Since 2002, the Harm Reduction Action Center has been Colorado’s primary provider of HIV/HCV prevention and services to injection drug users in the Metro-Denver community. The mission of the Harm Reduction Action Center is to educate, empower, and advocate for the health and dignity of Metro-Denver’s injection drug users (IDU) and affected partners, in accordance with harm reduction principles. Staff and volunteers meet drug users “where they’re at” and have developed a reputation for accessing IDUs that would not otherwise have appropriate health education, healthcare services, and emotional support, thus avoiding duplication of already available community services.

**Syringe Access** – Clean syringes Monday through Friday from 9:00am – noon.

**Health Education Classes** – HIV & HCV prevention are the cornerstones of agency services.

*Break the Cycle:* IDUs recognize their personal power in reducing HIV/HCV prevalence, refuse to participate in other people’s initiations into injection drug use, and reduce risk of participating in actions that compromise their morals. Evaluations have demonstrated that after participating in the BTC program, the majority report having more skills to refuse initiation requests and were more aware of their unintentional influence on non-injectors.

*HIV & HCV 101:* a group-level educational intervention to educate users about the similarities and differences between HIV and HCV, risk factors for transmission, and IDU risk-reduction behaviors.

*Vein Care:* a group-level educational intervention to educate users on injection-related health conditions including HIV and Hepatitis C as well as bacterial infections such as abscess, cellulitis, and endocarditis; this class also provides an opportunity for users to learn how to incorporate more hygienic and lower-risk practices into their injection techniques.

**Safe Syringe Disposal Initiative** - provides IDU-led community cleanups and free, disposal services to both IDUs and other Metro-Denver individuals facing similar challenges to properly dispose of medically-related syringes.

**HIV/hepatitis C/Chlamydia/Gonorrhea Testing** – HRAC staff provide on-demand testing.

**Overdose Prevention & Treatment with Access to Naloxone** – Naloxone is an opiate-reverser for folks experiencing an opiate overdose. After a 2 hour training, a physician will prescribe Naloxone to opiate users and 3rd parties to save a life while continuing to call 911. HRAC is the only agency in Colorado providing this service; has trained over 200 people and have had 61 lives saved due to access to Naloxone.

**Bridges to Access** – HRAC connects with healthcare providers statewide to discuss the challenges and opportunities of working with injection drug users. It is a common misconception that injection drug users do not care about their health. HRAC is working to build mutual understanding between healthcare providers and IDU patients and to bridge the access to healthcare for our community’s most vulnerable populations. The HRAC daily refers people to healthcare providers.
Recovery Accessibility Initiative - seeks to provide dual-diagnosis substance abuse treatment support and/or therapy through an integrated approach. The HRAC daily refers people to substance abuse services and mental health treatment. Methadone Emergency Assistance – Collaboration with Empowerment Program. Averages assistance for 30 opiate users every month.

IDU Advisory Committee – Every month, 25-35 active injection drug users meet at HRAC to discuss issues in the community, define relevancy for the HRAC’s programs/services, updates within the agency, and pursue projects for staff/committee members to push forward with in the Metro-Denver community.

Street Outreach - reach on average 25 persons weekly through mobile distribution of legal harm reduction supplies and wraparound service referrals. Staff/volunteers seek out IDU’s that do not access social service agencies. Over 1,000 contacts were made on the streets of Denver, along the river, and in parks in 2012.

Advocacy - HRAC works to encourage IDUs to share their stories and provide their experiences on various health and social issues that directly impact their overall health and well-being as IDUs through participation in meetings and IDU-led awareness events. Overdose Awareness, AIDS Awareness, and Veteran remembrance opportunities are provided for community members to learn more about health and social issues that are shared with injectors and larger society, who at times stigmatize them.

Legislation - While HRAC provides direct service, I would like to take this opportunity to alert you of our advocacy success over the past few years. As you can imagine, it’s important the streets influence the policy at our State Capitol and locally, with City Council.
-2010: Clean Syringe Exchange Program Legislation (SB 189). Status: Successful
-2011: Changes of Denver City Ordinance for Denver SAP with City Council. Status: Successful
-2012: 911 Good Samaritan Law (SB 20). Status: Successful
-2012: Worked with City Attorney's and Law Enforcement for HRAC participant exemption from injection device charges. Status: Successful
-2013: 3rd Party Naloxone Legislation with Access to Naloxone. (SB 14) Status: Successful
-2013: Statewide Participant Exemption From Possession of Syringes. (SB 208) Status: Successful
-2013: Passed Mobile Syringe Exchange at City Council. Status: Successful

Acupuncture Detoxification – Volunteer Acupuncturist provides weekly sessions for clients
Access to Homeless Outreach Worker – Weekly HOW meets with HRAC clients for folks to garner identification cards, birth certificates, transitional housing, etc.

Re-register former felons and the homeless to vote – Important for every voice in the community to be heard, to be re-integrated in community discussions. 253 were registered to vote with us in 2012.

Case Management/Community Referrals – Provided every day in every way.
Volunteers - HRAC’s 100+ community volunteers are as diverse as the community that we serve, including family members of clients and community leaders, filling shoes that the staff of four cannot. The dedication of volunteers impacts IDU clients beyond health improvement; it reinforces their value as human beings, worthy of additional efforts to reach them.
The Harm Reduction Action Center has successfully created a tiny oasis within Denver where IDUs can be themselves as human beings—not as addicts, criminals, psychiatric conditions or ‘lost’ individuals. The problems and issues of injection drug users demand a holistic approach in regaining their self-esteem and empowerment while bringing awareness to the greater community. The Harm Reduction Action Center continues society’s goal to reach the most marginalized, create community where there is not, and help the most lost find a direction home.

We asked our participants to critique our programs and services. Here is what they had to say:

- My arms are no longer infected, I'm always using clean needles, or I have to clean them one time to reuse them and I more time. Sometimes I can come in right away to exchange them. It has helped 100% for my arms and the infections have stopped.
- Yes, I don't feel so alone and helpless. I realize that the disease, addiction, is able to be beat and life is always worth living and this can be a positive phase in my life. When I gain control of my life I want to help people like me and the homeless. When complete strangers treat you like family it heals you. And knowledge has saved me from death and suicide.
- They have been here on the days I would have jumped in front of a bus and talked me into taking a leap of faith and patience instead.
- Just thank you all very much for everything you do and thank God for you, the selfless.
- Thank you for caring about the people at the bottom. To know that someone cares enough to help and assist during hard time and difficult situations to overcome. Thanks for all you do for us.
- I no longer share needles or need to use old, use syringes. I feel cleaner and safer knowing my chances of being exposed to HIV are drastically reduced.
- Well I don't have to worry about sharing needles in the past if that all you had then that’s what you did
- I'm a lot more knowledgeable about my use, I'm cleaner and more sterile when using. I eat more!
- I am no longer living on the streets, moved in with my dad and I am starting on methadone.
- Thank you for all your hard work and dedication! It means a lot to know that there are people out here who care!
- I'd like to express the gratitude to all the staff members here day after day with smiles and cheer to each person who walked through the door! I don't have a clue how ya'll do it, but you do! I always feel welcome safe and respected, thank you!
The DOPE Project “Quick & Dirty” Narcan Training Checklist

1)  [www.anypositivechange.org](http://www.anypositivechange.org) – great video that will teach folks all of this information, as well.

2)  **Mechanism of overdose:** when someone dies it’s because their breathing slows to the point where they stop getting enough oxygen to stay conscious, and without air, eventually the heart stops. With an upper overdose, the heart stops, or person has seizures or stroke.

3)  **Risk Factors:**
   a)  **Mixing:** opioids with alcohol/pills, or cocaine → **Prevention:** use one drug at a time, don’t mix highest risk ones.
   b)  **Tolerance:** exiting jail, hospital, detox, esp. methadone detox → **Prevention:** use less when tolerance at these times.
   c)  **Quality:** unpredictable → **Prevention:** tester shots, use reliable/consistent dealer.
   d)  **Using Alone:** behind closed, locked door, where cannot be found, esp. in SROs. → **Prevention:** fix with a friend. Leave door unlocked. Call someone.
   e)  **Health:** liver, breathing problems (asthma), compromised immune system, active infections, lack of sleep, dehydration, malnourishment all increase risk of OD → eat, drink, sleep, see doctor, carry inhaler, treat infections, etc.

4)  **Recognition:** The line between high vs. overdosing: **unresponsive.** Other signs to look for: slow, shallow breathing, pale, blue, snoring/gurgling for opiate OD; chest pains, difficulty breathing, dizziness, foaming at the mouth, lots of sweat or NO sweat, racing pulse, puking, seizures, loss of consciousness for stimulant OD.

5)  **Response (upper/stimulant OD):**
   a)  There is no antidote to a stimulant OD, like Narcan—call 911 if you see the signs of a seizure, heart attack or stroke.
   b)  If the person is still conscious, have them sit. Loosen any clothing around waist, chest and neck.
   c)  Breathing into a bag can help reduce panic and hyperventilation. Make sure they are getting some air and the room is ventilated (open a window if you have one!) Benzos (like ONE benzo) can help with overamping, similar to a panic attack. This is what they would give you if you went to the ER.
   d)  If they are having a seizure, make sure there is nothing within reach that could harm them (objects that could fall, furniture they could bump themselves on, etc).
   e)  Do not hold the person down, if the person having a seizure thrashes around there is no need for you to restrain them, just make sure objects are out of the way.
   f)  Do not put anything in the person's mouth. Contrary to popular belief, a person having a seizure is incapable of swallowing their tongue so you do not have to stick your fingers or an object into their mouth.
   g)  Do not give the person water, pills, or food until fully alert.
   h)  If overheated and/or they have stopped sweating, cool them down with ice packs, mist or fanning.
   i)  If they pass out or become unresponsive, open their airway and immediately call 911!
   j)  If the person is unconscious, check for breaths/pulse. Begin rescue-breathing/CPR if needed!

