Committee Report

REGULAR CALENDAR

February 12, 2019

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on Health, Human Services and Elderly Affairs to which was referred HB 638,

AN ACT requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed. Having considered the same, report the same with the following resolution: RESOLVED, that it is INEXPEDIENT TO LEGISLATE.

Rep. James MacKay

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**HB 638**
Title:	**requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.**
Date:	**February 12, 2019**
Consent Calendar:	**REGULAR**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

This legislation would require that a health care provider shall require a patient to sign a disclosure form that informs them as to the dangers of addiction when using opioid prescriptions and that they should only be used for severe pain. It also requires use of alternative medications and the committee felt it represents an unnecessary mandate that interferes with the scope of practice certified by health care procedures. In fact, such a form does already exist and is included in Administrative Rules. This form should stay as a rule where it can be easily changed as practice requires and not in legislation which is more difficult to change

Vote 12-6.

Rep. James MacKay
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

HB 638, requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed. **MAJORITY: INEXPEDIENT TO LEGISLATE. MINORITY: OUGHT TO PASS WITH AMENDMENT.**

Rep. James MacKay for the **Majority** of Health, Human Services and Elderly Affairs. This legislation would require that a health care provider shall require a patient to sign a disclosure form that informs them as to the dangers of addiction when using opioid prescriptions and that they should only be used for severe pain. It also requires use of alternative medications and the committee felt it represents an unnecessary mandate that interferes with the scope of practice certified by health care procedures. In fact, such a form does already exist and is included in Administrative Rules. This form should stay as a rule where it can be easily changed as practice requires and not in legislation which is more difficult to change **Vote 12-6.**

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

February 12, 2019

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on Health, Human Services and Elderly Affairs to which was referred HB 638,

AN ACT requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed. Having considered the same, and being unable to agree with the Majority, report with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. William Marsh

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**HB 638**
Title:	**requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.**
Date:	**February 12, 2019**
Consent Calendar:	**REGULAR**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT 2019-0287 h**

STATEMENT OF INTENT

This bill, as amended, would simply move from the administrative rules to the statutes rules MED 502-04(h) and 502-05(f). No additional work would be required of prescribers. The minority recognizes the great work done by the New Hampshire Medical Society and others in reducing opioid prescriptions in NH by 30 to 50 percent by means of these rules. Given that the Joint Commission for Accreditation of Hospitals stated in 2000 that "there is no evidence that addiction is a significant issue when persons are given opioids for pain control," the minority finds that moving this requirement from the rules to the statutes where it cannot by easily changed by "the experts" is advisable.

Rep. William Marsh
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

HB 638, requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed. **OUGHT TO PASS WITH AMENDMENT.**

Rep. William Marsh for the **Minority** of Health, Human Services and Elderly Affairs. This bill, as amended, would simply move from the administrative rules to the statutes rules MED 502-04(h) and 502-05(f). No additional work would be required of prescribers. The minority recognizes the great work done by the New Hampshire Medical Society and others in reducing opioid prescriptions in NH by 30 to 50 percent by means of these rules. Given that the Joint Commission for the Accreditation of Hospitals stated in 2000 that "there is no evidence that addiction is a significant issue when persons are given opioids for pain control," the minority finds that moving this requirement from the rules to the statutes where it cannot by easily changed by "the experts" is advisable.

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

COMMITTEE: Health.

BILL NUMBER: HB 638

TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed

DATE: ______ **CONSENT CALENDAR:** YES ☐ NO ☒

☐ **OUGHT TO PASS**

☐ **OUGHT TO PASS W/ AMENDMENT**

☒ **INEXPEDIENT TO LEGISLATE**

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

Amendment No. ______

STATEMENT OF INTENT:

This legislation would require that a health care provider shall require a patient to sign a disclosure form ~~that informs them as to the disclaimer form~~ that informs them as to the dangerous of addiction when using opioid prescription and that they should only for severe pain. It also require alternate medication. The committee majority felt that represents an unnecessary mandate that interferes with the scope of practice utilized by health care providers. In fact, such a form does already exist and is included in Administrative Rules Med 502. This form should stay as a rule where it can be easily changed as practice requires and not in legislation which is more difficult to change.

