



PA 19-191—sHB 7159
General Law Committee
Public Health Committee

AN ACT ADDRESSING OPIOID USE

SUMMARY: This act 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 prior law (§§ 1 & 2);
2. allows pharmacists to designate a trained pharmacy technician to access the state's Connecticut Prescription Monitoring and Reporting System ("CPMRS") 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) certain 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 the opioid antagonist naloxone (§ 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 to develop and implement a policy by January 1, 2020, 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 to the legislature 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 the 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);

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11. requires hospitals, starting January 1, 2020, to administer a mental health screening or assessment on patients treated for a nonfatal opioid drug overdose 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 (ED) (§ 13).

The act 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).

EFFECTIVE DATE: Various, see below (the provision replacing the reference to a licensed mental health professional is effective upon passage).

§§ 1 & 2 — PHARMACIST CONSULTATIONS

The act 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 offer in writing. A written offer must give the patient the option to communicate in person at the pharmacy or by telephone.

The act’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 act, 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) a patient’s refusal of counseling, refusal to provide information regarding counseling, or inability to accept counseling.

Under prior law pharmacists had to 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 act similarly allows pharmacists to designate a pharmacy technician to consult the CPMRS before dispensing such controlled substance prescriptions. It generally subjects 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 act, before designating a pharmacy technician to access the CPMRS, the supervising pharmacist must train the technician in how to do so.

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The training must designate a pharmacist to ensure such access is confined to what is permitted under the act 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 prescription information is limited as required by law.

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

By law, the CPMRS collects prescription data on Schedule II-V controlled substances in a centralized online database (CGS § 21a-254(j); Conn. Agencies Regs. § 21a-254-2 et seq.). It seeks to present a complete picture of a patient's controlled substance use to pharmacists and prescribing practitioners, including prescriptions from other practitioners.

EFFECTIVE DATE: Upon passage

§ 4 — MANUFACTURER'S DUTY TO REPORT CERTAIN DECISIONS TO DCP

The act requires DCP-registered drug manufacturers and wholesalers to report to DCP's Drug Control Division, or a designated electronic system, of their decision to stop distributing or refuse to distribute a schedule II through V controlled substance to a state-licensed pharmacy or practitioner because of potential diversion concerns. (Practitioners include physicians, dentists, veterinarians, and advanced practice registered nurses, among others.) They must do this in writing 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

The act 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. It 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

The act requires a prescribing practitioner who prescribes more than a 12-

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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. It must also include, to the extent possible, nonopioid treatment options such 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 act 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 act, 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 and make such locations 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 act requires DMHAS, in collaboration with DSS and the Department of Public Health (DPH), to review and report on literature about the efficacy of using licensed providers of substance use disorder treatment services (e.g., home health agencies) to provide home-based treatment and recovery services for certain people with opioid use disorder.

Under the act, the review must include the provision of medication-assisted treatment to Medicaid recipients who visit an ED (1) due to a suspected opioid drug overdose or (2) (a) with a primary or secondary opioid use disorder diagnosis and (b) an ED physician determines that the patient has a moderate to severe risk of relapse and the potential for continued opioid drug use.

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

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§ 9 — PATIENT EDUCATION REQUIREMENTS FOR TREATMENT PROGRAMS

The act 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 act 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 whom 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 act requires all applicants 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.

National Certification for Certain EMS Personnel

Starting January 1, 2020, the act generally requires applicants for EMR, EMT, or advanced EMT certification to obtain certification from a national organization for emergency medical certification in lieu of prior state certification and licensure requirements. The table below lists prior law’s initial certification requirements; the act’s requirements follow the table.

Prior Law’s Initial Certification Requirements for EMRs, EMTs, and Advanced EMTs

Profession	Prior Law’s Education and Training Requirements for Initial Certification
EMR	(1) Complete a 60-hour DPH-approved training that includes written and practical examinations or (2) be 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 licensed as a physician, registered or advanced practice registered nurse, or physician

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Profession	Prior Law's Education and Training Requirements for Initial Certification
	assistant and complete a 30-hour DPH-approved refresher course and pass written and practical examinations
Advanced EMT	(1) Be certified as an EMT and (2) 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

Initial Certification. Under the act, 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 prior law, have no pending disciplinary action or complaint against them.

Certification Renewal. The act requires EMRs, EMTs, advanced EMTs, and EMS instructors to renew their certifications every two years, rather than every three years as under prior law.

The act 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 prior law, the act 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 act 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. It also requires hospitals to provide screening or assessment results to the patient or his or her parent, guardian, or legal representative, if medically appropriate.

EFFECTIVE DATE: October 1, 2019

§ 13 — STUDY ON DETENTION PROTOCOLS

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The act 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

Related Act

PA 19-118 contains similar provisions on licensing EMS personnel, but also includes new certification requirements for EMS instructors.