COLORADO CONSORTIUM
for Prescription Drug Abuse Prevention

TO: Patty Salazar, Executive Director, Colorado Department of Regulatory Agencies
Members of the Colorado General Assembly

FROM: Colorado Consortium for Prescription Drug Abuse Prevention

DATE: July 1, 2023

RE: 2022-2023 Prescription Drug Monitoring Program Task Force Report

The Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) submits the enclosed report on behalf of the Prescription Drug Monitoring Program (PDMP) Task Force pursuant to 12-280-409(2), C.R.S. This report details the Consortium's work in response to the DORA Executive Director's requests to the PDMP Task Force.

Respectfully,

Colorado Consortium for Prescription Drug Abuse Prevention

COLORADO ELECTRONIC
PRESCRIPTION DRUG MONITORING PROGRAM

2022-2023 TASK FORCE REPORT

July 1, 2023

Table of Contents

COLORADO ELECTRONIC PRESCRIPTION DRUG MONITORING PROGRAM

2022-2023 TASK FORCE REPORT

Introduction:

Pursuant to Section 12-280-409(1), Colorado Revised Statutes (C.R.S.), the Executive Director of the Department of Regulatory Agencies (DORA) is required to create a Prescription Drug Monitoring Program (PDMP) Task Force or consult with and request assistance from the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) to:

1. Examine issues, opportunities, and weaknesses of the program, including how personal information is secured in the program and whether inclusion of personal identifying information in the program and access to that information is necessary;

2. Make recommendations to the Executive Director on ways to make the program a more effective tool for prescribers and pharmacists in order to reduce prescription drug abuse in Colorado; and

3. Evaluate and make recommendations to the Executive Director, after engaging in a stakeholder process, regarding balancing the program as a health-care tool with the enforcement of Colorado Revised Statutes, Title 12, Article 280.

Should the Executive Director convene a Task Force, it shall submit an annual report to the Executive Director and the General Assembly detailing its findings and recommendations, per §12-280-409(2), C.R.S.

This report provides the recommendations of the Task Force to the Executive Director in response to the items assigned to the Task Force by the DORA Executive Director as detailed below.

Requests for 2022-2023 Task Force Report

Following the issuance of the 2021-2022 PDMP Task Force Annual Report, DORA's Executive Director requested the Task Force to evaluate the following:

Task #1: Evaluate Potential Statutory Changes to Strengthen the PDMP as a Clinical Decision Support and Public Health Tool by Collecting and Sharing Fatal and/or Non-Fatal Overdose Information

The 2021-2022 Task Force report noted that several states allow their PDMPs to receive information regarding fatal and non-fatal overdoses and discussed how that information is shared with entities such as a patient's treating providers. I request that the Task Force evaluate the potential benefits and risks of allowing for fatal and/or non-fatal overdose data to be collected by the Colorado PDMP and shared with that patient's treating providers.

Task #2: Evaluate Potential Statutory Changes to Allow Practitioners with Prescriptive Authority but Lack a DEA License to Access Colorado PDMP Information

§12-280-404(3), C.R.S. delineates authorized access to PDMP data for certain healthcare practitioners, among other authorized roles. Current law requires practitioners to have controlled substance prescriptive authority to access Colorado PDMP information for any current patient of the practitioner. I request that the Task Force evaluate the potential benefits and risks of statutory changes that would allow practitioners (physicians, physician assistants, advance practice nurses with prescriptive authority, dentists, podiatrists, optometrists, and veterinarians) who do not hold an active registration with the Drug Enforcement Administration to access Colorado PDMP information for current patients of such practitioners.

The Executive Director's requests can be found in **Appendix A.**

Task Force Review and Responses to DORA Executive Director's Request for Assistance

The Executive Director's requests were submitted to the PDMP Work Group at the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium), which was designated as the PDMP Task Force by the Executive Director. Established in 2013, the Consortium is a coordinated, statewide, inter-university/inter-agency network. It now supports 11 different work groups with more than 1,000 participants, including providers, professionals, laypersons and other stakeholders. The participants and work groups study, recommend and implement ways to reduce prescription drug abuse in Colorado. The PDMP work group focuses on issues relating to the use and improvement of the state's PDMP.

The PDMP Work Group at the Consortium is composed of representatives with medical, legal, or health information technology expertise, interested patients and family members, members of the Colorado legislature, as well as representatives from various state and federal agencies. A full list of the PDMP Work Group members and their corresponding organizations can be found in **Appendix B**.

Task #1: Evaluate Potential Statutory Changes to Strengthen the PDMP as a Clinical Decision Support and Public Health Tool by Collecting and Sharing Fatal and/or Non-Fatal Overdose Information

The 2021-2022 Task Force report noted that several states allow their PDMPs to receive information regarding fatal and non-fatal overdoses and discussed how that information is shared with entities such as a patient's treating providers.

Evaluate the potential benefits and risks of allowing for fatal and/or non-fatal overdose data to be collected by the Colorado PDMP and shared with that patient's treating providers.

Response to Task #1

As discussed in Appendix I of the 2021-2022 PDMP Task Force Annual Report, a 2020 Pew Research Center report concerning policy changes that could bolster PDMPs recommends that:

> policymakers seeking to incorporate overdose data within their state PDMP should consider requiring any first responder—including emergency medical personnel, health care professionals, and law enforcement—to promptly report information regarding all drug overdoses to the state agency that operate the PDMP, including those caused by illicit substance use, to help ensure that clinicians and others have access to the information in a timely fashion.[1]

The Pew report further recommends that states with such non-fatal overdose reporting through their PDMPs should leverage unsolicited reports to proactively notify a patient's prescribing practitioner of the patient's non-fatal overdose to ensure practitioners are made aware of the incident.

[1] Pew Research Center. Apr. 23, 2020. Policy Changes Could Bolster Prescription Drug Monitoring Programs. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/policy-changes-could-bolster-prescription-drug-monitoring-programs.

Several states, including Colorado,[2,3] include certain overdoses as a reportable disease or condition for state reporting along with a variety of other reportable conditions for public health surveillance and epidemiological purposes[4] as well as the State Unintentional Drug Overdose Reporting System (SUDORS), a voluntary system in Colorado.[5] The HIPAA Privacy Rule permits covered entities to disclose protected health information (PHI) to

> A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.[6]

However, state laws and regulations which mandate reporting of overdoses to public health agencies often only require demographic information regarding a patient experiencing an overdose for these public health purposes. Additionally, state laws that govern the use and release of personally identifiable information (PII) by health departments frequently prohibit the release of PII[7] which can preclude such information from being shared with other programs such as PDMPs.

Though these existing reporting systems are not a viable pathway for the sharing of fatal or non-fatal overdose information with PDMPs, this information informs public health authorities of emergent clusters of overdoses to assist public health authorities in directing resources for overdose prevention measures in communities. State health departments report to CDC fatal overdoses from SUDORS and non-fatal overdose data from syndromic surveillance to the CDC's Drug Overdose Surveillance and Epidemiology (DOSE) system[8] which is updated monthly. Additionally, the National Emergency Medical Services Information System (NEMSIS), operated by the National Highway Traffic Safety Administration's Office of Emergency Medical Services,[9] provides public dashboards regarding suspected non-fatal opioid overdoses using nationally submitted Emergency Medical Services (EMS) data and is updated on a weekly basis to identify emerging opioid overdose trends.

§12-280-404(2)(b)(I), C.R.S. allows the Board of Pharmacy to adopt rules to identify prescription drugs and substances by using evidence-based practices, in addition to controlled substances, that have a substantial potential for abuse and must require pharmacists and prescription drug outlets to report those prescription drugs and substances to the Colorado PDMP. However, the Board of Pharmacy only has the statutory authority to require pharmacists or prescription drug

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[2] 6 CCR 1009-7. Effective January 14, 2018. www.sos.state.co.us/CCR/DisplayRule.do?action=ruleinfo&ruleId=2420&deptID=16&agencyID=142&deptName=1000%20Public%20Health%20and%20Environment&agencyName=1009%20Disease%20Control%20and%20Environmental%20Epidemiology%20Division&seriesNum=6%20CCR%201009-7.

[3] Colorado Department of Public Health and Environment. 2021. *Communicable Reportable Conditions*. drive.google.com/file/d/16H86FrKGjoK3nDaYBpfqbR9YrcFNs9Gq/view.

[4] The Network for Public Health Law. 2017. *State Non-Fatal Overdose Reporting Requirements Fact Sheet*. www.networkforphl.org/wp-content/uploads/2020/01/State-Non-Fatal-Overdose-Reporting-Requirements-Fact-Sheet.pdf.

[5] Colorado Department of Public Health & Environment. State Unintentional Drug Overdose Reporting System. cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/state-unintentional-drug.

[6] 45 C.F.R. § 164.512. www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164/subpart-E/section-164.512.

[7] Begley et al. 2017. Personally Identifiable Information in State Laws: Use, Release, and Collaboration at Health Departments. *American Journal of Public Health*. 2017 Aug;107(8):1272-1276. doi: 10.2105/AJPH.2017.303862. www.ncbi.nlm.nih.gov/pmc/articles/PMC5508150.

[8] Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html and DOSE Dashboard: Nonfatal Overdose Data. www.cdc.gov/drugoverdose/nonfatal/dashboard/index.html.

[9] NEMSIS Opioid Overdose Tracker. nemsis.org/opioid-overdose-tracker.

outlets to report information to the Colorado PDMP. The reporting of suspected non-fatal overdoses and/or naloxone administrations would require changes to Colorado statute to grant Board of Pharmacy the authority to require reporting by entities such as hospitals, practitioners, or emergency medical services (EMS) and would likely require changes to the statutes related to these entities to require them to report the information to the PDMP.

Risks for Patients Experiencing Non-Fatal Overdose and Treatment Gaps for Substance Use Disorder

In 2021, 106,249 Americans died of a drug overdose, including 1,887 Coloradans.[10] Many more Americans experience non-fatal overdoses. In 2017 (the most recent year for which non-fatal overdose totals could be found), there were 70,237 drug overdose deaths compared to 967,615 non-fatal overdoses treated in emergency departments.[11] The NEMSIS Non-Fatal Opioid Overdose Surveillance Dashboard reported 210,751 opioid overdoses treated by EMS providers in the United States between March 27, 2022 and March 26, 2023, of which 21.6% of patients were not transported to a medical facility.[12] Individuals who experience a non-fatal overdose are at high risk for future overdose or death. Estimates of death rates within one year of being treated for a non-fatal overdose in a hospital range from 5.5-7%, approximately two-thirds of which were directly related to a subsequent opioid-related overdose.[13,14] Patients who experienced a non-fatal overdose are at a high risk of dying of a subsequent overdose and immediate treatment and/or referral for substance use disorder treatment is key for reducing opioid-related deaths. While healthcare providers make efforts to refer patients to treatment for substance use disorder (SUD) or opioid use disorder (OUD) following a non-fatal overdose, patients often do not receive treatment due to a variety of factors. One recent evaluation found that 16.6% of commercially insured patients obtained follow-up treatment for opioid use disorder within 90 days of receiving treatment for a non-fatal overdose.[15] Another estimate from 2019 found that fewer than 35% of adults with OUD had received treatment for opioid use within the past year. Additionally, 64% of those with OUD also had a diagnosed mental illness and only 24.5% of adults with both OUD and a mental illness had received both mental health and substance use treatment services, indicating that co-occurring substance use and mental disorders are common among those with OUD and that expanding access to comprehensive service delivery models that address both substance use and mental health co-morbidities for those with OUD is needed.[16] The most common barriers preventing broader access to medication-assisted treatment (MAT) for OUD includes stigma, inadequate professional education and training regarding the use of MAT, challenges in connecting individuals with treatment due to delivery system fragmentation, regulatory and legal barriers, barriers related

[10] Centers for Disease Control and Prevention. National Center for Health Statistics. Drug Overdose Mortality by State. www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm.
[11] Vivolo-Kantor AM, Hoots BE, Scholl L, et al. Nonfatal Drug Overdoses Treated in Emergency Departments — United States, 2016-2017. MMWR Morb Mortal Wkly Rep 2020;69:371–376. DOI: http://dx.doi.org/10.15585/mmwr.mm6913a3
[12] NHTSA NEMSIS Non-Fatal Opioid Overdose Surveillance Dashboard. March 27, 2022 – March 26,2023. nemsis.org/opioid-overdose-tracker.
[13] Weiner SG, Baker O, Bernson D, Schuur JD. One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. Ann Emerg Med. 2020 Jan;75(1):13-17. doi: 10.1016/j.annemergmed.2019.04.020. Epub 2019 Jun 20.
[14] Spencer MR, Flagg LA, Jackson G, DeFrances C, Hedegaard H. National Hospital Care Survey Demonstration Projects: Opioid-involved Emergency Department Visits, Hospitalizations, and Deaths. Natl Health Stat Report. 2020 Jun;(141):1-19. PMID: 32600515. pubmed.ncbi.nlm.nih.gov/32600515.
[15] Kilaru AS, Xiong A, Lowenstein M, et al. Incidence of Treatment for Opioid Use Disorder Following Nonfatal Overdose in Commercially Insured Patients. *JAMA Netw Open*. 2020;3(5):e205852. doi: 10.1001/jamanetworkopen.2020.5852.
[16] Jones CM, McCance-Katz EF. Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug Alcohol Depend. 2019 Apr 1;197:78-82. doi: 10.1016/j.drugalcdep.2018.12.030. Epub 2019 Feb 14.

to public and private health insurance coverage, and reimbursement and payment policies that do not incentivize the provision of care for OUD.[17]

The overdose and polysubstance use crises have led to the development of low-barrier, transitional SUD treatment models, including bridge clinics which offer immediate access to medications for OUD and other SUD treatment and fill important gaps in the care continuum for patients with SUD, as long wait times for outpatient treatment are common; yet outpatient treatment is especially critical for patients with high clinical complexity and significant structural barriers to care such as high rates of fentanyl and multiple substance use, psychiatric and medical comorbidities, homelessness, and acute care utilization.[18] Multiple bridge clinic models have emerged including hospital-based outpatient bridge clinics, emergency medicine-based bridge clinic models and virtual bridge clinics. One analysis of a bridge clinic in Boston, MA found 87% of the clinic's first 150 patients were linked to opioid treatment programs (OTP) for at least one visit for methadone dosing and 58% of these patients maintained OTP participation one month following their emergency department visit.[19]

Screening Brief Intervention Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for those with SUDs and those who are at risk of developing SUDs.[20] These interventions and evaluations can be performed by physicians, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, nurse practitioners and physician assistants who have undergone training regarding SBIRT services.[21] These screenings can be performed in hospital settings for patients experiencing non-fatal overdoses and have been shown to be valid and reliable in identifying and improving outcomes for people who use substances.[22] One analysis comparing the efficacy of three interventions for opioid dependence: 1) screening and referral to treatment; 2) screening, brief intervention, and facilitated referral to community-based treatment services, and; 3) screening, brief intervention, emergency department-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up found that 78% of patients in the third intervention were engaged in addiction treatment 30 days following their emergency department visit compared to 45% in the second intervention and 37% in the first intervention. This indicates that SBIRT efforts in combination with emergency department-initiated buprenorphine significantly increased engagement in addiction services.[23] The Legislative Analysis and Public Policy Association recently released a Model Substance Use Disorder Treatment in Emergency Settings Act which recommends SBIRT in hospital emergency departments, emergency department-initiated substance use disorder treatment, and coordinated care to connect patients to community

[17] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder; Mancher M, Leshner AI, editors. Medications for Opioid Use Disorder Save Lives. Washington (DC): National Academies Press (US); 2019 Mar 30. 5, Barriers to Broader Use of Medications to Treat Opioid Use Disorder. www.ncbi.nlm.nih.gov/books/NBK541389.
[18] Taylor, J.L., Wakeman, S.E., Walley, A.Y. *et al*. Substance use disorder bridge clinics: models, evidence, and future directions. *Addict Sci Clin Pract* 18, 23 (2023). doi.org/10.1186/s13722-023-00365-2.
[19] Ibid.
[20] U.S. Department of Health & Human Services. Substance Abuse and Mental Health Administration. Screening, Brief Intervention, and Referral to Treatment (SBIRT). www.samhsa.gov/SBIRT.
[21] Colorado Department of Health Care Policy & Financing. Screening, Brief Intervention, and Referral To Treatment (SBIRT) Program. hcpf.colorado.gov/sbirt-manual.
[22] New York State Office of Addiction Services and Supports. SBIRT: Screening, Brief Intervention & Referral to Treatment. oasas.ny.gov/sbirt.
[23] D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015 Apr 28; 313(16):1636-44. doi: 10.1001/jama.2015.3474.

resources as seen in bridge care models.[24] Leveraging PDMPs to communicate non-fatal overdoses with a patient's controlled substance prescribers is not mentioned in this model act.

Access to OUD and SUD treatment has improved in recent years, yet treatment gaps remain. From 2010 to 2019, Colorado saw a 243.9% increase in the number of individuals receiving medications for OUD with an 18.5% increase from 2018 to 2019.[25] A recent evaluation of the OUD treatment gap in Colorado estimated that in 2019, 53% of individuals with OUD received treatment with buprenorphine, though less than 20% of individuals with OUD received treatment with buprenorphine in 10 of 47 rural and frontier counties. Additionally, the median distance traveled by patients in Colorado to receive MAT services was 9.9 miles, but in 17 counties the median distance was greater than 60 miles and in 8 of those counties the median distance was over 100 miles.[26]

Section 1262 of H.R. 2617 (Consolidated Appropriations Act, 2023) removes the federal requirement for practitioners to obtain a DATA Waiver (X-Waiver) from the Substance Abuse and Mental Health Services Administration (SAMHSA) to prescribe buprenorphine for the treatment of OUD.[27] Previously, physicians were required to complete eight hours of training and physician assistants were required to complete 24 hours of training through SAMHSA to obtain an X-Waiver from the DEA for authorization to prescribe buprenorphine for OUD. This regulatory change will dramatically increase the number of practitioners eligible to prescribe medication to treat OUD, though it remains to be seen how many practitioners will prescribe medications for OUD. An evaluation of buprenorphine prescribing between April 2017 and January 2019 found that of the 55,938 clinicians with a DATA waiver, only 50.9% wrote at least one prescription for buprenorphine during the 22-month evaluation period.[28] Practitioners with an X-Waiver rarely met or approached their patient threshold and those who did not prescribe buprenorphine most frequently reported this was due to a lack of demand.[29] Additionally, the U.S. Food and Drug Administration approved naloxone nasal spray for over-the-counter, nonprescription use which will dramatically expand access to naloxone.[30] These regulatory changes will give additional tools to primary care practitioners and the public at large to treat OUD and reverse opioid overdoses.

In summary, the opioid overdose epidemic is a complex challenge with numerous systemic barriers to treatment, but innovative treatment models and recent regulatory changes provide additional opportunities for the public and primary care practitioners to intervene and prevent overdose deaths. With the complexity of these challenges, it is not clear whether leveraging PDMPs to communicate a patient's overdose with their prescribers would influence patient outcomes. Additionally, while there are many systemic barriers to treatment for SUD, a lack of timely communication regarding a non-fatal overdose to a patient's providers has not been

[24] Legislative Analysis and Public Policy Association. Model Substance Use Disorder Treatment in Emergency Settings Act. March 2023. legislativeanalysis.org/wp-content/uploads/2023/03/Model-Substance-Use-Disorder-Treatment-in-Emergency-Settings-Act-2.pdf
[25] Krawczyk, Noa et al. Has the treatment gap for opioid use disorder narrowed in the U.S.?: A yearly assessment from 2010 to 2019. International Journal of Drug Policy, Vol 110, 2022, 103786. doi.org/10.1016/j.drugpo.2022.103786,
[26] Gold, Stephanie, MD et al. 2021. Closing the Treatment Gap for Opioid Use Disorder in Colorado. Eugene S. Farley, Jr. Health Policy Center, University of Colorado Anschutz Medical Campus. Brief #19 April 2021. medschool.cuanschutz.edu/docs/librariesprovider231/default-document-library/co-oud-treatment-gap-april-2021.pdf
[27] Substance Abuse and Mental Health Services Administration. 2023. Removal of DATA Waiver (X-Waiver) Requirement. March 29, 2023. www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement.
[28] Duncan A, Anderman J, Deseran T, Reynolds I, Stein BD. Monthly Patient Volumes of Buprenorphine-Waivered Clinicians in the US. *JAMA Netw Open*. 2020;3(8):e2014045. doi: 10.1001/jamanetworkopen.2020.14045.
[29] Jones CM et al. HHS Survey. Under Review. 2023. Presented at 2023 Rx and Illicit Drug Summit: "Beyond the Waiver: Other Barriers & Opportunities."
[30] U.S. Food and Drug Administration. FDA News Release. FDA Approves First Over-the-Counter Naloxone Nasal Spray. March 29, 2023. www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray.

identified as a significant barrier to treatment. In the following sections, we summarize and analyze current overdose reporting mechanisms in Colorado and the overdose reporting activities through PDMPs in several states.

Overdose Reporting in Colorado

The Colorado Department of Public Health and Environment (CDPHE) requires diseases, syndromes, or conditions known or suspected to be related to exposure to a toxic substance, prescription drug, over-the-counter medication, controlled substance, environmental media, or contaminated product that results in hospitalization, treatment in an emergency department, or death and is suspected of being a cluster, outbreak or epidemic, a risk to the public due to ongoing exposure, at an increased incidence beyond expectations, or related to a healthcare setting or contaminated medical devices or products, such as diverted drugs, to be reported within 24 hours.[31] Reporting under these circumstances is used primarily to identify emergent clusters of overdoses and reporters are only required to provide demographic information regarding a patient and the reportable condition. Identified patient information is only required to be reported if CDPHE identifies an imminent need to treat, control, investigate, or prevent adverse drug reactions that are dangerous to public health.[32]

CDPHE also receives billing data from the Colorado Hospital Association regarding fatal and non-fatal overdoses which does not identify patients unless CDPHE demonstrates a specific need for personal identifier data. The de-identified overdose data is used for epidemiological purposes such as determining the number of overdoses and their trends in Colorado and relevant demographic information regarding those who experience an overdose.

Colorado's Health Information Exchanges (HIE) receive admissions, discharge and transfer (ADT) data from nearly all hospitals in Colorado, and many other healthcare facilities share patient health information through HIEs. This is made available to a patient's treating practitioners, either through the HIE's web portal or as a data feed sent to a patient's treating practitioners depending on the practitioner's level of participation with the HIE. However, patients must consent to their information being shared through HIEs per the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.[33]

Overdose Reporting via PDMPs in Other States

The Task Force researched state laws to determine which states share fatal and/or non-fatal overdose information concerning a patient through their PDMP, reviewed statutes and rules in these states, and contacted PDMP administration in these states for additional detail concerning how the information is received and shared, the timeframes for receiving and sharing this information, what contexts are or are not included regarding overdoses, and whether such information sharing has been formally evaluated. PDMP state profiles generated by the Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC) were reviewed to identify which states reported that their PDMP included alternative data

[31] 6 CCR 1009-7, Regulation 1(I)(D)(2). Effective Jan 14, 2018. www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7447&fileName=6%20CCR%201009-7.
[32] 6 CCR 1009-7, Regulation 1(II)(B). Effective Jan 14, 2018. www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7447&fileName=6%20CCR%201009-7.
[33] CFR Title 45, Subtitle A, Subchapter C, Part 160. www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-160. CFR 45 Title 45, Subtitle A, Subchapter C, Part 164. www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164. See also, for example: Office of the National Coordinator for Health Information Technology, Patient Consent for Electronic Health Information Exchange. www.healthit.gov/topic/patient-consent-electronic-health-information-exchange.

sources from naloxone administrations or overdoses (fatal and/or non-fatal). However, responses to these state surveys were not always accurate. Therefore, state statutes, rules and regulations were reviewed in addition to outreach to state PDMP staff requesting additional information and clarification regarding such reporting. States whose PDMP TTAC state profile indicated they received such information but whose statutes and regulations did not reference naloxone administration or overdose reporting to their PDMP and that did not respond to our requests for additional information and clarification are not included in this assessment.

The Task Force identified seven states that receive information regarding fatal and/or non-fatal overdoses through their PDMP and share this with practitioners who had recently prescribed a controlled substance to the patient who experienced suspected overdose. However, several of these states only collect and share overdose information in certain circumstances. Additionally, there is no national standard regarding the reporting mechanisms or reporting timeframe requirements among these states. States have developed the infrastructure for this information sharing in a variety of ways depending on the state agency or department administering the PDMP and whether the PDMP was developed in-house or by a vendor. Arkansas and Nevada have laws authorizing their PDMP to receive and share this information but have not implemented a mechanism to share this information with their PDMPs.

ARKANSAS

The Arkansas Prescription Monitoring Program (PMP) is housed under the Arkansas Department of Health. In Arkansas, if the Department of Health is notified of a drug overdose of an Arkansas resident, the Arkansas PMP may notify any practitioner that had prescribed a controlled substance to that patient within an applicable period prior to the overdose as determined by the Secretary of Health, or any practitioner that may prescribe or dispense a controlled substance within one year of the drug overdose.[34] However, Arkansas PMP staff advised the Work Group that they are not currently receiving identifiable data from entities who would report such information to their Department of Health as data reporters have rules prohibiting the release of patient information for this purpose.

NEVADA

The Nevada Prescription Monitoring Program (NVPMP) is housed under the Nevada State Board of Pharmacy. Nevada law requires that, to the extent that money is available, their PDMP is required to provide the ability of the Chief Medical Officer of the Nevada Department of Health and Human Services Division of Public and Behavioral Health to upload information to the NVPMP relating to drug overdoses,[35] which is required to be reported to the Department of Health and Human Services.[36] However, NVPMP staff advised the Work Group that this information is not currently reported to the NVPMP as there is not currently an avenue for reporting such information to the NVPMP.

KENTUCKY

The Kentucky PDMP, known as the Kentucky All Schedule Prescription Electronic Reporting (KASPER) is housed under the Kentucky Cabinet for Health and Family Services Office of the

[34] AR Code § 20-7-604(a)(1)(B)(iii). Adopted July 22, 2021. www.healthy.arkansas.gov/images/uploads/rules/PDMP_Final_2021.pdf
[35] Nevada Revised Statutes (NRS) 453.162(1)(f)(3). www.leg.state.nv.us/NRS/NRS-453.html#NRS453Sec162.
[36] NRS 441A.150. www.leg.state.nv.us/NRS/NRS-441A.html#NRS441ASec150.

Inspector General, Division of Audits and Investigations, Drug Enforcement and Professional Practices Branch.[37] The KASPER system is one of the most robust PDMPs in the nation and was developed in-house.[38] The Cabinet for Health and Family Services Office of Inspector General also houses the Kentucky Health Information Exchange (HIE) in the Division of Health Information. Kentucky law requires acute care hospitals or critical access hospitals to report to the Cabinet all positive toxicology screens that were performed by the hospital's emergency department to evaluate the patient's suspected overdose.[39] Kentucky regulations specify that to meet these reporting requirements, hospitals must report to the Cabinet all positive toxicology screens ordered by the hospital's emergency department to evaluate a patient's suspected drug overdose via the HIE as part of its syndromic surveillance reporting.[40]

KASPER staff also advised they receive fatal overdose data under a data use agreement with the Kentucky Office of Vital Statistics. KASPER is integrated with the HIE, allowing KASPER users to access the HIE through KASPER. Patient reports in KASPER for clinical users include alerts that a patient may have information related to a non-fatal overdose in the HIE and can follow a link within KASPER to view this information in the HIE. Per Kentucky regulations, only specific medical codes related to a suspected overdose and drug screening results are used to generate a linkage to a patient's KASPER report from the HIE.[41] Additionally, KASPER sends unsolicited notices via mail to notify a patient's prescribing practitioners when a patient experiences a fatal overdose.

MARYLAND

Maryland's PDMP is overseen by the Maryland Department of Health, Public Health Services and is operated by its regional HIE, the Chesapeake Regional Information System (CRISP).[42] CRISP receives non-fatal overdose information from hospitals participating in CRISP and from Emergency Medical Services. If CRISP receives notice of a non-fatal overdose, users with clinical access to CRISP or clinical access to both CRISP and the Maryland PDMP would see a "priority alert" when querying either CRISP or the PDMP for that patient advising that the patient experienced a non-fatal overdose. Users can view additional detail regarding the non-fatal overdose through CRISP.[43]

The Maryland Vital Statistics Administration also shares death data with CRISP. Alerts are placed in the Maryland PDMP and CRISP for patients who have died from any cause. Maryland PDMP staff advised that practitioners who prescribed an opioid or benzodiazepine to a patient with an opioid-related overdose death within three months of their death are also notified of the patient's death.

OKLAHOMA

Oklahoma's PDMP is overseen by the Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBN) and its system is operated by the vendor Bamboo Health (formerly Appriss Health). Oklahoma law requires both fatal and non-fatal overdose information to be reported to the OBN

[37] KASPER – Kentucky All Schedule Prescription Electronic Reporting. www.chfs.ky.gov/agencies/os/oig/dai/deppb/Pages/kasper.aspx.
[38] Kentucky Revised Statutes (KRS) Title XVIII. Public Health § 218A.202. apps.legislature.ky.gov/law/statutes/statute.aspx?id=46716.
[39] KRS 218A.202(4). apps.legislature.ky.gov/law/statutes/statute.aspx?id=46716.
[40] 902 KAR 55:110 Section 1(g); Section 2(g). apps.legislature.ky.gov/law/kar/titles/902/055/110.
[41] Ibid.
[42] Maryland CRISP PDMP Overview. www.crisphealth.org/applications/prescription-drug-monitoring-program-pdmp.
[43] CRISP Learning System Overdose Alerts. www.crisphealth.org/learning-system/overdose-alerts.

but this information is not loaded to the PDMP and is not available to PDMP users, but is shared with certain state agencies and regulatory boards that license practitioners.

Per Oklahoma statute, the State Medical Examiner is required to promptly report to the offices of the Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control, the Executive Director of the State Board of Medical Licensure and Supervision and the Executive Director of the State Board of Osteopathic Examiners all deaths occurring within the state which were the result or probable result of abuse of a controlled dangerous substance.[44] Additionally, all OBN registrants are required to report any person appearing at a medical facility with a drug overdose to the OBN using an online reporting form.[45] Per Oklahoma law, information regarding fatal and non-fatal overdoses, other than statistical information must remain completely confidential, except for the Director of the Oklahoma OBN or their designee, the Chief Medical Examiner, certain state agencies and boards that are authorized to access Oklahoma's PDMP, and the registrant that reports a fatal or non-fatal overdose to the program. Additionally, upon completion of an investigation in which it is determined that a death was caused by an overdose, either intentionally or unintentionally, of a controlled substance, the medical examiner is required to report the decedent's name and date of birth to the OBN and the OBN is required to maintain a database containing the classification of medical practitioners who prescribed or authorized controlled dangerous substances associated with the overdose death.[46]

SOUTH CAROLINA

South Carolina's PDMP, known as the South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS) is housed under the South Carolina Department of Health and Environmental Control (DHEC), and South Carolina's PMP is operated by Bamboo Health. In 2019, South Carolina passed H.3728[47] with an effective date of January 1, 2021, which requires healthcare facilities and first responders to report opioid antidote administrations to DHEC no later than 30 days after the patient's discharge date and requires DHEC to establish and maintain a program to monitor the administering of opioid antidotes, which is maintained in the SCRIPTS database.[48] SCRIPTS purchased a license for the Bamboo Health product ERvive[49] which came at a cost to the state. In 2021, SCRIPTS staff onboarded 37 healthcare facilities to the ERvive platform. ERvive allows healthcare facilities and first responders to report an opioid antidote administration.

Per conversations with SCRIPTS administrative staff, healthcare facilities create accounts through ERvive and are responsible for uploading their data monthly. Most healthcare facilities assign responsibility for this reporting to a clinical pharmacist and have programmed their Electronic Health Records (EHR) systems to generate an extract which is manually uploaded by the clinical pharmacist. Naloxone administration information from fire departments, police departments and EMS providers comes from ImageTrend[50] which is the data management

[44] Oklahoma State Courts Network. 63 O.S. § 2-105 (OSCN 2023). www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=98856..
[45] Oklahoma Bureau of Narcotics & Dangerous Drugs Control. Non-Fatal OD Reporting. www.obndd.ok.gov/programs-and-services/non-fatal-od-reporting.
[46] Oklahoma State Courts Network. 63 O.S. § 2-309D (OSCN 2023). www.oscn.net/applications/oscn/deliverdocument.asp?id=439323.
[47] South Carolina A 65, R85, H3728. Signed May 16, 2019. www.scstatehouse.gov/sess123_2019-2020/bills/3728.htm.
[48] South Carolina Department of Health and Environmental Control. New PDMP Law FAQs. scdhec.gov/healthcare-quality/drug-control-register-verify/prescription-monitoring/new-pmp-law-faqs.
[49] Appriss Health (now Bamboo Health). ERvive Patient Data Integration Admin Support Manual. November 2020. scdhec.gov/sites/default/files/media/document/ERvive-Comprehensive-Guide-Nov-2020.pdf.
[50] ImageTrend. www.imagetrend.com.

software for first responders. Each department designates an individual responsible for extracting the data from ImageTrend and delivering it to SCRIPTS staff. SCRIPTS staff load this data to the SCRIPTS database monthly.

In 2021, SCRIPTS received 20,504 naloxone administration events.[51] Practitioners who recently prescribed a controlled substance to a patient who received an opioid antidote administration receive an unsolicited clinical alert regarding the patient through the NarxCare[52] platform and the patient's Narx Score[53] displays as 991-999 on a scale of 0-999, with the last digit representing the number of active controlled substance prescriptions listed on the patient's report. The Narx Score is only available to clinical users viewing a patient's report.

UTAH

Utah's PDMP, known as the Controlled Substance Database (CSD), is overseen by the Utah Department of Commerce, Division of Professional Licensing.[54] Utah developed its PDMP in-house but partners with the vendor RxGov for prescription data submission.[55] Utah law requires hospitals to report information to the CSD regarding individuals admitted to a general acute hospital for poisoning or overdose involving a prescribed controlled substance,[56] including identifying patient information, each drug or other substance found in the person's system that may have contributed to the poisoning or overdose, the name of each person whom the hospital has reason to believe may have prescribed a controlled substance to the person, and the name of the hospital and date of admission within three business days after the person is admitted.[57] Utah CSD users submit this information through their CSD user account. The Division of Professional Licensing (Division) is required to provide each practitioner who may have prescribed a controlled substance identified by the hospital as being involved in their poisoning or overdose with a copy of the report provided by the hospital and the information obtained from the CSD that led the Division to determine that the practitioner receiving the information may have prescribed a controlled substance to the person named in the hospital's report within three business days of receiving the report from the hospital.[58] These reports are emailed to practitioners.

Utah law also requires that if a medical examiner determines that the death of a person resulted from poisoning or overdose involving a prescribed controlled substance, the medical examiner must send a written report to the Division that includes the decedent's name, each drug or other substance found in their system that may have contributed to the poisoning or overdose, and the name of each person the medical examiner has reason to believe may have prescribed a controlled substance to the decedent.[59] In turn, the Division is required to provide each practitioner identified by the medical examiner with a copy of the medical examiner's report and may offer the practitioner an educational visit to review the report within five business days of receiving the report from the medical examiner.[60]

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[51] South Carolina Prescription Drug Monitoring Program 2021 Annual Report. May 2022. scdhec.gov/sites/default/files/media/document/2021-pmp-annual_final_version_1.pdf
[52] Bamboo Health. NarxCare Clinical Decision Support & Analytics Solution. bamboohealth.com/solutions/narxcare.
[53] Bamboo Health. What is a Narx Score? How is it Calculated? narxcare.zendesk.com/hc/en-us/articles/4409648586899-What-Is-a-Narx-Score-How-Is-It-Calculated-
[54] Utah Controlled Substance Database. dopl.utah.gov/controlled-substance-database.
[55] Utah Controlled Substance Database. Submit Data. dopl.utah.gov/controlled-substance-database/submit-data
[56] Utah Code 58-37f-201(5)(b), 58-37f-201(6)e). le.utah.gov/xcode/Title58/Chapter37F/58-37f-S201.html?v=C58-37f-S201_2022050420220504
[57] Utah Code 26-21-26(1). le.utah.gov/xcode/Title26/Chapter21/26-21-S26.html
[58] Utah Code 58-37f-702(1). le.utah.gov/xcode/Title58/Chapter37F/58-37f-S702.html?v=C58-37f-S702_2019051420190514
[59] Utah Code 26-4-10.5. le.utah.gov/xcode/Title26/Chapter4/26-4-S10.5.html
[60] Utah Code 58-37f-702. le.utah.gov/xcode/Title58/Chapter37F/58-37f-S702.html?v=C58-37f-S702_2019051420190514.

In the case of both fatal and non-fatal overdoses, these requirements only apply to patients who experienced an overdose related to a prescribed controlled substance. Overdoses or poisonings related to an illicit substance and/or those who are treated for a suspected overdose by emergency medical services are not required to be reported to the CSD. With a high proportion of overdoses being due to illicit fentanyl and its analogues in recent years, Utah law only requiring reporting to the CSD regarding overdoses due to prescribed controlled substances means many overdoses are not reported.

WEST VIRGINIA

West Virginia's PDMP, known as the Controlled Substance Monitoring Program (CSMP) is overseen by the West Virginia Board of Pharmacy and contracts with the vendor RxDataSystems for program operations.[61] In 2017, West Virginia House Bill 2620 established the Office of Drug Control Policy (ODCP) within the West Virginia Department of Health and Human Resources.[62] This bill also requires health care providers, medical examiners, law enforcement agencies, emergency response providers and hospital emergency rooms to report information to the ODCP regarding the treatment of fatal and non-fatal overdoses, including identifying patient information, whether an opioid antagonist was administered, whether the overdose was fatal or non-fatal, and the suspected controlled substance involved in the overdose within 72 hours of responding to the incident.[63,64] Information reported to OCDP regarding a non-fatal overdose is shared with the CSMP. CSMP staff review and work with their vendor to match the patient's reported overdose to the patient's CSMP record and add information related to the overdose into the patient's CSMP record, usually within 5-6 weeks of the overdose.[65] The CSMP also sends notices to practitioners who prescribed a controlled substance in the 60 days prior to the suspected non-fatal overdose incident. A sample of the notice is available in Appendix E of footnote number 65.

WISCONSIN

Wisconsin's PDMP, known as the Wisconsin Enhanced Prescription Drug Monitoring Program (ePDMP) is overseen by the Wisconsin Controlled Substances Board[66] within the Department of Safety and Professional Services and contracts with the vendor NIC Wisconsin for program operations. Per 2015 Wisconsin Act 268,[67] law enforcement agencies are required by Wisconsin law to submit reports based on "reasonable suspicion" or "belief" when: an officer suspects that a person violated the Controlled Substances Act with a prescription drug, such as diversion or unlawful possession; when a person is suspected of having experienced a fatal or non-fatal opioid-related overdose; or when a person reports to law enforcement that their controlled substance prescription has been stolen. Law enforcement agencies are required to report the name and date of birth of the individual who meets one of these criteria. Law enforcement agencies are also required to report the name of the prescribing practitioner, the prescription number, and the name of the drug if a prescription medicine container was in the vicinity of

[61] WV Board of Pharmacy Controlled Substance Monitoring Program. www.csappwv.com/Account/Login.aspx.
[62] West Virginia Legislature 2017 Regular Session. House Bill 2620. www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2620%20SUB%20ENR.htm&yr=2017&sesstype=RS&i=2620
[63] West Virginia Code §16-5T-4. www.wvlegislature.gov/wvcode/chapterentire.cfm?chap=16&art=5T&section=4.
[64] West Virginia Legislative Rule §69-14. Effective April 13, 2020. apps.sos.wv.gov/adlaw/csr/rule.aspx?rule=69-14.
[65] Centers for Disease Control and Prevention. 2021. Leveraging Prescription Drug Monitoring Program (PDMP) Data in Overdose Prevention and Response. Appendix E. www.cdc.gov/drugoverdose/pdf/Leveraging-PDMPs-508.pdf
[66] State of Wisconsin Department of Safety and Professional Services. Controlled Substances Board. dsps.wi.gov/Pages/BoardsCouncils/CSB/Default.aspx
[67] Wisconsin State Legislature. 2015 Wisconsin Act 268. docs.legis.wisconsin.gov/2015/related/acts/268

the suspected violation, drug overdose, or death or if a controlled substance prescription was reported stolen. There are no defined reporting timeframe requirements and if a law enforcement agency determines that submitting any of this information would interfere with an active criminal investigation, the law enforcement agency may postpone its reporting until the investigation concludes.[68] Disclaimers on these alerts advise that an alert does not necessarily mean that the individual was arrested, convicted, or is guilty of any violation of law.[69] When the ePDMP receives a report from law enforcement, an alert is placed on a patient's PDMP profile, which is only visible to healthcare professional users and their delegates, and unsolicited reports are sent to the patient's controlled substance prescribers through the ePDMP portal. According to its most recent Annual Report, 79% of survey respondents indicated that law enforcement-reported alerts were "very or extremely useful."[70]

The Wisconsin ePDMP provides a public dashboard detailing the numbers and types of law enforcement alerts reported by county. In 2021, the ePDMP received 2,387 alerts from law enforcement, with 210 suspected narcotic-related deaths, 635 stolen controlled substance prescription reports, 1,128 suspected non-fatal opioid-related overdoses, and 414 suspected Controlled Substances Act Violations.[71] While 210 suspected narcotic-related deaths were reported by law enforcement to the ePDMP in 2021, Wisconsin reported 1,765 drug overdose deaths,[72] indicating that only a portion of overdoses are being reported to its PDMP.

Summary of Overdose Reporting to PDMPs in Other States

Suspected fatal and/or non-fatal overdoses or opioid antidote (naloxone) administrations are currently being reported to PDMPs in at least seven states while an additional two states have the authority to collect this information but have not determined or developed reporting mechanisms for such reporting due to conflicts with laws surrounding patient health information sharing or challenges in identifying funding to implement the reporting infrastructure. Among these states, there is no national standard for reporting mechanisms or timeframes for reporting such information to their PDMP. In Kentucky and Maryland, the PDMP is operated by or is housed under the same state agency as the state HIE and reporting of overdose information is done through a connection between the PDMP and HIE where a user viewing a patient's PDMP report is alerted that the HIE has information regarding a suspected overdose. In Oklahoma, suspected overdoses are shared with the Oklahoma Bureau of Narcotics and Dangerous Drugs Control (OBN) which also operates its PDMP, but this information is not shared with PDMP users and is only shared with law enforcement and regulatory bodies. With Oklahoma's more enforcement oriented PDMP, a patient's prescribers are identified through the PDMP and reported to the OBN, which could leverage this information to investigate the patient's controlled substance prescriber(s). In South Carolina, only naloxone administrations by medical personnel are reported to its PDMP, which generates alerts on a patient's PDMP profile. Suspected overdoses for other controlled substances or suspected overdoses for which naloxone was not administered by a mandated reporter are not reported to its PDMP. Additionally, this is only updated in the PDMP monthly which reduces its effectiveness in terms of timely reporting. In Utah, general acute hospitals are only required to report when a patient is admitted to the hospital for a suspected overdose involving a prescribed controlled substance. Suspected

[68] Wis. Stat. § 961.37. docs.legis.wisconsin.gov/statutes/statutes/961/iii/37.
[69] Wisconsin ePDMP. Law Enforcement Alert Statistics. pdmp.wi.gov/statistics/law-enforcement-alerts.
[70] Wisconsin Department of Safety and Professional Services. Controlled Substances Board. Wisconsin ePDMP Report 23: 2022 Quarter 4 and Year-End Summary. dsps.wi.gov/Documents/BoardCouncils/CSB/WIePDMPReport2022Q4.pdf
[71] Ibid.
[72] Wisconsin Department of Health Services. Substance Use: Drug Overdose Deaths Dashboard. www.dhs.wisconsin.gov/aoda/drug-overdose-deaths.htm.

overdoses due to illicit substances such as fentanyl or methamphetamine are not required to be reported to its PDMP. In West Virginia, a wide range of mandated reporters are required to report any suspected fatal or non-fatal overdose within 72 hours and alerts, but these reports can take weeks to translate into an alert through its PDMP. In Wisconsin, only law enforcement agencies are mandated reporters to the PDMP and law enforcement is required to report incidents such as stolen prescriptions and suspected violations of the Controlled Substances Act in addition to suspected fatal or non-fatal overdoses. However, a comparison of the number of overdose deaths reported by law enforcement to the PDMP against the total number of overdose deaths suggests such reporting to the PDMP is incomplete.

While some states have publicly reported statistics of reports received by the PDMP related to suspected overdoses, no studies have evaluated whether these communications have translated into improved patient outcomes such as higher rates of treatment for SUD or OUD or safer prescribing practices by a patient's treating practitioner, nor have there been evaluations concerning potential unintended consequences of overdose reporting through the PDMP, such as patients losing access to care due to stigma associated with a non-fatal overdose or SUD, or concerns by practitioners that they may be subject to law enforcement or regulatory board scrutiny due to prescribing to patients with a history of non-fatal overdose.

Mandated Overdose Reporting Through Other Avenues

In addition to the states discussed above, as of 2017, Arizona, Florida, Illinois, New Mexico, Rhode Island, Tennessee, Texas and Wyoming have state laws mandating the timely reporting of suspected overdoses to the state. Mandated reporters in these states are required to report this information to state health departments. Of these states, Arizona, Illinois, New Mexico, Tennessee required patient-identifying information to be reported. However, this information is used for public health purposes and is not shared with the state PDMP.[73]

Washington state passed legislation in 2019 requiring the Washington State Department of Health to establish a statewide emergency medical services (EMS) data system and adopt rules requiring licensed ambulance and aid services to report and furnish patient encounter information to the electronic EMS data system.[74] This law requires the collection of data on suspected drug overdoses for the purposes of identifying individuals to engage substance use disorder peer professionals, patient navigators, outreach workers, and other professionals as appropriate to prevent further overdoses and to induct patients into treatment and provide other needed supports as may be available.

Recommendation: Task #1

Mandated reporting of overdose-related information through PDMPs has only been implemented in seven states and most of these states do not appear to capture all non-fatal overdoses due to exemptions for certain entities or types of overdoses. Additionally, the information is not always reported to PDMPs or shared by PDMPs with practitioners in a timely manner. Furthermore, this reporting has not been evaluated with respect to patient outcomes, safer prescribing practices, or unintended consequences for patients or practitioners. As seen in states that have passed legislation allowing for such information to be shared with PDMPs but

[73] The Network for Public Health Law. State Non-Fatal Overdose Reporting Requirements Fact Sheet. Updated December 31, 2017. www.networkforphl.org/wp-content/uploads/2020/01/State-Non-Fatal-Overdose-Reporting-Requirements-Fact-Sheet.pdf.
[74] S.S.B. 5380, 66th Leg., Reg. Sess. (Wash. 2019). RCW 70.168.090(2). lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5380-S.SL.pdf

have not implemented such reporting, legislation allowing or mandating such reporting would require significant coordination and collaboration with a variety of organizations, which is likely to present logistical challenges. Though there are numerous known barriers to treatment for SUD, the sharing of overdose information through PDMPs or information sharing with a patient's primary care providers in general are not identified as an activity with potential to increase access to treatment or for beneficial patient outcomes. Those involved in treating a patient for a non-fatal overdose may be in a better position to provide bridge care and/or refer the patient for treatment than practitioners who had previously prescribed a controlled substance to a patient and who may not have an extensive treatment history with the patient. Without evidence to support the efficacy of the reporting of fatal and/or non-fatal overdoses to PDMPs, the Task Force recommends caution with respect to this activity.

Task #2: Evaluate Potential Statutory Changes to Allow Practitioners with Prescriptive Authority but Lack a DEA License to Access Colorado PDMP Information

Current law requires practitioners to have controlled substance prescriptive authority to access Colorado PDMP information for any current patient of the practitioner.

Evaluate the potential benefits and risks of statutory changes that would allow practitioners (physicians, physician assistants, advance practice nurses with prescriptive authority, dentists, podiatrists, optometrists, and veterinarians) who do not hold an active registration with the Drug Enforcement Administration to access Colorado PDMP information for current patients of such practitioners.

Response to Task #2

Authority to access the Colorado PDMP has seen incremental changes since its inception. From the inception of the Colorado PDMP in 2005 under HB 05-1130[75] until 2017 with the passage of SB 17-146,[76] practitioners with the statutory authority to prescribe controlled substances were only authorized to query the PDMP for a current patient of the practitioner to whom the practitioner was prescribing or considering prescribing a controlled substance. With the passage of SB 17-146, authorized access was expanded for practitioners with the statutory authority to prescribe controlled substances to any current patient of the practitioner without restrictions as to the reason or context for querying the PDMP. This change to authorized access for practitioners reflects the recognition of the value of PDMPs as a clinical decision support tool in contexts beyond controlled substance prescribing. The statutory history of the Colorado PDMP and major milestones of the program are detailed in **Appendix C**.

§12-280-103(40), C.R.S. defines "practitioner" as a person authorized by law to prescribe any drug or device, acting within the scope of the authority. §12-280-403(2)(a), C.R.S. requires each practitioner licensed in Colorado who holds a current DEA license to register and maintain a user account with the Colorado PDMP. §12-280-404(3)(b), C.R.S. grants authority to query the Colorado PDMP to any practitioner with the statutory authority to prescribe controlled substances, or an individual designated by the practitioner to act on their behalf as a delegated user, to the extent the query relates to a current patient of the practitioner. §12-280-405(3), C.R.S. allows the Division of Professions and Occupations to collect a fee during license renewal from an individual who holds a license from the Division that authorizes him or her to prescribe a controlled substance to fund the operations of the Colorado PDMP. This fee is currently $22 for a two-year license renewal. Physicians, dentists, podiatrists, veterinarians, physician assistants, nurse practitioners with prescriptive authority certificates, and optometrists hold licenses that authorize the practitioner to prescribe legend (non-controlled) drugs and grant the practitioner the authority to obtain a controlled substance license from the DEA.

Of Colorado-licensed practitioners with an in-state address on file, approximately 12% of physicians, dentists, and nurse practitioners, 7% of physician assistants, 5% of podiatrists, 52% of optometrists, and 30% of veterinarians do not have a DEA license and therefore lack controlled substance prescriptive authority. However, because these practitioners hold a license that grants them the authority to obtain a DEA license, they are assessed a PDMP fee

[75] Colorado House Bill 05-1130. Signed June 3, 2005. leg.colorado.gov/sites/default/files/images/olls/2005a_sl_272.pdf
[76] Colorado Senate Bill 17-146. Signed April 6, 2017. leg.colorado.gov/sites/default/files/2017a_146_signed.pdf

during their license renewal regardless of their DEA registration status. Those lacking a DEA license therefore do not have independent authority to access the Colorado PDMP but are assessed a PDMP fee in their license renewal.

The low rate of optometrists holding a DEA license is because they are limited to prescribing medications and certain controlled substances for the treatment of ocular disease. The relatively low rate of veterinarians holding a DEA license is because in some veterinary practices, only the owner holds a DEA license and controlled substances are ordered and dispensed from the practice under the practice owner's controlled substance dispensing authority. Optometrists and veterinarians may therefore warrant separate consideration from physicians, podiatrists, dentists, physician assistants and nurse practitioners with respect to PDMP access due to their different scopes of practice.

Controlled substance medications are known to interact with a wide range of other medications, including non-controlled (legend) prescription medications which may be prescribed by practitioners who have the authority to prescribe legend drugs but lack controlled substance prescriptive authority and these practitioners and their patients can benefit if the prescribing practitioner is aware of any controlled substance medications that their patient is currently being prescribed. For example, while concurrent opioid and benzodiazepine prescriptions are well-known to create an increased risk of accidental overdose,[77] opioid medications can also interact with alcohol and non-controlled prescription medications, including anti-seizure medications, certain antibiotics, antidepressants, antifungals, antiretroviral medications used for HIV infection, medications to treat psychiatric disorders and muscle relaxers.[78] Prescription amphetamines are also known to interact with 180 other drugs, of which 37 are known to have major interactions and 134 which have moderate interactions.[79,80] Testosterone is also known to interact with a number of other medications including levothyroxine for hypothyroidism and conditions such as liver disease, renal disease, polycythemia, carcinoma and diabetes and can suppress blood clotting factors.[81]

It is unclear what proportion of Colorado practitioners who lack a DEA registration are treating patients or prescribing medications, but these practitioners have the authority under their professional license to prescribe non-controlled (legend) prescription drugs. Due to the potential for dangerous interactions between legend prescription drugs and controlled substances and the potential for some controlled substances to create complications for patients with certain medical conditions, practitioners who lack a DEA license but treat patients may benefit from access to the PDMP as a clinical decision support tool.

While Colorado law allows DEA-licensed practitioners to authorize delegated users to access the PDMP, delegates are only authorized to access the PDMP on behalf of the supervising practitioner for a current patient of the supervising practitioner. These limits on delegate access mean practitioners who lack a DEA license and are delegated PDMP users of a supervising DEA-licensed practitioner are not accessing the PDMP for their own clinical decision-making but are instead accessing their patient's PDMP information on behalf of the supervisor. This

[77] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. Recommendation 11.
DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.
[78] Sparks, Dana. 2018. Risks for other drugs interacting with opioid medications. Mayo Clinic News Network. May 15, 2018. newsnetwork.mayoclinic.org/discussion/risks-for-other-drugs-interacting-with-opioid-medications.
[79] Amphetamine Drug Interactions. www.drugs.com/drug-interactions/amphetamine-index.html.
[80] Mayo Clinic. Dextroamphetamine and Amphetamine. www.mayoclinic.org/drugs-supplements/dextroamphetamine-and-amphetamine-oral-route/precautions/drg-20071758?p=1.
[81] Testosterone Interactions. www.drugs.com/drug-interactions/testosterone.html.

delegated access is allowed to reduce the time and effort for practitioners in accessing the PDMP, especially through the web portal where users must log in and manually query the PDMP. Practitioners without a DEA license may treat patients who are not current patients of their supervising DEA-licensed practitioner, and current law does not allow these delegated practitioner users to access the PDMP for a patient who is not a current patient of their designated supervisor.

At least nine states do not require practitioners to have controlled substance prescriptive authority to be granted independent access to their PDMPs. A review of state statutes and interstate data sharing worksheets that delineate role-based access in each state found that Delaware, Florida, North Dakota, Kansas, Nebraska, New York, and Montana do not require practitioners with legend drug prescriptive authority to have a DEA registration to access their PDMP. Tennessee grants independent authority to certified registered nurse anesthetists without prescriptive authority licenses to access their PDMP and Wisconsin grants independent access to registered nurses to access their PDMP. PDMP access to practitioners who do not hold an active DEA license yet have prescriptive authority appears to have low risk and may provide benefits for clinical decision support and patient safety.

Recommendation: Task #2

The Task Force finds that there is low risk and potential benefit with respect to patient safety due to potentially dangerous interactions or contraindications between controlled and legend prescription medications or between certain medical conditions and controlled substances. Current authorization for delegated access may not meet the needs of some practitioners without a DEA license.

Relatively few practitioners holding a Colorado prescriptive authority license lack a DEA license and it is unclear what proportion these practitioners treat patients or prescribe legend drugs. These practitioners are also assessed a PDMP fee during license renewal despite lacking the authority to access the Colorado PDMP. Practitioners who lack a DEA license but treat patients could benefit from PDMP access to understand their patients' controlled substance prescription history for clinical decision support due to the potential for dangerous interactions or contraindications between certain controlled substances and some legend prescription medications or certain health conditions. Delegated access under a supervising DEA-licensed practitioner may not always allow practitioners without a DEA license to access the PDMP for their current patients and access as a delegated user is authorized under Colorado law to reduce the time and effort required for DEA-licensed practitioners to access the PDMP through a web portal.

While PDMP registration should not be required for practitioners without a DEA license, granting them the independent authority to register and access the PDMP under their own independent authority through their Colorado prescriptive authority license regardless of their DEA license status could be considered for those who desire access the PDMP for their current patients.

Appendix A: DORA Executive Director's Requests to the PDMP Task Force

COLORADO
Department of Regulatory Agencies
Executive Director's Office

January 19, 2023

Robert J. Valuck, PhD, RPh, FNAP | Professor
University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences
On behalf of the Colorado Consortium for Prescription Drug Abuse Prevention
12850 E. Montview Blvd, Mail Stop C238
Aurora, CO 80045

Dear Dr Valuck:

On behalf of the Department of Regulatory Agencies (DORA or the Department), thank you and the Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) for your continued support and advice concerning the Prescription Drug Monitoring Program (PDMP), including the Consortium's 2021-2022 Task Force Report. The Consortium's support and expertise this past year was invaluable.

Section 12-280-409, Colorado Revised Statutes (C.R.S.) requires the Executive Director of the Department to consult with and request assistance from the Consortium as the PDMP Task Force. To that end, on behalf of the Executive Director, I am requesting assistance from the Consortium to examine issues and opportunities regarding the PDMP and to make recommendations on ways to make the PDMP a more effective tool to reduce prescription drug abuse in Colorado. In doing so, please prepare and submit an annual report to the Executive Director and the Colorado General Assembly detailing the Consortium's findings and recommendations by July 1, 2023.

Task #1: Evaluate the Risks and Benefits of Collecting and Sharing Fatal and/or Non-Fatal Overdose Information through the Colorado PDMP

The 2021-2022 Task Force report noted that several states allow their PDMPs to receive information regarding fatal and non-fatal overdoses and share this with a patient's treating providers. I request that the Task Force evaluate the potential benefits and risks of statutory changes that would allow for fatal and/or non-fatal overdose data to be collected by the Colorado PDMP and shared with that patient's treating providers.

Task #2: Evaluate the Risks and Benefits of allowing Practitioners with Prescriptive Authority but Lack a DEA License to Access Colorado PDMP Information

Current Colorado law requires practitioners to have controlled substance prescriptive authority to access Colorado PDMP information for the practitioner's current patients. Several other states allow practitioners without a controlled substance prescriptive authority to access PDMP information. I request that the Task Force evaluate the potential benefits and risks of statutory changes that would allow practitioners (physicians, physician assistants, advance practice nurses with prescriptive authority, dentists, podiatrists, optometrists and veterinarians) who do not hold an active registration with the Drug Enforcement Administration to access Colorado PDMP information for their current patients.

Sincerely,

Patty Salazar
Executive
Director
Colorado Department of Regulatory Agencies

CC: Jill Hunsaker Ryan, MPH | Executive Director, Colorado Department of Public Health and Environment (CDPHE)
Dr. Eric France, MD MBA | Chief Medical Officer, CDPHE

Appendix B: PDMP Work Group Members

Name/Date Joined	Organization
Hoppe, Jason, DO (Co-chair)	University of Colorado
Dmitry Kunin (Co-chair)	DORA Board of Pharmacy
Micucci, Shayna (Program Manager)	PDMP Work Group
Acre, Callie (4/2/21)	Regis University
Akerlund, Ashley (3/7/23)	Gunnison County Public Health
Archuleta, Dan (9/8/20)	Southern Colorado Harm Reduction Association
Barker, Eric	CCPDAP External Relations Strategist
Barron, Betsy (9/14/21)	CU Anschutz
Basche, John (11/8/22)	PharmChem
Belford, Kerry (4/28/21)	HardBeauty
Bemski, Julie, MD (1/31/18)	St. Josephs Hospital
Bernier, Benjamin, RN	Children's Hospital
Bhutani, Aminta (8/13/20)	DEA
Biehle, Ryan	Colorado Academy of Family Physicians
Bonaguidi, Angela (4/20/18)	UC Denver Addiction Research & Treatment Services
Borgelt, Laura	University of Colorado School of Pharmacy
Brasselero, Scott (12/19/18)	Crossroads Turning Points
Brooks, Marta J. PharmD	Rueckert-Hartman College for Health Professions
Brown, Amanda (11/10/22)	CCAR
Bryant, Hilary (6/24/22)	CCPDAP Program Manager
Brydon, Katie (6/10/19)	Road to Recovery
Canon, Megan (7/20/20)	CDPHE
Cantwell, Teresa	CCPDAP
Carpenter, Kristin (7/20/22)	CCPDAP External Relations Strategist
Casey, Alice	Pickens Technical College
Casper, Alana (10/28/21)	Community Member
Casucci, Charlene	Community Member
Cathie, Scott (5/31/22)	Sadas
Chang, Soojin, PharmD Cand. (1/24/18)	UC Denver School of Pharmacy
Clapp, Jonathan, MD	Physician Pain Consultants, L.L.C.
Coonan, Brian (1/11/23)	Array Behavioral Care
Davidson, Michael	CCPDAP Communications Professional
DeHerrera-Smith, Dayna (1/14/19)	Front Range Clinic
De la Cerda, Dionisia (12/19/18)	UC Denver Department of Family Medicine
Denberg, Tom, MD	Pinnacol
Dinkelberg, Pauline (4/19/22)	Vereniging Afbouwmedicatie
Eaddy, Jessica	CCPDAP External Relations Strategist
ELshehabi, Aya (7/28/22)	Graduate Student, Pharmacy

Esquibel, Jose	CCPDAP Associate Director
Feffer, Sophie (1/26/22)	CDPHE
Fischer, Matthew (7/16/20)	Colorado Health Network
Flores, Roland, MD	University of Colorado School of Medicine
Gabella, Barbara	CDPHE
Gauna, Danielle (4/4/18)	Opioid Advisory Group BOCO
Gibbens, Sally (1/25/23)	Urban Peaks Rehab
Goodman, Amy Berenbaum, JD, MBE (1/17/19)	Colorado Medical Society
Gorman, Fran, DNP, ANP-C, RN	Gorman Medical
Grace, Elizabeth S., MD	Center for Personalized Education for Physicians
Griggs, Connie (4/17/23)	Digital
Guerrero, Andres	CDPHE Prescription Drug Overdose Unit
Hara, Cheryl	Center for Personalized Education for Physicians
Harden, Michelle, Esq.	Messner Reeves, LLP
Harris, Helen	Epidemiologist, El Paso County Public Health
Harrison, J.M.	MD
Hart, Krystle (3/21/19)	Registered Nurse
Heath, Angela (5/31/22)	US Army PA/VHA PA
Hemler, Douglas, MD	Colorado Medical Society
Herting, Devon (10/11/22)	Community Member
Higgins, P.J. (1/22/20)	Community Health Partnership
Hill, Kyle Dijon (3/5/18)	Helping End the Opioid Epidemic (HEOE)
Hodson, Katie (3/8/23)	Jefferson County Public Health
Hoover, Lorraine (11/26/21)	Raymond Rountree Jr. Foundation
Howlett, Corinne (5/7/21)	School of Pharmacy
Iwanicki, Janetta	Rocky Mountain Poison and Drug Center
Jackson, Pam (6/29/19)	Retired, Attorney General's Office
Jenkins, Tom (2/12/18)	Western Colorado Health Network
Kato, Lindsey	CDC National Opioid Response Strategy
Keane, Ashli (9/1/20)	Gusto
King, Stephanie (4/13/22)	Renewal Health Group
Koons, Mike	Pinnacol Assurance
Krische, Elizabeth (2/19/21)	A Way Forward
Krueger, Jessica, MD (6/4/21)	CU Anschutz
Kumar, Anita, MD (7/7/22)	Axis Health System
Latta, Lucy (11/26/21)	Colorado State
Leach, Kara	M.D.
Leonard, Joanna (8/23/22)	Colorado Coalition for the Homeless
Li, Qing	Epidemiologist
Long, Mila (10/12/22)	Denver Recovery Group
Lopez, Elaine (12/28/22)	Community Member

Mackender, Jennifer	CCPDAP External Relations Strategist
McBurney, Christa, RN (10/5/18)	UC Health
McCarty, Craig, MD	Haxtun Hospital District
McDevitt, Kim (3/14/22)	Mile High Health Alliance
Meury, Kathleen (5/17/21)	Community Member
Mihok, Kristi	Walgreens
Milliken, Anne (6/3/21)	CDPHE
Miranda, Inez (1/11/23)	Community Member
Mulvihill, Sharon (1/12/19)	Riverstone Health
Murphy, Paul (7/10/20)	Office of e Innovation
Newlands, Sydney (12/2/22)	Community Member
Nickels, Sarah	Childrens Hospital Colorado
O'Keefe, Dawn (2/18/22)	Sierra Vista Hospital
O'Keefe, Julie	Pharmacist
Olberding, Gina	CCPDAP Assistant Director
Patel, Nashel	Pharmacy Student
Patterson, Kevin, DDS, MD (10/14/18)	Metropolitan Denver Dental Society, CDA
Paykoc, Carrie (2/13/23)	Innsena
Pellegrino, Robyn, RN (12/4/17)	RN Manager
Perry, Robert	M.D.
Pike, Erica, MS (1/6/22)	Colorado Academy of Family Physicians
Piotti, Louis (2/18/22)	Sober AF Entertainment
Prieto, Jose Tomas	Denver Health
Primavera, Dianne	Lt. Governor
Rael, Alexis (6/14/22)	Southern Colorado Harm Reduction Association
Ramzy, Nagy	Pharmacist, Retired
Reid, Ashley	Childrens Hospital
Reiskin, Julie (1/19/23)	Colorado Cross-Disability Coalition
Renner, Lindsey	San Luis Valley Behavioral Health Group
Ricards, Luke (2/1/18)	Cordant Health Solutions
Riebel, Lynda	Community Member
Robbins, Emily RN (4/28/18)	UC Health
Rollman, Anna (1/18/23)	Pharmacy
Rorke, Marion, MPH	Denver Environmental Health
Rubio, Chelsea (6/10/22)	Signal Behavioral Health
Rumely, Duke (2/18/22)	Sober AF Entertainment
Ryan, Courtnay (12/9/19)	Telligen
Schreiber, Terri	The Schreiber Research Group
Shehzad, Riaz Ul Haq (8/12/22)	MD
Shuler, James, MD	SUD Consultants

Bonnie Sihler (8/26/20)	Valley View Hospital
Sentence, Melinda (9/15/22)	Pueblo Dept. of Public Health & Environment
Shepard, Cristel (6/7/22)	Attorney General's Office
Simbeye, Lindsey (1/21/20)	CCPDAP External Relations Strategist
Sisson, C.B., MD (1/10/18)	Colorado Clinic
Smith, Theresa (8/30/22)	Arapahoe County
Stack, Kelly (6/13/22)	Bamboo Health
Stewart, Stephanie	UC Denver
Sullivan, Katie (5/7/21)	CDPHE
Swan, Sarah E.	State Govt. Affairs, Bristol Myers Squibb
Thomas, Andrea Y. (4/29/19)	Voices for Awareness Foundation
Thompson, Evan (12/17/21)	CU Forensic Psychiatry Program
Tiernan, Shane (4/4/18)	L.A. Healthcare
Tuetken, Tiffany	Cordant Health Solutions
Usher, Nelson (11/22/22)	Hyper Ltd
Valuck, Robert, PhD	Center Director
Vanderveen, Kevin, MD	Kaiser Permanente of Colorado
Veeneman, Hayes	Community Member
Wall, Lawrence	Wall Consulting
Walsh, Kori (12/28/22)	CAHEC
Weir, Mike (7/10/20)	Office of e Innovation
Whitney, Kaitlyn (3/2/23)	CU Dept. of Orthopaedics
Wipf, Justin	DORA
Wolf, Katie	Wolf Public Affairs
Zimdars-Orthman, Marjorie	Community Member

Appendix C: PDMP Statutory History and Milestones

The progression of the Colorado PDMP includes the following milestones:

- In 2005, House Bill 05-1130 (HB 05-1130) authorized the creation of the Colorado PDMP. Pharmacies began submitting prescription data to the Colorado PDMP in 2007, and the Colorado PDMP web portal went live to users in 2008.

- In 2011, Senate Bill 11-192 (SB 11-192) reauthorized the Colorado PDMP through 2021.

- In 2013, Colorado began sharing PDMP data with other states through PMP InterConnect.

- In 2014, an administrative change increased controlled substance dispensing reporting from bi-weekly to daily, thereby providing up to date PDMP patient data for prescribers and pharmacists.

- In 2014, House Bill 14-1283 (HB 14-1283) made several updates to the PDMP, including:

    - The Colorado Department of Public Health and Environment (CDPHE) was authorized to collect PDMP data for population-level analysis, expanding Colorado's ability to study the effectiveness of the PDMP through statistical analysis, including CDPHE's Prescription Drug Data Profiles for each of Colorado's 64 counties.[82] This access also allows CDPHE to work with healthcare organizations to evaluate the effectiveness of PDMP integration and other organizational initiatives related to controlled substance prescribing and PDMP utilization, including CDPHE's PDMP integration pilot project evaluation and the University of Colorado's PDMP integration.

    - Prescribers and pharmacists were authorized to designate up to three delegates to access the PDMP on their behalf with proper authorization.

    - The Colorado PDMP was authorized to issue unsolicited reports (Push Notices) to prescribers and pharmacies that inform them of their patients being prescribed controlled substances by multiple prescribers, at multiple pharmacies, over set periods of time. These Push Notices reduce potential patient misuse, abuse, and diversion of controlled substances, while increasing patient safety.

- In 2014, the Colorado Dental Board, Colorado Medical Board, State Board of Nursing, State Board of Pharmacy and the Nurse-Physician Advisory Task Force for Colorado Healthcare collaborated to develop *The Policy for Prescribing and Dispensing Opioids* to provide meaningful guidance to prescribers and dispensers of opioids in Colorado. This Policy was subsequently adopted by the State Board of Optometry and the Colorado Podiatry Board and endorsed by the Colorado State Board of Veterinary Medicine. This policy was the first of its kind to be adopted across numerous healthcare boards and groups within the Division of Professions and Occupations ("the Division").

[82] Colorado Department of Public Health and Environment. (2017). Prescription Drug Data Profiles. https://www.colorado.gov/pacific/cdphe/prescription-drug-data-profiles

- In 2015, DORA was awarded a grant through the US Department of Justice Bureau of Justice Assistance (BJA). DORA contracted with the University of Colorado as a grant subrecipient and researcher. Pursuant to the grant, funding was used to strengthen PDMP efforts to develop and test innovative strategies and to implement evidence-based approaches that demonstrate the impact of expanded use of PDMP data to support decision making.

- In 2017, Senate Bill 17-146 (SB 17-146) broadened access to the PDMP, allowing prescribers and pharmacists to check the PDMP for reasons apart from controlled substance prescription considerations, including drug-drug interactions, dangerous side-effects and possible abuse or diversion issues. Specifically, the Bill authorized:

    - Prescribers to query the PDMP to the extent the query relates to a current patient of the prescriber;
    - Pharmacists to query the PDMP when considering dispensing any prescription drug to a specific patient; and
    - Veterinarians to query the PDMP when they suspect a client (person responsible for the animal) is diverting the patient's (animal) controlled substance(s) or when they suspect a client is purposely abusing the animal to obtain a controlled substance.

- In 2018, the Colorado prescribing boards and State Board of Pharmacy published the *Guidelines for the Safe Prescribing and Dispensing of Opioids* ("Opioid Guidelines") after soliciting statewide stakeholder feedback, consulting with experts in the fields of pain management, addiction and mental health, and reviewing current literature, policy and guidelines related to the safe prescribing and dispensing of opioids for pain. These guidelines updated the 2014 *Policy for Prescribing and Dispensing Opioids* to both harmonize the guidelines with current policies and to provide Colorado prescribers and dispensers with current, evidence-based guidance with best practices including regularly checking the PDMP, risk assessment, assessing pain and function, considering opioid alternatives, patient education and treatment agreements, collaboration with members of a patient's healthcare team, establishing a strategy for reducing or discontinuing opioids, identifying aberrant drug-related behavior and referral for treatment of opioid use disorder.

- In 2018, the PDMP initiated Prescriber Scorecards. These individual scorecards are sent to eligible prescribers and provide information such as prescription volume data, PDMP usage, morphine milligram equivalent (MME) dosing information, and assessments comparing an individual's prescribing history to others within the same specialty to assist prescribers in making more informed prescribing decisions.

- In 2018, Senate Bill 18-022 (SB 18-022) began limiting a prescriber from prescribing more than a seven-day supply of an opioid to a patient who has not had an opioid prescription in the last twelve months by that prescriber, with exceptions for chronic pain, cancer pain, post-surgical pain, or transfer of care from another prescriber who had prescribed an opioid to the patient. The law also restricted a second fill to a seven-day limit with a requirement that prescribers query the PDMP prior to prescribing a second seven-day fill.

- In 2019, Senate Bill 19-228 (SB 19-228) expanded PDMP access to Colorado medical

examiners and elected coroners for patients whose death occurred under unusual, suspicious, or unnatural circumstances and are the subject of an autopsy, and mandated opioid prescribers to complete up to four credit hours of training per licensing cycle in order to demonstrate competency regarding: best practices for opioid prescribing, recognition of substance use disorders, referral of patients with substance use disorders for treatment, and the use of the PDMP.

- In 2019, CDPHE was awarded the CDC Overdose Data to Action (OD2A) grant. CDPHE and DORA entered into an inter-agency agreement with funding from the OD2A grant. This inter-agency agreement is funding a Program Analyst position at DORA for the PDMP as well as funding to make improvements to the Colorado PDMP. The three-year OD2A grant was extended for a fourth year in 2021, ensuring continued funding through August 2023.

- In 2019, DORA was awarded a second grant from BJA. DORA contracted with the University of Colorado as a grant subrecipient and researcher and is using the funding to systematically investigate the impact of mandated PDMP use, automated PDMP screening, and adding high risk clinical features to PDMP screening, measuring the effects of each modification in all care settings and hospitals used in the research.

- In 2019, the Office of eHealth Innovation (OeHI) formed a new strategic policy subgroup that reports to the Consortium PDMP Task Force (PDMP Task Force) to advance statewide PDMP integration planning and implementation and to ensure alignment between various state agencies. This subgroup, comprised of representatives of the Department of Health Care Policy and Financing (HCPF), CDPHE, Office of Information Technology (OIT), DORA and OeHI, was focused on formulating recommendations involving funding, policy, governance, data sharing, research, and the future state of the PDMP technical architecture to advance PDMP integrations statewide.

- In 2020, the Division and CDPHE reimbursed PDMP integration costs for healthcare organizations through the award of mini grants via a Request for Applications (RFA) procurement process leveraging Overdose Data to Action grant funding from the Centers for Disease Control and Prevention (CDC).

- In 2020, OeHI and HCPF received funding from The Centers for Medicare and Medicaid Services (CMS) to implement the requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act)[83] to expand integrated PDMP access for Medicaid providers.

- In 2021, Senate Bill 21-098 (SB 21-098) reauthorized the Colorado PDMP until September 1, 2028. The bill authorized the Board of Pharmacy to adopt rules to require reporting of certain non-controlled drugs with the potential for abuse to the Colorado PDMP and to adopt rules for a retention schedule for PDMP data. The Colorado State Board of Pharmacy considered this authority and after thorough review, discussion and receipt of stakeholder feedback, decided it was not necessary or beneficial for the PDMP to collect this information.

[83] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (SUPPORT Act), H.R.6, 115th Cong. (2018). https://www.congress.gov/bill/115th-congress/house-bill/6

- In 2021, House Bill 21-1276 (HB 21-1276) required the Division to enable the RxCheck data sharing hub for integrating the PDMP into the electronic medical records of practitioners and health systems within the state by December 1, 2021. This bill also allowed medical examiners and coroners to query the PDMP for individuals who are the subject of a death investigation. Also, within the PDMP statute, this bill required practitioners to query the PDMP before prescribing any opioid or benzodiazepine, subject to certain exceptions. However, this bill resulted in conflicts regarding the statutory requirement of when to query the PDMP in 12-30-109(1)(b), C.R.S. versus 12-280-404(4), C.R.S. leaving PDMP query requirements unclear.

- In 2021, DORA began work on building out the requirements for the next PDMP RFP as the current vendor's contract was nearing expiration. In tandem with this effort, the Division led a market research effort to collect feedback from various private and government stakeholders, through individual and large stakeholder meetings regarding the PDMP RFP requirements. In 2022, the Division selected Bamboo Health (previously named Appriss, Inc.) to continue as the PDMP vendor.

- In December 2021, the Division enabled RxCheck for in-state integrations. Work continues to improve the functionality of this system and to incorporate RxCheck utilization data into a unified audit trail within vendor-provided analytical tools.

- In 2022, Senate Bill 22-027 (SB 22-027) clarified that the statutory PDMP query requirement enacted in HB 21-1276 applies to any opioid or benzodiazepine prescription, subject to certain established exceptions. The bill also clarified that all DEA-licensed practitioners and all pharmacists licensed in Colorado are required to register and maintain a user account with the Colorado PDMP and requires the PDMP Task Force to evaluate and make recommendations to the DORA Executive Director, after engaging in a stakeholder process, regarding balancing the program as a health-care tool with the requirements of Title 12, Article 280, C.R.S.

- In 2022, House Bill 22-1115 (HB 22-1115) also clarified the statutory PDMP query requirement enacted in HB 21-1276 applies to any opioid or benzodiazepine prescription, subject to certain established exceptions. It also removed restrictions on the number of delegate users that a practitioner or pharmacist may authorize to query the PDMP on the supervising practitioner or pharmacist's behalf. The bill also required the Division to implement a process whereby practitioners and pharmacists may apply for and receive reimbursement from the Division for all or a portion of the costs of integrating the PDMP with electronic medical records.

- In 2023, House Bill 23-1072 (HB 23-1071) authorized the creation of a prescriptive authority certificate to certain psychologists which authorizes the psychologist to prescribe psychotropic medications. Psychologists with a prescriptive authority certificate will be authorized to obtain a DEA license to prescribe psychotropic controlled substance medications. These prescribing psychologists will be subject to the PDMP requirements applicable to DEA-licensed practitioners.