COMMITTEE VOTE: 12 – 6

RESPECTFULLY SUBMITTED,

- Copy to Committee Bill File
- Use Another Report for Minority Report

Rep. James P. MacKay
For the Committee

Rev. 02/01/07 - Yellow

MINORITY REPORT

COMMITTEE: HHS & EA

BILL NUMBER: HB638

TITLE: OPIOID DISCLOSURE FORM

DATE: 2-12-19 **CONSENT CALENDAR:** YES ☐ NO ☒

☐ **OUGHT TO PASS**

☒ **OUGHT TO PASS W/ AMENDMENT**

☐ **INEXPEDIENT TO LEGISLATE**

☐ **INTERIM STUDY** (Available only 2nd year of biennium)

Amendment No. Ø287H

STATEMENT OF INTENT:

THIS bill, as amended, would simply move from the rules to the statutes rules ~~HHS~~ MED 502.04(h) and 502.05(f). No additional work would be required of prescribers. The minority recognizes the great work done by the New Hampshire Medical Society and others in reducing opioid prescriptions in NH by 30-50% by means of these rules. Given that the Joint Commission for Accreditation of Hospitals stated in 2000 that "there is no evidence that addiction is a significant issue when persons are given opioids for pain control," the minority finds that moving this requirement from the rules to the statutes where it cannot be easily changed by "the experts" is advisable.

COMMITTEE VOTE: 12-6

• Copy to Committee Bill File

RESPECTFULLY SUBMITTED,

Rep. [signature] WILLIAM MARSH

For the Minority

Rev. 02/01/07 - Blue

Rep. Marsh, Carr. 8
February 5, 2019
2019-0287h
01/05

Amendment to HB 638

Amend the title of the bill by replacing it with the following:

AN ACT requiring health care providers to document informed consent when prescribing opioids.

Amend the bill by replacing section 2 with the following:

2 New Section; Controlled Drug Act; Opioid Informed Consent. Amend RSA 318-B by inserting after section 1-c the following new section:

318-B:1-d Informed Consent for Opioid Prescriptions Required. Licensed health care providers shall document in writing informed consent when prescribing opioid drugs for acute or chronic pain including risks and alternatives, including, but not limited to, the risk of addiction and the alternative of non-opioid medication. The documentation required under this section may be used to satisfy the requirements of RSA 318-B:41, II(a)(5). The commissioner may adopt rules, pursuant to RSA 541-A, relative to the documentation required under this section.

2019-0287h

AMENDED ANALYSIS

This bill requires health care providers to obtain informed consent in writing when prescribing opioids.

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on HB 638

BILL TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

DATE: February 12, 2019

LOB ROOM: 205

MOTIONS: **INEXPEDIENT TO LEGISLATE**

Moved by Rep. MacKay Seconded by Rep. Woods Vote: 12-6

CONSENT CALENDAR: NO

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Susan Ticehurst

Rep Susan Ticehurst, Clerk

~~Subcommittee Chairman/Clerk~~

HOUSE COMMITTEE ON

Health Human Services & Elderly Affairs

EXECUTIVE SESSION on HB 638

BILL TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

DATE: 2-12-19

LOB ROOM: 205

MOTION: (Please check one box)

☐ OTP ☒ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ________ *(if offered)*

