Proposal categories

1. Clinical Practice (sub-divided into 5 categories)
    a. PDMP
    b. Provider Education
    c. SBIRT (Screening, Brief Intervention, Referral to Treatment)
    d. Patient/Public Education
    e. Other Clinical Practice (ie: number of opioids, days per prescription)
2. Safe Disposal
3. Law Enforcement
4. Harm Reduction
5. Workforce
6. Payment Reform
7. Treatment/Recovery Support
8. Funding coalition work
9. Other legislative
10. Other non-legislative

Clinical Practice

Sub-divided into 5 categories

PDMP

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Dr. Jason Hoppe
Email address:	Jason.hoppe@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	University of Colorado-Department of Emergency Medicine

PROBLEM OR ISSUE

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

1) Any policy limitation on controlled medication prescribing or required educational components for providers (which we are in favor of) should be accompanied by a plan to evaluate the impact of these interventions on patient care and outcomes. This should include evaluating PDMP use by providers and past/future use by patients in addition to hospitalizations, overdoses, treatment, etc.

1a) It's very difficult to get controlled medication (opioid, sedatives etc.) and provider PDMP use data from the PDMP for research purposes. We'll never know the true utility of the PDMP as a public health tool unless we have the capacity to evaluate its use and the associated outcomes on patients. Several groups in state, including the University of Colorado, have the capacity to do this in a way that protects patients and provider privacy, but are limited by issues with access to the information.

2) We are unable to tell specialty of prescribers for controlled medications. Providing prescribing feedback (e.g. unsolicited reports and provider report cards) to medical providers is not useful unless they are placed in context with comparable healthcare providers. i.e. emergency medicine physicians should be compared to other emergency physicians not oncologists or pain medicine providers.

3) DORA does a great job managing the PDMP with very limited resources. Consider moving the PDMP to CDPHE where there are more resources and tools to improve the utility and link to other ongoing state projects.

4) Unable to tell if prescriptions are for humans or pets. If our state is concerned about the contribution of veterinary medicine and people abusing pets to get controlled medications we need to be able to clearly track pet and link to owner.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Include a box for primary specialty on medical license registration that can be carried over to PDMP.

2. Include a box in PDMP for human vs. pet and if pet, owner's name.

3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Improve mechanism of (1) permission for and (2) data access for approved, bonafide public health research. This would include linking clinical hospitalization and emergency department visits with patient opioid use and prescriber PDMP use.
2. Our PDMP staff works hard with what they have but are woefully understaffed and has a tremendous amount of turnover when compared to other states. For the amount of time and money invested in the issue and the importance of the PDMP (both locally and nationally), PDMP staffing should be protected and supported to bring us up to national standards.
3. Consider moving the PDMP to CDPHE where there are more resources and tools to improve the utility and link to other ongoing state projects if money is not available to support the program at DORA.
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:	Frank Cornelia
Email address:	fcornelia@cbhc.org
If submitting on behalf of an organization, provide organization name*:	Colorado Behavioral Healthcare Council

PROBLEM OR ISSUE: Colorado PDMP utilization is low

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

Colorado's PDMP system has demonstrated potential as an effective tool to guide prescribing practices as well as the management of care for individuals who are at risk for a substance use disorder (SUD.) PDMP utilization is low in Colorado due to complexity of the system, limitations on providers, and perceived low worth. Increasing effectiveness and promotion will help take use of this tool to greater scale.

The following policy recommendations have received support from CBHC membership, specifically in the Managed Service Organization membership category.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. The committee should consider requesting a presentation from HCPF, or other State departments, to understand the implications of allowing State department access to PDMP data.
    a. Based on this information, the committee may consider legislation to allow HCPF access to PDMP data. Access to the PDMP by state Medicaid authorities is considered best-practice and is allowable in 35 other states.

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

1. Introduce legislation to examine the potential impact and costs associate with mandatory utilization of the system, integration into healthcare EHR systems, and increasing efficacy of the software.

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:	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. Benzodiazepines like alprazolam, diazepam and lorazepam (Xanax, Valium and Ativan) are present in about 1 in 3 fatalities attributed to opioids, and opioids are present in 77.2% of deaths involving benzodiazepines.[i] This is partially because both benzodiazepines and opioids are central nervous system depressants that can compromise the respiratory system, resulting in an increased risk of death when combined.

The reality of this risk was underscored by an experience one of our members had recently. This psychiatrist had prescribed a patient 1mg klonopin to take twice daily. Upon checking the PDMP at a previous visit, the psychiatrist learned the patient had been placed on buprenorphine (suboxone, a partial opioid) for chronic pain by another physician due to previous history of misuse of prescription opioid pain medication. At the next visit, the psychiatrist decreased the dose of the klonopin to 0.5mg in the morning and 1mg in the evening due to risk of combining buprenorphine and benzodiazepine. When the patient came for a refill on the klonopin, the psychiatrist checked the PDMP again, where she discovered that patient had recently seen a new physician who had subsequently prescribed klonopin 1mg three times a day as well as more than 50 morphine milligram equivalents (MMEs) of oxycodone. Had the physician checked the PDMP database, he would have known the patient was recently prescribed klonopin by his psychiatrist and had a significant history of prescription opioid misuse. Thankfully, the psychiatrist did check the PDMP before refilling the prescription which enabled her to appropriately manage the patient and mitigate his high risk of unintentional overdose; she obtained a release of information to speak with the new physician about the patient's medications and provided the patient and his family with naloxone (narcan) script and education.

The CDC Guidelines state, "Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as . . . higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present."[ii] Mandatory use of the PDMP would ensure prescribers have the knowledge to follow these guidelines.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1.
2.
3.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Mandatory use of PDMP – require prescribers to check the PDMP when prescribing a first refill of opioids or benzodiazepines and intermittently thereafter, if adequate state funding is provided to ensure seamless or 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

---

[i] Jones, C.M., Mack, K.A., Paulozzi, L.J., 2013. Pharmaceutical overdose deaths, United States 2010. JAMA 309, 657–659.

[ii] Errata. Vol. 65, No. RR-1. MMWR Morb Mortal Wkly Rep 2016;65:295. DOI: http://dx.doi.org/10.15585/mmwr.mm6511a6

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Angela Bonaguidi
Email address:	Angela.Bonaguidi@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Treatment for Opioid Dependence (COTOD)

PROBLEM OR ISSUE

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

Colorado Opioid Treatment Programs are required to submit patient registry information to the Colorado Department of Human Services, Office of Behavioral Health, for patients on methadone or buprenorphine products administered onsite. At present, the patient registry (Central Registry) is managed by the Office of Behavioral Health by a local Microsoft program and staff member. There is a significant barrier to treatment when the individual is out of office, or the program is not working properly. As a result, individuals are forced to wait hours to days to enter treatment.

In 2013, there was a sunset review conducted on the Colorado Licensing of Controlled Substance Act, where an online system was recommended:

This Recommendation 4 is very similar to Recommendation 3. They both suggest facilitating access to centralized information, helping achieve the program's mission by preventing drug diversion, and making the treatment system more efficient.

To prevent drug diversion, OBH has instituted a central registry where all patients enrolled in treatment programs are listed. Prior to admitting a prospective patient to treatment, the treatment facility is required to submit information to OBH in —formats acceptable.‖ No patient can be admitted to treatment when the registry shows him or her currently enrolled in another treatment program. The —formats acceptable‖ are a hard copy of a document that is faxed by the treatment facility to OBH.

This is an antiquated way of doing business and has caused problems. For example, if OBH is closed due to bad weather or holiday, or staff is unavailable there is no way to get rapid access and approval. The only way to know if a patient is enrolled in another program is to call every other program in the state, ask if the individual is enrolled there, or turn the patient away until clearance can be confirmed. When that happens there is risk to the patient and the public. If a patient is turned away, there is no guarantee he or she will return.

The solution is to develop a secure online system to register individuals and verify eligibility for enrollment. The system should only be accessible to licensed facilities. This is similar to the PDMP database. Placing the central registry online will ensure that regardless of the circumstances, an individual will be enrolled in treatment regardless of any bureaucratic logjam.

An online system will also create administrative efficiencies because agency labor will be minimized. There will no longer be a need to have a person physically collect hard copies, record and file the information, and then access the information when it is requested. OBH can merely direct facilities to input and update the information as necessary.

As a result, the General Assembly should direct OBH to provide secure online access to the central registry.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
2.
3.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. The Colorado Department of Human Services, Office of Behavioral Health must create and maintain an online registry for Colorado Opioid Treatment Programs.
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:	Robert Valuck
Email address:	robert.valuck@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Consortium for Prescription Drug Abuse Prevention

PROBLEM OR ISSUE

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

The Colorado Prescription Drug Monitoring Program (PDMP) could be more useful to clinicians and to the state of Colorado, if a few changes were made to how it functions.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Encourage Providers (prescribers and pharmacists) to check the PDMP for every controlled substance prescription, for all patients.
2.
3.

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

1. Give DORA (Quad Regulator Boards) the authority to add additional drugs to those that are tracked/monitored in the PDMP: these include naloxone, gabapentin, muscle relaxants (carisoprodol, cyclobenzaprine), and non-benzodiazepine sleeping medications (zolpidem, eszopiclone, etc.).
2. Require DORA (PDMP Program) to send provider "report cards" to all opioid prescribers in Colorado, showing them their prescribing patterns relative to their peers and to all physicians in Colorado.
3. Fund (systematically or by incentives) connections between Electronic Health Record (EHR) systems and the PDMP, to improve work flow and ease of PDMP checking for prescribers.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

If the PDMP can be made easier to use, and integrated into the physician's work flow, then mandatory PDMP checking may be supported more broadly.

*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:	Marjorie Zimdars-Orthman
Email address:	mzorthman@comcast.net
If submitting on behalf of an organization, provide organization name*:	Although, members of the PDMP work group know I am in favor of better funding, this proposal has not been discussed.
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Prescription Drug Monitoring Program database and software sustainability is the challenge. When the current CDC funding and other grant funding ends in approximately 2 years, how will DORA sustain it. Fees from doctor licenses can only be raised by small increments, and a significant percentage of doctors rarely have a need to consult the PDMP. Ongoing enhancements to the software, software maintenance, improvements in software and database design, reporting needs of DORA and CDPHE and the continuing work and needs of Electronic Health Record integration will not have adequate funding.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Legislature should fund an OIT position for DORA for the PDMP software database reporting and design needs of DORA and CDPHE and a help desk for users instead of relying almost totally on the outside contractor. If there are restrictions in place regarding DORA able to have a funding line in their budget for this program, pass the approval for an exception.	
2. Impose a $ 0.10 tax on all Controlled Substance prescriptions or a $ 0.25 tax on opioid prescriptions to have funds for the sustainability and proper functionality of the PDMP database.	
3. Have a permanent annual allocation from the marijuana tax fund to provide some of the funding for the PDMP.	
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE	
It is important to have database and data reporting expertise within state government for the agency that is responsible for this program. This software is too important to have just a revolving door of software contract employees. This software application is undergoing industry acquisitions and keeping continuity of service with inhouse expertise is advisable.	

*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:	Diane Rossi-MacKay
Email address:	Diane.RossiMacKay@cha.com
If submitting on behalf of an organization, provide organization name*:	Colorado Hospital Association
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders:	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. The Prescription Drug Monitoring Program (PDMP) should be adequately resourced so that the system can be more readily integrated into electronic health records in facilities and medical offices statewide. The State of Iowa now has full integration of its PDMP with Electronic Health Records (EHRs), the Health Information Exchange (HIE) and its Pharmacy Dispensing Systems (PDS) and could serve as a model for Colorado. Additional information on PDMP Best Practices can be found at the Prescription Drug Monitoring Program Training and Technical Assistance Center- http://www.pdmpassist.org/.	
2. Health insurance products regulated by the Division of Insurance should be required to include the drug Naloxone – or same-class alternative – in their formularies to increase access to high-risk patients.	
3. Federal law requires parity in treatment for both physical and behavioral health care needs, including pain management and substance abuse treatment. The Division of Insurance should improve enforcement of this requirement.	
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE	
1. Encourage the state to provide resources for needle exchange programs for communities who support them. **2.** Increase access to care via MAT programs through workforce development, uniform coverage of care, and reduction of regulatory burdens.	

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Currently, third-party insurers and health plan sponsors may only have access to data for prescriptions they have paid for, but not for patients who pay out of pocket, creating a blind spot for payers who are trying to help by monitoring their data.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change) **The Quad Council to mandate prescriber education initiatives to enhance prevention efforts**	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Authorize all payers access to the PDMP data, which could bolster efforts and foster collaboration with states as strategic partners to prevent abuse and misuse.	
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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
1. Insufficient utilization of PDMP by prescribers which enables patients to "doctor shop" for prescriptions and/or increase the risk for overdose if a patient is prescribed opioids, skeletal muscle relaxers and benzodiazepines at the same time.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Mandate prescribers consult the PDMP before writing a prescription, which could flag a patient who is making appointments with multiple prescribers and/or mitigate circumstances in which a patient is prescribed opioids, skeletal muscle relaxers and benzodiazepines at the same time	
2. Mandate state medical boards use PDMP data to monitor prescribing practices and intervene when they see outliers.	
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

Provider Education

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Richele Mein, MPT
Email address:	richelemein@gmail.com
If submitting on behalf of an organization, provide organization name*:	Professional – Physical Therapist/Community Member directly affected by opioid related death of an adolescent

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Too many adolescents are being prescribed opioids following sports related injuries and oral surgeries, such as wisdom teeth extraction, **without the proper education** needed to help prevent misuse, addiction and overdose. For many adolescents this is their first exposure to opioids, and due to their lack of frontal lobe development, puts them at a higher risk for misuse and addiction based on their age alone. Now that we know nearly half of all *opioid overdose deaths* involve a prescription opioid and that misuse of prescription pain meds can lead to heroin addiction, we need to take every step possible to educate parents and their children about opioids. Because one child lost to opioid addiction or death, is one too many. Every doctor or dentist prescribing an opioid to an adolescent or child for **acute pain** should be required to provide educational material on proper use and disposal of these medications. In turn, parents should be required to sign an acknowledgement of receipt of these educational materials. The goal being: To create a program to require health care workers who prescribe opioid pain medications to adolescents to adequately inform their patients that they are being prescribed an opioid; are offered non-opioid and/or non-pharmacological alternatives for pain management; are being questioned to determine if there is an increased risk of addiction due to family history or circumstances involving their injury (ie. depression caused by no longer being able to participate in a sport due to injury); educated on discontinuing use of their pain medication when pain is no longer present; educated on the proper storage and disposal of unused pain medication; understand the legal issues around giving, selling or sharing prescription pain meds.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Require all prescribing physicians of opioid pain medication for acute conditions to educate adolescent patients and their parents regarding proper use of opioid pain medications so that parents and their child: 1) know that they are being prescribed an opioid, 2) understand that opioids can be addictive and can have serious consequences when used with other drugs and alcohol 3) are offered non-opioid and non-pharmacological alternatives for pain management, 4) are being questioned to determine if there is an increased risk of addiction due to family history or circumstances involving their injury (ie. depression caused by no longer being able to participate in a sport due to injury), 5) are educated on discontinuing use of their pain medication when pain is no longer present, 6) are educated on the proper storage and disposal of unused pain medication, 7) understand the legal issues around giving, selling or sharing prescription pain meds.

2. Create a multi-lingual informational handout, brochure or video and require all adolescent patients and their parents who have been prescribed an opioid pain medication to read, listen, or watch educational material regarding the proper use, risks, alternatives, storage and disposal relating to prescription pain meds and signing an acknowledgement of receipt of these educational materials.

3. Create a campaign to increase community knowledge of names of common medications that contain opioids, their effects, side-effects, non-pharmacological alternatives for pain management, proper storage and disposal, legal issue related to the selling, giving, and sharing of prescription pain medications so all parents can make informed decisions regarding proper care and treatment for themselves and their children.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1.
2.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Great policy changes are being made to combat the opioid crisis in the State of Colorado. However, we still have a long way to go when it comes to community education and outreach. Too many of our youth and young adults who have been prescribed pain medications following sports related injuries or wisdom tooth extraction, become addicted to opioids. We need to address this problem by **requiring** all prescribing physicians to educate their adolescent patients and families on the proper use and disposal of opioids. So much of our focus is on treatment but not enough is being done on community education and prevention. The end of opioid addiction, starts in the doctor's office.

*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:	Mike Koons
Email address:	Mike.koons@pinnacol.com
If submitting on behalf of an organization, provide organization name*:	Pinnacol Assurance

PROBLEM OR ISSUE

Pinnacol Assurance is a workers' compensation carrier and opioids are a major problem in workers' compensation. Much of this stems from the fact that WC concentrates on treating a very high percentage of acute musculoskeletal injuries that are painful and for which many prescribers are likely to introduce patients to an opioid prescription.

- The gravity of the situation is evidenced nationally by observing that injured workers who are prescribed even one opioid have average claim costs that are 4x greater than similar claims from workers who are not prescribed opioids (National Safety Council. www.nsc.org/learn/NSC-Initiatives/Pages/prescription-painkillers-for-employers.aspx).
- An injured worker who receives more than a one-week supply of opioids soon after an injury doubles a worker's risk of being disabled one year later (Ibid.).
- Opioids - including OxyContin - account for a whopping 17.4% of all prescriptions written for injured workers in Colorado (NCCI presentation titled: By the Numbers: Opioid Use in Colorado, presented April 19th, 2017 by Raji Chadarevian and Susan Schulte).
- Finally, during the second quarter of 2017, a remarkable 44.9% of Pinnacol's injured workers who received a prescription, received an opioid prescription (Internal Pinnacol data on opioid prescribing; compiled August 2017).

