage of inpatient and residential treatment programs.

2. Increase funding for training programs for behavioral health professionals broadly as well as funding specifically for training of behavioral health and primary care clinicians for MAT.

3. Fund evidence-based youth programs in schools and communities known to prevent

substance use disorders.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Consider requiring education on safe opioid prescribing for all medical schools, nurse practitioner and physician assistant programs and incorporating buprenorphine waiver training into primary care residency programs.

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Chris Johnson
Email address:	Cjohnson@csoc.org
If submitting on behalf of an organization, provide organization name*:	County Sheriffs of Colorado

PROBLEM OR ISSUE
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: County jails that are experiencing unprecedented levels of opioid addicted detainees in the jails. How to get more tools, so to speak, to reduce the level of addicts coming back repeatedly to jail, and get them into treatment.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1.
2.
3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Overall providing more resources to the county jails would improve ability to create stability and healthy transition from incarceration. County Jails are limited in the resources accessible to them due to the criminogenic element with this population.
2.The addition of long acting Naltrexone to be funded under the Medicaid system for Colorado as a treatment option to help addicts maintain sobriety and helping keep them from returning to jail.
3. Establish treatment centers for "in custody" mental health individuals with chronic/persistent mental health conditions. CMHIP no longer is an option for county jails beyond competency and restoration.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
These suggestions are supported by the membership

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Anna Weaver-Hayes
Email address:	anna@coloradopsychiatric.org
If submitting on behalf of an organization, provide organization name*:	Colorado Psychiatric Society

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders:

The Colorado Psychiatric Society is concerned about the increased risk of unintentional overdose when a patient is prescribed a benzodiazepine and an opioid concurrently. We previously submitted a proposal form with additional details, but would like to suggest another recommendation that we have heard discussed. We are still gathering feedback from members on the recommendation below.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)

1. A mandatory check of the PDMP for first time users of controlled schedule II, III and IV substances, if adequate state funding is provided to ensure one-click availability to the PDMP database.

2.

3.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

*Note: If responding in behalf of an organization, please indicate if the suggested policy recommendations have already received support from organizational leadership or members

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Jade Woodard & Jillian Adams
Email address:	jwoodard@illuminatecolorado.org jadams@illuminatecolorado.org
If submitting on behalf of an organization, provide organization name*:	Illuminate Colorado & SEN Steering Committee

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Prenatal substance exposures, specifically Fetal Alcohol Spectrum Disorders, are the leading cause of preventable brain injury in children. Neonatal Abstinence Syndrome – newborn withdrawal from opioids – has increased in Medicaid claims 91% from 2012 to 2016. The Colorado SEN Steering Committee was established in 2008, as a subcommittee of the Colorado Substance Abuse Trend and Response Task Force. State and Federal Law both address prenatal substance exposure as a key issue for giving babies the healthiest start possible. The SEN Steering Committee prioritizes consistency in prevention, identification, and treatment - for women and their babies – across the state of Colorado.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Universal verbal screening of women during prenatal care (once every trimester), labor & delivery, postpartum visit, and early well baby checks using a validated tool with a consideration for the integration with a behavioral health screen
2. Infants should be discharged from the hospital with a (documented) plan of safe care, and depending on risk factors this may include a multidisciplinary care conference.
3. Additional research is needed on prevalence of prenatal substance exposures, tracking mechanisms, interactions between substance use and breastfeeding, child fatalities (safe sleep, abusive head trauma, & others), and child welfare involvement.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)

1. Expand access to substance use disorder treatment for pregnant women and women up to 12 months postpartum with considerations for women staying with their children, geography of providers, gender-specific treatment, and funding sources (Special Connections funding and private insurance coverage).
2. Revise the Children's Code to deemphasize the focus on testing and controlled substances in favor of identification of risk (including by not limited to testing).
3. Babies should be tested based on maternal and infant indicators for the purpose of promoting health and safety of the baby in the hospital and after discharge. Babies should be tested for prenatal exposure at the provider's discretion as part of standard medical care with the notification of the parent regardless of consent.
4. Implement universal access to a minimum of one home visit for everyone baby born in CO within one week from discharge.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

*All recommendations developed by the Substance Exposed Newborns Hospital Learning Collaborative, a project of Illuminate Colorado. Recommendations set to be vetted at a Substance Exposed Newborns Summit on November 2nd, 2017. An additional recommendation centers around the development of a toolkit & guidelines for hospitals and healthcare providers on prenatal substance exposure and substance exposed newborns issues, and engagement of professional associations to support implementation of recommendations.