Governor's Commission on AOD Opioid Task Force

Healthcare Sector Work Group Meeting
Offices of the NH Hospital Association, Airport Rd, Concord
Thursday, September 24, 2015

Minutes

Present: Lindy Keller, Lisa Muré, Peter Mason, Bill Goodman, Jack Wozmak, Molly Rossignol, Sarah Blodgett, Kathy Bizarro-Thunberg, Janet Monahan, Joe Harding, Mary Bidgood-Wilson, Julie Hazellfeld, Adrian Thomas, Tom Barnes, Michelle Rico, Patrick Clary (phone).

Introductions were made around the table.

Review of the prior meeting minutes were deferred due to time constraints.

Optimizing opioid prescribing in NH and how it plays in to preventing opioid misuse & opioid associated harm.

- It may or may not have changed behaviors.
- Guidelines in many places.
    - 12 national organizations here and in Canada that has created opioid prescribing guidelines directed at chronic pain.
    - CDC (Center for Disease Control) did a crosswalk of those guidelines about a year ago and found a lot of very common points in them.
    - They convened an expert group to develop CDC national guidelines. They have not yet come out.
    - Sneak peak on a webinar of the CDC evolving draft recommendations.
    - There are a lot of clinician concerns about two or three of the recommendations.
- The Medical Society has guidance that has been posted with templates. https://www.nhms.org/resources/opioid
    - Of the common recommendations risk screening tools, templates for documentation, information on urine drug screening, information on referral to substance abuse treatment, information on referral to pain clinics, etc.
- The Governor's office has proposed to go from actually providing guidelines and professional standards into to adopting rules.
    - By rules it is meant: "legislatively adopted rules that would tell doctors how to practice."
    - Are we at a point where this should happen or are there ways to encourage clinicians.
    - Comment: it wouldn't be an issue if the Board of Medicine were really well staffed. If you had ten knowledgeable people who could receive concerns or randomly review records to make sure people were complying with what we consider professional standards. If the Board of Medicine were able to proactively uphold professional standards instead of taking professional complaints and investigating when there is a critical level of concern it might not be an issue that would be up for discussion.
    - Each hospital that is credentialed has to have medical staff offices that are obligated to perform routine quality assessments on their providers. An argument could be made to have another ten to address interpersonal relationships and

another ten for dress code. There are agencies that are already doing this. These people oversee anybody who is on the medical staff.
- Jack Wozmak stated he would like hospitals to develop their internal protocols around the use of opioids and the managing of chronic pain. So it doesn't have to be legislative because we are all sensitive about legislation and what it might say.
- Hospitals should create the guidelines versus legislating what those guidelines are.
- It would be unfortunate to legislate rather than having it voluntary.

Question: Was the governor's letter intended to push a little bit?(The governor wrote a letter to the Board of Medicine and suggested very proscribed pieces mandated behavior that looked like it was going to be legislative.) There are differing opinions about the launch of that letter. The intent was certainly to start the discussion and make sure it is galvanized. There were six specific things that the letter suggested and it opened the discussion. There is a group that is meeting with the Board and the Governor's staff to work through the area we should end up with.

- One of the board members has been meeting with Maryann Dempsey and folks from the Attorney General's office who not only to they have the role of Board Counsel but they prosecute our cases and they are of the opinion that we need mandatory requirements and not guidelines. They do not feel guidelines are sufficient to prosecute cases.
- Suggestions were: mandatory referral to a pain specialist after ninety days of treatment; mandatory CME's. Some of the other issues that have come up "no long acting opioids for acute pain." The discussions have been about mandated clinical guidelines.
- The Board of Medicine has received a request from the Governor's office to work with people at the Governor's office and from the Attorney General's office to change the Board of Medicine rules. The Board of Medicine wrote back to the Governor's Office requesting that other stakeholders be involved in this discussion.
- It would be good to have someone from the pain community in on this discussion since they are experts on pain management and opioid prescribing.
- If they are going to pass rules on opioid prescribing there should be somebody who is able to review available evidence. Who has clinical experience and is networked well with the rest of the community.
- The Board feels very strongly that stakeholder input is critical in this process before anything goes into effect.
- There is talk about the rules going interim which does not have a public comment hearing before they go into effect.
- The goal is to get draft rules to the Board by its October meeting.

Question: Is there a reason not to ask that the Governor's Commission on Alcohol and Drug Abuse, Prevention, Treatment and Recovery Healthcare Workgroup do this instead of having another group convened to do this? *(The Healthcare Workgroup was put together to advise the Governor on policies related to healthcare and alcohol and other drugs*.) *Can we take this back to the Governor's office? These rules will have massive impact on patients and many unintended consequences. If interim rules are put into place this will cause more harm.*

    - Having this in regular rule making would give us much greater opportunity for stakeholder input.
    - This group should write a letter to the Board of Medicine for their October meeting and explain some of the concerns and the thought about doing this through regular rulemaking to give the opportunity for stakeholders to voice concerns. Also this group could make recommendations for stopgap measures. Seddon will ask Tym the Chairman of the Governor's Commission on Alcohol and Drug Abuse, Prevention, Treatment and Recovery if this is a possibility.
- Education and Training
    - The Medical Society has been interested in at the level of either DEA or PDMP registration have to demonstrate a certain knowledge base. This would assure that prescribing physicians/clinicians understand the rules and regulations. They understand why drugs are scheduled and the addictive potential.
    - The idea would be a thirty question online.
    - It needs to be said that everyone has to do it.
    - The Board of Medicine never did not collect DEA information. We did not know the percentage of licensee that had DEA numbers. It is only now the Board of Medicine has started to gather this. We are going to start to request this information on new applications and renewals. Folks that show that they have a DEA number would have to take a certain number CMEs. They would have to supply those CMEs to get their licensing/renewal.
    - Requiring CMEs is a proposal at this time. The Board has not yet approved the draft rules.

Comment: Physicians are frequently derided as being a primary cause. Many legislatures think something has to happen. Some education that is required, if doesn't do any harm you have to give something up to the public. You have to have a galvanized message that says "you got to do something." I think the balance is for this group because there is great political pressure here is not to be confused with clinical or practical items. The Governor wants to stand up and say "we have done certain things that will help all these other efforts. We found the right balance between practicing medicine and guiding public policy as a foundation of the action that we take in responding to a public health crisis." Right now the guidelines in the Governor's view are absolutely meaningless. They are soft. That can't go on.

    - Clinicians have oversight of people in their neighborhood.
    - The reason the guidelines are soft is because clinical scenarios are so diverse. In medicine you can't write rules that cover every clinical case that comes up without hurting people.
    - Having the Board say "our rule is going to be that every healthcare system, clinical practice, hospital based practice, adopt guidelines and uphold those guidelines among their medical staff. Our recommendation is they consider including this" and this is where the guidelines would go in.
    - What is the point of reviewing the guidelines if the Governor thinks they are weak?
    - To review guidelines which are suggested to change a behavior that everyone will embrace without having to wait for the CDC.
- Summary on what is the good plan
    - The chief medical officer of each hospital to require their opioid prescribers within the next sixty days to have renewed and reviewed the proposed CDC or similar guidelines and sign them and return them to the chief medical officer.
        - Change the word review to something with more substance.

- It is a great idea to put something on the table that is responsive and consistent with the very discussions that these people are having.
- The CDC guidelines suggest referring a client to a pain management after ninety days.
- The purpose of the CDC guideline is to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (i.e., pain lasting longer than 3 months or past the time of normal tissue healing) outside end-of-life care.
- The CDC guidelines are still in draft form. They are now receiving input from providers. They will be very different in the end.
- There is a difference between politics and policy. It seems we are trying to put something together that political to be able to have someone say everyone's looked at this but we will still actually still be working on policy.
- The problem we are running into is we are trying to do work but someone is trying to say they get results.
- If people sign these things they are going to interpret them as either rules or requirements that they can be judged upon. There will be a lot of confusion about that. We need agree upon some of the recommendations early on in order to make things right.
- If everyone could agree on the CDC guidelines there would be no problem. But we are not there yet.
- We should keep this on the agenda as something to work especially if we are going to be called upon to advise on.
- We should work on developing what the guidelines are and establishing the standard and then work on the adoption second.
- The CDC guidelines should be completed by January 1, 2016.
- Summary: We want to defer implementation of interim rules of rules so that there can be public input into the rules. We would like to propose that the this group provide input into whatever rules are develop even prior to public input in collaboration with the Board of Medicine.

- Next Step
  - Draft a letter.
  - Send it around that includes no interim rules and Governor's Commission to advise.
  - One paragraph. There is a problem and we want to work with you on it. There is a sensitive timeline. Work against interim rules.

PDMP

- Putting together a program specific how to utilize the Prescription Drug Monitoring Program.
- We are working on an online course.

Brief Updates

- Naloxone Taskforce
  - There has been a subgroup of this group working on making naloxone available.
  - Focusing on two things. 1. Enhancing prescriber comfort with new law and helping them understand it. Helping clinicians to prescribe not only to patients that are at risk but to family and friends that are at risk. 2. Distribution of naloxone through various channels. Department and Health and Human Services have been championing distribution. They have almost 5,000 inter-nasal kits available with

instructions and two dose kits that are being distributed to CHC's, law enforcement and to public events where training is taking place.
    - The other large scale distribution that is imminent is through pharmacies.
    - On Tuesday there is going to be a press conference in Governor's Council Chambers. The conference is to educate the press and public about these things.
    - There are materials developed to support standardized prescriptions and attached to them are education. The dispenser is charged with the education.

Needle Disposal

- There have been discussions on needle exchange.
- There are naloxone prescriptions available in both nasal and by needle.
- Vermont is giving out naloxone free to anyone coming in for a needle exchange.
- NH law prohibits needle exchange. There are other ways that NH has to dispose of needles. Some police departments have a box to put used needles in.
- Should we recommend legislation that permits needle exchange?
    - It has been brought up but it seems to be a political hotspot.
    - Right now we have enough going on with regards to legislation and it might be good not to diversify further even though this is a really important issue.
    - Needle exchange programs are great when you have a full complement or continuum of care to help get people into treatment.
- How would you leverage naloxone and the needles to support exchange?
    - Some of the people who administer will be using a needle but it would be a take back rather than an exchange.
- There currently is a bill to establish a commission on infectious disease SB 56 http://gencourt.state.nh.us/legislation/2015/SB0056.html and that may be a venue for them to figure that out.
- How are people supposed to dispose of needles?
    - The thinking is that if they are getting the prescription for naloxone from the pharmacy that the pharmacy will provide instructions on it on what to do with the used needle.
    - Does anybody know this for sure?
    - Sarah Blodgett will speak to the pharmacies about this and report back.

Medicated Assisted Treatment (MAT) Expansion

- A group of expert panelists, have been meeting and learning about the different types of medicated assisted treatment taking place in New Hampshire have made some recommendations on "Best Practices" in some of the literature.
- The state wants to collect the knowledge from what is happening in the state now and "Best Practices" and come up with key components of high quality medicated assisted treatment to then begin an effort to encourage more people to do it and follow "Best Practices."
- Fundamental to this effort is developing a strategy to promote further capacity involvement in this area that takes a hard look at what are challenges for medical practices for providing medicated assisted treatment.
- What resources do they need available? What is the education that comes with it? What consultation is available to them?
- What is the business or organizational practices?
- Hopefully will be done by year end.

- The Bureau of Drug and Alcohol Services submitted a proposal for a Medication Assisted Treatment Grant from SAMHSA (Substance Abuse and Mental Health Services Administration).
    - Whether or not we get the grant, it was an opportunity to say we are going to do this.
    - When we wrote the grant we also initiated other resources.
- There is an upcoming statewide conference on the opioid issue that will touch on law enforcement, fire, EMS, physicians, general healthcare, educators, people in recovery, the public, etc.
    - Some law enforcement are asking for and "Addiction 101" so they can understand and reduce some of the stigma.
    - There are about 20 breakout sessions in the plans.
    - It really is a statewide summit that looks to get as many of the pivotal issues for as many of the stakeholders possible to galvanize a broad statewide discussion that recognizes as many aspects as possible of the people this affects.

Events, conferences, gatherings

- SBIRT Summit at the Grappone Center on October 19.
- On December 4 at Dartmouth they are having an all-day (8:30 am to 4:00 pm) conference on medicated assisted treatment. It will cover prescriber and policy issues. It will also examine some of the barriers. The audience is healthcare professionals, addiction professionals, law enforcement, policy makers and really anybody.
- On November 3 there will be a panel discussion at the Red River Theater on raising awareness on appropriate opioid prescribing. Short version of the "Hungary Heart."
- November 13 Dr. Seddon Savage will be speaking in Bedford, NH on opioid misuse, scope of pain education and safe practice and use of opioids, pain management without opioids.
- On November 13 there is a training for Behavioral Health, specifically for SUD treatment professionals to be trained the different ways to work and skills they need to work in a graded setting with primary care.
- This afternoon at 1:00 pm the Medical Society will be having a Medical Marijuana symposium from 1:00 pm to 5:15 pm.

Next meeting October 22, 2015●9:00 am to 10:30 am
at the Offices of the NH Hospital Association