Moved by Rep. MacKay Seconded by Rep. Woods Vote: 12-6

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ________ *(if offered)*

Moved by Rep. ________ Seconded by Rep. ________ Vote: ________

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ________ *(if offered)*

Moved by Rep. ________ Seconded by Rep. ________ Vote: ________

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ________ *(if offered)*

Moved by Rep. ________ Seconded by Rep. ________ Vote: ________

CONSENT CALENDAR: ____ **YES** __X__ **NO**

Minority Report? X Yes _____ No If yes, author, Rep: _____ Motion_____

Respectfully submitted: Susan Ticehurst
Rep Susan Ticehurst, Clerk

OFFICE OF THE HOUSE CLERK

1/14/2019 3:22:00 PM
Roll Call Committee Registers Report

2019 SESSION

Health, Human Services and Elderly Affairs

Bill #: 638 **Motion:** ITL **AM #:** _____ **Exec Session Date:** 2-12-19

Members	YEAS	Nays	NV
Weber, Lucy M. Chairman	✓		
Campion, Polly Kent Vice Chairman			✓
MacKay, James R.	✓		
Snow, Kendall A.			✓
Freitas, Mary C.	✓		
Ticehurst, Susan J. Clerk	✓		
Knirk, Jerry L.	✓		
Salloway, Jeffrey C.	✓		
Cannon, Gerri D.	✓		
Nutter-Upham, Frances E.	✓		
Osborne, Richard G.	✓		
Schapiro, Joe	✓		
Woods, Gary L.	✓		
McMahon, Charles E.		✓	
Nelson, Bill G.			✓
Guthrie, Joseph A.		✓	
Fothergill, John J.			✓
Marsh, William M.		✓	
Pearson, Mark A.		✓	
Acton, Dennis F.	✓		
DeClercq, Edward		✓	

OFFICE OF THE HOUSE CLERK

1/14/2019 3:22:00 PM
Roll Call Committee Registers Report

2019 SESSION

Health, Human Services and Elderly Affairs

Bill #: _____ **Motion:** _____ **AM #:** _____ **Exec Session Date:** _____

Stapleton, Walter A.		✓	
TOTAL VOTE:	12	6	

Sub-Committee Actions

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 638

BILL TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

DATE: February 5, 2019

Subcommittee Members: Reps. Ticehurst, MacKay, Snow, Fothergill, Cannon, Nutter-Upham, Schapiro, Guthrie, Acton and Marsh

Comments and Recommendations: Attachment: packet from Board of Medicine.

MOTIONS: **OUGHT TO PASS WITH AMENDMENT**

Moved by Rep. Marsh	Seconded by Rep. Snow	AM Vote: 2-7
Amendment # 2019-0287 h		
Moved by Rep. Marsh	Seconded by Rep. Snow	Vote: 2-7

MOTIONS: **INEXPEDIENT TO LEGISLATE**

Moved by Rep. Rep. Fothergill	Seconded by Rep. Rep. Snow	Vote: 8-1

Respectfully submitted,

Rep. Susan Ticehurst
Subcommittee Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 638

BILL TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

DATE: 2-5-19

Subcommittee Members: Reps. MacKay, Snow, Ticehurst, Fothergill, Cannon, Nutter-Upham, Schapiro, Guthrie, Marsh, Acton.

Comments and Recommendations:

Attachment: Packet from Board of Medicine

OTP on Amendment

MOTIONS: OT, (OTP/A), ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. Marsh Seconded by Rep. Snow AM Vote: _____

Adoption of Amendment # 2019-0287h

Moved by Rep. ? Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, (OTP/A), ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. Marsh Seconded by Rep. Snow AM Vote: ?

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: 2-7

_____ Amendment Adopted _____ Amendment Failed

Motion: ITL Fothergill, 2nd: Snow 8-1

Respectfully submitted,

Rep. Susan Ticehurst
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

SUBCOMMITTEE WORK SESSION on HB 638

BILL TITLE: requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

DATE: 2-12-19

Subcommittee Members: Reps. MacKay, Snow, Ticehurst, Fothergill, Cannon, Nutter-Upham, Schapiro, Guthrie, Marsh and Acton

Comments and Recommendations:

No Action Taken

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr)
(Please circle one)

Moved by Rep. _____ Seconded by Rep. _____ AM Vote: _____

Adoption of Amendment # _____

Moved by Rep. _____ Seconded by Rep. _____ Vote: _____

_____ Amendment Adopted _____ Amendment Failed

Respectfully submitted,

Rep. Susan Ticehurst
Subcommittee Chairman/Clerk

Rep. Marsh, Carr. 8
February 5, 2019
2019-0287h
01/05

Amendment to HB 638

Amend the title of the bill by replacing it with the following:

AN ACT requiring health care providers to document informed consent when prescribing opioids.