6)  **Response (downer/opiate OD):**
   a)  Noise: call name, yell “cops, or I’m going to narcan you!”
   b)  Pain: shake, slap, sternum rub.
   c)  Airway: head tilt, chin lift.
   d)  Check breathing and clear airway (check for syringe caps, undissolved pills, cheeked Fentanyl patches, toothpicks, gum, etc.)

7)  **Recovery Position:** put person on their side if you have to leave them alone to call 911.

8)  **Calling 911:**
   a)  Say: (location), “someone is unconscious, not breathing.” Not: "overdose.”
   b)  Cops in SF generally do not arrest; there to help paramedics and 1st to respond in medical emergency.
   c)  **Narcan only works on opiates,** not benzos or alcohol. Need 911 as backup.

9)  **Rescue Breathing**
   a)  If you’re alone with the overdosing person, start rescue breathing and then go get narcan after you’ve given a few breaths. If you’re not alone, start rescue breathing while other person goes to get the narcan.
   b)  Head tilt, chin lift
   c)  Look, listen, feel: to see if chest rises/falls; listen/feel for breath.
d) Two breaths: normal sized, not quick, not a hurricane!

e) One breath every five seconds (count one-one thousand, two-one thousand…)

f) Explain need: brain damage/death after 3-5 min. without oxygen to brain, ambulance may take longer, have to breathe for person until narcan kicks in or paramedics arrive.

10) Administering IM Narcan

a) Assembling shot: remove cap on vial, draw up 1cc of Narcan into muscling syringe.
b) Site location: arm (deltoid), thigh, butt. Shoot into muscle, not vein, not abscess.

**Administering Nasal Narcan**

a) Pull off yellow caps, screw spray device onto syringe
b) Pull red cap of the vial of Narcan and gently screw into bottom of syringe
c) Spray half of vial up one nostril, half up the other

11) While you're waiting for the narcan to kick in…

a) Start rescue breathing again, until you see the person start to breathe on their own.
b) Wait 2-3 minutes (it seems like forever!) until you give a second dose of narcan. Give it a chance to work, it doesn’t always work instantaneously.
c) If you get no response after 2-3 minutes, give a second dose and start rescue breathing again. If there is still no response, continue breathing until paramedics arrive and let them take over, and if you haven’t called 911 yet, do it now! There could be something else wrong, they may have taken different drugs that narcan doesn’t work on, or it could be too late for narcan to work.

10) Aftercare:

a) Takes several minutes to kick in; wears off in 30-45 minutes
b) Person won't remember overdosing; explain what happened
c) Don’t allow to do more opioids—will be wasting drugs, could OD again
d) Need to watch person for at least an hour
e) Could need to administer another dose of Narcan

11) Narcan care:

a) Keep out of sunlight, and keep at room temperature (not too hot, not too cold—don't put in fridge!)
b) Expires in about two years—date will be on your narcan itself.

For more information, contact the Lisa from the Harm Reduction Action Center at 303-572-7800 or at Lisa.harm.reduction@gmail.com
**Intranasal Naloxone Drug Request**
April 30, 2013 (follow-up from Jan 2013 P&T meeting)

**Intranasal naloxone request - OUTPATIENT ONLY**

**Requesting provider:** Dr. Kerry Broderick

**Target population:** patients on high dose opioid medications and patients with opioid abuse not in remission

**Setting:** CHS clinics

**Estimated utilization:** 100 doses (patients)/year

**Training and education:** dispensed from pharmacy, educated in the clinics by providers to patients/family members

<table>
<thead>
<tr>
<th></th>
<th>Acquisition Cost for 2mg Dose</th>
<th>Per patient</th>
<th>Annualized</th>
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<tbody>
<tr>
<td>Naloxone 2mg inj</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atomizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
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</tbody>
</table>

Updated ABC price as of 4/23/13

**Follow-up request from P&T Committee**

1. Clear understanding of the intended patient population. Patients with opioid abuse not in remission are pretty straightforward. The committee wanted to hear a more specific proposal for which patients on high dose opioid therapy would be offered naloxone prescriptions. Is there any data to support a particular group of these patients who are at high (or low) risk of unintentional OD?

2. We need a better understanding of the number of patients we anticipate to threat (estimate of 100 patients).

3. Although our intent is that the naloxone would be administered to the person to whom it was prescribed, several on the committee felt that because use on third parties was foreseeable, legal needed to review.

4. We would appreciate knowing more about your plans for patient education / teaching, both for patients prescribed naloxone by their PCP and for patients prescribed naloxone from the ED.
## Naloxone

<table>
<thead>
<tr>
<th>Reference</th>
<th>Trial design</th>
<th>Demographics</th>
<th>Treatment</th>
<th>Study findings</th>
<th>Evidence</th>
</tr>
</thead>
</table>
| Merlin MA, et al. 2010 | Retrospective cohort, clinical review | N = 96 (pts. with confirmed opiate overdose). Average age = 40 Male = 65% | IN naloxone 2 mg (1 mg in each nostril) vs. IV naloxone 0.4-2 mg. | • Change in RR was 6 for the IV group and 4 for the IN group (p = 0.08).  
  • Change in GCS was 4 for the IV group and 3 for the IM group (p = 0.19)  
  • IN naloxone was statistically as effective as IV naloxone at reversing the opioid effects of patients with confirmed overdose. | Level 2   |
| Robertson TM, et al. 2009 | Retrospective cohort clinical review | N = 154 (Pts. with suspected opiate overdose). Average Age = 43 Male = 63% | IN naloxone 2 mg every 5 minutes vs. IV naloxone 1 mg every 5 minutes until RR > 8. IM or IV doses were administered to pts not responding to IM naloxone (see study protocol for specific parameters) | • Clinical response was noted in 33 (66%) and 58 (56%) of the IN and IV groups respectively (p = 0.3).  
  • Mean time from naloxone administration to clinical response was longer in the IN group (12.9 vs. 8.1 min., p = 0.02), however mean time from initial patient contact to clinical response was not significantly different between the two groups (20.3 vs. 20.7 min, p = 0.3)  
  • IN naloxone appeared to be a useful and potentially safer alternative to IV naloxone. | Level 2   |

Abbreviations: RR – Respiratory Rate. CGS – Glasgow Coma Score. IN – Intranasal. IV – Intravenous

References:


DENVER HEALTH AND HOSPITALS
PHARMACY AND THERAPEUTICS COMMITTEE OF THE MEDICAL STAFF
REQUEST FOR FORMULARY REVIEW

Please submit this application to request the addition/deletion of a drug or change of status of an existing entity on the Formulary. Complete specific areas of the application as applicable to your request. Please return completed form with pertinent articles to the Pharmacy and Therapeutics Mailbox at pharmacy-Therapeutics@dhha.org OR return to the Chair of the P&T Committee at Mail Code 0180.

NOTE: Due to the lack of complete safety data on newly licensed medications, The Pharmacy and Therapeutics Committee will generally consider medications FDA approved within the last 18 months for addition to the Denver Health formulary if reliable and supporting evidence demonstrate major patient benefit will outweigh the potential risks.

REQUEST (check all that apply):
Addition to the Formulary (please complete the form in its entirity)
Change in formulary status (please complete the form in its entirity)
Deletion to the Formulary (please complete Part I, questions 1 – 3 ONLY)

PART I: SUMMARY

1. GENERIC NAME: Naloxone

2. PROPRIETARY (TRADE) NAME: Narcan

3. DOSAGE FORM(S) AND STRENGTH(S) REQUESTED: 2mg intranasal

4. TYPICAL COURSE OF THERAPY: one time dose

5. CLINICAL INDICATION(S) REQUESTED: opiate overdose; send home for any patient the provider feels is at high risk of opiod overdose

6. CURRENT FORMULARY PREPARATION(S) USED FOR THE SAME INDICATION(S): none for outpatient

7. ADVANTAGES OVER CURRENT FORMULARY PREPARATION(S): NA

8. EVIDENCE TO SUPPORT REQUEST (Provide at least 3 references - one must be a well designed study):

Is there a Cochrane Review (http://www2.cochrane.org/reviews/)? YES NO
Is there a NICE evaluation (http://guidance.nice.org.uk/)? YES NO
Is there a society guideline available? (if there are any available references above, please include this in your request) YES NO

(continued on next page)

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Updated 10/04/10; 05/14/12 by K.Yamasaki, Pharmacy 2013 P&T PACKET

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PART II: CRITERIA FOR USE

All requests for new drugs must be accompanied by criteria for use. This criteria must be explicit enough to differentiate its appropriate use on an individual patient.

1. TARGETED PATIENT POPULATION (list characteristics of patients who are appropriate candidates for drug, patients who should NOT receive this drug and/ or criteria for use at DH): Patients on high dose opioid medications and patients with opioid abuse not in remission

2. ESTIMATED # DOSES/YEAR OR # PATIENTS/YEAR (anticipated utilization): 100/100

3. RESTRICTIONS, IF APPLICABLE: None

FINANCIAL DISCLOSURE/CONFLICT OF INTEREST (Please check the appropriate box(es) below – THIS MUST BE COMPLETED):

XX I have no potential conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject matter or materials discussed in the request for formulary review.

OR

☐ I certify that all my potential conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject matter or materials discussed in the request for formulary review (eg, employment/affiliation, grants or funding, consultancies, honoraria, speakers bureaus, stock ownership or options, expert testimony, royalties, donation of medical equipment, or patents filed, received, pending, or in preparation), are disclosed here:

REQUESTED BY: Kerry Broderick, MD

Signature: 

DATE: 12.19.12

SERVICE DIRECTOR: Chris Colwell, MD

Signature: 

DEPARTMENT: ED

You will be notified of when your request for formulary review will be placed on the P&T agenda. Requests will be presented at the P&T Committee by the requestor or sponsor. The P&T Committee meets the last Tuesday of each month, 3:30 – 5 PM in the Davis building, 3rd floor conference room.

Please allow 1-week for notification of P&T decision.

Incomplete request forms will not be reviewed, and sent back to the requestor to complete.

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Updated 10/04/10; 05/14/12 by K.Yamasaki, P&T 2013 P&T PACKET
Naloxone for Opioid Overdose Prevention Program at Denver Health

Instructions:

Step 1: Identify a “high-risk” patient

- IVDU
- Takes high dose prescription opioids
- Chronic pain syndromes that require high dose opioids +/- sedatives or muscle relaxants
- Seen for opioid overdose
- Elderly or opioid naïve patients given prescriptions for moderate to high dose opioids

Step 2: Alert SBIRT Educators or ED pharmacist

- Education using patient and family education sheets along with sample Naloxone kit will be used

Step 3: Give patient a prescription for naloxone inj.

- Use provided stickers in binder and place on a blank prescription, sign, date, and attach a patient registration sticker

Notes:

Naloxone will not be given straight from the ED or clinics. The patient must deliver the prescription to the outpatient pharmacy and will be filled and billed to the patient’s payer source if one exists.

Currently, all DH formularies will cover naloxone. DH has no control over whether outside insurance plans will cover the agent. If the patient pays cash, it will cost them $21.

Contact Kevin Kaucher, Kerry Broderick, or Josh Blum with any questions. Thank you.

1/2014
Dear Primary Care Clinician and Colleague,

The Denver Health has recently approved the use of intranasal naloxone for patients at high risk for opioid overdose. This is wonderful news. Intranasal naloxone administered by a bystander such as a family member or friend has been shown to prevent fatal opioid overdose in high-risk patients. We are targeting this intervention to patients on high doses of chronic opioids, defined as at least 200 mg per day of morphine equivalents. You have been identified as the primary care provider of a patient who falls into this high risk group. There was recently a bill passed that protects prescribers of naloxone from liability. This was unanimously supported by all medical groups who were invited for comment. Thank you for considering prescribing this potentially life-saving intervention to your higher-risk patients.

There is an excellent video on opioid use and overdose with naloxone instructions. It is about 11 minutes long but very helpful. The link is: http://prescribetoprevent.org/prescribe-naloxone-now

The prescription should be written as: Naloxone 2mg/2ml. “For suspected Opioid Overdose, Spray ½ the syringe in each side of nose. Repeat in 2-3 minutes if person does not wake up. Call 9-1-1”. Dispense #1 ampule.

Pharmacy has built the Sig code above, which are the same as the directions on the informational handout each patient should be given. If you wish to change the directions, it will be reflected on the patient’s prescription label.

Sincerely,

Josh Blum, MD, Kerryann Broderick, BSN, MD, Kevin Kaucher, PharmD
Opioid Overdose Prevention Program

An opioid overdose means someone has taken too much pain medicine or drug like heroin. Opioids can be Vicodin, Norco, Percocet, MS Contin, Oxycontin, Dilaudid, methadone, or other drugs. Narcan or naloxone can reverse the effects of these drugs.

**Overdose can occur when:**
- You take too much of your opioid pain medicine
- You use too much heroin
- You’re alone and no one is around to help you
- You mix your pain medicine or heroin with other drugs or alcohol

**Signs of an overdose are:**
- Slow breathing
- Blue or grayish lips or fingernails
- Sleepiness or won’t wake up to yelling their name

**What to do in an overdose?**
1. Check to see if the person is breathing
2. Call 911 for help
   a. Tell the operator “someone is not responding and not breathing”.
   b. Tell them your address
3. If not breathing or not responding, give Narcan
   a. Open kit and pull off yellow caps
   b. Screw rubber nasal device and syringes together
   c. Spray quickly ½ of the syringe into each side of the nose
4. Give them oxygen or a rescue breath and call 9-1-1
   a. Tilt head back, lift chin, pinch nose
   b. Give a breath every 5 seconds
5. If they are still not breathing and unresponsive, give CPR

**HOW TO GIVE NASAL SPRAY NARCAN (Naloxone)**

1. Pull or pry off yellow caps.
2. Pry off purple cap.
3. Grip clear plastic wings.
4. Screw capsule of naloxone into barrel of syringe.
5. Insert white cone into nostril; give a short, vigorous push on end of capsule to spray naloxone into nose; one half of the capsule into each side of the nose.

**Who do I call if I have questions or problems?**
If you have questions call the clinic at (303)___________. You can also call the Denver Health NurseLine at (303) 739-1211 any time day or night.

**Special instructions:**

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© Reproduced with permission, Opioid Overdose Prevention and Survival, 5/2013. Copyright Harm Reduction Organization
E38-1173 Doc 1 of 1 (12/13) DH

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Programa de Prevención de Sobredosis de Opiáceos

Una sobredosis de opióceos significa que alguien ha tomado demasiada medicina para el dolor o drogas similares a la heroína. Los opióceos pueden ser Vicodin, Norco, Percocet, MS Contin, Oxycontin, Dilaudid, metadona u otras drogas. El Narcan o la naloxona pueden revertir los efectos de estas drogas.

La sobredosis puede ocurrir cuando:
- Ud. toma demasiada medicina con opióceos para el dolor
- Ud. está solo y no hay nadie para ayudarle
- Ud. mezcla su medicina para el dolor o heroína con otras drogas o alcohol

Signos de sobredosis son:
- Respiración lenta
- Labios o uñas azules o grisáceas
- Somnolencia o no se despierta al llamarle por su nombre

¿Qué hacer en una sobredosis?
1. Controle que la persona esté respirando
2. Llame al 9-1-1 por ayuda
   a. Dígale al operador “alguien no está respondiendo y no está respirando.”
   b. Indíqueles su dirección
3. Si no está respirando o no está respondiendo, dele Narcan
   a. Abra el equipo y saque las tapas amarillas
   b. Conecte el dispositivo nasal de caucho a la jeringa
   c. Rocie rápidamente la ½ de la jeringa en cada fosa nasal
4. Dele oxígeno o respiración boca a boca y llame al 9-1-1
   a. Extienda la cabeza hacia atrás, levante la barbilla, ocluya la nariz
   b. De una respiración cada 5 segundos
5. Si todavía no está respirando y no responde, aplique RCP

CÓMO DAR EL SPRAY NASAL DE NARCAN (Naloxone)

1. Hale o saque las tapas amarillas.
2. Saque la tapa morada
3. Corte las aletas plásticas transparentes.
4. Meta la cápsula de naloxona en el cilindro de la jeringa.
5. Inserte el cono blanco en la fosa nasal, dé un corto y vigoroso empuje en el extremo de la cápsula para roscar la naloxona en la nariz. La mitad de la cápsula dentro de cada lado de la nariz.

¿A quién llamo si tengo preguntas o problemas?
Si tiene preguntas llame a la clínica al (303) ___________. También puede llamar a la Línea de la Enfermera de Denver Health al (303) 739-1211 a cualquier hora día o noche.

Instrucciones especiales:
<table>
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<tr>
<th>Provider</th>
<th>Plan/Formulary Name</th>
<th>Coverage</th>
<th>Reimbursement/Cost</th>
<th>Notes</th>
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<tbody>
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<td>MedicareRx Saver Plus</td>
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<td>$40 (pharm 30day), $105 (mail 90day)</td>
<td>Tier 4 (non-preferred), 1mg</td>
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<td></td>
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<td>Tier 2 (non-preferred generic), 1mg</td>
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<td>PrimeScriptionRxPlus</td>
<td>Silver</td>
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<td>$10 (pharm 30day), $30 (mail 90day)</td>
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<td>Part D Value Plus</td>
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<td>Preferred Rx Plan (Medicare)</td>
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<tr>
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</table>
We are excited about new state laws that place the antidote for one of the leading causes of injury death into the right hands.

**Did you know?** Colorado currently has the second highest rate of prescription pain killer abuse in the United States after Oregon, according to the 2012 report from the National Survey on Drug Use and Health.

**Did you know** that in 2010, prescription drug overdose killed twice as many Coloradans as drunk driving-related car crashes and was a leading cause of injury death?

**Did you know** you can give the people at risk for an overdose and their family members a prescription for the antidote? Last year the law changed allowing physicians to prescribe Naloxone to the loved ones around a person at-risk of an opiate overdose such parents, spouses, siblings, service providers, friends, aka Third Parties. Naloxone can be safely administered by a lay person to reverse an overdose with minimal harmful side effects and no potential for abuse. With the support of the Colorado Medical Society, on May 10, 2013, Governor John Hickenlooper signed Senate Bill 13-014 in to law to allow prescribing to Third Parties.

**What are other health systems doing?**

- Denver’s **Harm Reduction Action Center** is Colorado's largest public health agency serving injection drug users with health education programs, referrals, testing, syringe access, and Naloxone. Naloxone trainings occur weekly for opiate users and their friends/family (Third Party). Since the program began in May 2012, over 200 opiate users and Third Parties have been trained to administer Naloxone, and 75 lives have been saved.

- **Denver Health and Hospital** – In the Fall 2013, Denver Health added Naloxone to their formulary, making it easier for all physicians in the Denver Health system to prescribe Naloxone to their patients (opiate users and Third Party). In addition, opiate users brought to the Emergency Department for observation after an opiate overdose are discharged with a prescription for Naloxone.

- The **Addiction Recovery Centers (ARC)** at Boulder County Public Health is holding their first friends and family (Third Party) training that will target parents of youth who use opiates in recovery programs with the ARC.

**What effective prevention strategies can your hospital implement?** Consider changing your emergency department policies:

1. Add Naloxone to your formulary to increase prescribing of this life-saving drug.
2. Change your emergency department policies to be sure that all patients (or their friends/family) presenting with opiate use/abuse leave with a prescription for Naloxone.
3. Host trainings for friends/family of opiate users to learn how to use Naloxone in case of an overdose.
4. **Contact Lisa Raville, Director of the Harm Reduction Action Center, with any questions about Naloxone, Third Party prescribing, or trainings for family members.** 303-572-7800 lisa.harm.reduction@gmail.com.

**Need information to share with your patients on the safe disposal of prescription drugs to prevent an accidental overdose?** Learn more about prescription drug take back programs in your area at [www.colorado.gov/cdphe/rxdrug](http://www.colorado.gov/cdphe/rxdrug).

We hope you support this great work!
WHEREAS, International Overdose Awareness Day is recognized around the world as a day to acknowledge individual loss and family grief for people who have suffered an overdose; and

WHEREAS, Colorado currently has the nation's second highest rate of prescription abuse. In 2010, prescription drug overdose killed twice as many Coloradans as drunk driving-related car accidents and was the leading cause of accidental death statewide; and

WHEREAS, Overdose Awareness Day recognizes overdoses from all drugs, because it reflects the reality of the overdose epidemic, allowing us to speak and educate more broadly about the issues; and

WHEREAS, Overdose Awareness Day hopes to publicly challenge the stigma associated with drug use and overdose; and

WHEREAS, Overdose Awareness Day sends a strong message to current and former drug users that they are valued; and

WHEREAS, Overdose Awareness Day provides an opportunity for people to publicly mourn for loved ones, some for the first time, without feeling guilt or shame;

Therefore I, John W. Hickenlooper, Governor of the State of Colorado, do hereby proclaim August 31, 2013,

OVERDOSE AWARENESS DAY

in the State of Colorado.

GIVEN under my hand and the Executive Seal of the State of Colorado, this thirty-first day of August, 2013

John W. Hickenlooper
Governor
Prescription Drug Overdose in Colorado

Unintentional poisoning deaths are one of the leading causes of injury death. According to the data (Figure 1), unintentional poisoning death rates are slightly lower than the death rates from falls yet higher than the death rate from all transportation injuries.¹

Poisonings include deaths from a variety of toxic substances, not only prescription drugs. While there are far fewer deaths specifically from opioid overdose deaths than all poisonings combined, the rate of opioid deaths in Colorado has nearly tripled between 2000 and 2012.

The Injury, Suicide and Violence Prevention (ISVP) Branch staff is collaborating with the Colorado Prescription Drug Misuse Prevention Consortium to implement best practice strategies. The ISVP Branch is funded by the Centers for Disease Control to achieve the following outcome measures by 2015:

- Decrease the rate of deaths due to prescription drug overdose (all intents) among Coloradans ages 15+ from 20.4 deaths per 100,000 population in 2011 to 18.4 deaths.
- Decrease the rate of emergency department visits due to prescription drug overdose (all intents) among Coloradans ages 15+ from 107.1 visits per 100,000 population in 2011 to 89.4 per 100,000 population.
- Decrease the rate of hospitalizations due to prescription drug overdose (all intents) among Coloradans ages 15+ from 344.7 hospitalizations per 100,000 population in 2011 to 17.5 hospitalizations.

¹Colorado Health Information Dataset
²Health Statistics Section, Colorado Department of Public Health and Environment.
³Definitions used based on NCHS Data Brief, No. 81, December 2011, “Drug Poisoning Deaths in the United States, 1980-2008”. ⁴Some deaths in which the drug was poorly specified or unspecified may involve opioid analgesics.
Abstract

Objective: To present a summary of the existing literature on syringe exchange programs (SEPs) and to discuss the potential role of pharmacists in providing support for injection drug users (IDUs) and such programs.

Data sources: To identify relevant articles published since 2000, a search of PubMed and Medline was conducted using syringe exchange programs and needle exchange programs as search terms. A manual review of each article’s citation list was also conducted.

Data extraction: By the authors.

Data synthesis: Information is presented in four categories: state and federal support of SEPs, characteristics of SEP users, epidemiological studies, and social reluctance for SEP support. The information summarized in these sections is then used as a foundation for a review of the potential role of the pharmacist.

Conclusion: SEPs have demonstrated a clear effect in improving the health outcomes of IDUs by decreasing the transmission of blood-borne disease and lowering high-risk injecting behaviors. Despite conflicting support for SEPs at both the federal and local levels, pharmacists can play a pivotal role in the health of IDUs by providing sound medical advice and, in some states, acting as an alternative channel for obtaining clean syringes. Efforts should continue to focus on educating pharmacists about this role and how their individual actions can benefit the health of the entire population.

Keywords: Syringe access, syringe exchange programs, pharmacy services.

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Acknowledgments: To Karen W. Lee, PharmD, BCPS, for reviewing and providing support.
Injection drug users (IDUs) represent a population that is disproportionately affected by the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), hepatitis B virus (HBV), and hepatitis C virus (HCV). In 2006, approximately 19% of all people living with HIV/AIDS acquired the virus through injection drug use. In that same year, 54% of people with confirmed HBV and approximately 50% of those with acute HCV reported injection drug use.1 Because sharing of contaminated syringes is a major route of transmission for diseases such as these, providing access to and encouraging the use of sterile injection equipment is believed to be a central strategy in the effort to reduce the transmission of HIV and other blood-borne pathogens.2 Based on the philosophy of harm reduction, syringe exchange programs (SEPs) allow IDUs to obtain sterile syringes and other injection equipment at little to no cost and to safely dispose of used injection equipment. Many of the programs require participants to exchange used syringes for sterile ones, which results in the safe disposal of used equipment and a reduction in the number of syringes disposed of improperly in the community. With the primary goal of reducing the spread of infectious disease among IDUs, their sexual partners and children, and the public at large, many national organizations and government bodies support the establishment of SEPs.2,3 Specifically, the Centers for Disease Control and Prevention recommends that IDUs use a sterile syringe for each injection.2 Another means to increasing access to clean equipment is the sale of syringes by pharmacists. Accordingly, pharmacists are presented with the opportunity to provide patient counseling or referrals to other health-related services and to help expand access to care and supplement the work of SEPs, particularly in areas in which SEPs have not been established.4

In the early 1980s, HBV and HCV rates among IDUs sparked concern among health care providers. The need for supplying sterile syringes to this patient population was first recognized during this period. However, it was not until the HIV/AIDS pandemic that the importance of these programs was accepted worldwide and the rapid establishment of SEPs began.5 In the United States, the first SEPs were established in New York City (NYC), Oregon, San Francisco, and Washington in the late 1980s.6 By 2005, 28 states had operating SEPs, for a total of 166 programs nationwide.7 According to the North American Syringe Exchange Network (NASEN), at least 211 SEPs currently exist in 36 states and territories.8 Table 1 shows the states with SEPs as publicly listed on the NASEN website.

The benefits of SEPs extend to both IDUs and other members of the community. Most importantly, SEPs protect the health of the public by reducing the spread of blood-borne infections, directly through decreased sharing of syringes or accidental contact with contaminated syringes by individuals in the community and indirectly through sexual contact. However, in addition to the exchange and safe disposal of used syringes and injection equipment, SEPs also offer a greater public health benefit by providing a range of additional services, including but not limited to health education and counseling; free sharps containers and condoms; on-site HIV testing and screening for HBV, HCV, and tuberculosis; referrals to substance abuse treatment; and other medical and social services.9 These additional services are invaluable, especially in rural communities and for individuals with limited access to health care. Much debate and controversy surrounds the social policy of SEPs. Perceptions of the effectiveness, importance, and appropriateness of these programs vary among IDUs, health care professionals, and policy makers. In the United States, a ban preventing federal funding for SEPs was lifted in December 2009. This change may result in greater overall acceptance and support of the establishment of SEPs nationwide; however, this change may develop slowly and/or be met with resistance because of deep-rooted controversy and lack of awareness and education. Therefore, as health care professionals, pharmacists must remain aware of the evidence surrounding the effectiveness of SEPs. Evidence has demonstrated that SEPs are associated with declines in the incidence and prevalence of HIV, HBV, and HCV and of high-risk injecting behaviors (e.g., needle sharing between HIV-negative and -positive IDUs).2,9

**Objective**

The goal of the current work is to present a summary of the existing literature surrounding SEPs in the United States. This
Summary will address the outcomes of SEPs in the IDU population, including rates of disease transmission and injection risk behaviors. High-risk injection behaviors can include injecting with a used syringe, giving used syringes to other IDUs, sharing injection paraphernalia such as cotton or cookers, reusing a syringe more than once, or not bleaching a used syringe before injecting. We also address the potential role of pharmacists and how their support and work can further the public health benefits of SEPs. Because the success of SEPs depends in part on the sale of syringes by pharmacists—a considerable change in the practice of pharmacy—data addressing the personal beliefs of pharmacists regarding this policy are discussed. A review of past and current U.S. regulations and funding issues is also presented.

Search strategy
PubMed and Medline were searched using the terms syringe exchange programs and needle exchange programs. The selection was restricted to English-language articles outlining the outcomes of SEPs in the United States after 2000. A total of 657 studies were identified. Articles were excluded if they focused on data from outside the United States, were restricted to SEPs in correctional facility populations, and did not specifically address the impact of SEPs or the role of pharmacists. All articles considered potentially applicable were reviewed by the authors independently before being included in the final review. As a result, 33 articles were identified for inclusion. A manual review of each article’s citation list was conducted to identify any other applicable articles. Additional articles were used to supplement these findings as appropriate.

State and federal support of SEPs
Despite the evidence supporting the public health benefit of SEPs, financial support for these programs varies on the federal and state levels. In 1988, a federal ban on funding for SEPs was enacted and has been subsequently restated and supported. In 1998, this ban was nearly lifted by the Clinton Administration; however, the final outcome was to allow local communities to determine whether such programs should be supported. In 2009, the passing of the bill was a crucial development that will provide states and communities with the resources needed to ensure sufficient SEP coverage. Additionally, the act further supports the importance of pharmacists in taking a more active role in participating or providing education regarding syringe safety and exchange activities.

Current laws in place
According to a review of 16 states, recommendations for the safe disposal of used syringes vary greatly and are derived from or regulated by a variety of agencies. The review concluded that communities need to develop low-cost and easy-to-use systems by which IDUs can safely dispose of used syringes; developing SEPs was one suggestion for accomplishing this. The topic of SEPs highlights an unfortunate dichotomy in priorities for a government that seeks to curb illicit drug use but also supports the safe use of injectable drugs to prevent the spread of disease. These same issues exist on the state level, with conflicting priorities between public health departments and law enforcement agencies. In 2002, 47 states had drug paraphernalia laws in place with criminal penalties for possessing or selling syringes for the purpose of injection drug use. These laws may impose penalties for the sale, distribution, or possession of syringes and as a result may promote fear of arrest and criminal punishment among IDUs. This may cause IDUs to be reluctant to store used syringes for future disposal at an SEP. As of 2008, eight states had syringe prescription laws that prohibited the dispensing or possession of syringes without a valid medical prescription. A total of 21 states had pharmacy regulations or practice guidelines regulating the sale of syringes. The current work demonstrates the varied degrees of support for SEPs at both the state and federal levels.

Characteristics of SEP users
Studies have indicated that participants of SEPs have higher rates of injection frequency, unemployment, jail time, homelessness, cigarette use, and alcohol use compared with IDUs who do not participate in SEPs. This suggests that IDUs who participate in SEPs represent a distinct and higher-risk subpopulation of injectors. Numerous studies have shown that, in general, minority men represent the largest portion of partici-

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### Table 1. States with active syringe exchange programs

<table>
<thead>
<tr>
<th>State</th>
<th>District</th>
<th>Illinois</th>
<th>Maine</th>
<th>North Carolina</th>
<th>Oregon</th>
<th>Washington</th>
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<td>Alaska</td>
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<td>Illinois</td>
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</table>

These states allowed the North American Syringe Exchange Network to list their contact information on its website.
pants of SEPs.\textsuperscript{4,9,19} Data also reveal that women are underrepresented among SEP participants, as the majority of studies of SEP clients evaluate predominantly male populations.\textsuperscript{9,20}

As one of the largest SEPs in the United States, the Chicago Recovery Alliance (CRA) found that considerable variation existed in terms of participant demographics by geographic location and hours of operation among its multiple sites throughout the city. During a 4-year period (1994–1998), a total of 11,855 IDUs, with a median age of 41 years and the majority being men (73.5%), visited CRA at least once. One-half (50%) of the participants during this time were black, 37.6% white, 10.3% Puerto Rican, and 2.2% "other" (Latin American or Native American). When analyzed in terms of geographic location, results revealed that younger (<30 years), white, and Puerto Rican IDUs were attracted to certain sites, whereas older participants (>30 years), who tended to be black, were attracted to others. At the time of the study, CRA had nine sites that were open only during the daytime and participants were predominantly black (60.9%) and the proportion of participants 30 years or younger was less than 9.8%. In contrast, for the 10 sites that were open only at night, participants were predominantly white (46.2%) and Puerto Rican (32.2%) and the proportion of participants 30 years or younger was 21.9%. Results also revealed that women tended to frequent sites that were open both during the day and at night.\textsuperscript{9}

The findings discussed above indicate that SEPs do not attract all types of IDUs; a subset of the population might prefer not to participate in or does not have access to SEPs. For these individuals, obtaining clean syringes through other channels may be challenging. As noted previously, some states permit the sale of syringes by pharmacists without a legal prescription. Although a portion of the population will purchase syringes for medical reasons such as diabetes, we focus specifically on the impact of syringe sales by pharmacists in the IDU population. According to a small study of 62 individuals purchasing nonprescription syringes at pharmacies in NYC and Albany, NY, 74% of participants reported purchasing syringes for injection drug use and 36% for medical use. Additionally, participants who purchased for drug use were significantly more likely to be black or Hispanic than to be white ($P < 0.001$). Regarding injection practice, 60% of participants reported reusing the same syringe, 26% had shared syringes in their lifetime, and 10% had shared syringes in the previous month. No differences were observed in sharing or reuse of syringes by race/ethnicity, gender, or age.\textsuperscript{4} The study showed that sharing and reuse of syringes is a common practice among all IDUs, regardless of demographics.

With varying characteristics among IDUs and, as evidence has shown, among IDUs who participate in SEPs, pharmacists have a valuable role in their communities. One-on-one and telephone interactions with IDUs and their family members provide pharmacists with opportunities to help and support both patients and SEPs. Awareness of provided services and hours of operations of local SEPs allows pharmacists to refer patients appropriately. In addition, pharmacists may be able to provide feedback and/or information regarding unmet needs of the community directly to SEPs. For pharmacists practicing in states that do not permit the sale of syringes at a pharmacy, becoming familiar with these programs and building relationships with them is equally important.

### Epidemiological Studies

The main goal of SEPs is to decrease the incidence of blood-borne diseases such as HIV, HBV, and HCV. As mentioned previously, SEPs represent a method for achieving this goal by decreasing the circulation of contaminated syringes in and beyond the IDU community.\textsuperscript{21} Numerous studies have examined the impact of SEPs on a variety of endpoints, and the most recent and clinically relevant studies are reviewed below. Specific endpoints examined include seroconversion rates of HIV, HBV, and HCV, high-risk behavior among IDUs, and how these differ between SEP and non-SEP users.

#### Impact of SEPs on HIV, HBV, and HCV Transmission Rates

A large number of studies have examined the correlation between HIV and, to a lesser extent, HBV and HCV infection rates and SEPs. Although some of these studies have found a lower risk of infection transmission in SEP participants, results from other studies have reported either a negative effect or no effect. A 1995 study by Hagan et al.\textsuperscript{22} found that not participating in an SEP led to a five times greater risk of HBV infection and a seven times greater risk of HCV infection. In a literature review article, Gibson et al.\textsuperscript{23} examined 42 studies from 1989 to 1999 that evaluated the effectiveness of SEPs. Although the focus of their review was the United States, it also contained data from Canada, the United Kingdom, and the Netherlands. Of these 42 studies, 28 found a positive effect of SEPs on HIV risk behavior and seroconversion, 2 found a negative association, and 14 found either no difference or a mix of positive and negative effects. It has been hypothesized that these 14 studies failed to find an association as a result of dilution or selection bias.\textsuperscript{23} These two types of bias are a common occurrence in SEP studies. Dilution bias arises when both the SEP and non-SEP IDU population have equivalent access to sterile syringes. This bias has been seen in studies conducted in cities where non-SEP IDUs had access to sterile syringes through the legal sale by a pharmacist or as a result of IDUs participating in an SEP that provides them with sterile syringes.

Conversely, selection bias relates to the observed phenomenon that SEP IDUs tend to be less socially integrated and more prone to excessively high baseline risk behaviors, therefore creating a disproportionate concentration of high-risk IDUs among SEP users.\textsuperscript{24} This bias was reported in a study by Riley et al.\textsuperscript{25} that compared the characteristics of IDUs using standalone SEPs with those using pharmacy-based SEPs. Standalone SEPs attracted a greater majority of high-frequency injection users. Hagan et al.\textsuperscript{26} also explored this phenomenon of selection bias by examining the characteristics of an IDU cohort ($n = 2,027$) that began or stopped participating in a Seattle SEP during a 12-month period. The study reported that IDUs with certain high-risk characteristics such as dai-
Effect of SEPs on IDU behavior

The impact of SEP participation on IDU behavior has also been examined. Reducing high-risk behaviors is often thought to lead to the SEP’s protective effect rather than the SEP participation itself. As demonstrated previously, the majority of IDUs who participate in SEPs tend to have a higher number of injections per day and higher baseline risk behaviors than IDUs who do not use SEPs. This is thought to be partly a result of SEP participants being less socially integrated than their non-SEP counterparts. However, the results of these studies have shown that SEP participants share syringes and other drug paraphernalia less frequently than their non-SEP counterparts. The study by Gibson et al. reinforces this viewpoint, as the review also found that not only were SEPs associated with a decrease in transmission rates but also in preventing behaviors associated with a higher risk of HIV transmission. Results from a study conducted by Longshore et al. among IDUs in Providence, RI, who attended an SEP (n = 248) also reinforce a decreased risk in the sharing of syringes and other injection equipment with an increased frequency of visits to an SEP. The study demonstrated that lower frequency of SEP attendance was associated with a greater likelihood of syringe sharing, as indicated by the AOR for IDUs attending two to four times per month (2.04, P = 0.02) and for those attending no more than once per month (3.20, P = 0.01). Regarding the sharing of injection equipment, the results demonstrated that lower frequency of SEP attendance was associated with a greater likelihood of sharing cookers (IDUs attending two to four times per month: AOR 2.00, P = 0.02; IDUs attending no more than once per month: AOR 2.55, P = 0.04).

In addition to examining HCV rates, Holtzman et al. examined the effect of SEP participation on high-risk injection behavior. The study reported a significant correlation between more recent SEP participation and daily injection drug use among IDUs. However, this same IDU population, despite injecting more frequently, was significantly less likely to share paraphernalia (AOR 0.77 [95% CI 0.67–0.88]) compared with non-SEP IDUs.

Regarding younger IDUs, Bailey et al. surveyed 700 IDUs aged 18 to 30 years from 1997 to 1999. The majority of participants were younger than 26 years (64%), and almost two-thirds (65%) had not used an SEP in the 6 months before baseline. Additionally, on average, only 13% had used an SEP more than once per month. The study assessed risk factors based on the frequency of SEP visits (no visits, one to six visits, or seven or more visits). Participants who had visited SEPs seven times or more had the highest injection frequency rate (AOR 2.88 [95% CI 1.69–4.91], P < 0.001) but also the highest percent of not sharing syringes (0.32 [0.19–0.54], P < 0.001). This high-SEP use group was also the most likely to inject only once per syringe (0.25 [0.13–0.45], P < 0.001) and the least likely to share various injection paraphernalia such as cookers and cotton (0.51 [0.30–0.83], P = 0.013) and to backload (0.39 [0.19–0.81], P = 0.21). Finally, IDUs with the highest SEP use were also the most likely to use condoms with both regular and casual sex partners; however, only the regular partners com-
parison was significant (2.95 [1.56–5.56], \( P = 0.001 \)). This study further reinforces the trend that although SEP users have a tendency to inject more frequently than those with less SEP frequency, overall they exhibit less high-risk drug behavior. However, the study also exposed a particular subgroup of IDUs who did not appear to use SEPs to a great extent (i.e., those aged 18–30 years).

Huo and Ouellet\(^{35} \) also reported an observed decrease in injection risk behaviors for SEP users in a Chicago IDU population (n = 901). Compared with non-SEP users, IDUs who frequented SEPs injected drugs more frequently and were more likely to be HIV positive; however, this was expected because the SEP was located in an area with the highest HIV prevalence. However, the results of the study demonstrated that relative to non-SEP users, SEP-using IDUs were less likely to share syringes (odds ratio [OR] 0.33 [95% CI 0.23–0.46]), lend a used syringe (0.55 [0.41–0.75]), share other drug paraphernalia like cotton filters and cookers (0.70 [0.52–0.95]), and reuse their own syringes (0.18 [0.10–0.30]) and more likely to bleach syringes used by others before injecting (2.28 [1.37–3.80]). Additional evidence from a cohort study by Hagan and Thiede\(^{33} \) and a meta-analysis by Ksobiech\(^{34} \) also reported that IDUs who used an SEP were less likely to inject with a used syringe than non-SEP-using IDUs.

Gibson et al.\(^{35} \) followed 338 IDUs and examined the effect of SEP participation on HIV risk behavior. Follow-up interview time from baseline was 10.7 months. At baseline, 31% and 33% of all participants reported using SEPs and having a high risk, respectively. IDUs were determined to be low risk if they only used unsterilized syringes with a regular sex partner they believed was HIV negative or if they bleached used syringes before injecting with them. High-risk IDUs were those who shared syringes with nonregular sex partners or with a regular partner whose HIV status was unknown or positive. The study evaluated whether SEP participation provided any protective benefit against HIV risk behavior. The results of the study showed that no significant difference existed in frequency of injections per month between IDUs who used and did not use SEPs. However, borrowing sterile (27% vs. 50%) or unsterile (17% vs. 35%) syringes occurred significantly less frequently in SEP users. Additionally, the rate of high-risk behavior was also significantly higher in the non-SEP group (12% vs. 24%). It was also shown that SEP use provided a more than twofold protective effect on HIV risk behavior (OR 0.45 [95% CI 0.21–0.92]). When access to other sources of syringes was evaluated along with SEP access, the odds of HIV risk behavior decreased sixfold if IDUs did not have syringe access beyond SEPs. The study once again demonstrated the evident protective effect of SEPs on HIV infection prevention.

Bluthenthal et al.\(^{36} \) examined the effect of SEPs on 340 high-risk IDUs from 1992 to 1996. All patients reported sharing syringes at baseline. The study then followed these participants after the opening of an SEP in their community, and the results were based on two follow-up interviews 6 months apart. Overall, 60% (204 of 340) of the participants at follow-up reported that they had quit sharing syringes. Starting and continuing SEP participation was associated with syringe-sharing cessation. Patients who had steady sex partners who were also IDUs were found to be less likely to stop sharing syringes compared with those who did not have steady sex partners (52.1% vs. 67.2%). Furthermore, to determine whether SEP participation was independently associated with syringe-sharing cessation, the authors conducted a multivariate analysis that controlled for a number of variables (e.g., total number of interviews, age, presence of a steady sex partner). The results of the study demonstrated that IDUs who started SEP use (AOR 2.68 [95% CI 1.35–5.33], \( P = 0.005 \)) and IDUs who continued SEP use (1.98 [1.05–3.75], \( P = 0.003 \)) were both associated with ceasing syringe sharing, but independently of each other. The study further highlights the positive benefit of SEPs on syringe sharing.

Huo and Ouellet\(^{37} \) studied the positive effect of SEPs on injection behavior and high-risk sexual behavior. Their study examined the impact of SEPs on IDU sexual risk behaviors in 889 IDUs in Chicago between 1997 and 2000. Of participants, 717 used SEPs. The study examined three aspects of sexual risk behaviors: number of partners, frequency of condom use, and number of unprotected sex acts. Patients were interviewed at baseline with three additional annual follow-up visits. The results of the study showed that no difference occurred in the number of sexual partners between the two study groups across time (\( P = 0.40 \)). The number of unprotected sex acts also was not different between the two groups at baseline; however, the number decreased by 26% per year in the SEP group and only 10% in the non-SEP group (\( P = 0.02 \)). Additionally, SEP users were more likely to use condoms consistently with their main partners (\( P = 0.001 \)). However, no difference between the two groups was reported in condom use with casual or commercial sex partners. The study concluded that use of SEPs may encourage less high-risk sexual behavior, which in turn could lead to a decrease in blood-borne viral transmission.

Results from the studies discussed above demonstrate the significant amount of evidence supporting the positive health aspects of SEPs; however, the location of an SEP and whether it affects the overall health benefits achieved has not been addressed. Hospital-based SEPs are common in countries such as Canada and the United Kingdom but are not widespread in the United States. This type of SEP would be advantageous because IDUs tend to frequent hospital emergency departments as their primary source of care, which is extremely costly. A randomized-controlled trial by Masson et al.\(^{38} \) examined this specific topic. The study compared the effectiveness of hospital- and community-based SEPs on IDU health status and injection practices. The study enrolled 166 people during a 2-year period. Patients were randomly assigned to receive syringes from either hospital- or community-based SEPs, with follow-up assessments at 6 and 12 months. The study reported that SEP location had no significant effect on either injection behaviors or health status. However, both groups reported a decrease in high-risk behavior and an improvement in overall physical health. Additionally, IDUs assigned to the hospital SEP had 83% more inpatient admissions and 22% more ambulatory
care visits than those in the community SEPs. The study demonstrated that the location of an SEP did not lead to a difference in reducing high-risk injection behavior; however, hospital-based SEPs had the additional advantage of providing easy access to outpatient care services for IDUs.

Sustainability of the effects of SEPs
The current work provides considerable clinical evidence demonstrating the positive effect of SEPs on high-risk injecting behavior and transmission rates. However, little evidence exists indicating whether this positive SEP effect can be sustained over time. Braine et al. interviewed IDUs at the Tacoma Syringe Exchange Program in 1997 (n = 197) and again in 2001 (n = 326). The study examined change in injection risk behavior of SEP participants over time. The authors found that in 1997, 987,000 syringes were exchanged and, by 2001, the total had increased to 1.44 million. The frequency of injections per day did not change significantly over time, with the majority of patients in both periods injecting two or more times per day (54%, 1997; 65%, 2001). Change in injection risk behaviors was also examined during the 4 study years. These behaviors included backloading with used syringes, giving a used syringe to someone else, and self-injection with a known used syringe. For all three behaviors, the frequency of backloading (18% vs. 22%), giving a used syringe (23% vs. 30%), and injecting with a used syringe (23% vs. 27%) did not significantly decrease from 1997 to 2001. Factors that affected injecting with a used syringe in both time periods included having depressive symptoms 30 days before the study interview and the combination of being younger than 35 years and coinjecting with amphetamines. Other factors that affected used syringe sharing changed from year to year. In 1997, more women shared syringes than men, but by 2001 this trend had reversed. Finally, the researchers examined the HIV incidence rate in 12 new injectors who had been IDUs for 5 years or less. They found that none of the 12 IDUs were HIV positive. Although injection risk behavior did not decrease over time, the study demonstrated that injection risk behavior among Tacoma Syringe Exchange Program participants remained stable from 1997 to 2001. Additionally, the frequency of injection did not increase significantly during the period of study. This demonstrates the sustainability of the impact of SEPs and again reinforces the benefit of SEPs in the IDU population.

Although IDUs who frequent SEPs tend to have a higher injection rate frequency, these programs also lead to a substantial decrease in high-risk drug behavior among participants. IDUs who participate in SEPs also exhibit safer sex practices. Further, some studies have shown that SEP participants have lower rates of HIV, HCV, and HBV. However, a considerable number of barriers regarding SEPs and IDUs remain. As seen in the study by Bailey et al., the percent of young IDUs who used SEPs was very low. This appears to be a segment of the IDU population in which additional education and outreach on the benefits of SEPs are needed. Additionally, the potential benefit of SEPs that are integrated in the hospital setting represents another avenue that should be further examined. It is common for IDUs to use the emergency department as their primary source of care. Given that this population tends to have a number of chronic medical conditions, having access to impatient care, along with access to SEPs, would be beneficial in the long term as well. Finally, legal issues surrounding SEPs in the United States, as well as support at the state level, also play a major role in decreasing transmission and high-risk behavior.

Social reluctance for SEP support
With the relatively low number of SEPs currently operating in the United States and conflicting support at both the state and federal levels, considering available alternatives for IDUs is important. Without SEPs, IDUs could obtain syringes either through unauthorized channels or at the pharmacy, with or without a prescription depending on state regulations. As previously described, state laws differ in view on the over-the-counter sale of syringes to IDUs in pharmacies. Although this may not be an option in all places, pharmacies provide an ideal setting for this method of distribution for several reasons, including convenient location in the community, counseling and referral to additional resources by pharmacists when necessary, and protection of IDUs’ privacy if they are unwilling to identify themselves through use of an SEP.

Research on pharmacists’ personal beliefs regarding SEPs is limited; however, reports of their personal beliefs on the sale of syringes at the pharmacy are readily available. Looking specifically at the legality of selling syringes, many pharmacists are uncertain how to interpret laws and policies. In many states, the laws and pharmacy regulations may not provide pharmacists with clear answers regarding the legality of the sale of syringes. Many of these laws and regulations allow the sale of syringes for a legitimate medical purpose, but that is another concept that is loosely defined and open to interpretation. For example, some individuals may feel that distributing clean needles to prevent the spread of disease is a legitimate medical purpose, whereas others may feel that it simply furthers drug abuse. Regardless of state laws or regulations or how pharmacists interpret them, for the sale of syringes to IDUs, the final decision to sell belongs to the individual pharmacist. Although often a controversial topic, it has been shown that this decision is greatly dependent on the beliefs and perceptions of the individual pharmacist.

Surveys have been conducted to better identify specific barriers that would deter a pharmacist from making this type of sale. Several structural and individual barriers that prevent pharmacists from selling syringes to IDUs have been reported. A qualitative study conducted among a sample of pharmacists from Atlanta, GA, sought to identify and classify some of these barriers. The analysis found that pharmacists’ concerns and hesitations to sell syringes could be categorized into three groups: personal attitudes and beliefs about drug users and HIV/AIDS, concerns about deception, and concerns about legality. Pharmacists who viewed drug addiction as a personal choice and a matter of personal responsibility were less likely to sell syringes to an IDU. Some pharmacists were hesitant to sell syringes to IDUs because of their concern that the syring-
Discussion: Roles for pharmacists

Several barriers exist surrounding pharmacist acceptance of the value of increasing syringe access in the IDU population; however, the role of the pharmacist is an important element of combating the spread of blood-borne viruses and infections in the IDU population. Therefore, it is important to examine steps that can be taken at the pharmacy level to change these negative perceptions and encourage a proactive view for the pharmacist when dealing with IDUs seeking sterile syringes.

Pharmacists have the potential to play a key role in preventing the transmission of major blood-borne viruses in the IDU population through the provision of sterile syringes and injection equipment, patient counseling (e.g., substance abuse treatment, safe injecting practices, safe disposal practices, safe sex practices), and support of local SEPs. The sale of syringes by pharmacists supplements the work of SEPs by operating in locations that lack SEPs, operating during hours during which SEPs might be closed, and appealing to a subpopulation of IDUs who may be less likely to participate in SEPs. Despite the benefits of supplemental syringe access at the pharmacy level, data from a study among IDUs in Harlem and the Bronx, NY, demonstrate that even with pharmacy-based expanded access to syringes, SEPs remained the most frequently used source of syringes. This further emphasizes the importance of the support needed for SEPs from other health care professionals, including pharmacists.

Surveys of various populations of pharmacists regarding their attitudes about selling syringes without a prescription to IDUs have repeatedly highlighted that, as a result of both individual and structural barriers, pharmacists can be divided into three groups: one that strongly favors the sale of syringes, a second that strongly opposes such sales, and a third that is unsure. Individual barriers included pharmacists’ personal attitudes and beliefs about drug abuse and HIV/AIDS and concerns of deception. Structural barriers included state laws and regulations that addressed the sale of syringes without a prescription, as well as pharmacy regulations and practice guidelines. Because pharmacies represent an important and convenient alternative to SEPs for IDUs to obtain sterile syringes, examining how some of these barriers can be addressed is necessary.

Many of the personal barriers that were identified may be related to misconceptions that can be changed by exposing pharmacists to additional education surrounding the issue. Although changing state laws and regulations regarding the sale of syringes may not be possible, current laws and regulations can be clarified and education on their proper interpretation can be provided. The ultimate decision to sell syringes without a prescription belongs to the individual pharmacist. Unfortunately, pharmacists may be reluctant to perform the sale simply because they do not truly understand the proper interpretation of laws, regulations, and policies. Outreach efforts to educate pharmacists on these laws and regulations can help ensure that they have a similar understanding of the meaning of the laws and regulations for their specific state(s) and are better informed in making a decision on performing the sale of a syringe without a prescription. In addition, this also lends to a more consistent practice among pharmacists regarding the sale of syringes. Increasing educational efforts targeted at these issues could increase pharmacists’ willingness to sell syringes to IDUs and their willingness to support and participate in SEPs.

Education of pharmacists is particularly important when laws and regulations change. After syringe sales were deregulated in four states (Minnesota, New Mexico, New York, and Washington), outreach efforts were made to inform and promote the acceptance of the new laws among both the IDU and pharmacy communities. One study conducted in New Mexico found that pharmacists were generally not well informed about recent changes in pharmacy laws or about SEPs. The study concluded that an educational outreach supported by the department of health was well received and that similar programs in other states may be beneficial to help increase pharmacist knowledge and acceptance of the issues surrounding increased access to clean syringes for IDUs. Sustained promotional efforts may be necessary, as the reluctance to sell syringes to IDUs and to buy them from pharmacies is rooted in decades of laws and regulations.
ing and reuse of syringes. Ensuring that IDUs have access to sterile syringes can help reduce this risk and the corresponding risk of spreading diseases to others. SEPs have demonstrated a clear effect in improving the health outcomes of IDUs. Opponents of SEPs believe that such programs imply societal condoning of illicit drug use. However, many IDUs either will not stop injecting drugs or cannot get into substance abuse treatment programs; therefore, the need to provide IDUs with this support is crucial for them and for the public at large. SEPs have demonstrated a clear effect in improving the health outcomes of IDUs, which ultimately benefits overall public health. Participation in SEPs has been shown to decrease the transmission of blood-borne disease and high-risk injecting behaviors. In addition to SEPs, in some states, IDUs have the option of purchasing syringes without a prescription. Although pharmacists play a pivotal role in the health of IDUs by providing an alternative channel for obtaining clean syringes, acknowledging that they can play a pivotal role simply by being aware of and supporting active SEPs is important. Pharmacists are knowledgeable and accessible sources of health information and can counsel IDUs regarding syringe access and disposal and addiction treatment programs. Therefore, pharmacists should be aware of SEPs in their community and provide the appropriate information to IDUs when requested.

Efforts are needed to educate pharmacists about their roles in syringe access and how their actions can benefit the health of the entire population. Concerns or misconceptions that pharmacists have about IDUs, SEPs, blood-borne diseases, and the interpretation of state and federal laws regarding syringe sales must be addressed. Providing this education will help increase pharmacist participation in this crucial public health activity.

References


SENATE BILL 13-014

BY SENATOR(S) Aguilar, Guzman, Kefalas, Newell, Steadman, Tochtrop, Todd, Ulibarri; also REPRESENTATIVE(S) Pettersen, Fields, Ginal, Hullinghorst, Kagan, Labuda, Melton, Moreno, Pabon, Rosenthal, Ryden, Singer, Williams, Young.

CONCERNING THE USE OF OPIATE ANTAGONISTS TO TREAT PERSONS WHO SUFFER OPIATE-RELATED DRUG OVERDOSE EVENTS, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds that:

(a) Drug overdose is the leading cause of unintentional death in Colorado, ahead of motor vehicle deaths;

(b) Opiate overdose may be reversible with the timely administration of an opiate antagonist;

(c) Opiate antagonists have been shown to be safe and effective at reducing overdose death; and

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.
Access to opiate antagonists is often limited unnecessarily by laws that pre-date the overdose epidemic.

Now, therefore, the general assembly hereby encourages the administration of opiate antagonists for the purpose of saving the lives of people who suffer opiate-related drug overdose events. A person who administers an opiate antagonist to another person is urged to call for emergency medical services immediately.

SECTION 2. In Colorado Revised Statutes, add 18-1-712 as follows:

18-1-712. Immunity for a person who administers an opiate antagonist during an opiate-related drug overdose event - definitions.

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(1) Legislative declaration. The general assembly hereby encourages the administration of opiate antagonists for the purpose of saving the lives of people who suffer opiate-related drug overdose events. A person who administers an opiate antagonist to another person is urged to call for emergency medical services immediately.

(2) General immunity. A person other than a health care provider or a health care facility who acts in good faith to administer an opiate antagonist to another person whom the person believes to be suffering an opiate-related drug overdose event shall be immune from criminal prosecution for such act.

(3) (a) Licensed prescribers and dispensers. A person who is permitted by law to prescribe or dispense an opiate antagonist shall be immune from criminal prosecution for:

(I) Such prescribing or dispensing; or

(II) Any outcomes resulting from the eventual administration of the opiate antagonist by a layperson.

(b) A prescriber or dispenser who dispenses an opiate antagonist is strongly encouraged to educate persons receiving the opiate antagonist on the use of an opiate antagonist for
OVERDOSE, INCLUDING BUT NOT LIMITED TO INSTRUCTION CONCERNING RISK FACTORS FOR OVERDOSE, RECOGNITION OF OVERDOSE, CALLING EMERGENCY MEDICAL SERVICES, RESCUE BREATHING, AND ADMINISTRATION OF AN OPIATE ANTAGONIST.

(4) The provisions of this section shall not be interpreted to establish any duty or standard of care in the prescribing, dispensing, or administration of an opiate antagonist.

(5) Definitions. As used in this section, unless the context otherwise requires:

(a) "Health care facility" means a hospital, a hospice inpatient residence, a nursing facility, a dialysis treatment facility, an assisted living residence, an entity that provides home- and community-based services, a hospice or home health care agency, or another facility that provides or contracts to provide health care services, which facility is licensed, certified, or otherwise authorized or permitted by law to provide medical treatment.

(b) (I) "Health care provider" means:

(A) A licensed or certified physician, nurse practitioner, physician assistant, or pharmacist; or

(B) A health maintenance organization licensed and conducting business in this state.

(II) "Health care provider" does not include a podiatrist, optometrist, dentist, or veterinarian.

(c) "Opiate" has the same meaning as set forth in section 18-18-102 (21).

(d) "Opiate antagonist" means naloxone hydrochloride or any similarly acting drug that is not a controlled substance and that is approved by the federal food and drug administration for the treatment of a drug overdose.

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(c) "OPIATE-RELATED DRUG OVERDOSE EVENT" MEANS AN ACUTE CONDITION, INCLUDING BUT NOT LIMITED TO A DECREASED LEVEL OF CONSCIOUSNESS OR RESPIRATORY DEPRESSION RESULTING FROM THE CONSUMPTION OR USE OF A CONTROLLED SUBSTANCE, OR ANOTHER SUBSTANCE WITH WHICH A CONTROLLED SUBSTANCE WAS COMBINED, AND THAT A LAYPERSON WOULD REASONABLY BELIEVE TO BE AN OPIATE-RELATED DRUG OVERDOSE EVENT THAT REQUIRES MEDICAL ASSISTANCE.

SECTION 3. In Colorado Revised Statutes, add 13-21-108.7 as follows:

13-21-108.7. Persons rendering emergency assistance through the administration of an opiate antagonist - limited immunity - legislative declaration - definitions. (1) Legislative declaration. THE GENERAL ASSEMBLY HEREBY ENCOURAGES THE ADMINISTRATION OF OPIATE ANTAGONISTS FOR THE PURPOSE OF SAVING THE LIVES OF PEOPLE WHO SUFFER OPIATE-RELATED DRUG OVERDOSE EVENTS. A PERSON WHO ADMINISTERS AN OPIATE ANTAGONIST TO ANOTHER PERSON IS URGED TO CALL FOR EMERGENCY MEDICAL SERVICES IMMEDIATELY.

(2) Definitions. AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "HEALTH CARE FACILITY" MEANS A HOSPITAL, A HOSPICE INPATIENT RESIDENCE, A NURSING FACILITY, A DIALYSIS TREATMENT FACILITY, AN ASSISTED LIVING RESIDENCE, AN ENTITY THAT PROVIDES HOME- AND COMMUNITY-BASED SERVICES, A HOSPICE OR HOME HEALTH CARE AGENCY, OR ANOTHER FACILITY THAT PROVIDES OR CONTRACTS TO PROVIDE HEALTH CARE SERVICES, WHICH FACILITY IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED OR PERMITTED BY LAW TO PROVIDE MEDICAL TREATMENT.

(b) (I) "HEALTH CARE PROVIDER" MEANS:

(A) A LICENSED OR CERTIFIED PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, OR PHARMACIST; OR

(B) A HEALTH MAINTENANCE ORGANIZATION LICENSED AND CONDUCTING BUSINESS IN THIS STATE.
(II) "HEALTH CARE PROVIDER" DOES NOT INCLUDE A PODIATRIST, OPTOMETRIST, DENTIST, OR VETERINARIAN.

(c) "OPIATE" HAS THE SAME MEANING AS SET FORTH IN SECTION 18-18-102 (21), C.R.S.

(d) "OPIATE ANTAGONIST" MEANS NALOXONE HYDROCHLORIDE OR ANY SIMILARLY ACTING DRUG THAT IS NOT A CONTROLLED SUBSTANCE AND THAT IS APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION FOR THE TREATMENT OF A DRUG OVERDOSE.

(e) "OPIATE-RELATED DRUG OVERDOSE EVENT" MEANS AN ACUTE CONDITION, INCLUDING BUT NOT LIMITED TO A DECREASED LEVEL OF CONSCIOUSNESS OR RESPIRATORY DEPRESSION RESULTING FROM THE CONSUMPTION OR USE OF A CONTROLLED SUBSTANCE, OR ANOTHER SUBSTANCE WITH WHICH A CONTROLLED SUBSTANCE WAS COMBINED, AND THAT A LAYPERSON WOULD REASONABLY BELIEVE TO BE AN OPIATE-RELATED DRUG OVERDOSE EVENT THAT REQUIRES MEDICAL ASSISTANCE.

(3) **General immunity.** A PERSON OTHER THAN A HEALTH CARE PROVIDER OR A HEALTH CARE FACILITY WHO ACTS IN GOOD FAITH TO ADMINISTER AN OPIATE ANTAGONIST TO ANOTHER PERSON WHOM THE PERSON BELIEVES TO BE SUFFERING AN OPIATE-RELATED DRUG OVERDOSE EVENT SHALL NOT BE LIABLE FOR ANY CIVIL DAMAGES FOR ACTS OR OMISSIONS MADE AS A RESULT OF SUCH ACT.

(4) (a) **Licensed prescribers and dispensers.** A PERSON WHO IS PERMITTED BY LAW TO PRESCRIBE OR DISPENSE AN OPIATE ANTAGONIST SHALL NOT BE LIABLE FOR ANY CIVIL DAMAGES RESULTING FROM:

(I) SUCH PRESCRIBING OR DISPENSING; OR

(II) ANY OUTCOMES RESULTING FROM THE EVENTUAL ADMINISTRATION OF THE OPIATE ANTAGONIST BY A LAYPERSON.

(b) A PRESCRIBER OR DISPENSER WHO DISPENSES AN OPIATE ANTAGONIST IS STRONGLY ENCOURAGED TO EDUCATE PERSONS RECEIVING THE OPIATE ANTAGONIST ON THE USE OF AN OPIATE ANTAGONIST FOR OVERDOSE, INCLUDING BUT NOT LIMITED TO INSTRUCTION CONCERNING RISK
FACTORS FOR OVERDOSE, RECOGNITION OF OVERDOSE, CALLING EMERGENCY MEDICAL SERVICES, RESCUE BREATHING, AND ADMINISTRATION OF AN OPIATE ANTAGONIST.

(5) THE PROVISIONS OF THIS SECTION SHALL NOT BE INTERPRETED TO ESTABLISH ANY DUTY OR STANDARD OF CARE IN THE PRESCRIBING, DISPENSING, OR ADMINISTRATION OF AN OPIATE ANTAGONIST.

SECTION 4. In Colorado Revised Statutes, 12-36-117, add (1.7) as follows:

12-36-117. Unprofessional conduct. (1.7) The prescribing, dispensing, or distribution of an opiate antagonist by a licensed health care practitioner shall not constitute unprofessional conduct if he or she prescribed, dispensed, or distributed the opiate antagonist in a good faith effort to assist:

(a) A person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.; or

(b) A family member, friend, or other person who is in a position to assist a person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.

SECTION 5. In Colorado Revised Statutes, 12-42.5-123, add (3) as follows:

12-42.5-123. Unprofessional conduct - grounds for discipline. (3) The dispensing or distribution of an opiate antagonist by a pharmacist shall not constitute unprofessional conduct if he or she dispensed or distributed the opiate antagonist in a good faith effort to assist:

(a) A person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.; or

(b) A family member, friend, or other person who is in a position to assist a person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.
POSITION TO ASSIST A PERSON WHO IS AT INCREASED RISK OF EXPERIENCING OR LIKELY TO EXPERIENCE AN OPIATE-RELATED DRUG OVERDOSE EVENT, AS DEFINED IN SECTION 18-1-712 (5) (e), C.R.S.

SECTION 6. In Colorado Revised Statutes, 12-38-117, add (6) as follows:

12-38-117. Grounds for discipline. (6) The prescribing, dispensing, or distribution of an opiate antagonist by an advanced practice nurse shall not constitute grounds for discipline if he or she prescribed, dispensed, or distributed the opiate antagonist in a good faith effort to assist:

(a) A person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.; or

(b) A family member, friend, or other person who is in a position to assist a person who is at increased risk of experiencing or likely to experience an opiate-related drug overdose event, as defined in section 18-1-712 (5) (e), C.R.S.

SECTION 7. In Colorado Revised Statutes, 12-42.5-102, add (42) (b) (XIV) as follows:

12-42.5-102. Definitions. As used in this article, unless the context otherwise requires or the term is otherwise defined in another part of this article:

(42) (b) "Wholesale distribution" does not include:

(XIV) The distribution of naloxone.

SECTION 8. In Colorado Revised Statutes, amend 12-42.5-105 as follows:

12-42.5-105. Rules. (1) The board shall make, adopt, amend, or repeal rules in accordance with article 4 of title 24, C.R.S., that the board deems necessary for the proper administration and enforcement of the responsibilities and duties delegated to the board by this article, including
those relating to nuclear pharmacies.

(2) **ON OR BEFORE JANUARY 1, 2014, THE BOARD SHALL ADOPT OR AMEND RULES AS NECESSARY TO PERMIT THE DISPENSING OF AN OPIATE ANTAGONIST, AS DEFINED IN SECTION 18-1-712 (5) (d), C.R.S., BY A PHARMACIST TO A PERSON WHO IS AT INCREASED RISK OF EXPERIENCING OR LIKELY TO EXPERIENCE AN OPIATE-RELATED DRUG OVERDOSE EVENT, AS DEFINED IN SECTION 18-1-712 (5) (e), C.R.S., OR TO A FAMILY MEMBER, FRIEND, OR OTHER PERSON WHO IS IN A POSITION TO ASSIST SUCH A PERSON, SO LONG AS THE PRESCRIPTION FOR THE OPIATE ANTAGONIST PROVIDES FOR THE DISPENSING OF THE OPIATE ANTAGONIST TO SUCH A FAMILY MEMBER, FRIEND, OR OTHER PERSON.

**SECTION 9. Appropriation.** (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the division of professions and occupations cash fund created in section 24-34-105 (2) (b) (I), Colorado Revised Statutes, not otherwise appropriated, to the department of regulatory agencies, for the fiscal year beginning July 1, 2013, the sum of $8,318, or so much thereof as may be necessary, to be allocated for the implementation of this act as follows:

(a) $6,000 to the division of professions and occupations for board meeting costs; and

(b) $2,318 to the executive director's office and administrative services for the purchase of legal services.

(2) In addition to any other appropriation, there is hereby appropriated to the department of law, for the fiscal year beginning July 1, 2013, the sum of $2,318, or so much thereof as may be necessary, for the provision of legal services for the department of regulatory agencies related to the implementation of this act. Said sum is from reappropriated funds received from the department of regulatory agencies out of the appropriation made in paragraph (b) of subsection (1) of this section.

**SECTION 10. Safety clause.** The general assembly hereby finds,
determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

____________________________  ____________________________
John P. Morse         Mark Ferrandino
PRESIDENT OF         SPEAKER OF THE HOUSE
THE SENATE         OF REPRESENTATIVES

____________________________  ____________________________
Cindi L. Markwell    Marilyn Eddins
SECRETARY OF         CHIEF CLERK OF THE HOUSE
THE SENATE         OF REPRESENTATIVES

APPROVED______________________________

________________________________________
John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO