Governor's Commission on AOD
Healthcare Task Force

Offices of the NH Hospital Association, Airport Rd, Concord
Thursday, December 17, 2015

***draft minutes

Present:
Lindy Keller, Bureau of Drug and Alcohol Services
Gene Harkless, Chair of Department of Nursing University of New Hampshire
Mary Bidgood-Wilson, LRG Healthcare
Kathy Bizarro-Thunberg, NH Hospital Association
Amy Pepin, Center for Excellence
Adrian Thomas, NH Spine Institute
Tom Barnes, Pinewood Professionals Pain Medicine
Molly Rossignol, Addiction Medicine & Family Practice
Janet Monahan, NH Medical Society
Seddon Savage, Pain Medicine & Addiction Medicine
Peter Mason, Family Practice buprenorphine provider
Jack Wozmack, Governor's Office
Susan Laverack, Partnership for Public Health
Polly Morris, CADY Prevention

Seddon opened the meeting and introductions were done around the table.

October 22, 2015 minutes were approved.

There is a special legislative task force that has been addressing the opioid epidemic. They are more globally looking at different interventions and strategies. It has been a very collaborative practice.

Joint Task Force for the Response to the Heroin and Opioid Epidemic in New Hampshire Interim Report.

- The task force divided the proposals into designations of "expedited", "early", or "regular order."
- "Expedited" means they will have a joint House and Senate Hearing on January 6, 2016 and with the joint committee.
    - They hope to have a recommendation by the end of the week for action by the House and Senate.
    - By January 21, 2016 this should be on the Governor's desk for signature.
- "Early" bills they hope to have them processed and done about two weeks later.
- "Regular" order would be House and Senate hearings with a crossover date at the end of March.

- The “Expedited” were discussed by the Taskforce.
  - Making the penalty for the manufacture, sale, possession with intent to sell various amounts of fentanyl the same penalty for manufacture, sale, and possession with intent to sell of the same amounts of heroin or crack cocaine.
  - Requiring health insurance carriers to use criteria established the American Society of Addiction Medicine (ASAM).
  - To produce a long-term plan on the use and distribution of Narcan in New Hampshire.
  - Requiring all public schools in the state to provide age appropriate drug and alcohol education in grades kindergarten through 12.
  - Expand access to the Prescription Drug Monitoring Program (PDMP) to the designees of prescribers and dispensers and to prescribers and dispensers in federal facilities such as VA hospitals and the Chief Medical Examiner for investigating death.
  - Adding two physicians to the Board of Medicine and requiring one of the physician members of the subcommittee to practice in pain medicine and anesthesiologist.
    - What we want is somebody who has broad training in psychological approaches and is an addiction specialist.
    - It was suggested one be practicing pain management and one be a practicing addiction specialist.
    - The physician should be certified through the American Board of Pain Medication or certified in Addiction Medicine.
    - Comments can be offered on January 5, 2016 at the hearing.
  - Allow the Prescription Drug Monitoring Program (PDMP) to accept state funding and grants.
  - Mandated use of the PDMP for all prescribers.
  - Require three hours of continuing education or an on-line examination on pain management and addiction disorder for all prescribers with a Drug Enforcement Administration (DEA) license as a condition of licensure or renewal. Has to board approved by the various boards.
  - 24-Hour hotline.
    - 211 you can only get a live person from 8am to 5 pm.
    - 211 are now tracking the referrals calls that they get and time they call.
    - 211 have more to do with information and referral where a hotline has more to do with people in crisis.
    - Need accessible 24 hour helpline.
    - Looking at the feasibility of costing out.
    - A hotline should be separate from the 211 line.
    - A hotline is for people in crisis to get them talked down before they even make sense about what information/referral they need.

        - Another part of the conversation is should this include mental health along with addiction.
    - Allow access by law enforcement.
        - The language needs further development.
        - There might be push back on this.
        - Confidentially will be a concern.
- Early Classification, new LSR's for early consideration and Regular Order
    - Reinstatement of the 100 dose limit
        - Healthcare Taskforce and a group made up of almost the same members are in opposition to the reinstatement of the 100 dose limit.
        - Felt it would affect the sickest patients including hospice and palliative care and those with major complex surgery.
        - It won't actually reduce opioids' available for apparent diversion as clinicians would just write more prescriptions for people who needed them.
        - Concerned it would shift people from short acting to the long acting which is sometimes appropriate but not always because you can write for fewer dose limits.
        - Reduce time and efficiency as the clinician would have to write more prescriptions.
        - Do specific prescribing directions belong in legislation or should they be Board of Medicine rules? The less detailed in statute the better you are from administrative rules perspective you have more control. The group agrees that the Board of Medicine should write the prescribing rules.
        - The reason it ended up in statute as it was there once before.
        - Another concern is the co-pays the patient would have to pay.
    - Requiring all the boards to adopt rules for prescribing controlled drugs using mandatory standards for such rules.
        - The bill has way to much detail.
    - Appropriating $130,000 for technical upgrades to the PDMP.
    - Establishing a state grant program with the Dept. of Safety, Division of State Police to make and appropriation for state police to assist state and local law enforcement agencies in addressing the opioid crisis.
    - Appropriation for the acquisition and equipping of new state police cruisers.
    - Drug Courts. Right now there are only a few counties that have them and the goal is to get 11 of them running.
    - Narcan to be available over-the-counter.

Comment: Some of LSR's in the recommendations provide a lot of detail. We are going to have to weigh in on them early on to try to get it out of statute and allow for it in rule making.

Acute Pain

- The question is what would our ideal rules be for prescribing?
  - ➢ It is hard to make rules on something when you are not there.
    - o For example, need emergency room clinicians input for emergency room guidelines
  - ➢ Limits set a clinician up for more calls and visits if the patient is not getting what they need and the patient up for delays in relief.
  - ➢ Requires clinical judgment of the clinician.
  - ➢ Acute pain is highly variable in terms of dose requirements and duration.
- There have been suggestions that acute pain have 3-5 days limit of prescribing.
  - ➢ Getting 60 Percocet for a sprained ankle or impacted wisdom tooth, not likely they will never use the entire prescription.
  - ➢ The obstacles are co-pays and work flows.
- Need to create guideline with exemptions, ie can prescribe larger doses with clear documentation of the rationale.
- ➢ We need to use the PDMP to identify patients who are misusing and because it is collecting data.
  - o Mandate that the PDMP get used.
  - o Mandatory testing and training.
- In a year or two we will be able to identify the outliers and take action to correct use and prescribing when appropriate.
  - ➢ Look at documentation to see if it makes sense because of the kind of patients that they have.
- At the Federal level there is consideration of partial fills.
- It is not the right time to make rules when things are changing as may narrow the problem and many things might take care of themselves in this process.

Brief updates

- Naloxone Taskforce has discussed needle exchange which is a big topic.
- MAT expansion is still meeting. The draft of the MAT Guidance Document is done. Will be made available in early January. Also releasing RFA (Request for Application) specifically targeted to the Community Health Centers and the Community Mental Health Centers.
- SBIRT - CHC'S (Community Health Centers) are already enrolled.
- NH Treatment Locator – is out there and being promoted.
- Crossfit Gym focuses on people in recovery and is located in Derry. Working to try and get marketing information out there. They do bible studies, wellness, and exercise, etc. Spread the word.
- Concord Hospital is working on a March meeting to discuss "Scope of Pain."

The next meeting is January 28, 2016
at the NH Hospital Association, 9:00 am to 10:30 am