Amend the bill by replacing section 2 with the following:

2 New Section; Controlled Drug Act; Opioid Informed Consent. Amend RSA 318-B by inserting after section 1-c the following new section:

318-B:1-d Informed Consent for Opioid Prescriptions Required. Licensed health care providers shall document in writing informed consent when prescribing opioid drugs for acute or chronic pain including risks and alternatives, including, but not limited to, the risk of addiction and the alternative of non-opioid medication. The documentation required under this section may be used to satisfy the requirements of RSA 318-B:41, II(a)(5). The commissioner may adopt rules, pursuant to RSA 541-A, relative to the documentation required under this section.

2019-0287h

AMENDED ANALYSIS

This bill requires health care providers to obtain informed consent in writing when prescribing opioids.

Hearing Minutes

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 638

BILL TITLE: **requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.**

DATE: **January 30, 2019**

LOB ROOM: **205** Time Public Hearing Called to Order: **1:00 PM**

Time Adjourned: **1:16 PM**

Committee Members: **Reps. Weber, Campion, Ticehurst, MacKay, Snow, Freitas, Knirk, Salloway, Cannon, Nutter-Upham, R. Osborne, Schapiro, Woods, McMahon, Guthrie, Fothergill, Marsh, M. Pearson, Acton and Stapleton**

Bill Sponsors:
Rep. Janigian **Rep. Gay** **Rep. Marsh**
Sen. Rosenwald

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

*** 1 Introduced by Rep. Marsh, Sponsor –**
Requiring health care providers to require patients to sign a form upon dispensing controlled drugs, explaining the addictive nature of such drugs. The bill does not add anything to what already exists in rules. Moves rules into statute where they become more difficult to change. Opioid prescription practices have changed over time, and previous practices are not always in ways that are now considered to be best practice. This bill does not legislate what has to be done but extends the practice of doctors informing patients. The current rules require an informed consent, even in circumstances such as in the emergency room. This would also apply when in statute. It would not be necessary to add the requirement for a conversation, because the legal definition of informed content includes having a conversation.

Rep. Magipudi –
Spoke about her personal experience refusing pain medication. As a condition of discharge from the hospital in 2015, she was required to purchase ten pills she did not wish to take. If the system is working so beautifully why are we having such a big problem? Does not favor adding another form but does want a real conversation between doctor and patient. Some people cannot advocate for themselves. This bill would provide a tool for patients and doctors.

Respectfully submitted,

Susan Ticehurst

Rep. Susan Ticehurst, Clerk

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING ON HB 638

BILL TITLE: **requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.**

DATE: 1/30/19

ROOM: 205 Time Public Hearing Called to Order: 1:06

Time Adjourned: 1:16

(please circle if present)

Committee Members: Reps. Weber, Campion, Ticehurst, MacKay, Snow, Freitas, Knirk, Salloway, Cannon, Nutter-Upham, R. Osborne, Schapiro, Woods, McMahon, Nelson, Guthrie, Fothergill, Marsh, M. Pearson, Acton, DeClercq and Stapleton

Bill Sponsors:
Rep. Janigian Rep. Gay Rep. Marsh
Sen. Rosenwald

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

House Committee on Health, Human Services & Elderly Affairs
Public Hearing on HB 638-FN

Bill Title:	requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed		
Date:	1/30/19		
Room:	205	Time Public Hearing Called to Order:	1:00
		Time Adjourned:	1:16

Committee Members Present:

X	Shapiro
X	Cannon
X	Stapleton
X	Nutter-Upham
X	Marsh
X	Salloway
X	Fothergill
X	Freitas
X	Snow
X	MacKay
X	Ticehurst
X	Weber

	DeClerq
X	Osborne
X	Acton
X	Woods
X	Pearson
X	Knirk
X	Guthrie
	Nelson
X	McMahon
X	Campion

Testimony

* Use asterisk if written testimony and/or amendments are submitted.

*	Attch #	Name	Testimony:
*	1	Introduced By Rep. