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## **OLR Bill Analysis**

### **sHB 7159 (as amended by House "A")\***

#### ***AN ACT ADDRESSING OPIOID USE.***

#### **SUMMARY**

This bill makes various changes in the statutes to prevent and treat opioid use disorder. Among other things, it:

1. generally requires pharmacists to offer consultations to all patients when dispensing a prescription, not just Medicaid patients as under current law (§§ 1 & 2);
2. allows pharmacists to designate a trained pharmacy technician to access the state's Connecticut Prescription Monitoring and Reporting System ("CPMRS"; see BACKGROUND) on their behalf (§ 3);
3. specifies that prescribing practitioners or their agents are not prohibited from disclosing CPMRS information about pharmacy- or veterinarian-dispensed prescriptions to the Department of Social Services (DSS) to administer medical assistance programs (e.g., Medicaid) (§ 3);
4. requires drug manufacturers and wholesalers to report to the Department of Consumer Protection (DCP) decisions to terminate or refuse an order from a pharmacy or prescribing practitioner for schedule II to V controlled substances (§ 4);
5. prohibits life insurance and annuity policies or contracts from excluding coverage solely based on an individual having received a prescription for naloxone (an opioid antagonist) (§ 5);
6. requires prescribing practitioners who prescribe an opioid drug with more than a 12-week supply to establish a treatment agreement with the patient or discuss a care plan for chronic

- opioid drug use (§ 6);
7. requires higher education institutions, by January 1, 2020, to develop and implement a policy on the availability and use of opioid antagonists by students and employees, and generally notify emergency medical providers when an opioid antagonist is used (§ 7);
  8. requires the Department of Mental Health and Addiction Services (DMHAS) to review and report on literature about the efficacy of providing home-based treatment and recovery services for opioid use disorder to certain Medicaid beneficiaries (§ 8);
  9. generally requires DMHAS-operated or -approved treatment programs to educate patients with opioid use disorder, and their relatives and significant others, on opioid antagonists and how to administer them (§ 9);
  10. makes various changes to credentialing of certain emergency medical services (EMS) personnel, such as requiring applicants on or after January 1, 2020, to complete (a) mental health first aid training and (b) national training and examination requirements (§ 10);
  11. requires hospitals, starting January 1, 2020, to administer a mental health screening or assessment on patients treated for a nonfatal opioid drug overdoses if it is medically appropriate to do so (§ 11); and
  12. requires DMHAS to study and report on the protocol for police detention of someone suspected of overdosing on an opioid drug and the implications of involuntarily transporting such a person to an emergency department (§ 13).

The bill also makes technical, conforming, and minor changes including replacing a reference to “licensed mental health professional” in the alcohol and drug counselor credentialing statutes

with “licensed behavioral health professional” (§ 12).

\*House Amendment “A” strikes the underlying bill, replacing it with similar provisions and adding the provisions concerning higher education institutions, the literature review on home-based treatment, patient education, EMS personnel mental health first aid training, hospital patient mental health screenings, police detention protocol, and a reference to licensed mental health professionals.

EFFECTIVE DATE: Various, see below.

### **§§ 1 & 2 — PHARMACIST CONSULTATIONS**

The bill requires pharmacists or another pharmacy employee, whenever practical and before or while dispensing a drug, to offer for the pharmacist to counsel a patient on the drug and its use. The requirement does not apply if the (1) person picking up the prescription is not the patient or (2) pharmacist determines it is appropriate to make the consultation offer in writing. A written offer must give the patient the option to communicate in person at the pharmacy or by telephone.

The bill’s consultation requirement applies to (1) hospital pharmacies, when dispensing a drug for outpatient use or use by an employee or the employee’s spouse or children, and (2) state-licensed pharmacies. Under the bill, pharmacists are not required to provide counseling if a patient refuses it.

Pharmacists must keep a record for three years of (1) any counseling provided and (2) if a patient refuses counseling, refuses to provide information regarding such counseling, or is unable to accept counseling, such action.

Under current law, pharmacists must make such consultation offers and keep related records only when dispensing prescriptions to Medicaid patients (CGS § 20-620).

EFFECTIVE DATE: October 1, 2019

**§ 3 — PHARMACY TECHNICIANS' ACCESS TO CPMRS**

By law, prescribing practitioners can designate an agent (e.g., medical assistant or registered nurse) to consult the CPMRS before writing certain controlled substance prescriptions, as required by law. The bill similarly allows pharmacists to designate a pharmacy technician to consult the CPMRS before dispensing such controlled substance prescriptions. The bill generally subjects these pharmacy technicians and their supervising pharmacists to the same requirements that apply to prescribing practitioners and their agents (e.g., confidentiality and liability for the agent's database misuse).

