Governor's Commission on AOD
Healthcare Task Force

Offices of the NH Hospital Association, Airport Rd, Concord, NH
Thursday, August 25, 2016

Present:
Kathy Bizarro-Thunberg, NH Hospital Association
Mary Bidgood Wilson, NH Nurse Practitioner Association
Molly Rossignol, Addiction Medicine Physician Concord Hospital
Janet Monahan, NH Medical Society
Julie Hazell-Felch, Manchester Community Health Center
Melissa Silvey, Goodwin & Strafford County PHN
Seddon Savage, Pain Medicine and Addiction Medicine
Laurie Harding, NH Commission on the Primary Care Workforce
Courtney Gray, NH Providers Association
Tom Barnes, PMC Medical Group
Michele Merritt, New Futures
Abby Shockley, Department of Health & Human Services, Division for Behavior Health
Susan Latham, Program Director Merrimack River Medical Services – called in.

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

Minutes were reviewed and approved.

Opioid Prescribing Update and Review of Checklist:
NH RSA 318-B:41 Rulemaking for Prescribing Controlled Drugs
Administrative Rules Med 502 Opioid Prescribing
Doctors have been having difficulty in implementing opioid prescribing giving requirements now not just best practices and guidelines. Health systems are integrating some of them into the EHRs so people in private practice may have a more difficult time. There are concerns that people will be cut off from opioids when they are actually needed which can lead to undertreatment.

Janet Monahan and Kathy Bizarro-Thunberg have gone through the law to see all the requirements in 576, HB1423 and Board of Medicine Rules and created a checklist based on the rules to make it easier for prescribers to adhere. This reflects the Board of Medicine proposed rules are expected to be passed at the joint legislative committee on administrative rules (JLCAR) meeting the first Thursday of October.

There were questions on whether the PDMP (Prescription Drug Monitoring Program) on the patient could be printed and it has recently been changed so that the PDMP can be printed and put in the file for documentation.

Checklist is as follows

For All Pain (see handout "Checklist for Use of and Prescribing of Opioids")
http://www.nh.gov/medicine/documents/opioidpatientchecklist.pdf

- History and physical documented in medical record.
- Consideration of non-**opioid** options for pain.
- Patient risk factors for opioid misuse using Board approved risk assessment tool.
- Treatment Plan.
- Informed consent and risk assessment information shared with patient.
- Query the NH PDMP*

**Exceptions for PDMP use: Controlled Rx administered to patient; PDMP inaccessible due to electronic issue; or ED with high patient volume that querying the PDMP would create a delay in care.*

Acute Pain

- Document opioid prescription and rationale.
- Prescription limited to seven days when issued in emergency dept., urgent care or walk-in clinic.
- For unresolved acute pain where continuity of care is anticipated: No obligation to prescribe opioids for more than thirty days but required in-office, follow-up appointment prior to issuing new script.

Chronic Pain

- Treatment Agreement**
- Periodic review of the Treatment Plan.
- Re-check PDMP, at least twice per year.
  Prescriber may want to print the PDMP query results/screen shot for the medical record.
- Urine Drug Screens** at least annually for patients taking opioids > 90 days.
- Consideration of pain consultation for patients receiving 100mg morphine equivalent daily dose > 90 days.

If the clinician is going to prescribe more than 30 days they need to have a follow-up appointment with the patient.

***Not required for patients in long-term, non-rehab facility when opioid is administered and for patients with episodic intermittent pain receiving no more than 50 dose units in a three month period.*

This will be for any licensee not just physicians. Theoretically all the rules are going to be the same. The Checklist was developed from the law and the language can be adapted to fit the clinicians using it.

The question is: *How are we going to get this distributed?* We can work with the Boards to get this out to the field.

Need to wait until rules are adopted and right now they are all in process. This is in HB1423 https://legiscan.com/NH/text/HB1423/id/1287445

*We will revisit this next month and plan a strategy of release.

MAT Trainings
Shawn LaFrance was unable to attend the meeting today but hopefully will be here next month. The substance use disorder project contract was approved mid-July with Governor and Council. Shawn is in the midst of hiring a person specifically to work with practices on educating physicians and others to do MAT (Medicated Assisted Treatment) training. Another component of that contract is to work with emergency departments identifying individuals with substance abuse issues and how to connect them with services. Once the person is hired they will be attending the Healthcare Taskforce meetings monthly.

Integration of MAT with the 1115 Waiver - We will invite Deb Fornier to do a presentation on the 1115 Waiver as this works is completely resonant with the focus of this Task Force. Also Jeanne Ryer from CHI (Community Health Institute) is also doing an integration grant. She has a mental health learning collaborative going on.

Medicaid MAT
There seems to be some barriers for MAT particularly for the expansion population. On the managed care side of this relationship the department has contractual oversight of the managed care companies. When MAT was rolled out we heard about issues with prior authorization, requiring a certain number of drug screens that were putting up barriers while we are trying to expand MAT services. As of January 1 the state will pay for premiums but administration of the benefit and coverage really falls between the plans, the private carrier the same way we all have to deal with our personal insurance cards through our employers. The benefits have been keyed to the state benchmark plan. The benchmark plan outlines the minimum benefit. It has to comply with the ten essential health benefits that any plan offered on the State exchange can have for services. It does include in that plan MAT. The issues we are encountering are how plans are administering those benefits.

Healthcare providers have expressed a number of concerns regarding variable and sometimes clinically unnecessary or challenging requirements that may impede implementation of medication-assisted treatment (MAT) of opioid addiction for patients on the NH Health Exchange and NH Health Protection Program. At a time when the State of NH is seeking to expand access to MAT for persons with opioid addiction such requirements may serve as barriers to clinicians' offering medication-assisted treatment and to patients receiving the care that they need. Staff from one clinic report needing to hire a full time worker to obtain the necessary approvals to provide MAT clinical care to just 30 patients. Creation of a rational, uniform set of expectations will facilitate expansion of access to care and help to engage more providers in providing this service.

The following requirements or policies were identified as concerns that may be necessary impediments to care by some insurers. They will be shared with the Behavioral Health Parity Committee convened by the NH Dept. of insurance of which Peter Mason member of this committee is also a member.

- Required monthly pregnancy tests on women of child bearing age.
  - Buprenorphine is not a teratogenic drug. While it is important that all pregnant women be engaged in pre-natal care, the need for such care is not altered by use of buprenorphine. While it is important that clinicians be aware of the potential for neonatal abstinence syndrome in babies of women on MAT, monthly pregnancy tests serve no medical purpose.
  - A reasonable alternative might be prior to initiation, at six months and when indication/concern of pregnancy arises.
- Required drug-free UDTs for prior authorization change of dose, or continuation of treatment.
  - Addiction is a relapsing disease and the presence of opioids in the urine suggests the need for more intensive treatment, not abandonment of care. While consistent and repeated positive UDTs may indicate the need for change in plan, this must be a clinical judgment.
- Clinical demonstration of failure one treatment in order to obtain another treatment. Cited example: need to fail oral naltrexone prior to receiving depot naltrexone.
  - This seems to reflect confusion of the use of naltrexone for alcohol use disorder with the use of naltrexone for opioid use disorder. No evidence supports routine use of oral naltrexone in treatment of OUD (opioid use disorder); use of depot naltrexone is standard.
  - Requirement for trial oral naltrexone to establish tolerability is distinguished from the therapeutic trial of oral naltrexone.
- Maximum number of UDTs covered/mandatory minimum of UDTs required
  - Frequency of UDTs needs to be determined by clinician based on the clinical status of the patient. Had to hire someone to do prior authorizations for MAT for thirty patients. Unstable or early treatment patients may require weekly or more frequent UDTs. Stable, long-term, engaged patients may require quarterly or less.
- Requirement for no use of opioid analgesics in past thirty days for prescription to be authorized.
  - Acute pain related to injuries or illness and exacerbation of chronic pain conditions can occur and result in appropriate use of opioids for pain.
- If providing buprenorphine as MAT rather than using buprenorphine to assist in withdrawal, a requirement to provide rationale for long term SUD treatment
  - Buprenorphine is routinely used long-term for MAT. Diagnosis of OUD is the rationale for MAT with buprenorphine; should not require further justification.
- Indicate plan for tapering within a specified period of time (commonly 12 or 24 mos.)
  - While trial tapers may be considered in stable patients, longer term treatment is supported by evidence with high rates of relapse on withdrawal. Routine tapering in 12-24 months should not be a clinical expectation.
- Need to share with insurer several months' worth of notes and UDT at a time.

- This is not common practice for treatment of other medical conditions; what is the rationale and justification of this requirement in the context of MAT?

The next meeting is Thursday, September 22, 2016
at the NH Hospital Association, 9:00 am to 10:30 am