The workers' compensation statutes in Colorado stipulate that carriers may not "direct" care. In practice, this means that if a workers' compensation insurer attempts to steer a patient to receive a particular course of treatment, the Division can fine them if the Division determines that treatment is not explicitly allowed under existing statute and rules. The current tools deployed by Pinnacol have been helpful to impact appropriate utilization of opioids, but they are predominantly voluntary and have not had sufficient impact.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
These recommendations have received support from organizational leadership

1. Opioid prescribing limitation of 7 days for initial prescriptions in the setting of acute pain (definition to be determined by the committee). In this context, we recommend the use

of short-acting opioids only for initial prescribing in the setting of acute pain. Exemptions (to be worked on at a later date) would include (chronic pain, cancer pain, palliative care, and sickle cell anemia).
2. Mandatory, high-quality provider education (definition to be determined at a later date). A few examples would be: (1) practical advice about how to deal with counterproductive patient expectations, and (2) the provision of useful, easily actionable information related to weaning opioids and providing alternative, non-opioid therapies for acute and chronic pain.
3. Mandatory use of the PDMP at intervals that make sense given the realities of clinical practice (i.e. initial evaluation, prescription refill, every 90 days, etc.).
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
At Pinnacol, we believe the key to success in this fight is prevention, not creating and then having to solve the problem afterwards, so the most effective policy changes will focus on preventing the problem rather than treating it after the fact. By implementing restrictions on opioid-prescribing for medical practice in general, all Colorado residents will benefit from a direct, precise, and proactive way of preventing their initial exposure to narcotics which, in the vast majority of instances, are not only inappropriate as first-line treatment, but also serve as the gateway to potential addiction. Finally, a uniform approach to prescribing limits, provider education, and PDMP use across the State has advantages for providers who will otherwise be burdened by a patchwork of confusing rules and regulations. A uniform approach will also help ensure that all Colorado residents reap the benefits.

*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:	Brad Young
Email address:	brad@rxplus.com
If submitting on behalf of an organization, provide organization name*:	RxPlus Pharmacies, Inc.
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: The challenge is to dispense prescribed opioids while minimizing the danger of opioid abuse.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. RxPlus Pharmacies recommends that the State of Colorado consider adopting a practice recommendation for prescribers. An initial opioid prescription should be limited to a minimum number of days. The practice recommendation should state that prescribers may provide multiple prescriptions that are predated to be filled at future dates. Each prescription should be filled at the same pharmacy as the original fill. This proposal is based on a procedure that is currently used by some prescribers and pharmacies to address patient needs while minimizing the distribution of unnecessarily dispensed opioids.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.	
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:	Charles Sheffield
Email address:	csheffield@colohealthplans.org
If submitting on behalf of an organization, provide organization name*:	Colorado Association of Health Plans

PROBLEM OR ISSUE

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

If a patient receives a prescription for opioids from a prescriber who is not part of the plan's provider network, the plan may not be aware that the patient is receiving that particular prescription.

Plans must also balance the priority of minimizing the burden placed on a patient to fill a prescription with the desire to limit the amount of medication a patient receives, especially on initial fills. In other words, a limit on the amount of opioids a patient may receive in any given prescription may require that patient to visit the pharmacy more often to receive subsequent refills. For patients who are recovering from operations, or for individuals who may not live nearby a pharmacy, this can add significant burden to refill prescriptions. Additionally, depending on the benefit design of the patient's health coverage plan, this may add more monetary costs to the consumer as well.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Encourage prescribers to regularly refer to the PDMP when writing new prescriptions for opioids, especially for new patients or for patients with whom they do not have an established relationship.

2. Encourage follow-up with a patient who receives an opioid prescription to ensure proper medication adherence and to screen for early signs of developing dependency.

3.

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

1. If regulating the amount of opioids a patient may receive with a prescription, minimize the cost to patients and plans by allowing a single dispensing fee to apply to full course of treatment.

2. Establish a new set of criteria by which prescribers and dispensing pharmacies would be required to check the PDMP for indications of over-prescription or "doctor shopping."

3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Ensure all stakeholders have adequate time to fully review and respond to any policy proposals. Be cognizant of the administrative costs and implementation timelines for any new policies. Place priority on evidence-based strategies that minimize costs to consumers.

*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:	Katie Wolf
Email address:	kewolf@michaelbeststrategies.com
If submitting on behalf of an organization, provide organization name*:	Colorado Pharmacists Society – Taskforce Representatives Gina Moore & Jeff Llama

PROBLEM OR ISSUE

Pharmacists are responsible for all prescriptions they dispense. Federal controlled substance laws are clear that pharmacists have a corresponding responsibility to ensure controlled s reubstance prescriptions are for a legitimate medical purpose. Pharmacists want to ensure patients with legitimate opioid prescriptions receive their medications as expeditiously as possible and appropriately counsel patients on safe use of medications. Because of the opioid epidemic, pharmacists must often obtain additional information from the prescriber and/or patient to verify the legitimacy of controlled substance prescriptions. Diagnosis codes, limiting prescription quantities, and encouraging the use of e-prescribing all enable the pharmacist to work collaboratively with physicians to ensure appropriate patients receive appropriate quantities of pain medications.

Another issue pharmacies and pharmacist face is the lack of registration of technicians in Colorado. Without registration and training standards, we can easily have an individual working in our pharmacies with a previous controlled substance conviction that is difficult to identify and track. If diversion did occur, it would increase the amount of illegitimate drugs available on the street and put the license of the pharmacist at risk.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Mobilize pharmacy students in a naloxone awareness and training campaign

2. Restrict to one prescriber and one pharmacy: Patients that do need chronic opioids should be ideally be restricted to one prescriber and one pharmacy with all parties have a stake in the pain contract. Pharmacists have the documentation they generally need, and all parties know the rules around ongoing medication provision (More than 90 days use = one patient, one doctor, one pharmacy). If this was implemented, there would need to be an easy way to identify and track which patients are enrolled with a pain contract; or would require the pharmacists to also have pain contracts with patients to ensure they're only using one prescriber and one pharmacy.

3. Public awareness of where drug take-back receptacles are: Encourage better public awareness of where drug take-back receptacles are. Encourage pharmacies to share that information with their patients.

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

1. Require a diagnosis on opioid prescriptions. Pharmacists have a "corresponding responsibility" to ensure a controlled substance prescription is for a legitimate medical purpose, yet are often in a difficult position as they may not have access to the patient's medical record and diagnosis. To add to that, the prescriber and patient unaware of the pharmacist's responsibility, which may lead to misunderstandings when a pharmacist needs to call a prescriber for additional information or seek additional information

from the patient. Listing a diagnosis (or ICD-10 code?) on controlled substance, especially opioid, prescriptions may help eliminate unnecessary calls and ensure patients that do need the medication obtain it more easily
2. Pharmacy technician registration: One of the easiest ways Colorado could help diversion of opioids and other controlled substances would be the registration of pharmacy technicians. Currently Colorado is only one of five states that do NOT require any regulation over pharmacy technicians, and therefore there are no standards for education or training. This is an easy and fairly inexpensive way to help limit, or catch, any diversion that might be taking place currently.
3. Increase e-prescribing CII prescriptions: E-Prescribing CII prescriptions more commonly may allow smaller quantities to be prescribed initially, and an additional quantity be made available if necessary. Opioids prescriptions are often written initially for a quantity of 30 (or more) to make sure the patient has ample amounts, but that often leads to patients mistakenly thinking they need to take that quantity or patients taking one or two tablets, then having a lot of unneeded medication sitting in patient's home, which we know often leads to that medication in the hands of someone other than for whom it was prescribed. If we can drive adoption of e-prescribing, that may be a better situation than partial fills, which is a good idea, but problematic in terms of how it is implemented, due to conflicts with federal regulations and computer system limitations.
4. Limit to 7 days' supply: Limiting the days supplied for opioid prescriptions written for the treatment for acute pain (such as surgical pain or an injury). For instance, the initial prescription could be written for 7 days. An additional prescription could be written if the patient is still experiencing pain for an additional 7 days.
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:	Brad Evans, RN, MSN, CHPN
Email address:	palliativebrad@aol.com
If submitting on behalf of an organization, provide organization name*:	Hospice and Palliative Nursing Association (HPNA) – Position statements approved by board of directors in 2017 and 2012. HPCAR

PROBLEM OR ISSUE

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

With increasing media portrayal of a "crisis" or "national emergency" regarding opioid overdose deaths, the public perception of opioids continues to be a negative one. Neither the general public nor the medical professional have been immune from controversy, scandal and tragedy surrounding opioids.

In my nursing practice I routinely encounter patients and families with a "never" attitude when it comes to the use of opioids in their care. Others have used opioids appropriately for decades without apparent negative sequelae. I am encountering an increasing number of diversionary situations in homes and facilities with regard to opioids; they are sought out by those seeking.

The specialty of palliative care nursing - helping people live with chronic illness, and particularly the aspect of hospice care surrounding the end of life, is one skilled in the appropriate use of opioids for symptom management of pain and shortness of breath. As public opinion and thus policy changes occur, it is imperative patients who need opioids to achieve quality of life or who need palliation of symptoms in their final hours have access to them.

The Hospice and Palliative Nursing Association (HPNA) offers nursing practice guidance in decision making through their position statements regarding opioids: *"Pain Management"* and *"The Ethics of Use of Opioids in Palliative Nursing"*. *"Pain Management"* identifies opioids as a necessary tool when non-opioids are not effective. It describes patient and family aversion to opioids related to "irrational fears of addiction" and "lack of access to opioids" as **reasons pain is under-treated**. The position statement identifies uncontrolled

pain as an "emergency with all healthcare professionals taking responsibility to provide relief". Particularly relevant today, the statement advises "The need for regulatory control of opioids must be balanced with access to opioids for all who need them".

"The Ethics of Use of Opioids in Palliative Nursing" position statement addresses public concerns of risk respiratory depression, harm, and overdose-style deaths when opioids are used. Key points of note in the statement include "There is broad consensus among professional groups, ethicists, courts, and many state legislatures that clinicians have a duty to administer opioids for symptom relief to patients at the end of life" including those with "active or a history of substance abuse". It suggests opioid administration at end of life is "consistent with widely accepted ethical and legal principles", and that "hospice and palliative nurses and organizations must ensure access to opioids for those at end of life".

We see the essential role opioids can play in providing comfort and symptom relief to those with chronic illness and at end of life. We owe it to those who are suffering to allow access to opioids while at the same time reducing risk of harm in the community.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Follow established guidelines for the use of opioids in symptom management (WHO, AMA, AAHPM, HPNA, etc.)

2. Continue educating patients and families about the appropriate use of opioids, tolerance, dependency, and addiction. Medicare COPs require discussion of policies regarding management and disposal of medications at the time they are first ordered (couldn't find this specific rule to tag at CMS today).

3. Provide secure dispensing devices, lock boxes, subscription refills to patients and families for those situations where drug diversion is a risk or is known.

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

1. Legislation to indemnify palliative care organizations for putting opioids in the community if they are not disposed of at time of patient's death with family/MDPOA acknowledgement.

2. Consider ways to reuse unopened, unexpired medications – In 2007 it was estimated waste of unused medications totaled $1 Billion (Stat doesn't identify US or globally). Reference:

   https://nurseslearning.com/courses/hpna/meddisposalissuesinhospice/meddisposal.pdf

3.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

Links to HPNA position statements:

http://hpna.advancingexpertcare.org/wp-content/uploads/2015/08/Pain-Management.pdf

http://advancingexpertcare.org/wp-content/uploads/2017/07/Ethics-of-Use-of-Opioids-in-Palliative-Nursing.pdf

*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:	Angie Baker, CCPC Lobbyist Nikki Price, RPh, CCPC Opioid Committee Task Force Chair
Email address:	bakerpublicaffairs@gmail.com Nikki.price@albertsons.com
If submitting on behalf of an organization, provide organization name*:	Colorado Chain Pharmacy Committee (c/o Colorado Retail Council)
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: CCPC members operate 700 + retail pharmacies in the state of Colorado. As such, our members serve the largest number of Colorado patients for their pharmacy care. Chain pharmacies have created a variety of extensive and robust loss prevention and internal security systems to ensure that prescription drugs are accounted for every step along the way to stem opportunities for diversion, support law enforcement efforts to see that perpetrators are brought to justice, support Colorado's efforts to create a robust PDMP, among other efforts to address patient education, etc. Our members take their role in helping to ensure safe use of medications very seriously but they cannot do it alone.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. **E-prescribing:** The Colorado Chain Pharmacy Committee supports mandatory electronic prescribing. E-Prescribing offers much more protection from diversion opportunities than the current system of paper and oral prescriptions. Electronic controlled substance prescriptions cannot be altered, cannot be copied, and are electronically trackable. With systems in place in other states, the DEA rules for electronic prescribing of controlled substances puts in place strict security measures, such as two-factor authentication, that reduce the likelihood of fraudulent prescribing.	
2. **Limited Fill Prescribing:** The Colorado Chain Pharmacy Committee supports limiting initial fills for controlled substances. We support such laws that are standardized with respect to the day supply limit duration (ex., 7 days, the type of prescriptions subject to the limit, and	

exemptions for prescriptions for the treatment of certain medication conditions: palliative care, cancer care, etc.)
3. **Take Back and Disposal of Consumer Unused Medications:** The Colorado Chain Pharmacy Committee supports legislative efforts that will enhance and offer more support for the safe and effective disposal of unwanted consumer medications, including controlled substances. It is important for patients to have a wide variety of options for how they can dispose of their unused medications and pharmacies need the flexibility to create programs that best serve the needs of their patients.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
These policy recommendations have received support from organizational leadership and members.

*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.

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Jennifer Goodrum
Email address:	jennifer@cdaonline.org
If submitting on behalf of an organization, provide organization name*:	Colorado Dental Association

PROBLEM OR ISSUE

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

- Common prescriber of opioids to treat dental pain (among top 3 prescribers of opioids). Most dental pain is short-term, acute pain (abscess, extractions, gum surgeries, etc.), but some more infrequent cases (trauma/facial reconstruction, trigeminal neuralgia, etc.) may require long-term or chronic pain management.
- There are not consistent medical protocols around treatment of acute pain, leaving much variance in practice behaviors among providers. There is concern that overprescription may lead to leftover opioid doses that may later be abused.
- Dentists are often not well equipped to manage drug-seeking patients, including SBIRT protocols and connecting with resources to aid the patient.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Develop practice consensus and consistent protocols around management of acute pain (including full normalization of utilizing non-opioid pain management techniques and limiting prescribing of opioids to minimum quantities)

2. Consider non-opioid methods of pain mitigation where possible, and strongly consider limiting opioid prescriptions for opioid naïve patients with acute conditions (3-7 days)

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

1. Update and streamline the programming of the PDMP system to make it easier for prescribers to effectively utilize the program (needs funding)

   a. Fully integrate the PDMP within common medical and dental electronic medical records platforms to promote better efficiency, and ultimately utilization of the PDMP (note that dental EMRs are not the same as medical EMRs)

   b. Create a secure application that can be accessed via mobile phone to enable providers to check the PDMP with afterhours requests

   c. Create better mechanisms within the PDMP to identify patients that need help and get intervention/treatment resources to that patient – perhaps a way to "flag" patients of concern (with someone authorized to conduct followup), or information/training resources for providers within the system on how to best help a patient of concern (currently there is no easy next step within the system for a provider who identifies a patient of concern)

2. Work with the Colorado Dental Board on rule changes to require certain CE hours as part of dental license renewals on best practices in pain management and opioid prescribing, as well as

SBIRT options for patients of concern
3. Consider a standard policy recommendation/limitation (perhaps in the quad board regulatory policy) on what quantity of medication should be prescribed for a non-established patient calling a provider to seek an immediate prescription for pain relief related to an acute condition (weekends, after hours) – or perhaps even new patients who decline treatment in lieu of pain medication. Establishing a standard protocol in these cases may help address practical business-related concerns of providers who receive poor business reviews (social media, etc.) from (often known) drug-seeking patients that are refused prescriptions for narcotics. If there is a rule or guidance that a prescriber can point to and a standard is uniformly applied, this may give providers a backstop to limit prescribing and limit blowback. A standard of this nature would need to be crafted with great care (and likely some exceptions) to avoid keeping non-drug seeking patients with acute conditions that cannot be immediately treated in substantial pain.
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:	**Katie Wolf**
Email address:	kewolf@michaelbeststrategies.com
If submitting on behalf of an organization, provide organization name*:	**Colorado Academy of Family Physicians – Taskforce designees: Dr. Jantz & Dr. Watchl**

PROBLEM OR ISSUE

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

Family physicians find themselves at the crux of the issue, balancing care of people who have chronic pain with the challenges of managing opioid misuse and abuse. Pain is one of the oldest challenges for medicine. Despite advances in evidence and understanding of its pathophysiology, chronic pain continues to burden patients in a medical system that is not designed to care for them effectively. Opioids have been used in the treatment of pain for centuries, despite limited evidence and knowledge about their long-term benefits, but there is a growing body of clear evidence regarding their risks. As a result of limited science, external pressures, physician behavior, and pharmacologic development, we have seen the significant consequences of opioid overprescribing, misuse, diversion, and dependence.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Patient Video on Opioids: An orthopedic surgeon in California has had success in developing youtube videos about opioids that he requires all his patients to view. This has helped him dramatically scale back his opioid prescribing (almost never giving more than 6 pills after surgery). We discussed producing a video that CAFP members or any primary care doc could use with patients. https://www.youtube.com/watch?v=7b6yrgSnvgg

2. Explore developing guidelines around "acute" prescribing best practices for family physicians specifically.

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

1. Fund a substantial public health campaign to change public/patient/provider views on appropriate use of opioids

2. Eliminate barriers to non-opioid adjuvants (e.g. provide insurance coverage by insurance)

3. Support recommendations submitted by the Colorado Medical Society.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

In the face of this growing crisis, family physicians have a unique opportunity to be part of the solution. Both pain management and dependence therapy require patient-centered, compassionate care as the

foundation of treatment. These are attributes that family physicians readily bring to their relationships with patients. While our currently fragmented health care system is not well-prepared to address these interrelated issues, the specialty of family medicine is suited for this task.

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
1. Knowledge deficit among prescribers regarding effective pain management strategies, including how to prescribe opioids safely 2. Knowledge deficit among medical providers regarding screening for addiction and knowing what to do if a patient has become dependent on substances or presents with a substance use disorder	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change) **The Quad Council to mandate prescriber education initiatives to enhance prevention efforts:**	
1. Develop core competencies related to opioids and SUDs that all graduating students are expected to learn and put into practice (including how to screen for addiction and what to do if a patient presents with a SUD)	
2. Expand continuing medical education requirements for opioid prescribers and dispensers	
3. Require prescribers to discuss the risks of opioid dependence with their patients prior to the first prescription	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.	
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

SBIRT

(Screening, Brief Intervention, Referral to Treatment)

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Elizabeth M. Pace
Email address:	Epace@peerassist.org
If submitting on behalf of an organization, provide organization name*:	Peer Assistance Services, Inc. August 25, 2017

PROBLEM OR ISSUE

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

From a public health perspective, the 25% percent of the adult population that misuses alcohol accounts for the majority of the problems that result from alcohol in our society- more than the far smaller percent of individuals- approximately 4-5% with a severe alcohol use disorder. Alcohol misuse is by far our most prevalent substance use problem in the United States.

- An evidence-based response is Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent substance use, and severe alcohol, marijuana prescription and illicit drug use disorders. SBIRT is a prevention service that is recommended routinely in health care settings.
- SBIRT was initially developed to address alcohol misuse and is now also applied to marijuana, illicit substance use (e.g., heroin) and to nonmedical use of prescription medications such as opioids. SBIRT helps clinicians identify an individual patient's level of substance use ***before*** they prescribe opioids or other medications that carry a high risk for misuse or could result in serious interactions between alcohol or marijuana and prescription medications.
- Alcohol screening and brief intervention is one of the most effective preventive services for prevention of death, injury and disease and one of the most cost-effective services to deliver – yet has still not been widely adopted in health care settings.
- Less than one in six U.S. adults report that a health care professional has discussed alcohol with them. SBIRT increases patient and provider awareness about the preventable health issue of alcohol and drug misuse and encourages patient-directed behavior change.
- The overall goal is to establish SBIRT as a universal, routine preventive service in adolescents and adults to help prevent acute health effects such as injuries, violence, suicide, and chronic health effects including hypertension, weight gain, cardiovascular disease, cancer, and severe substance use disorders.
- SBIRT is a public health approach that addresses the full continuum of prevention including , primary prevention to prevent substance use disorders, secondary prevention to intervene earlier to reduce negative consequences of substance use, and tertiary prevention to engage individuals with more severe substance use disorders in effective treatment and recovery services. .
-

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Promote widespread implementation of SBIRT in health care settings including health care services provided in criminal justice settings for adolescents and adults and in schools and college health settings.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Enhance funding for SBIRT training for health and mental health professionals statewide; including technical assistance, and consultation to providers, healthcare organizations, and stakeholders; coordinated with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; with the goal of universal screening across the state in primary care practices, emergency departments, FQHCs, school based health centers, etc.
2. Expand on-line training capacity through the use of simulated alcohol and drug use modules – a no cost opportunity to learn the basics of SBIRT; including videos and virtual patient simulations for pharmacists, dentists, nurses, physicians, mental health clinicians, and others; promote utilization of online and in person training in health professions training programs for nurses, physicians, social workers, physician assistants and other professions.; promote use in rural and frontier areas where access to in-person continuing education is more limited.
3. Expand funding for current and other statewide public awareness campaigns for Coloradans to promote conversations about alcohol and other substances in order to help prevent substance use disorders, avoid diseases and injuries, improve family and work life, and promote overall well-being.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
The utilization of the SB16-202 funding mechanism has considerable merit. This includes support of the continuum of care, prevention, early intervention, treatment, and recovery. This will serve to decrease substance use and the associated cost to the workplace, healthcare, and society as a whole. Going forward, this is a viable model for the field.

*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:	Daniel Darting
Email address:	ddarting@signalbhn.org
If submitting on behalf of an organization, provide organization name*:	Signal Behavioral Health Network (SUD MSO for NE Colorado, Metro Denver, and SE Colorado)

PROBLEM OR ISSUE
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Prevention is a critical area of need to push back the opioid and substance use crisis. Adolescence, in particular, is a period of life where substance misuse and abuse takes root for many people. Additionally, prevention strategies (such as SBIRT) aimed at integration with existing primary care to identify and link behavioral health needs earlier and more synergistically, is critical.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1. Participation in the PDMP should be expanded.
2. Awareness of the need for prevention focused on adolescents should be expanded and invested in.
3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Participation in the PDMP should be expanded and a review should be made as to the feasibility of requiring participation Statewide.
2. Enhance funding for SBIRT training for health and mental health professionals statewide; including technical assistance, and consultation to providers, healthcare organizations, and stakeholders; coordinated with primary care, mental health, integrated health care, and substance use prevention, treatment and recovery efforts; with the goal of universal screening across the state in primary care practices, emergency departments, FQHCs, school based health centers, etc. A vehicle for funding is the SB16-202 action plan and budgetary process, which directs the State's SUD Managed Service Organizations (MSOs) to invest in prevention (as well as treatment and recovery). SB202 has already invested in SBIRT expansion with rural clinics in the Northeast and Southeast Colorado. But much more is needed.
3. Consider investing in SBIRT via online trainings to reach a larger workforce. Additionally, consider if this training could be coupled with Medication Assisted Treatment (MAT) curricula to expand the prescriber base across Colorado.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Please note that these recommendations have the full support of Signal Behavioral Health Network.

*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:	Qing Li, MD, DrPH
Email address:	qing.li@mail.sdsu.edu
If submitting on behalf of an organization, provide organization name*:	Member of Colorado Consortium Heroin Response Work Group, Substance Exposed Newborns Steering Committee, Colorado State Epidemiological Outcomes Workgroup, and Graduate School of Public Health San Diego State University.

PROBLEM OR ISSUE
Neonatal abstinence syndrome (NAS) had grown nearly fivefold from 2009 to 2012 in the U.S. In Colorado, NAS cases increased 83% from 132 in 2010 to 242 in 2015; and quality of these data requires evaluation. Pregnant women are the sentinel and priority population in the epidemic of opioid and other substance use disorders. Pregnant women in jails are highly regulated, under-funded, and not included in the Substance Exposed Newborns Hospital Learning Collaborative. So far, six states including Colorado C.R.S. §13-25-136 enacted in 2012 have decriminalized disclosure by women of substance use during pregnancy to create a zone of safety (ZOS) and promote SBIRT. A successful public health approach to prevent NAS in hospitals and jails requires the interim study committee to strongly champion collective collaboration across disciplines and an integrated systems response (e.g., public health, medicine, and law enforcement).
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1. Establish a statewide reporting and monitoring system of NAS, Screening, Brief Intervention, and Referral to Treatment (SBIRT), causes, risk and protective factors, and disparities.
2. Train providers, coordinate the collaboration in prompt SBIRT in primary care settings and early treatment in specialties, and emphasize both prevention and treatment in high risk women.
3. Monitor the time period between screening of substance use disorders during pregnancy and the prevention of NAS across counties and institutions and related barriers & cost-effectiveness.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Include NAS as a condition which each county is required to report validly and reliably, provide funding and technical support to highly regulated, under-funded institutions (e.g., jails).
2. Amend Colorado statute C.R.S. §13-25-136 with incentives and assistance to counties and institutions, which perform differently to comply.
3. Amend Colorado statute C.R.S. §13-25-136 to decriminalize disclosure by women of substance use expanding to one-year postpartum and promote early intervention during pregnancy (e.g., one reason is that women can be eligible for Special Connections program).
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
NIH program officers have discussed our aims in a grant proposal on integrated systems change to decriminalize disclosure of substance use in prenatal screening in Colorado and recommended our submission in October. The success of our NIH proposal also needs support from the interim study committee (e.g., effective communication, plan a prospective study). Colorado can be a leader in the country to investigate and inform evidence-based public health law prevention.

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

Patient/Public Education

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Marjorie Zimdars-Orthman
Email address:	mzorthman@comcast.net
If submitting on behalf of an organization, provide organization name*:	Although members of the Affected Family and Friends work group know I have concerns about patient education, this proposal has not been discussed.

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Patients prescribed opioids for the first time and patients on long term opioid therapy do not receive enough or any education regarding responsibilities, risks and dangers. Prescribers should be required to provide educational materials to patients and have a designated person in their office to answer patient's questions on the provided educational materials. Opioid safety is a shared patient/doctor responsibility.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Prescribers should provide patients with educational information when they are first prescribed an opioid.

2. The patient education information should include the following:
Patient Responsibility- Encourage the patient to designate a family member or trusted friend on their HIPPA forms so that a person concerned about their health has the permission to discuss any medical concerns with the doctor or practitioner.
Patient Notice on PDMP entry of their opioid prescription in the PDMP database.
Patient Notice that is on each prescription – Caution Federal Law prohibits the transfer of this drug to any person other than the patient for whom it is prescribed.
Patient Responsibility for safe storage in a locked drawer or safe of their opioid prescription and if the full prescription not needed safely dispose of at a pharmacy or law enforcement agency.
Patient Dos and Don'ts –
Do not drink alcohol and take your pain medication.
Follow instructions for tapering down or stopping your pain medication, and call your doctor's office with any additional questions.
Patient Information on the Physical, Psychological and Emotional effects of opioids.
Patient Information on the Physical, Psychological and Emotional effects of pain.
Information for specific medical situations such as Dental Surgery, Orthopedic Surgery, General Surgery, Laparoscopic Surgery, Injuries, Chronic Back Pain, Chronic Pain greater than 30 days, etc.
Information for specific age groups such as age 12-17, age 18-50, age 50+
Shared Patient and Doctor Responsibility-Analyze and monitor for any proclivity toward addiction behavior.
State of Colorado Responsibility-Provide a Network of free pain support groups.

3.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. I am not sure if any funding would be needed to gather people to write the different areas of patient education information.
2. Provide funding for a network of free pain support groups in every county in the state.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Please note that the above is not a complete list of patient education topics.

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Public does not understand the magnitude of the opioid epidemic and the important role the public can play in addressing the issue.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. Develop a state-wide prevention strategy to devise targeted prevention messages that employ cutting-edge methods of market and communications, including implementation of evidence-based prevention programs in schools.	
2. Develop a state-wide communications strategy to increase coverage of Take Meds Seriously and Take Meds Back campaigns, i.e., funding for TV and radio advertisements in both Spanish and English, billboards.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.	
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:	Robert Valuck
Email address:	robert.valuck@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Consortium for Prescription Drug Abuse Prevention

PROBLEM OR ISSUE

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

There is a continuing need for public awareness / patient education programs in Colorado, specifically in the areas of: safe use/storage/disposal of opioids, stigma reduction, treatment awareness/access, naloxone availability, and alternatives to opioids for pain management.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Encourage providers/organizations to distribute Public Awareness and patient education materials in their settings (systematically and regularly).
2.
3.

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

1. Fund an ongoing Public Awareness campaign(s) on safe use/storage/disposal, stigma reduction, treatment awareness/access, naloxone, and alternatives to opioids.
2.
3.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

Ongoing Public Awareness work should be coordinated across state agencies (CDPHE, DHS/OBH, DORA, HCPF) to assure consistent messaging and avoid duplication of work.

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

Other Clinical Practice

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Lindsey Myers
Email address:	lindsey.myers@state.co.us
If submitting on behalf of an organization, provide organization name*:	CDPHE. The recommendations submitted here have initial support from CDPHE leadership, but the department will need to review specific bills before they can be supported.

PROBLEM OR ISSUE

Drug-related poisoning deaths nearly tripled in Colorado from 351 deaths in 2000 to 912 deaths in 2016. At least 33 percent of the 2016 drug-poisoning deaths were due to prescription opioid analgesics. Additionally There were 228 heroin overdose deaths in 2016, an increase of 68 deaths in one year. According to a recent survey of methadone clinic clients, 70 percent of respondents said that prescription drugs played a role in their decision to use heroin. This underscores the need for policies that promote primary prevention strategies to impact both prescription drug misuse and heroin use. The Prescription Drug Monitoring Program (PDMP) is a tool that can help prescribers make informed prescribing decisions, yet only approximately 26 percent of prescribers that are registered for the PDMP use it regularly. CDPHE is currently conducting several pilot projects to integrate the PDMP with Colorado's health information exchanges and electronic health records. However, there is currently not funding to sustain these connections beyond August 2019.

Additionally, CDPHE's Health Facilities and Emergency Medical Services (EMS) Division reports that EMS agencies are often called to respond to non-emergent situations where a patents report having pain and request opioids. EMS providers currently do not have the ability to check the PDMP prior to making the decision to administer opioids.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Educate prescribers about how to use the PDMP.
2. Pilot test ways to make the PDMP easier for providers to use and access.
3. Educate providers on best practice opioid prescribing guidelines.

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

1. Increase funding for the Colorado Department of Regulatory Agencies to sustain full integration of the PDMP with Colorado's health information exchanges and electronic health record systems.
2. Allow EMS providers to access the PDMP so that they can check the PDMP prior to administering opioids to patients with chronic conditions.
3. Expand Medicaid's new policy on limiting the number of pills doctors can prescribe for new prescriptions to include all payors.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Nancy Steinfurth
Email address:	nsteinfurth@liverhealthconnection.org
If submitting on behalf of an organization, provide organization name*:	Liver Health Connection

PROBLEM OR ISSUE

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

According to the Centers for Disease Control and Prevention: "HCV [hepatitis C virus] transmission primarily occurs through percutaneous exposure to blood; thus, injection drug use is an important risk factor (*3*). HCV incidence has increased 294% nationally from 2010 to 2015 (*4*). This increase in acute cases of HCV is largely attributed to injection drug use (*2*). "....and HCV therapy can cure >90% of infected persons, thereby reducing the risk for HCV-associated mortality and transmission of HCV to others. State laws and policies can enhance or limit access to HCV prevention and treatment services, particularly for persons who inject drugs (*5*)." MMWR, May 12, 2017

The United States Preventive Services Task Force (USPSTF) recommends persons at high risk (those who inject or intranasally use drugs) and those born between 1945 and 1965 be tested for the hepatitis C virus (grade "B").

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. We recommend that Colorado Health Care Policy and Financing remove hepatitis C treatment restrictions so that everyone enrolled in Medicaid with the virus may access a cure. Current restrictions include having at least a fibrosis score of 2 (on a scale of 0 to 4, where 4 is cirrhosis) for all men and for women beyond child-bearing age. The latest pan-genotypic treatment has an acquisition cost of $27,000 (before HCPF discount of 23.1% and before HCPF-negotiated supplemental rebate), making it affordable as a treatment option. This is truly a cure for at least 95% of patients who complete treatment and reduces the impact on patients' diabetes, arthritis, heart disease, kidney disease, and may reduce their risk for liver cancer and other forms of cancer.

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

1. We recommend amending C.R.S. 25-4-2005 so that persons with high risk of hepatitis C infection associated with injecting or intranasally using drugs are added as a target audience and that the test be mandatory in health care settings. Because the test has been given a grade "B" by the USPSTF, it is reimbursed through our health care system.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Citation: https://www.cdc.gov/mmwr/volumes/66/wr/mm6618a2.htm These recommendations have been approved by the Advocacy Committee and by the Board of Directors of Liver Health Connection.

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

Safe Disposal

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Unused medications pose a risk for accidental exposure, misuse and abuse. Research indicates many individuals with opioid use disorder get prescription drugs from friends or relatives. Current drug take-back programs need to be simplified, i.e., increase accessibility and make part of individuals' practice when going to the pharmacy where they purchase their medications.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Implement regulations that mandate retail pharmacies to collect unused or unwanted controlled pharmaceutical drugs from ultimate users in compliance with DEA and Colorado Board of Pharmacy regulations.	
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

Law Enforcement

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Jamie Feld, MPH
Email address:	jfeld@bouldercounty.org
If submitting on behalf of an organization, provide organization name*:	Boulder County Public Health – Committee member of the Colorado Heroin Task Force

PROBLEM OR ISSUE

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

Local law enforcement and criminal justice systems throughout the state are facing the impact of the opioid crisis. These repercussions include increases in drug possession charges and overcrowding of jails.

Law Enforcement and Community Support

Develop a system map to create a diversion program for individuals with substance use disorders who engage in criminal activity. The goal is to reduce incarceration and recidivism and to ensure that individuals are receiving treatment and case management support. These diversion pathways will provide a streamlined mechanism for diverting people away from the criminal justice system and to case management and follow up to ensure individuals meet their needs including housing, peer recovery, treatment, needle exchange, detox, and other needed resources. This diversion pathway will be cost effective in directing resources away from high cost of incarceration.

This proposal is in alignment with focus area identified by the Heroin Task Force of the Colorado Consortium for Prescription Drug Abuse and Prevention led by the Rocky Mountain High Intensity Drug Trafficking Areas (HIDTA), which highlighted 'Expand the Offender Re-Entry Program' as a targeted area of focus.

Background:

Local law enforcement and criminal justice are responding to the adverse effects of the opioid crisis throughout the state. According to the Heroin in Colorado Report, reported heroin seizures in Colorado by law enforcement have increased from 2011 - 2015. The number of incidents of heroin seizures increased 2,035 percent from 20 to 427 incidents. Pounds of heroin seized increased 1,562 percent from 16.1 to 268.7 pounds. Reported arrests for heroin offenses in Colorado have increased by 515 percent from 743 in 2011 to 4,575 in 2015.

The opioid crisis is a burden on local communities and a strain on local government resources. This includes housing and treating individuals in the jail; increasing operating expenses for syringe exchange supplies; limited treatment options; and limited wrap-around services.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Champion efforts such as the forthcoming Law Enforcement Assisted Diversion (LEAD) pilot

program and PAARI (Police Assisted Addiction and Recovery Initiative) that aim to reduce or eliminate criminal charges for low level/non-violent drug offenders and concurrently strengthen support systems that link individuals to mental health and substance use disorder treatment, wrap around care, and case management.

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

1. Fund local governments to develop and implement action plans to address the complex opioid issue. Recommend that funding is administered to a coordinating agency that may reside in or out of government. Funding should support systems level implementation of locally supported diversion structures.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

The work reflected in this recommendation has received the support from the Boulder County Public Health executive director, Twentieth Judicial District Attorney, Boulder County Sheriff's Office, and other law enforcement agencies and department heads. This proposal focuses on one of the five priority areas highlighted in a proposal submitted by Boulder County Public Health director, Jeff Zayach.

This recommendation is by no means isolated to one county; this issue has been highlighted by groups throughout the state of Colorado.

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

Harm Reduction

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Lisa Raville
Email address:	Lisa.harm.reduction@gmail.com
If submitting on behalf of an organization, provide organization name*:	Harm Reduction Action Center

PROBLEM OR ISSUE

In Colorado there is a fatal overdose every nine hours and 36 minutes. 174 people died of overdose just in the City and County of Denver in 2016. Nationwide, this statistic is counted in minutes rather than hours as overdoses have now surpassed deaths caused by both car accidents and gunshots. It is a serious challenge but, fortunately, one that has a solution. Supervised injection facilities, commonly known as SIFs, bridge the gap between people who inject drugs and public health interventions that are proven to reduce the spread of HIV and viral hepatitis and also prevent fatal overdoses. **In fact, of 102 SIFs currently operating around the globe, not one has reported a single fatal overdose on its premises**.

What does this mean to our community? Colorado currently lacks proper public health interventions to significantly reduce rates of public injection, something many community members have experienced through observing people utilizing public bathrooms to inject as well as open injecting in common spaces such as parks, sidewalks, and alleyways. These venues are neither sterile nor safe and, sadly, are often the very places where people, without proper supervision or intervention, die of overdose. A Colorado SIF would significantly impact rates of public injection and would serve to help connect our marginalized citizens to evidence-based health care and support. In essence, a SIF would help remove people who inject drugs from parks and business bathrooms into a controlled, staffed, and medical environment.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Encourage county jails to keep people on their medicated assisted treatment.

2.

3.

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

1. Exemption of use and possession of drugs from the state nuisance law so that supervised injection facilities can operate without fear of their property being seized.

2. Exempt identification cards from being necessary to access methadone and suboxone and/or have the clinics have an agreement with the DMV to figure out how to work with folks that lack a proper identification card.

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:	Theresa Baillie
Email address:	Theresa.baillie@adaptpharma.com
If submitting on behalf of an organization, provide organization name*:	Adapt Pharma

PROBLEM OR ISSUE

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

National Opioid Epidemic – Colorado is not immune. We are committed to working with the state of Colorado to impact this epidemic through supporting effective naloxone policies and collaborating with CDPHE, CHI, OBH and the Colorado Consortium Work Group.

- CDC Opioid overdose deaths in Colorado: From 2013-2015 there were 1,342 Coloradans that died due to opioid or heroin overdose. 2016 data to be released soon will show an increase of the number of deaths in CO and the continuous rise of the epidemic
- Approximately $3.5M opioids were prescriptions were written in Colorado in 2015
- 22,000 Coloradans reported abuse or dependence on opioids, including heroin, annually from 2011-2014. Only 4000 received treatment.
- Remove any distribution barriers to accessing naloxone, a life-saving medication that quickly reverses an opioid overdose

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. All Law Enforcement and all First Responders shall carry naloxone
2. All persons in treatment shall have access to naloxone
3. All persons leaving incarceration with history of substance use disorder shall receive naloxone
4. Establish naloxone prescribing guidelines/programs in Emergency Room Departments state-wide
5. All shall have access to two doses of naloxone that has been approved by the Federal Food and Drug Administration

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

1. Co-Prescribing naloxone (formulation that has been approved by the Federal Food and Drug Administration) alongside the CDC guidelines
2. Prescribers Shall co-prescribe naloxone for all patients when :
   - The opioid medication prescribed is >50 MME/day
   - The opioid medication is being prescribed in combination with benzodiazepines
   - The patient has history of opioid overdose
   - The patient has history of substance use disorder

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Emphasis on implementation of naloxone that has been approved by the Federal Food and Drug Administration

*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:	James Gould
Email address:	jamesagould123@gmail.com
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Due to the unregulated nature of the black market, people who use illicit drugs often take impure or adulterated substances, and often are consuming entirely different drugs than they intend to consume. Drug checking kits exist which can be used to check substances for the presence of various drugs. There are numerous barriers to providing drug checking however, including civil and criminal liability and funding. Attached at the end of this document is a fact sheet that explains the specifics of drug checking, including limitations and additional benefits.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. Implement drug checking programs under existing or new syringe access programs. Colorado's syringe access law exempts all employees, volunteers, and participants from drug paraphernalia laws, including those that apply to drug checking.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Pass legislation protecting those providing drug checking services (and potentially other harm reduction services) from civil liability.	
2. Pass legislation decriminalizing or legalizing drug paraphernalia. These laws contribute to criminalization of people who use drugs and act as barriers to harm reduction services such as drug checking.	
3. Pass legislation explicitly regulating drug checking services, eliminating liability and setting up an official framework for these programs that can cater to their specific needs, similar to existing syringe access laws.	
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE	
"Drug checking" in this document refers to reagents used to test for the presence of certain drugs in substances. These kits have severe limitations, but are relatively cheap if managed by a single volunteer, providing hundreds of tests per kit. Gas chromatography / mass spectrometry machines exist that can provide far more detailed analysis of substances, but providing these machines for each jurisdiction is prohibitively expensive, and other harm reduction services	

should generally be prioritized for cost effectiveness. "Drug checking" is the preferred nomenclature for these services over "drug testing," to avoid confusion with drug testing of people, such as urine analysis, or hair follicle testing.

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

Drug Checking Fact Sheet

What is drug checking?

Drug checking is a harm reduction practice that provides people who use unregulated substances with information regarding the substances they're considering using. The most accessible form of drug checking is reagent testing. According to Merriam Webster, a reagent is, "a substance that is used to test for the presence of another substance by causing a chemical reaction with it." Reagent test kits for common unregulated drugs generally involves using multiple reagents to test a substance.

Who should consider drug checking?

Due to the unregulated nature of the black market, illicit substances are frequently of unknown purity, quality, source, and composition. Any person who intends to consume or is considering consuming an unregulated substance, especially a synthetic one, should engage in drug checking. Anyone who consumes unregulated substances is at risk of consuming adulterants or unintended substances. This increases the risk of a physical or mental health emergency that could put the lives and safety of themselves or others at risk.

What are the benefits of drug checking?

Drug checking allows people to be more informed about what they are using. This can often allow for healthier, less risky decisions to be made. According to a study conducted at Vancouver's Insite program regarding the presence of fentanyl, a powerful and dangerous opiate, in substances:

> Clients who checked prior to consumption, with a positive result [for fentanyl], were 10 times more likely to reduce their dose and clients who reduced their dose were 25% less likely to overdose.

According to a study by Johns Hopkins University on supposed MDMA tested through DanceSafe's festival drug checking program: :

> Of the 168 participant responses, 46 percent of those whose substances contained MDMA said they intended to take their drug, compared with 26 percent of participants whose substances tested negative for MDMA.

What are the negatives of drug checking?

Drug checking does not make consuming unknown substances completely safe, nor does it guarantee purity. A positive result simply means that the substance contains the chemical it tested positive for, or a similar chemical. A negative result does not guarantee that a substance does not contain a specific substance. Without further regulation, or expensive laboratory-level testing equipment, purity and safety of any illicit substance cannot be assessed with full accuracy.

What are the laws on drug checking?

Drug checking kits are currently classified as drug paraphernalia in C.R.S. § 18-18-426.

> "Drug paraphernalia" means all equipment, products, and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, **testing, analyzing,** packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of the laws of this state.

Employees, volunteers, and participants of syringe access programs are exempt from all drug paraphernalia laws including C.R.S. § 18-18-426 in C.R.S. § 18-18-430.5

> A person shall be exempt from the provisions of sections 18-18-425 to 18-18-430 if he or she is participating as an employee, volunteer, or participant in an approved syringe exchange program created pursuant to section 25-1-520, C.R.S.

Summary:

Drug checking is a harm reduction practice. It does not entirely eliminate all risks of consuming illicit substances, but it does mitigate them . Anyone considering consuming illicit drugs should engage in drug checking. There is no evidence that drug checking services encourage drug usage, in fact there is evidence that participants are actually more likely to reduce or avoid potential drug consumption.

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Jamie Feld – Boulder County Opioid Advisory Group
Email address:	jfeld@bouldercounty.org
If submitting on behalf of an organization, provide organization name*:	Submitting in consultation with Rebecca Millett from St Vrain School District (SVVSD) - millett_rebecca@svvsd.org

PROBLEM OR ISSUE

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

In April 2015, Senate Bill 15-053 expanded access to the life-saving drug naloxone, used to reverse overdoses to narcotic drugs such as certain prescription medications and heroin. As a result of the new law, the chief medical officer of the Colorado Department of Public Health and Environment (CDPHE) may issue standing orders for naloxone to be dispensed by pharmacies and harm reduction organization employees and volunteers to help expand statewide naloxone access.

While this law does allow for naloxone to be dispensed by pharmacies, harm reduction organizations and other entities, it does not allow for naloxone to be dispensed by school districts.

There is funding available for every high school in the United States to apply to access a free naloxone kit through an Adapt Pharma. However, currently schools are not able to apply for these free naloxone kits because they do not have standing orders.

A 2013 national survey on drug use and health showed that there were 2.2 million adolescents aged 12 to 17 who were current illicit drug users. School districts throughout Colorado are interested in having the capability to dispense naloxone. The National Association of School Nurses (NASN) developed a position statement recommending that 'schools review local and state policy on how to access naloxone and implement its use as part of their school emergency protocol.'

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Advanced Practice Nurses with prescriptive authority be added to the list of providers who can write standing orders
2. School districts develop a policy on naloxone in schools, similar to legislation on stock Epinephrine auto injectors

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. A revision to Senate Bill 15-053 could be made to add school districts to the list of approved organizations that can dispense naloxone. The following portion of the Senate Bill 15-053 could be amended: 12-36-117.7. Prescribing opiate antagonists - definitions. "(1) A PHYSICIAN OR PHYSICIAN ASSISTANT LICENSED PURSUANT TO THIS ARTICLE MAY PRESCRIBE OR DISPENSE, DIRECTLY OR IN ACCORDANCE WITH STANDING ORDERS AND PROTOCOLS, AN OPIATE ANTAGONIST TO:" to include school districts.
2.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
School districts expressed desire to have naloxone in the school but had encountered policy barriers. There is **no cost to implement this policy change** as a private funding is available to schools to access naloxone. This issue was identified as a need through a collective action process involving multiple stakeholders at a local level. This issue received support from members of the Naloxone Work Group of the Colorado Consortium and the Colorado Department of Education.

*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:	Michael Nerenberg MD
Email address:	nerenberg1@q.com
If submitting on behalf of an organization, provide organization name*: I am not submitting on behalf of these organizations, but am active on this issue with these organizations	Pueblo Heroin Task Force, Pueblo City/County Board of Health, Consortium, Pueblo Harm Reduction Resource Center, Pueblo Human Relations Commission

PROBLEM OR ISSUE
Describe the specific challenge in your field of expertise, related to opiates: Despite the shortage of providers, inflexible regulations requiring limits on how many patients a Suboxone Provider can carry limits how many patients can be treated. Counselors, also in short supply, are also limited in how many patients they can carry. Together, this results in long waiting lists for care. We are, essentially, forcing people to continue using heroin. While we are calling this a crisis, we continue to carry on a regulatory "business as usual," making it difficult to manage the "crisis." As an ED MD, when we had a disaster notification, we temporarily suspended the usual procedures in order to handle the influx of patients. We should be doing that in regards to the opiate epidemic. I know of a methadone clinic that has been working on its Medicaid status for over 1 year, for example.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1.Eliminate the prior authorization requirement to prescribe MAT meds. This can sometimes take days, or even longer with private insurance companies, and interferes with initiation of treatment. This was done in Maryland.
2.With the severe work-force shortage in the addiction treatment field, it seems counter-productive to require everyone in need of treatment to have a complete treatment team in place to enter and maintain themselves in treatment. Provision could be made to at least get patients the medication they need when they express the desire to stop illicits, and provide counseling when a counselor becomes available, and it is clear that counseling would be useful.
3.It is little known that ED MD's and others can provide 3 days of Suboxone on an emergency basis, whether or not the MD's are Suboxone waivered. There have been several studies done showing efficacy to that approach – in terms of decreased illicit drug use and increased entry into treatment. This should be widely publicized and encouraged.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1.When talking about changing strategies in dealing with the crisis, local law enforcement complains that possession of any heroin is a felony which they can't ignore. They feel that if a waiver on this were in place, they would be able to experiment with different approaches – such as LEAD or PAARI.

2.Increasingly, data is showing Harm Reduction Principals to be more effective in improving lives and social functioning and decreasing the social costs of addiction than the current methods of dealing with this crisis, such as attempts at interdiction and other legal interventions. This should become the state priority. That includes Syringe Access Programs; Safe Injection Facilities; legal system diversion programs; and other programs showing promise around the world.

3. Requiring treatment centers to collect and report data is a real need. There is significant question as to the efficacy of the usual "Drug Free Rehab" model, and tremendous resources being spent. It would seem useful to know if our resources are being spent effectively. And, in addition, the consensus is increasing that this is a long term condition, and I know of no one who is collecting long term outcome data. Funding might be required to enable centers to collect and disseminate this data.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

Fundamentally, it is difficult to devise a strategy when there has been little, if any, discussion of what the actual goals are. How do we know we are succeeding if we don't have a clear set of goals? While a drug free state would be nice, that has not been proven feasible, and the costs of pursuing that goal unsustainable. Reducing or eliminating OD deaths; reducing crime; reducing illicit drug use; reducing drug related infectious disease; improving individual and family functioning; removing barriers to treatment; all seem like goals that should be considered.

There is a serious lack of resources for dealing with young people already involved in addiction. It is, in fact, very difficult to obtain data on the numbers of kids involved. More effort needs to be made in that direction.

I am a retired ER MD, having worked for 24 years in a Pueblo ED. In addition to my involvement with the entities listed above, I am a part-time, volunteer Suboxone Provider at a local treatment center.

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

Workforce

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Jennifer Miles
Email address:	jennifer@frontlinepublicaffairs.com
If submitting on behalf of an organization, provide organization name*:	Colorado Providers Association (COPA) and long list of stakeholders (attached). Officially supported by COPA's membership. Other stakeholders may still need to get official support.

PROBLEM OR ISSUE

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

Colorado faces a health care workforce shortage in many areas, including behavioral health care providers who work with patients with co-occurring mental health and substance use disorders (SUDs). With an opioid epidemic and skyrocketing overdose rate impacting all corners of the state, the need for SUD health professionals is particularly acute. Providers who hire mental health and SUD professionals report difficulty in filling positions, leading to reduced services even though they have the physical space for beds or outpatient treatment rooms.

*See attached concept paper

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1. Create an arm/category of the Colorado Health Service Corps for behavioral health (both mental health and substance use disorder) health care professionals.
2. Add 2 additional members to the existing CHSC Advisory Council, to include one representative from each of the following organizations:
    - A membership organization representing substance use disorder providers (COPA)
    - A substance use disorder health provider who has experience in rural health, safety net clinics, or health equity (mirrors existing language)
    - Note: CBHC and a mental health provider are already included
3. Outline those professionals eligible for student loan repayment to include the following with mental health and SUD services within their scope of practice (determined by education, training, skills development and supervised experience):
    - Licensed Addiction Counselors (LAC)
    - Certified Addiction Counselors III (CAC-III only)
    - Licensed Professional Counselors (LPC)
    - Licensed Clinical Social Workers (LCSW)
    - Clinical Psychologists (Psy.D. or Ph.D.)

- Psychiatric Nurse Practitioners (APN with psychiatric scope of practice)
- Physicians with specific boarding and/or training in addiction medicine, pain management, and/or psychiatry

4. Require CDPHE to develop a new shortage designation category specific to behavioral health providers through a Board of Health rulemaking process with stakeholder input. The methodology for this category would measure an area's need for mental health and SUD services as compared to available providers to determine if a "shortage" exists.
5. Allow candidates for licensure who have completed a master's degree and are gaining the required supervised experience hours for licensure to be eligible for student loan repayment if they commit to 3 years in a shortage area (to include the candidate time period of approximately 2 years and approximately 1 year with the license)
6. Develop a scholarship fund for two purposes:
    a. Provide a scholarship for licensed professionals practicing in shortage areas who agree to commit time and resources to providing experience and supervision to licensure candidates.
    b. Provide scholarships to help Certified Addiction Counselors obtain the required clinically supervised work experience, education, and training to progress from a CAC I or CAC II up to the level of CAC III or LAC. The scholarship would require those achieving the higher levels to practice in shortage areas for a period of time after CAC III or LAC is reached.
7. Prioritize nonprofit and public employers for providers with loan repayment, but allow other employers who can demonstrate an underserved population, a practice model with a shortage of providers (an example would be Medication Assisted Treatment or MAT), or other consideration to apply and be considered by the Advisory Council.
8. Provide funding for the program of $2.5 million from the Marijuana Tax Cash Fund. But, also monitor the multi-state lawsuit against opioid manufacturers as a possible funding source. Estimates indicate that with $1 million in annual funding, the program could create 3 year contracts with 18 or 19 health professionals. The amount of annual loan repayment awarded would impact these estimates. Funding would also be needed to cover the development of a new shortage designation category and administrative costs. The scholarship fund for supervisors and addiction counselors would require additional funds.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

*See attached concept paper for further description of the existing CHSC and why it doesn't work well for the SUD provider shortage. The concept paper also includes a Glossary of Key Terms, including info about the health professionals that would be included.

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

First	Last	Agency	Email	
Agnieszka	Baklazec	CO Association of Addiction Professionals (CAAP)	agnieszkabaklazec@yahoo.com	
Alice	Gibbs	CO Community Health Network	agibbs@cchn.org	
Alicia	Haywood	CDPHE	alicia.haywood@state.co.us	
Alyssa	Aberle	CO Association of Dental Hygienists	alyssa@codha.org	
Amy	Barton	University of Colorado College of Nursing	amy.barton@ucdenver.edu	
Angie	**Wold**	**Addiction Research and Treatment Services**	**?**	on phone
Ashley	Mills	Colorado Rural Health Center	amm@coruralhealth.org	
Bethany	Pace-Danley	Peer Assistance Services	bpace-danley@peerassist.org	
Brian	Turner	CBHC	bturner@cbhc.org	
Camille	Harding	OBH	camille.harding@state.co.us	
Cheri	Jahn	State Senator	cheri.jahn.senate@state.co.us	
Christy	**Doan sp?**	**Arapahoe House**	**?**	on phone
Colleen	Casper	CO Nurses Association	colleen@coloradonurses.org	
COPA Distribution List	* SEE BELOW		copamem@frontlinepublicaffairs.com	
Cristen	Bates	OBH	cristen.bates@state.co.us	
Debbie	Wagner	CO Psychiatric Society	debbie@lombarddayton.com	
Dustin	Moyer	The Colorado Health Foundation	dmoyer@coloradohealth.org	
Elisabeth	Rosen	Signal Behavioral Health	elisabeth.rosen@ymail.com	
Erin	Baurle	CO Pyschologists Association/MCPN	erin.baurle@mcpn.org	
Frontline Internal Distribution List	** See below		frontline@frontlinepublicaffairs.com	
Gil	Romero	Capitol Success Group	gil@capitolsuccess.com	
Howard	Notgarnie	Colorado Dental Hygienists' Association	howardrdhedd@gmail.com	
Jeannie	Vanderberg	CO Psychologists Association	jvanderburg@capstonegroupllc.com	
Jennifer	Goodrum	CO Dental Association	jennifer@cdaonline.org	
Katie	Wolf	CAAP	kewolf@michaelbeststrategies.com	
Kelly	Erb	CO Rural Health Center	ke@coruralhealth.org	
Lauren	Snyder	CDHS	lauren.snyder@state.co.us	
Lenya	Robinson	HCPF	lenya.robinson@state.co.us	
Marcia	Hunsaker	Advocates for Recovery Colorado	marcia_marcia09@yahoo.com	
Marija	Weeden-Osborn	CCHN	marija@cchn.org	
Michael	Nicoletti	CDPHE	michael.nicoletti@state.co.us	
NASW Distribution List		social worker Leg Cmte members	nasw@frontlinepublicaffairs.com	
Partnership Distribution List	*** See below		partnership@frontlinepublicaffairs.com	
Riley	Kitts	CDHS	riley.kitts@state.co.us	
Rob	Valuck	CO Consortiumon Rx Abuse Prevention	robert.valuck@ucdenver.edu	
Ruth	Aponte	Arapahoe House	raponte@aponte-busam.com	
Ryan	Biehle	CAFP	Ryan@coloradoafp.org	
Steve	Holloway	CDPHE	steve.holloway@state.co.us	
Tanya	Kelly Bowry	University of Colorado	Tanya@policymatters.com	
Terri	Hurst	Colorado Criminal Justice Reform Coalition	terri@ccjrc.org	

* COPA Membership List

Aleah	Horstman	Arapahoe House
Ailala	Kay	Omni Institute
Bill	Dolan	Sobriety House
Brad	Sjostrom	West Pines
Charlie	Davis	Crossroads
Christopher	Conway	Stout Street
Cheryl	Reid	Crossroads
Crystal	Colussi	Sobriety House
Dana	Smith	Phoenix Multisport
Daniel	Darting	Signal BH
Elizabeth	Pace	Peer Assistance Services (PACE)
Jay	Voigt	CeDAR
Jean	Denious	Omni Institute
Josh	Pruyn	Arapahoe House
Katie	Wolf	CAAP
Kristy	Jordan	SIgnal BH
Kristen	Dixion	ARTS
Leroy	Lucero	Crossroads
MaryAnn	Burdick	Metro Denver Partners
Megan	Farabaugh	Sobriety House
Mike	Butler	Arapahoe House
Mita	Johnson	CAAP
Marcela	Paiz	IDEA
Nicolas	Petrucelli	Stout Street
Paul	Scudo	Step 13
Bob	Dorshimer	Mile High Behavioral Helathcare
Steve	Millette	CeDAR
Susan	Dearing Bond	CeDAR
Tonya	Wheeler	Advocates for Recovery

**Frontline Internal Distrib List

Jennifer	Miles	COPA, CCHN, etc.
Diana	Protopapa	CO Association of Physician Assistants, CPHA
Rebecca	Meyers	NASW, CO Chapter
Adeline	Hodge	COPA, Faternal Order of Police

***Partnership Distirbution List:

Anna	Weaver Hayes	Colorado Psychiatric Society
Andrew	Romanoff	Mental Health Colorado
Aubrey	Eckle	
Bev	Marquez	Metro Crisis Services
Doyle	Forrestal	CBHC
Frank	Cornelia	CBHC
Moe	Keller	Mental Health Colorado
M	Grimley	
Heather	Laughlin	Natl Assoc of Social Workers
Samantha	Farro	
Stephanie	Wentz	Civica Management
Tonya	Wheeler	Advocates for Recovery
Rebecca	Richey	

Incentives for Substance Use Disorder Health Professionals and Employers

DRAFT Concept Paper for Opioid and Other Substance Use Disorder Interim Committee
UPDATED: August 18, 2017

Prepared by Jennifer Miles, jennifer@frontlinepublicaffairs.com or 303-668-3979

Problem Statement:

Colorado faces a health care workforce shortage in many areas, including behavioral health care providers who work with patients with co-occurring mental health and substance use disorders (SUDs). With an opioid epidemic and skyrocketing overdose rate impacting all corners of the state, the need for SUD health professionals is particularly acute. Providers who hire mental health and SUD professionals report difficulty in filling positions, leading to reduced services even though they have the physical space for beds or outpatient treatment rooms.

An existing program for recruiting and retaining other types of health professionals does not work well for mental health and substance use disorder professionals. The Colorado Health Services Corps (CHSC) is a student loan repayment program established in 2009 for health professionals who commit to practicing in a designated health professional shortage area (HPSA) for a minimum of 3 years. The current program is open to specific provider types in specific types of shortage areas working in certain settings. While these requirements are well suited for primary health care and psychiatric care for serious and persistent mental illness (SPMI), the requirements do not address the support of health professionals trained to address other mental health disorders or substance use disorders, as noted below:

- *Addiction counselors* are not eligible for loan repayment.
- The shortage area criteria used to determine if a geographic area qualifies for loan repayment is based on an old psychiatric care model for SPMI and does not measure the shortage of other mental health or SUD professionals effectively.
- Student Loan Repayment is currently available to those providers who have a full license, which takes 2 years or longer after completion of a Master's degree. During this 2-year period, the need for assistance with repaying student loans is at its greatest, as salary earnings are lower. Access to a loan repayment incentive during this period could increase the likelihood that a trained provider would seek practice in areas of greatest provider shortage.
- During this period of two years or more between graduation with a master's degree and obtaining licensure, candidates depend on licensed professionals to provide them with experience and supervision hours. Experienced professionals are not compensated for providing this supervision and candidates report difficulty finding licensed providers willing to serve in this role.

Proposed Policy Changes:

1. Create an arm/category of the Colorado Health Service Corps for behavioral health (both mental health and substance use disorder) health care professionals.
2. Add 2 additional members to the existing CHSC Advisory Council, to include one representative from each of the following organizations:

- A membership organization representing substance use disorder providers (COPA)
- A substance use disorder health provider who has experience in rural health, safety net clinics, or health equity (mirrors existing language)
- Note: CBHC and a mental health provider are already included

3. Outline those professionals eligible for student loan repayment to include the following with mental health and SUD services within their scope of practice (determined by education, training, skills development and supervised experience):
    - Licensed Addiction Counselors (LAC)
    - Certified Addiction Counselors III (CAC-III only)
    - Licensed Professional Counselors (LPC)
    - Licensed Clinical Social Workers (LCSW)
    - Clinical Psychologists (Psy.D. or Ph.D.)
    - Psychiatric Nurse Practitioners (APN with psychiatric scope of practice)
    - Physicians with specific boarding and/or training in addiction medicine, pain management, and/or psychiatry
4. Require CDPHE to develop a new shortage designation category specific to behavioral health providers through a Board of Health rulemaking process with stakeholder input. The methodology for this category would measure an area's need for mental health and SUD services as compared to available providers to determine if a "shortage" exists.
5. Allow candidates for licensure who have completed a master's degree and are gaining the required supervised experience hours for licensure to be eligible for student loan repayment if they commit to 3 years in a shortage area (to include the candidate time period of approximately 2 years and approximately 1 year with the license)
6. Develop a scholarship fund for two purposes:
    a. Provide a scholarship for licensed professionals practicing in shortage areas who agree to commit time and resources to providing experience and supervision to licensure candidates.
    b. Provide scholarships to help Certified Addiction Counselors obtain the required clinically supervised work experience, education, and training to progress from a CAC I or CAC II up to the level of CAC III or LAC. The scholarship would require those achieving the higher levels to practice in shortage areas for a period of time after CAC III or LAC is reached.
7. Prioritize nonprofit and public employers for providers with loan repayment, but allow other employers who can demonstrate an underserved population, a practice model with a shortage of providers (an example would be Medication Assisted Treatment or MAT), or other consideration to apply and be considered by the Advisory Council.
8. Provide funding for the program of $2.5 million from the Marijuana Tax Cash Fund. But, also monitor the multi-state lawsuit against opioid manufacturers as a possible funding source. Estimates indicate that with $1 million in annual funding, the program could create 3 year contracts with 18 or 19 health professionals. The amount of annual loan repayment awarded would impact these estimates. Funding would also be needed to cover the development of a new shortage designation category and administrative costs. The scholarship fund for supervisors and addiction counselors would require additional funds.

Glossary of Key Terms:

SUD Health Professionals include the following:

1. Addiction Counselors, including Licensed Addiction Counselors (LAC) and Certified Addiction Counselors (CAC-III, CAC-II, CAC-I). Requirements:

For the CAC-I Level

- Pass a criminal background check
- 1000 hours of clinically supervised work experience completed in a minimum of six months
- Experience in at least 3 of the following: Orientation, Admin Intake, Admin discharge, Service coordination, Case documentation and Client, Family or Community Education
- Direct supervision of 3 hours per month from a CAC-III or LAC

For the CAC-II Level

- Complete all parts of CAC-I above
- 2000 hours of clinically supervised work experience completed in a minimum of 12 months
- Experience in at least 6 of the following: Clinical Evaluation, Clinical Intake; Treatment Planning; Care coordination with linkage and referral; Co-Facilitation of individual, family or group counseling; Case management and Client, Family or Community Education; Documentation for clinical record
- Direct supervision of 3 hours per month from a CAC-III or LAC.
- Pass a national Addiction Counselor examination determined by the state (OBH)

For the CAC-III Level

- Complete all parts of CAC-II above unless you have a Master's or Ph.D. in a Behavioral Science in which case this requirement can be waived
- Must possess a Bachelor's degree in a behavioral science for an accredited university.
- 2000 hours of clinically supervised work experience completed in a minimum of 12 months. This is in addition to the CAC-II requirements above
- Experience in all of the following: Clinical Evaluation, Clinical Intake; Treatment Planning; Care coordination with linkage and referral; Co-Facilitation of individual, family or group counseling; Case management and Client, Family or Community Education; Documentation for clinical record
- Direct supervision of 2 hours per month from a CAC-III or LAC
- Pass a national Addiction Counselor examination

For the LAC Level

- Meet all requirements of the CAC-III above

- Have a Master's or Ph.D. in a Behavioral Science discipline from a regionally accredited university
- Pass a national Addiction Counselor examination determined by the Department

2. Social Workers (LCSW or candidates for LSW)

LCSW Requirements:

- Completion of Master's or Doctorate in Social Work from an accredited program
- Passage of national clinical examination
- Completion and documentation of 3,360 hours of experience over a minimum of 24 months; to include 96 hours of supervision, 48 hours of which must be face-to-face individual supervision, distributed evenly over 24 months

LSW Requirements:

- Completion of Master's or Doctorate in Social Work from an accredited program
- Requires passage of the ASWB Intermediate, Clinical or Advanced Generalist exam
- May be obtained for completing the required two years of post degree supervised experience before applying for LCSW

3. Licensed Professional Counselors (LPCs), Licensed Professional Counselor Candidate (LPCC)

LPC Requirements:

- Master's or Doctorate degree from approved program
- 2,000 hours of post-degree experience over minimum of 24 months, plus 100 hours of post-degree supervision over minimum of 24 months (70 face to face and individual)
- Pass National Counselor Examination (NCE)

LPCC Requirements:

- Master's or Doctorate degree from approved program
- Generally for those accruing required post-degree experience hours for LPC above

4. Licensed Marriage and Family Therapists (LMFT) – master's degree plus
5. Clinical psychologists (Psy.D. or Ph.D.)
6. Psychiatric Nurse Practitioners (APN with psychiatric scope of practice)
7. Physicians with specific boarding and/or training in addiction medicine, pain management, and/or psychiatry

Other Terms:

HPSA: Health Professional Shortage Area
CHSC: Colorado Health Service Corps
SLRP: Student Loan Repayment
SPMI: Serious and Persistent Mental Illness

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Daniel Darting
Email address:	ddarting@signalbhn.org
If submitting on behalf of an organization, provide organization name*:	Signal Behavioral Health Network (SUD MSO for NE Colorado, Metro Denver, and SE Colorado)
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: At a time of high need, the workforce for SUD is at crisis levels, with most organizations unable to hire, or expand capacity due to limited workforce. This is both a metro and rural issue, though it manifests in different ways.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Develop legislation that will direct appropriate departments (CDHS, CDPHE, DORA, *et al.*) to review regulations. The review should include strategies to expedite approval of licensure and certification of clinicians, reduce barriers, and cost. These changes in regulation should be designed with a specific goal in mind for expanding the workforce across a period of time. For example: expanding the number of Certified Addiction Counselors (CACS) by 20% over the next 2 years. Departments should be required to develop strategies that reduce administrative overhead to expedite processing of certifications and to ensure that these changes do not increase their departments' budgets.	
2. Many of the individuals entering behavioral health to provide services have lived experience. This is somewhat different than primary care professionals. As such, it is not uncommon for some of these motivated, dedicated individuals to have interacted with criminal justice in the past. But now, in recovery, and with a desire to help others, they are often subjected to a lengthier approval process—or in some cases, unfairly denied. This should be addressed to encourage motivated and needed individuals to enter the clinical workforce at a time of great demand.	
3. The State should continue to expand open State reciprocity regulations to encourage clinicians from other States to fill the open positions statewide.	
4. Require HCPF to allow LACs to practice as any other MA-level licensed clinician under the Medicaid State Plan.	
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE	
Please note that these recommendations have the full support of Signal Behavioral Health	

Network.

*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:	Frank Cornelia
Email address:	fcornelia@cbhc.org
If submitting on behalf of an organization, provide organization name*:	Colorado Behavioral Healthcare Council

PROBLEM OR ISSUE: Workforce challenges are persistent across the state

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

Colorado experiences substantial workforce challenges in behavioral health, with substance use disorder (SUD) service professionals demonstrating additional shortages across every region of the state. Rural communities face additional challenges in recruiting and retaining eligible workforce to treat the SUD population. **Low salaries, stressful conditions, and strict regulations** all contribute to **high turn-over rates and poor utilization** of existing resources. Several needs assessment and studies in the past decade have examined the issue, one study finding that the number of certified addictions councilors (CACs) in Colorado has remained roughly the same since 2010, although the state population has grown 10% (See WICHE study on Colorado's behavioral health workforce).

A consensus among studies demonstrates that workforce should be a priority for policy makers as they examine multi-faceted solutions to the workforce problem. Strategies between rural, frontier, and urban communities must be salient to meet the unique challenges that each region faces.

The following policy recommendations have received support from CBHC membership, specifically in the Managed Service Organization membership category.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Require State departments to examine highly restrictive credentialing regulations on the SUD workforce to ensure alignment between intent and reasonableness. This could include examination of the extensive background check process, requirements for psychological testing, and analyzing scope of practice for various levels of SUD professionals, with the intent of increasing and maximizing effectiveness of our state's SUD workforce.

2. Promote, or adopt, open state reciprocity regulations to encourage clinician from other states to fill the open position statewide. Examine multi-faceted solutions including telehealth to fill workforce shortages from other states.

3. The State should establish a goal of expanding the number of certified and licensed clinicians by a certain percentage (perhaps 25%) over a specified time range (perhaps 2 years), requiring CDPHE, DORA, and CDHS to work together to achieve this.

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

1. Provide legislative support to loan forgiveness, tuition reimbursement, and other benefit package enhancements specifically for the BH workforce, with priority for SUD providers (e.g.; CAC I, II, II and

LACs).
2. Support budget action that would increase funding that would directly and indirectly support the sustainable and expanded provision of SUD services. This could include increasing allowable expenses for payors, increasing flexibility for providers, or Require HCPF to allow LACs to practice as any other MA level licensed clinician under the Medicaid State Plan.
3. Reduce barriers to individuals pursuing licensure or certification with past lived or criminal history. Many individuals seeking to become clinicians are in recovery or intersected the criminal justice system in the past. DORA should implement regulations to clear this obstacle.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
CBHC strongly believes that the workforce shortages in our state cannot be addressed by one strategy and instead will require a multi-faceted approach to promote more new clinicians, increase effectiveness of existing workforce, and to invest in our workforce for long term success.

*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:	Angela Bonaguidi
Email address:	Angela.Bonaguidi@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Treatment for Opioid Dependence (COTOD)

PROBLEM OR ISSUE

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

Despite lower reimbursement rates compared to Mental Health services, the credentials required to provide substance use disorder services is higher. The ongoing discrepancy creates workforce development issues (poorer reimbursements drives lower pay for staff members) and significant operational strains on substance use disorder agencies. Following specialized training, it is common for staff to switch to the mental health side of service administration. As a result of continued loss, lower pay and few training resources, substance use disorder agencies are suffering and lack an appropriate workforce.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Allocation of funds to cancel or reduce student loans for individuals committed to provide substance use disorder services for at least three years.

2.

3.

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

1. Allocation of funds to cancel or reduce student loans for individuals committed to provide substance use disorder services for at least three years.

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

Payment Reform

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Frank Cornelia
Email address:	fcornelia@cbhc.org
If submitting on behalf of an organization, provide organization name*:	Colorado Behavioral Healthcare Council

PROBLEM OR ISSUE: Not all communities have access to a full continuum of services

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

Colorado communities and regions experience a range of accessibility to services on the substance use disorder (SUD) services continuum. Thanks to SB16-202 and the associated assessment we were able to identify gaps and limitations in resources across our state. To be effective in address the full scope of the opioid crisis, it is critical important to have a full continuum of services available to all Coloradans.

The following policy recommendations have received support from CBHC membership, specifically in the Managed Service Organization membership category.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Build on and invest in the SB202 framework to assess community needs based on stakeholder feedback and provide flexible funding directly to communities – recommend increased funding to support submissions which were not awarded. Many of the system expansion areas of prevention, treatment, and recovery are a part of the areas of target for this funding. Already many of those areas are being added and invested in, but more is needed.

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

1. Build on and invest in the SB202 framework to assess community needs based on stakeholder feedback and provide flexible funding directly to communities – recommend increased funding to support submissions which were not awarded. Many of the system expansion areas of prevention, treatment, and recovery are a part of the areas of target for this funding. Already many of those areas are being added and invested in, but more is needed.

2. When funding is allocated to the expansion of resources, there needs to be flexibility to invest in long-term projects that leverage community strengths and existing infrastructure. SB16-202 allocations may be enhanced by allowing funds from a given year to be invested in longer term projects and spent over 2 years instead of requiring they be spent in the current year.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

Additional resources for services will be most effective when they are rolled out to communities rapidly, efficiently, and towards programs that are salient to community members. With appropriate flexibility, resources can be utilized to develop initiatives that are directly based on stakeholder's feedback and intimate knowledge of their needs.

*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:	Jamie Feld – Boulder County Opioid Advisory Group
Email address:	jfeld@bouldercounty.org
If submitting on behalf of an organization, provide organization name*:	Boulder County Opioid Advisory Group

PROBLEM OR ISSUE

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

While the opioid epidemic has received substantive attention, benzodiazepine and opioid use is common to the degree that it is often called the 'silent epidemic'. Because both opioids and benzodiazepines cause respiratory depression, concurrent use is a high risk for overdose. Between 2001 and 2016, there were 515 deaths in Colorado related to concurrent use of benzodiazepines and opioids. Between 2001 and 2016 there were 912 deaths from benzodiazepines alone. In Colorado's Prescription Drug Monitoring Program (PDMP), 11.3% of patient prescription days were with overlapping opioid and benzodiazepine prescriptions.

According to a recent key informant interview survey in Boulder County, emergency room physicians and administrators highlighted the need for a low cost medical detox as the primary concern for emergency room physicians. Because benzodiazepine withdrawal is potentially lethal, non-medical detoxes will not take someone with a history of benzodiazepine use. Other options are unaffordable for clients. Law enforcement as a result often brings individuals to the emergency room. The emergency room experiences an additional strain on resources and does not have a place to send patients upon discharge.

The Opioid Task Force must address concurrent benzodiazepine use due to the high prevalence of use, high risk for overdose and lack of detox resources in the community.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Convene a group of stakeholders to research the barriers to access for medical detox
2. Research policy suggestions and evidence based strategies to increase number of medical detox sites
3. Interview medical providers and law enforcement to identify gaps to current detox community resources

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

1. Consider report on possible coverage for medical detox by Health Care Policy and Financing (HCPF)
2.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
This proposal was the result of interviews with medical staff and administrators at local emergency rooms. This proposal has not undergone a formal review process.

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Currently, only 13 state Medicaid programs include all of the available medications used to treat alcohol and opioid disorders on their Preferred Drug Lists (PDL)	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.Expand inclusion of all available medications used to treat alcohol and opioid disorders on Colorado's PDL.	
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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Colorado's Medicaid program uses benefit design requirements, such as prior authorization, to contain expenditures and encourage the proper use of medications for the treatment of alcohol and opioid disorders. These requirements may reduce a patient's access to treatment and result in poorer health and economic treatment outcomes.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. Reduce potential barriers to access by moving from paper-based prior authorization to an electronic, standardized process.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.	
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:	Elisabeth Fabrizio, FNP-BC
Email address:	bluezebra721@gmail.com
If submitting on behalf of an organization, provide organization name*:	1st Alliance Treatment Services, LLC Options Treatment, LLC

PROBLEM OR ISSUE

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

I was the medical director for 1st Alliance from January-July 31, when they had to close their BHO and MAT due to nonpayment from Medicaid for 6 months. They had a contract with DOC to provide behavioral treatment and medication assisted therapy with Vivitrol. The main problem was that Vivitrol is currently buy and bill in Colorado. My company went bankrupt buying Vivitrol for the Colorado state parolees, expecting to be fully reimbursed in a timely manner. The medication is over $1000 per dose. The program, unfortunately was unsustainable, and after spending hundreds of thousands of dollars, it was shut down. This was a tragic event. We were providing a much needed service that no one else has been willing or able to do. My boss took a huge risk and because of this buy and bill policy, the program failed and left hundreds of parolees without treatment for their substance use disorder, as well as hundreds of employees who were laid off and now getting unemployment.

Vivitrol needs to be a prescription benefit with Medicaid, or guess what? No one is going to take Medicaid clients who need Vivitrol. And these are the clients that need it the most!! This buy and bill policy is terrible, and Medicaid reimbursement process is horrific. No practice can afford to buy 25 shots at a time, waiting for reimbursement from this poorly managed and pathetic organization. This is a miracle drug for opiate use disorder and alcohol use disorder. And I can prove it with real life stories of many people who have finally been able to stay clean and sober for the first time in their lives. They are working, relationships are improving, they are happy. We did everything we could to keep this program alive, to include writing letters to every state legislator, even the governor himself could not help us. The state needs to be responsible for taking care of all people on Medicaid with opiate and alcohol use disorder. People are going to die.

I have a new job now. DOC is looking for new vendors. Nobody wants to touch Medicaid. Please change the policy to make Vivitrol a pharmacy benefit. My new practice, Options Treatment, LLC is happy to take Medicaid clients and can provide this treatment but not without payment.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Provide emergency funding for those businesses who are not getting reimbursed.

2.

3.
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Make Vivitrol a pharmacy benefit with Medicaid as soon as possible
2. Provide more funding for treatment, and new clinics, especially to treat the underserved.
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:	Angela Bonaguidi
Email address:	Angela.Bonaguidi@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Treatment for Opioid Dependence (COTOD)

PROBLEM OR ISSUE

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

The Medicaid reimbursement rate is notably lower for substance use disorder services than for comparable services under a license for mental health services. Nonetheless, the credentials required to provide substance use disorder services is higher than for mental health disorders. The Colorado Department of Human Services combined the two branches to create an oversight entity, the Office of Behavioral Health. The Office of Behavioral Health integrated rules in order to govern substance use disorder and mental health treatments, thus creating equality between the two historically divided interventions. The ongoing discrepancy creates workforce development issues (poorer reimbursements drives lower pay for staff members) and significant operational strains on substance use disorder agencies.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1. The reimbursement of a substance use disorder service described in subsection (1) of this section that is provided by a Colorado Department of Regulatory Agency (DORA) registered individual described in subsection (2) shall be in the same amount as the reimbursement paid under the policy to mental health professional (or agency) performing the service in the area served.
    1. Group therapy, Individual therapy

2. Registered Psychotherapist, Masters of Social Work, Masters of Professional Psychology, Masters of Marriage and Family Therapy, Certified Addictions Counselor II or Certified Addictions Counselor III
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:	Paul Egan
Email address:	Paul.a.egan@gmail.com
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Clients who are succeeding in treatment are losing their Medicaid benefits due exceeding income requirements.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. Expand Medicaid Buy-in Program for Working Adults with Disabilities to include opioid dependence as a pilot program. Expand to alcohol or other drugs of abuse if successful.	
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:	Edie Busam on Behalf of Dominion Diagnostics
Email address:	ebusam@aponte-busam.com
If submitting on behalf of an organization, provide organization name*:	Dominion Diagnostics

PROBLEM OR ISSUE

Dominion Diagnostics is solution oriented with regards to assisting with plans to address the opioid crisis. We do recognize the grave problem facing our healthcare teams and policy makers. We are concerned that testing for opioids in certain areas is poorly reimbursed. The standard of care in this area could be challenged if adequate funding is not considered for utilizing state of the art management tools and education for practitioners. Not offering these additional services impacts a client's ability to stay compliant with plan of care.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. The value proposition is that medication monitoring/urine drug testing is really the only objective tool available for clinicians to be able to determine if their patients being treated for addiction or chronic pain are following their course of treatment and taking prescribed medication, such as buprenorphine, and not taking other prescribed or illicit drugs that will cause adverse outcomes

2.
The testing Dominion Diagnostics performs is combined with extra wrap around services which are included in the testing reimbursement. These include education by our experts, a randomization scheduling tool that allows the clinicians to set up a random testing schedule, data analytics that show how the patient population is performing relative to the tests showing expected or unexpected results and if there are unexpected results which drug or drugs are causing the unexpected results, etc.

3.

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

1.
Funding increase for tools (lab diagnostics) that enhance diagnosing and treatment, specifically in the Medicaid area as the reimbursement has been reduced to where the enhanced services may not be offered to assist healthcare providers to best manage these patients.

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:	Abbye Silverstein, L.Ac
Email address:	abbyesilverstein@gmail.com
If submitting on behalf of an organization, provide organization name*:	

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: In July 2017, The Joint Commission revised standards to include both pharmacologic and non-pharmacologic pain treatment modalities as a result of the opioid crisis. The non-pharmacologic modalities are: acupuncture therapy, chiropractic therapy, osteopathic manipulative therapy, massage therapy and physical therapy. The new standard takes effect Jan. 1, 2018. Acupuncture is an essential benefit under the ACA. States who chose to include acupuncture, pay for it under the Medicaid expansion. Colorado did not choose acupuncture. In light of the current crisis and Joint Commission standards, Colorado Medicaid needs to include acupuncture to recover from opioids and manage pain.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Provide acu-detox treatment (bilateral 5 needle auricular protocol) for 90 days as an alternative to pharmacologic treatment for opioid addiction.
2. Provide full body acupuncture treatment for all recovering opioid users to manage their pain symptoms.
3.

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

1. Medicaid pays for acupuncture treatment (ie. acu-detox and full body acupuncture treatment for pain management).
2. Medicare in Colorado pays for acupuncture treatment (ie. acu-detox and full body acupuncture treatment for pain management).
3. All insurance providers pays for acupuncture treatment (ie. acu-detox and full body acupuncture treatment for pain management).

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:	Jennifer Miles
Email address:	Jennifer@frontlinepublicaffairs.com
If submitting on behalf of an organization, provide organization name*:	Colorado Providers Association (COPA), full support of members at August meeting

PROBLEM OR ISSUE

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

Lack of sufficient funding to provide the full spectrum of SUD services across the state to all people in need of services.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1. Additional funding is needed for SB16-202 and should be supported by the Interim Committee. The SB16-202 needs assessment and prioritization processes should be used to direct funds to those areas of the state and types of services most needed.

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:	Daniel Darting
Email address:	ddarting@signalbhn.org
If submitting on behalf of an organization, provide organization name*:	Signal Behavioral Health Network (SUD MSO for NE Colorado, Metro Denver, and SE Colorado)

PROBLEM OR ISSUE

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

Over the years as the State Legislature has directed funding towards addressing substance use prevention, treatment, and recovery, the initiatives have often been crafted as separated items, with coordination not always occurring. While any resources directed in this area are very important, it is helpful to have a central framework of planning around addressing these complex issues and funding solutions.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1. In the 2016 session, the State legislature sponsored a bill, SB16-202, to provide expanded funding for SUD prevention, treatment, and recovery. Colorado's SUD Managed Service Organizations (MSOs) were to operationalize this legislation by performing a needs assessment, creating action plans to address the needs identified in the assessment, and fund initiatives in line with those action plans.

The core of this process is the regional, community-based needs assessment, informing how resources should be directed in different areas of Colorado. Through that needs assessment there is community engagement and coordination of new resources across the entire continuum (prevention, treatment, and recovery).

SB202 allows for interconnected systems of care in SUD; this has often not been the case, resulting in poor outcomes for clients at times. Further, SB202 creates a system of prioritization for new resources as they are made available.

The MSOs received requests totaling over twice the amount of funding allocated in FY1718.

Even the requests that were made did not cover all of the areas of need noted in the needs assessment. Of greatest need: recovery care, residential treatment for all populations, clinically-managed and medical detox, prevention and residential treatment for adolescents, medication-assisted treatment expansion, SUD-integrated crisis services, and other priorities. These areas are critical to tackle the opioid crisis and the larger SUD need among Colorado's populations. As this committee is considering new resources to devote to this health crisis, we request that they be included inside of the SB202 framework to allow for maximum flexibility and effectiveness for clients in need.
2.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Please note that these recommendations have the full support of Signal Behavioral Health Network.

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

Treatment/ Recovery Support

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form: Craig Fiorini	
Email address: craigmfiorini@gmail.com	
If submitting on behalf of an organization, provide organization name*:	

PROBLEM OR ISSUE: Access to Vivitrol prescribers

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

-Many doctors defer to psychiatrists and will not prescribe or administer Vivitrol

-Many psychiatrists will not prescribe or administer Vivitrol because they defer to Substance Abuse Specialists or psychiatrists with specialized training

-Most of our clients are on Medicaid and the odds of finding a psychiatrist who takes Medicaid are slim and even worse for a client who requires attention during a very specific window of time (immediately following the cessation of withdrawal with a clean UA)

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Education for doctors about Vivitrol to manage fears of practicing outside of their scope of practice.

2. Access to better information regarding which providers will prescribe Vivitrol

3.

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

1. Changes to standard of care so that all doctors feel comfortable to prescribe and administer Vivitrol

2. Changes to standard of care which would allow providers to bill Medicaid for Vivitrol without an Opioid or Alcohol Use Diagnosis. Rationale: Many potential clients will be turned away from providers who do not feel competent to diagnose Substance Use Disorders. Many clients report discrimination or shaming by medical staff when self-identifying as an addict and would rather keep this information off of their medical record.

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:	Paula Riggs MD, Professor and Director, Division of Substance Dependence, Department of Psychiatry, University of Colorado School of Medicine Co-Chair, CCPDAP Treatment Workgroup
Email address:	Paula.riggs@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Treatment Workgroup Colorado Consortium on Prescription Drug Abuse and Prevention (CCPDAP)

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders). There has been a significant increase in state and federal funding to expand medication assisted treatment (MAT), naloxone, and other treatments for adults with opioid use disorders (OUD). However, but little has been done to address the current opioid crisis where it most often begins, during adolescence. According to SAMHSA, 85% of young adult injection heroin users report that they started abusing prescription opioid medications as adolescents before progressing to IV heroin. Of the 14.8 million adolescents in the U.S. with substance use disorders (SUD), 95% are still attending school, but only 4% of these receive substance treatment (NSDUH, SAMHSA, 2012). The estimated 10-15% of high school students in Colorado (and nationwide) who currently meet criteria for any SUD are among the highest risk groups for developing OUD. The CCPDAP Treatment Workgroup has identified statewide expansion of school-based substance screening and treatment as one of the workgroup's top three priorities and recommendations for addressing the current opioid crisis and the critical gaps in substance treatment access for Colorado's youth and families. It is unlikely that this recommendation will be realized without legislative support and funding.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Statewide implementation of standardized brief substance screening measures (e.g. S2BI; BSTADT) in school-based health clinics (SBHCs) for all students grades 7-12
2. Implementation evidence-based substance treatment services in high schools throughout the state.
3. Workforce training. Many SBHCs throughout Colorado have co-located licensed mental health counselors, but very few of these counselors are trained in evidence-based substance treatment interventions. Providing such training could efficiently leverage existing infrastructure and resources to rapidly increase adolescent substance treatment capacity and treatment access, especially for minority and disadvantaged youth.

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

Although the aforementioned "practice recommendations" do not require new legislation or policy change, it is unlikely that these recommendations will be adopted or implemented on a sufficiently broad scale to have meaningful impact without legislative support and funding. The CCPDAP Treatment Workgroup has previously collaborated with the State Attorney General's

Office and legislative sponsors on SB-17-074 that provides funding for a pilot program to expand the clinical workforce and medication assisted treatment (MAT) for individuals with OUD in under-served rural areas of the state (currently underway).

RECOMMENDATIONS:

1. The CCPDAP Treatment Workgroup requests and recommends that the Interim Study Committee consider similar legislation to fund a pilot program to implement school-based screening and substance treatment (evidence-based) with rigorous outcomes assessment in 2-3 large public high schools serving a diverse student population. The anticipated positive outcomes from this pilot demonstration project would inform further development of sustainable adaptations of the model that could be adopted or disseminated statewide to address the opioid crisis and the significant unmet need for adolescent substance treatment services in Colorado.

2. The CCPDAP Treatment Workgroup requests and recommends that the Interim Study Committee consider legislation to support and fund a statewide needs assessment in public middle schools and high schools to evaluate: 1) existing school-based substance and mental health services; 2) to what extent are current behavioral health services provided under the auspices of or co-located SBHCs and current funding or payer sources of school-based behavioral health services; 3) barriers to school-based substance screening and implementation of school-based substance treatment services; 4) current methods of identification, assessment, and referral of students in need of mental health health/substance treatment services; 5) acceptability and feasibility of school-wide substance screening; 6) current level of training and experience of existing school-based behavioral health clinicians; and 7) interest and need for substance intervention training and onsite school-based substance treatment.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

The CCPDAP Treatment Workgroup has not previously received support from organizational leadership or members for the proposed school-based initiatives.

Documentation of the CCPDAP Treatment Workgroup goals, priorities, and recommendations can be provided upon request.

*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:	Angela Bonaguidi
Email address:	Angela.Bonaguidi@ucdenver.edu
If submitting on behalf of an organization, provide organization name*:	Colorado Treatment for Opioid Dependence (COTOD)

PROBLEM OR ISSUE

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

According to the United States Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration states that housing discrimination related to Medication Assisted Treatment MAT sometimes arises in the context of residences for individuals in recovery. Individuals who live or want to live in halfway houses, recovery homes, or other residences for individuals in recovery are sometimes excluded because of their participation in MAT. This is illegal even though this type of discrimination occurs with some frequency. Patients participating in Medication Assisted Treatment for Opioid Use Disorder, specifically Methadone, are frequently detoxed or asked to taper Methadone in jails, prisons, half-way houses and residential treatment facilities. Unsupervised withdrawal from Methadone can lead to relapse and death.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1. Jails, prisons and residential facilities must work with local Medication Assisted Treatment providers to ensure continuation of care. Medication Assisted Treatment must be a consideration, ruling out the option to deny a person services jail/prison/inpatient/residential) when it is available as an option. Jails, prisons, inpatient and residential facilities must work within regulations to ensure a person's continued access to Medication Assisted Treatment.

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:	Marjorie Zimdars-Orthman
Email address:	mzorthman@comcast.net
If submitting on behalf of an organization, provide organization name*:	Some of the members of the Consortium are familiar with concerns I have expressed the last two years regarding access to pain management doctors, however I have not specifically discussed this proposal with any Consortium work groups.
PROBLEM OR ISSUE	
Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Long term opioid therapy (LTOT) patients and Medication Assisted Treatment (MAT) patients unfortunately have interruptions in their health care. The Colorado Crisis Services mental health crisis hotline does not list this as a reason to call and be able to get help in finding a resource. LTOT patients or MAT patients may lose access to a doctor, may have lost insurance or be in an insurance denial situation and are not able to resolve these situations before they run out of medication. LTOT patients are in a chronic pain situation. MAT patients are being treated for substance abuse and are in treatment trying to build their lives. Going to an ER most likely will not give them a resource to connect with. Or if they go to an ER they may be turned away without even any temporary treatment. The hotline should create a resource list of doctors and clinics who will help them. Having these patients who are in a dependency situation go into withdrawal or have no other option than illegal drugs or suicide, is not what should happen.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1. Expand the services of the DHS Colorado Crisis Services to LTOT and MAT patients for obtaining timely resources that will enable them to find a doctor or clinic for their needs.	
2. Revise the crisis line website to have interruptions in medical care of LTOP and MAT patients as a reason that this help line can be called.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1. If DHS cannot expand the services without additional funding to create the resource list for referrals and to expand the training for the professionals and counselors who staff the crisis line then the legislature should add funds to their current budget.	
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:	JK Costello, M.D., M.P.H.
Email address:	jkcostello@steadmangroup.com
If submitting on behalf of an organization, provide organization name*:	Harm Reduction Action Center

PROBLEM OR ISSUE

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

I am a physician and health care policy consultant. I examine ways to improve treatment of substance use disorders, particularly opioid dependence.

While many people cite the lack of providers of medication-assisted treatment (MAT)—specifically buprenorphine-- my research leads me to believe that there are enough qualified providers. Rather, the problem is matching demand and supply. The highest concentration of demand for MAT is in institutions like jails and hospitals. Individuals in these settings may have experienced significant consequences of opioid use such as overdose or incarceration. Their willingness to change their behavior is often high. Providing MAT in this setting may be more likely to succeed than in a community-based setting.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Encourage emergency departments to provide not only referrals to care but also a first dose of MAT to clients seeking treatment for opioid-related conditions. A recent study showed that retention in treatment is increased dramatically when MAT is provided in the emergency room to people who have experienced an overdose.
2. Similarly, clients in inpatient settings are often willing to attempt treatment after an opioid-related admission for overdose or other illnesses. While large research hospitals like UC may provide these services, most do not.

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

1. Provide MAT—specifically buprenorphine-- in jails and prisons. As we discussed at the interim opioid study committee, some jails provide injectable naltrexone for clients, but participation in this program has been low.

This policy would have several positive effects inside and outside jails. First, the overdose rates for people recently released from incarceration is astronomical; recently parolees were 129 times more likely to die of an overdose than residents of the state who were not incarcerated. Rates of overdose are far lower for former inmates provided with MAT during their incarceration.

Second, providing buprenorphine would decrease the illicit trade in this medication in jails and prisons. Many incarcerated people utilize buprenorphine illicitly to avoid withdrawal symptoms; providing this in a controlled setting would diminish this illicit market.

Third, former inmates on buprenorphine are more likely to reintegrate into society. In a large study on Rikers' Island, 3 times as many parolees reported for their post-release treatment when given buprenorphine versus methadone.
2. Provide funding for pilot programs to improve MAT provision in ER and inpatient settings as stated in items 1 and 2 above.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
These recommendations have been endorsed by Lisa Raville, executive director of the Harm Reduction Action Center.

JK Costello, M.D., M.P.H.
The Steadman Group
jkcostello@steadmangroup.com

August 23, 2017

To the esteemed members of the interim opioid study committee:

My name is JK Costello and I am a physician and health care policy consultant in Denver. I am a general physician and my policy expertise is in systems of care for mental health and substance abuse. I am writing you to give a brief summary of the cost-benefit of options for medication-assisted treatment for opioid use disorder as well as my expert opinion on this matter.

There were three medications discussed yesterday, including methadone, buprenorphine (trade name: Suboxone), and naltrexone (trade name for intramuscular version: Vivitrol). There are several studies of the effectiveness and cost-effectiveness of these medications. Here is a brief summary of the findings of the studies I considered; citations and links can be found below.

- Methadone is the cheapest by a significant margin
- Methadone has the highest treatment retention
- Buprenorphine may be more cost-effective when crime is taken into consideration
- Intramuscular (IM) naltrexone is the most effective at maintaining abstinence by a small margin
- IM Naltrexone is not cost-effective using generally accepted American standards

While methadone may seem ideal given these bullet points, one aspect that these studies did not consider was mortality due to methadone. In Denver, at least 12 of the 174 drug overdose victims in 2016 had methadone in their systems, per coroner's reports. This is consistent with my findings from previous years. Buprenorphine was not mentioned in any of the deaths.

Furthermore, engaging patients in treatment is paramount during recovery from substance use disorder. In my experience with clients at the Harm Reduction Action Center, where I completed my Masters' capstone, clients were most engaged in buprenorphine treatment. The convenience of buprenorphine dosing allowed them to engage in other recovery activities, such as work, family life, and recreation with a minimum of stigmatization.

Having a range of options is important, because no option is perfect for all clients. That said, I highly recommend that you consider buprenorphine treatment as first-line therapy for opioid use disorders. These three medications require very different systems for prescribing, payment, and administration, so legislative priorities should look at emerging trends in utilization. Buprenorphine is the best option for the greatest number.

Citations:

1. https://www.ncbi.nlm.nih.gov/books/NBK62286/
2. http://www.sciencedirect.com/science/article/pii/S0376871603001698
3. https://link.springer.com/article/10.2165/00019053-200523010-00007
4. http://www.tandfonline.com/doi/abs/10.1080/08897077.2015.1010031
5. https://www.ncbi.nlm.nih.gov/pubmed/28239984

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Judith Ann Miller, Ph.D., CACIII
Email address:	Redfeather7@earthlink.net
If submitting on behalf of an organization, provide organization name*:	Soaring Hope Recovery – For several year I have served on the Attorney General's Substance Abuse Taskforce and the Endangered Children Committee and Prescription Medication Overdose Committee.

PROBLEM OR ISSUE

Describe the specific challenge in your field of expertise, related to opioid or other substance use disorders: Our greatest challenge is getting the word out to people who are addicted to Opiates, Opioids, Benzos, SSRIs, to inform them that there is an innovative, science-based integrated recovery program that provides sustainable recovery safely, with no medications. Policy makers and professional referral people should know that there is a safe, effective method of treatment without the use of Medical Assisted Therapy (MAT).

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. **Care and Feeding of the Brain** – Soaring Hope Recovery (SHR) employs an FDA approved neurofeedback system that combined with science-based neurotransmitter rebalancing to bring the addicted brain to a functional level. This process is preliminary to applying the traditional addiction recovery therapies such as CBT, DBT, EMDR, trauma therapy.

2. Soaring Hope Recovery strategically integrates the evidence-based therapies without the use of medications. The SHR staff is headed up by an MD, Addiction Specialist, Medical Director. The staff is trained in trauma therapy, and treating the underlying causes of addiction including Adverse Childhood Experiences.

3. Soaring Hope Recovery is dedicated to treating the causes of addiction, not merely the symptoms of addiction. We recognize that addiction is an actual brain disorder and is a symptom of dealing with past trauma, transgenerational trauma, as well as the genetic component.

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

1. The emphasis on Harm Reduction is advantageous in saving lives and can actually serve as a first step to finding sustainable recovery.
2. Substance Abusers should be given the choice to accept care such as provided by Soaring Hope and other like programs rather than Methadone or Suboxone which are highly addictive.
3. Addicted persons on the MAT program should be given the information, education, and option to seek sustainable recovery rather than send many months, years, or a lifetime on Methadone and/or Suboxone.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
This is a strong recommendation for the committee to learn about and consider that there is a viable alternative to MAT. We recognize the value of MAT and are strongly in favor of any Harm Reduction process that will save lives. We have extensive experience in assisting people who have become addicted to Methadone and Suboxone to achieve sustainable recovery. The committee should know that recovery from Methadone and Suboxone is a lengthy, painful experience, much more painful than recovery from Opiates/Opiods.

*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:	Shaun Gogarty, MD
Email address:	wsgogarty@gmail.com
If submitting on behalf of an organization, provide organization name*:	

PROBLEM OR ISSUE

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

In the past few years, there has been a massive increase in the number of patients presenting to the emergency department for heroin/narcotic use related conditions: abscesses, endocarditis (32 cases last year), overdoses (720 cases last year), epidural abscesses. The cost on the system to evaluate and treat these patients is enormous. The effects on individuals, families and the community are staggering. **Patients and families seeking help in the ED are offered very little if anything and the treatment options in the community are ridiculously limited.** The proven solution of medication assisted treatment (MAT) with Suboxone is limited by the restrictions on its use and resulting inhibitors.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Make MAT more available by giving willing providers a place – outside their own practice - where they can see patients seeking treatment for addiction.
2. Statewide ED protocol for patients in withdrawal using a defined set of medications – including Suboxone - and connecting them with MAT provider within 72 hours.

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

1. Stop limiting providers of MAT to 30 patients the first year.
2. Stop the DEA from treating all MAT providers as potential criminals.
3. Require the DEA to provide treatment for every patient of any physician that they "shut down" for overprescribing narcotics

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

In the first 17 years of practicing emergency medicine at Parkview hospital in Pueblo, CO I took care of not more than 20 total heroin related cases. There was clearly a narcotic abuse issue but it wasn't heroin or IV abuse. Then about 2013(?) the DEA closed a few practices that provided the city with most of the prescription medications. They didn't provide any place for these patients to go for treatment/help. About the same time, the "boy from Nayarit" likely showed up with a treatment option: cheap heroin.

Providers must take 8 hours of training and can only see 30 MAT patients. Why would the average provider spend money and time to add just 30 "addicts" (most self-pay or Medicaid) to their practice. Additionally, the DEA has "raided" the few MAT providers and in one case shut down the practice for 2 days further deterring any interest in providing MAT.

Presently, many addicts are seeking help through the emergency department. If the community had a "MAT clinic" where providers could rotate in/out a few hours each month

and see "their 30", I believe more providers would be interested helping. The clinic could be in conjunction with the health department. The clinic could be organized and run by one entity so there is consistency from provider to provider and so that DEA requirements are met.

While needle exchanges have proven effective in harm reduction. MAT is really the next step in harm reduction. It doesn't cure anyone, but it helps them avoid the dangers of injecting and lets them have time to address their addiction rather than constantly be looking for their next fix. Having drained innumerable abscesses in the ED, treated many overdoses and felt helpless when addicts and family have sought my help, I believe it is imperative that we do everything possible to make MAT readily available.

Presently, in addition to my emergency medicine practice, I'm personally providing MAT through an office at Health Solutions one day per week.

*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:	Jeff Jones
Email address:	sjeffjones@me.com
If submitting on behalf of an organization, provide organization name*:	The Family Recovery Solution

PROBLEM OR ISSUE

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

- Family members don't understand their role in addiction or recovery (due to the demands from the needed focus on the addiction)
- Family members repeat old coping patterns when Addicted Individual (AI) is going into recovery
- Higher relapse rates (with the above)
- More conflict and distance (with above)
- Children repeat these patterns

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Referring family members to The Family Recovery Solution Deep Community (TFRS-DC) — http://www.thefamilyrecoverysolution.com/families/

2. Early Stage: Because of online community and anonymity option, TFRS-DC meets a gap in services (early intervention). Family engagement with ongoing invitation to AI to join community, makes TFRS-DC an early intervention model.

3. Mid Stage: Families can learn, practice what they've learned, and report back to the community - connect likeminded people with resources and expertise, when they are ready for it (not having to wait until higher and higher crisis to reach out)
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1.
2.
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Check out: http://www.thefamilyrecoverysolution.com/professionals/ and http://www.thefamilyrecoverysolution.com/families/ Our aim is to empower the family to be a stronger part of the solution in recovery.

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
A system of largely unregulated "Sober Homes" provides poor living conditions to people throughout the state who are grappling with substance abuse, homelessness and a return to life after prison.	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.Enact legislation to regulate sober living facilities. Suggested legislation enacted by the State of Arizona: *www.azleg.gov/legtext/52leg/2r/bills/hb2107p.pdf*	
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:	Rourke Weaver
Email address:	rourke@redrockrecoverycenter.com
If submitting on behalf of an organization, provide organization name*:	Strategy Working Group under the Colorado Consortium for Prescription Drug Abuse

PROBLEM OR ISSUE

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

Individuals who are coming out of a SUD often face having a legal record which makes makes finding meaningful employment very difficult and thereby perpetuating the cycle of addiction.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1.

2.

3.

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

1.

Creating legislation that supports businesses by incentivizing hiring of individuals

with a SUD through tax incentives related charges will create an impactful transition to a sustainable and meaningful life. Creating employment opportunities will have significant impact on the four pillars of recovery (Health, Home, Community and Purpose), lower recidivism rate, bolster community understanding as well as support the value of recovery. There have been States and Countries that have done this in different ways and we feel there is an opportunity to look at how we can provide wider options for those struggling to re-integrate. Our proposal is that we open the door to legislative change that makes sense for Colorado and directly impacts stigma and quality of life for the person in recvoery.

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

Funding coalition work

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Carrie Heltzel
Email address:	carrieheltzel@gmail.com
If submitting on behalf of an organization, provide organization name*:	San Luis Valley Joint Interagency Oversight Group

PROBLEM OR ISSUE

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

The San Luis Valley is experiencing an opioid epidemic that is impacting three generations of families (parents and children struggling with addiction and grandparents who are providing kinship care). We don't have enough local resources to meet the growing need, although we have been making strides. Below is a brief summary of recent initiatives:

1) The SLV Neonatal Task Force works is composed of several agencies (health and community) working together to improve health outcomes for babies. They are providing education to providers, law enforcement, and community agencies around system improvement for substance abusing pregnant women. The group has helped find funding for a project to reduce stigmas associated with pregnant women getting into treatment.

2) The Needle Exchange Program is in the process of getting approved (only in Alamosa County at this time). A Harm Reduction Program is a need in the SLV, with funding requested from a variety of sources. Harm reduction efforts will include HIV/Hepatitis C testing, clean injection kits, wound evaluation and wound care, education and warm handoffs, naloxone kits. We need more naloxone kits for the community to meet demand and to replace those that have expired. The Attorney General's Office has recently appropriated funds to supply law enforcement agencies in the 6 SLV counties with naloxone, to replace kits that have expired. We hope to expand this program to the other counties down the road.

3) Outpatient treatment (substance abuse) is offered through the San Luis Valley Behavioral Health Group, Crossroads' Turning Points and a few smaller organizations and private clinicians. There is a shortage of CAC trained staff and it is more challenging to offer training in rural areas. With budget cuts it is difficult to have adequate training budgets. It is also challenging to recruit providers to live in rural areas and also to be competitive (salaries) with urban areas to recruit and retain providers.

4) Crossroads' Turning Points has opened a methadone clinic, which is currently serving 53 clients and haws capacity to take more.

5) Healthcare: There is currently only one physician in the Valley who prescribes suboxone. She has a long wait list and is prioritizing pregnant women. We are working on more providers who are willing to prescribe.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)
1. We would like assistance with research findings/best practices regarding: • Working with adolescents with opioid addictions. What treatment options are most effective for this population...methadone, suboxone, vivitrol? • Successful strategies to help build recovery communities in rural areas
2. We would like assistance with data collection and analyses.
3. We would like assistance identifying what is working in other rural, impoverished communities. What protective factors are most helpful? How can we apply lessons learned?
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. We need resources in order to develop local intensive inpatient treatment programs. Most of our youth are sent to the Youth Recovery Center in Glenwood Springs, but there aren't enough beds; the current wait is up to three weeks. Lastly, many of our youth are experiencing long stays in detention (30-40 days) while waiting for beds in RTC's or at Division of Youth Services, which is not appropriate.
2. We are interested in designing increased substance abuse / intensive outpatient programming for youth and their families. This programming would need increased medically assisted treatment, increased workforce capacity, community and agency education, and peer support. We would need funding in a few different ways to support this: • Funding is needed to increase our <u>treatment provider capacity/retention</u> i.e., offering more training and money (salary incentives) for those who provide SUD / MH services. More support to provide/grow our own programs in rural areas, scholarships and salary support to get SUD/MH degrees. • Education/training for providers, communities and families so help increase the knowledge that inpatient treatment alone is not enough to support full recovery (it is not a magic wand). Intensive transition support needs to be built into treatment plans (with leverage if necessary) i.e., from Probation, DSS and Inpatient/residential placements. Individuals and families need continued support from communities i.e., intensive outpatient, outpatient, recovery programming. • Funding for recovery peer specialists/patient navigators to increase connections, outreach, support, recovery resources and family voice in services. • There is a need for a patient navigator as part of the Harm Reduction Program, to assist people who use drugs, those in recovery, and their family members, to access needed services for treatment and recovery along with social support.
3. We need more support for youth and their families who are transitioning back to the community from residential treatment. There is a high risk for relapse. Programs need to be tailored to adolescent treatment. There is also a huge gap in services for young females in our communities.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Thank you for the opportunity to provide input.

*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:	Ruchi Kapoor (Legislative Liaison)
Email address:	rkapoor@coloradoorpc.org
If submitting on behalf of an organization, provide organization name*:	Office of Respondent Parents' Counsel (ORPC)

PROBLEM OR ISSUE

Our office represents parents who have had cases filed in child welfare proceedings, and many of the parents that we represent are entangled in the court system because of active addictions. The purpose of child welfare proceedings is to work to reunite parents with children through treatment offered by the county department of human services; often our attorneys see parents at very late stages in their addictions.

One of the biggest barriers for people at this stage in their addictions and during the pendency of these proceedings is the lack of drug treatment resources in their communities that the department can access, which increases the wait time for evaluations, which often puts unnecessary delays in a case, which can then prolong the possibility of resolution for these families.

Another barrier to resolution in these cases is the lack of access to appropriate evaluations (for example, a parent might have an issue with opioid addiction, but because of availability, will only have access to evaluation by a mental health provider rather than a substance abuse provider). Appropriate evaluations are key to helping these parents get access to the treatment they need and increase the likelihood that a parent will successfully complete treatment and be reunified with his or her children.

Finally, there is just a general lack of understanding of the disease of addiction and the medical model of addiction amongst caseworkers and other county and department employees. Parents who are working on completing their treatment plans that include treatment for addictions might relapse during the pendency of a case. Rather than treating that relapse as part of the parents' disease and working to recalibrate treatment as suggested by most medical models, some child welfare workers might treat that relapse as an abject failure of the treatment which then increases costs for the system, because it might prolong a stay in foster care for a child.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Study and make best practice recommendations regarding methods and means for treating parents while keeping children in the home.
2. Educate county departments of human services about the disease model of addiction through active training
3.

POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)
1. Increase availability of resources for addiction treatment in non-metro areas of the state, perhaps through the department of human services. Or increase availability of transportation to treatment for these folks, either through paid vouchers or some sort of grant. (has received support from Executive Director and Deputy Director of ORPC)
2. Change CDHS regulations (Vol. 7) to make keeping children in the home during treatment for parents as a best practice requirement for first responses when the case is brought into intake by the county department. (has received support from Executive Director and Deputy Director of ORPC)
3.
OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
Sometimes what is overlooked for many addicted parents is that addiction is a trauma response or coping mechanism. It can often do more trauma to the family, not to mention increase costs to the system, to remove children from drug addicted parents without first looking at how these families can be helped through a holistic approach that incorporates all of the recent developments in addiction science and understanding of how the disease works.

*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:	Jeff Zayach
Email address:	jzayach@bouldercounty.org
If submitting on behalf of an organization, provide organization name*:	Boulder County Public Health

PROBLEM OR ISSUE

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

Between 2001 and 2016, there were over 400 unintentional drug overdose deaths in Boulder County. Since 2005 there have been more accidental deaths from drug overdose than motor vehicle accidents. From 2016 to 2017 to date, there have been more than 600 drug possession charges filed throughout Boulder County. Between 2010 and 2016, the number of clients accessing the Boulder County Public Health (BCPH) syringe exchange program has increased by 800%.

The opioid crisis is a burden on local communities and a strain on local government resources. This includes housing and treating individuals in the jail; increasing operating expenses for syringe exchange supplies; limited treatment options; and, limited wrap-around services. In 2016, the Criminal Justice Management Board led by the chief judge and agency officials signed off on a plan where Boulder County Public Health was tasked to convene an Opioid Advisory Group (OAG). The OAG uses a collective impact framework to prevent opioid initiation, promote harm reduction, move people into treatment, and support recovery. This interdisciplinary group is comprised of members from K-12 education, higher education, law enforcement, hospitals and medical providers, jail, district attorney's office, treatment, recovery, and community.

As a result of their recent action plan, the OAG identified **four** priorities:

Priority 1: Prevention
- Align prevention messaging across coalitions and other stakeholders/sector
- Include safe disposal campaigns (e.g., include prevention information when the Rx is filled.)

Priority 2: Treatment
- Wrap around case management for high-need medication assisted therapy (MAT) clients with housing, benefits etc.
- Simple, low threshold access to MAT from Emergency Departments and criminal justice diversion.
- Hotline for the Emergency Department to hand a client off -- to connect the client with need resources and referrals, e.g., housing, transportation, and counseling.

Priority 3: Data

- Identify, select and prioritize data indicators that measure progress across the county
- Build an evaluation plan using local and state data to gauge progress

Priority 4: Law Enforcement and Community Support

- Develop a system map to create a diversion program for individuals with substance use disorders who engage in criminal activity. The goal is to reduce jail incarceration and recidivism and to ensure that individuals are receiving treatment and case management support. These diversion pathways will help the person get connected with housing, peer recovery, treatment, needle exchange, detox, and other needed resources.

Priority 5: Clinical Setting

- Safe and affordable medical detox from benzodiazapines
- Peer recovery support in the emergency room after an overdose

Summary

The OAG operates with a shared leadership model, which means each agency is accountable to helping to solve this complex issue. Currently none of these partners are funded to participate in the OAG.

Current support for the OAG in Boulder County is in-kind, in addition to regular workloads. Addressing opioid addiction is complex and requires a multi-disciplinary approach which leverages leadership, resources and shared-decision from multiple entities. Public health plays a leading role in organizing partners, convening meetings, contributing best practices research and leading our community to action in a collaborative manner. Resources are needed immediately to implement identified priorities.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Create a Local Public Health Agency committee at the Colorado Consortium for Prescription Drugs as local public health is key to reversing this critical trend.
2.
3.

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

1. Fund local governments to develop and implement action plans to address the complex opioid issue, using the best evidence available. Recommend that funding is administered to a coordinating agency that may reside in or out of government. Funding should include money for convening stakeholders for at least three years; stakeholder participation; implementation of action plans for each priority identified, and identification of measures to evaluate success.
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

Other Legislative

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Frank Cornelia
Email address:	fcornelia@cbhc.org
If submitting on behalf of an organization, provide organization name*:	Colorado Behavioral Healthcare Council

PROBLEM OR ISSUE: Siloed and divided acute-care systems create barriers to treatment.

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

The barriers to accessing treatment in our state are critically salient when an individual seeks acute care such as withdrawal management or crisis stabilization. The silos created in funding, workforce, facility licensure, and even treatment of patient types creates barriers to accessing much needed. We know from practice and research that most individuals present with complex and integrated needs. Siloed healthcare systems frustrate families and clients and create poorer outcomes. The state has a critical role to play in ensuring that individuals aren't left to navigate confusing systems at their most vulnerable times.

The following policy recommendations have received support from CBHC membership, specifically in the Managed Service Organization membership category.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. State departments must work together to examine the way in which regulations created arbitrary divisions between types of clients based on presenting concerns, types of facilities, types of workforce, and the process of funding services.
2. State departments should create coding that accounts for integrated behavioral health/SUD services and patient needs. Diagnosis-based treatment, billing, and quality measures does not align with the reality of many patients and creates difficulties for providers and communities alike.

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

1. Introduce legislation to require CDPHE and other relevant State departments to reduce regulatory barriers to integrating acute behavioral health services. Strategies may include restructuring facility licensure to aligned acute behavioral health services, and reducing workforce and client type silos which are created by complex regulations.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

To meet the needs of complex individuals, it is important that we do not require them to attempt and navigate payment and healthcare systems during their time of need. Instead, our systems should be open to any individual who needs acute treatment and critical help, regardless of diagnosis or payor type.

*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:	**Katie Wolf**
Email address:	**kewolf@michaelbeststrategies.com**
If submitting on behalf of an organization, provide organization name*:	**Colorado Association of Addiction Professionals (CAAP)**

PROBLEM OR ISSUE

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

The scientific research aimed at understanding opiate abuse and dependence, and addictions in general, has illuminated many new understandings and discoveries over the last decade. The science clearly demonstrates that treating substance-related and addictive behaviors disorders is not the same as treating mental health or physiological health disorders. Treating substance-related and addictive behavior disorders requires short-term, long-term and potentially life-long engagement with treatment providers and community recovery supports. The dysregulation of the brain and the need to stabilize brain chemistry and physiological neurocognitive systems are foundational to the entire continuum of care from prevention through recovery and maintenance. The end goal of all efforts along the continuum of care is wellness and functionality. Regaining functionality and wellness requires systemic interventions that broadly address physiological, social, emotional, cognitive, familial, spiritual and environmental impairments. The Colorado Association of Addiction Professionals (CAAP) represents front line behavioral health addiction specialists (clinicians and service providers); preventionists, first responders, peer recovery supporters and mentors (those working to prevent use and abuse, offer community interventions and support resources); and organizations (treatment agencies, professional organizations, credentialing and regulatory bodies) that treat and address the systemic issues associated with the opioid crisis.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Having a "list" or "website portal" has not proven to be enough to connect primary care with addiction specialists. "Referral to treatment" components of SBIRT, nationally, have not proven to be enough to connect primary care, emergency and first responder systems and jails to community-specific addiction specialists. Community-specific efforts are needed to connect a primary care provider (physician, nurse practitioner, physician's assistant, psychiatrist, etc.) to the addiction specialists in their community. These efforts need to be tangible and meaningful; face-to-face introductions are remembered above and beyond technology-driven introductions. Efforts put towards meet & greets or lunch & learns make a big difference when looking at how community resources are utilized. Case management is

more than giving a physician, addictions specialist, or consumer/client a name and contact information.

2. Colorado has a vast amount of acreage classified as rural or frontier. Providers are heavily concentrated along the I-25 corridor from Fort Collins to Walsenburg. The rest of the state struggles to have qualified providers to help community members struggling with opiate use disorders. CAAP recommends that this barrier to service access be addressed using current technologies – bringing experts, specialists and clients together to help the client. Technologies such as video chats, video sessions, teleconferencing, etc. would bring the needed services throughout the state. By helping clinicians earn a Distance Counselor Credential – Colorado is building a qualified and valuable technology-enhanced workforce for the outlying areas. These technologies can also be used to bring qualified technology-based clinical supervision (i.e., LACs, addiction-specific psychiatrists and psychologists) to behavioral health providers in rural communities so the provider can work towards credentialing while providing excellence in care to its community members. These technologies would reduce barriers associated with supervision, credentialing, student loan repayment. Qualified individuals need practicum and internship sites, externship sites, residency sites, and employment sites *and* clinical supervision to earn the credentials they are working so hard to earn. If those sites are not available, qualified individuals who want to work with substance-related and addictive behavior disorders will not move to our rural and frontier areas where they are needed. Technology would help to bring the right cadre of people together to create a favorable treatment and recovery environment for our community members.

3. Another barrier that needs to be addressed – specific to the opioid crisis in our state – relates to treatment/recovery support options. There are viable options under (complementary and alternative medicine (technologies, tools, techniques, activities) that have data supporting the fact that they help clients (i.e., acupuncture, 12-step meetings, nonspiritual step meetings, sponsors, mentors, nutritional therapies, life skills development, yoga, Qigong, etc.).

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

1. The workforce needs appropriate and quick assessment tools that are specific to opiate and other drug use and abuse. ASSIST is a screening tool, developed through the World Health Organization, and used as part of the SBIRT protocols. It would be beneficial to require training on using the ASSIST tool and SBIRT protocol for all medical professionals while in their residency training. This would be a beneficial tool for the School of Dentistry students, nurses, first responders, etc. Building community-based behavioral health collaborative care teams. Fixing the M1 hold system in Colorado, based on previous legislation and directives.

2. Making opiate-use/abuse/addiction-specific education a requirement all prescribers, including dentists, veterinarians, etc. Educating public, professionals, paraprofessionals, educators, hospitals, prescribers, etc. – about the science and assessment of opiate use and

abuse. e-Prescribing legislation for all opioid prescriptions. Creating an "Opiate Crisis First Aid" module for training in Colorado. Creating a cadre of trainers who are mobilized to go into organizations to train the staff on addictions - taking the training to the professional.

3. Increase incentives and opportunities: loan forgiveness; employer incentives; employment; tax breaks to students; grants to employers; increase number of internship/externship sites. Provide cost-effective EHRs like DrCloud and training for better provider coverage.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE

- The crisis response system needs to train individuals/contractees, and hire qualified specialists, to address substance-related and addictive behavior issues when responding to a crisis. The statistics speak to the fact that many mental health and domestic violence crises occur when the perpetrator and/or the victim are not of sober and clear mind; the vast majority of crises occur while a person(s) is abusing substances. The crisis response system would benefit from specific training on assessing for substance-related issues and concerns.
    - ⇒ Providers need extensive training and supervision in addictions to understand the (a) science of opioid addiction, (b) neuro-biochemistry of opiate addiction, (c) evidence-based treatment strategies/tools that have positive outcome-driven data, and (d) community resources and supports that have been shown to maintain wellness and functionality. A person with only a Bachelor's, Master's or doctoral degree in behavioral health (i.e., social work, counseling, psychology, human services) with only a class or two or reading or two in addictions is qualified to address the opioid crisis in a long-lasting, community-building manner. There is no way to shortcut an addiction specialist's education, specialized training and field experience requirement - just as there would be no way to shortcut a cardiologist's education, specialized training and field experience requirement.

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

Other
Non-legislative

Opioid and Other Substance Use Disorders Interim Study Committee

Stakeholder Proposal Form

CONTACT INFORMATION	
Name of Person Submitting Form:	Brad Sjostrom
Email address:	bradley.sjostrom@sclhs.net
If submitting on behalf of an organization, provide organization name*:	I have not vetted the idea.

PROBLEM OR ISSUE

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

Prescription opioids are in great supply and easy to obtain. Roughly fifteen years ago, the pharmaceutical industries deliberately encouraged physicians to prescribe more opioids. Companies, such as Purdue Pharma, Teva Pharmaceuticals, and Johnson & Johnson have spent millions on marketing campaigns that trivialize the risks of opioids while overstating the benefits of using them for chronic pain. The companies have lobbied doctors to influence their opinions about the safety of opioids, borrowing a page from Big Tobacco.

PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)

1. Pursue a civil lawsuit and / or a class action lawsuit to diminish the amount of opioids available and garner money for treatment, prevention and recovery.

2.

3.

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

1.

2.

3.

OTHER SUGGESTIONS/COMMENTS FOR INTERIM COMMITTEE
I am not sure if this is the best venue to explore this idea. Several states have pursued civil litigation with moderate success.

*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:	Mary Steiner
Email address:	mary.steiner@ppchp.org
If submitting on behalf of an organization, provide organization name*:	
PROBLEM OR ISSUE	
Need for innovation to address pain management issues	
PRACTICE RECOMMENDATIONS (changes not requiring legislation or regulatory change)	
1.	
2.	
3.	
POLICY RECOMMENDATIONS* (changes requiring legislation, regulatory change, or funding)	
1.Support research initiatives at CU Anschutz to combat the epidemic and enhance treatment options, including alternative pain management strategies (example: Solodex a nerve catheter developed by two anesthesiologists in Colorado Springs) and treatment for vulnerable populations, such as pregnant women, and substance-exposed infants.	
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