Under the bill, before designating a pharmacy technician to access the CPMRS, the supervising pharmacist must train the technician in how to do so. The training must designate a pharmacist to ensure such access is confined to what is permitted under the bill and occurs in a manner that protects the confidentiality of patient information. The pharmacist overseeing the pharmacy technician may be subject to disciplinary action for the technician's acts. Additionally, the DCP commissioner may inspect any records documenting that (1) the required training was provided, (2) designated technicians have access to the CPMRS, and (3) patient information is limited as required by law.

Under the bill, no one can prohibit, discourage, or impede a designated pharmacy technician from consulting the CPMRS. The bill prohibits these technicians from disclosing any CPMRS requests unless authorized by the state Pharmacy Practice Act or dependency-producing drug laws.

EFFECTIVE DATE: Upon passage

**§ 4 — MANUFACTURERS' DUTY TO REPORT CERTAIN DECISIONS TO DCP**

The bill requires DCP-registered drug manufacturers and wholesalers to report to the department's Drug Control Division, or to a designated electronic system, in writing of their decision, based on potential diversion concerns, to stop distributing or refuse to distribute

a schedule II through V controlled substance to a state-licensed pharmacy or practitioner. (Practitioners include physicians, dentists, veterinarians, and advanced practice registered nurses, among others.) They must do this within five business days after making the decision and include in the report the name and location of the pharmacy or practitioner and the reasons for the decision.

EFFECTIVE DATE: October 1, 2019

### **§ 5 — OPIOID ANTAGONIST PRESCRIPTION INFORMATION AND LIFE INSURANCE AND ANNUITY POLICIES**

Regardless of other state laws, the bill prohibits life insurance or annuity policies or contracts delivered, issued, renewed, or continued in the state from excluding coverage solely based on an individual having received a prescription for naloxone (an opioid antagonist), a naloxone biosimilar, or naloxone generic.

The bill also prohibits related applications, riders, and endorsements to such policies or contracts from excluding coverage solely based on receiving such a prescription.

EFFECTIVE DATE: October 1, 2019

### **§ 6 — PRESCRIBING OPIOIDS**

#### ***Prescriptions Exceeding a 12-Week Supply***

The bill requires a prescribing practitioner who prescribes more than a 12-week supply of an opioid drug to treat a patient's pain to (1) establish a treatment agreement with the patient or (2) discuss with the patient a care plan for the chronic use of opioid drugs. The agreement or plan must include treatment goals, risks of opioid drug use, urine drug screens, and expectations for continued pain treatment with opioids, such as situations requiring the patient to discontinue their use and, to the extent possible, nonopioid treatment options. Such treatment options include such things as manipulation, massage therapy, acupuncture, physical therapy, and other regimens or modalities. The agreement or plan must be recorded in the patient's medical record.

EFFECTIVE DATE: October 1, 2019

**§ 7 — ACCESS TO OPIOID ANTAGONISTS AT HIGHER EDUCATION INSTITUTIONS**

The bill requires each higher education institution president in the state, by January 1, 2020, to (1) develop and implement a policy on the availability and use of opioid antagonists by students and employees, (2) submit it to DCP for approval, and (3) post it on the institution's website once it is approved.

Under the bill, each institution's policy must do the following:

1. designate a medical or public safety professional to oversee purchasing, storing, and distributing opioid antagonists on each of the institution's campuses;
2. identify where on each campus opioid antagonists are stored, which must be made known and accessible to students and employees;
3. require maintaining the opioid antagonist supply according to manufacturer guidelines; and
4. require an institution representative to call 911 or a local EMS provider after each observed or reported use, unless the treated person has already received medical treatment for the opioid-related drug overdose.

EFFECTIVE DATE: July 1, 2019

**§ 8 — HOME-BASED OPIOID USE DISORDER TREATMENT**

The bill requires DMHAS, in collaboration with DSS and the Department of Public Health (DPH), to review and report on literature about the efficacy of providing home-based treatment and recovery services for certain people with opioid use disorder by a licensed provider of substance use disorder treatment services (e.g., home health agencies).

Under the bill, the review concerns providing medication-assisted

treatment to Medicaid recipients who visit an emergency department (ED) (1) due to a suspected opioid drug overdose or (2) with a primary or secondary opioid use disorder diagnosis and an ED physician determines the patient has a moderate to severe risk of relapse and the potential for continued opioid drug use.

Under the bill, the DMHAS commissioner must report on the review's outcome to the Human Services and Public Health committees by January 1, 2020.

EFFECTIVE DATE: July 1, 2019

### **§ 9 — PATIENT EDUCATION REQUIREMENTS FOR TREATMENT PROGRAMS**

The bill requires DMHAS-operated or -approved substance use treatment programs that provide treatment or detoxification services to someone with an opioid use disorder to offer education on opioid antagonists and how to administer them. They must offer it to (1) patients when they are admitted to the program or receive first treatment services and (2) the patient's identified relatives and significant other.

Additionally, the bill requires a prescribing practitioner affiliated with a treatment program to deliver or issue a prescription for at least one dose of an opioid antagonist to a patient the prescriber determines would benefit from it. The prescription must be issued when the patient is admitted to the program or first receives treatment services.

EFFECTIVE DATE: October 1, 2019

### **§ 10 — EMS PERSONNEL**

#### ***Mental Health First Aid Training***

Starting January 1, 2020, the bill requires an applicant for a paramedic license or emergency medical technician (EMT), advanced EMT, or emergency medical responder (EMR) certificate to complete mental health first aid training as part of a program provided by a National Council for Behavioral Health-certified instructor.

This applies to both (1) standard applications and (2) applications for licensure by endorsement for individuals licensed or certified in other states.

***National Certification for Certain EMS Personnel***

Starting January 1, 2020, the bill generally requires applicants for EMR, EMT, or advanced EMT certification to obtain certification from a national organization for emergency medical certification in lieu of current state certification and licensure requirements.

Under current law, applicants for state certification must meet specified training requirements and pass written and practical examinations, as listed in Table 1 below.

***Initial Certification.*** Under the bill, applicants for initial certification as an EMR, EMT, or advanced EMT must (1) complete an initial training program consistent with the National Highway Traffic Safety Administration’s National EMS Education Standards for their respective profession and (2) pass the national organization for emergency medical certification’s examination for their respective profession or a DPH-approved examination.

In addition, applicants must (1) complete mental health first aid training as specified above and (2) as under current law, have no pending disciplinary action or complaint against them.

**Table 1: Current Initial Certification Requirements for EMRs, EMTs, and Advanced EMTs**

<b><i>Profession</i></b>	<b><i>Current Education and Training Requirements For Initial Certification</i></b>
EMR	(1) complete a 60-hour DPH-approved training that includes written and practical examinations or (2) be currently certified as an EMT, advanced EMT, or paramedic and pass the examination required for an initial EMR training program
EMT	(1) complete a 150-hour DPH-approved training that includes written and practical examinations or (2) be currently licensed as a physician,

<b>Profession</b>	<b>Current Education and Training Requirements For Initial Certification</b>
	registered or advanced practice registered nurse, or physician assistant and complete a 30-hour DPH-approved refresher course and pass written and practical examinations
Advanced EMT	(1) complete a 150-hour DPH-approved training that includes written and practical examinations or meets or exceeds the 2009 National EMS Education Standards for the profession and (2) be currently certified as an EMT

**Certification Renewals.** The bill requires EMRs, EMTs, advanced EMTs, and EMS instructors to renew their certifications every two years, rather than the current three years.

The bill requires applicants seeking to renew certification as an EMR, EMT, or advanced EMT to (1) successfully complete the continuing education required by the national organization or approved by DPH or (2) be currently certified in their respective professions by the national organization.

**Certification By Endorsement.** As under current law, the bill requires EMR, EMT, and advanced EMT applicants for certification by endorsement (i.e., those currently certified in another state) to present satisfactory evidence to the DPH commissioner that they are currently certified in good standing in their respective profession by a state with requirements DPH determines are at least as strict as Connecticut's. It additionally grants certification to such applicants who are currently certified by the national organization.

EFFECTIVE DATE: October 1, 2019

## **§ 11 — MENTAL HEALTH SCREENINGS FOR CERTAIN HOSPITAL PATIENTS**

Starting January 1, 2020, the bill requires licensed hospitals that treat patients for nonfatal opioid drug overdoses to administer mental

health screenings or patient assessments if it is medically appropriate to do so. And it requires hospitals to provide screening or assessment results to the patient or to the patient's parent, guardian, or legal representative, if medically appropriate.

EFFECTIVE DATE: October 1, 2019

### **§ 13 — STUDY ON DETENTION PROTOCOLS**

The bill requires DMHAS, in collaboration with DPH and any other relevant entity the agencies designate, to study the (1) protocol for police officers when detaining someone suspected of overdosing on an opioid drug and (2) implications of involuntarily transporting someone suspected of overdosing on such drug to the ED and referring the person to a recovery coach to help him or her obtain or receive recovery resources.

The DMHAS and DPH commissioners must report on the study to the Public Health Committee by January 1, 2020.

EFFECTIVE DATE: Upon passage

### **BACKGROUND**

#### ***CPMRS***

The Prescription Drug Monitoring Program collects prescription data on most controlled substances (i.e., Schedule II-V) in a centralized online database, the CPMRS (CGS § 21a-254(j) & Conn. Agencies Regs. § 21a-254-2 et seq.). The CPMRS seeks to present a complete picture of a patient's controlled substance use to pharmacists and prescribing practitioners, including prescriptions from other practitioners.

#### ***Related Bill***

sSB 1057 (File 731), favorably reported by the Public Health Committee, contains similar provisions to §§ 7-12.

### **COMMITTEE ACTION**

General Law Committee

Joint Favorable Substitute

Yea 15 Nay 1 (03/21/2019)

Public Health Committee

Joint Favorable

Yea 23 Nay 1 (04/24/2019)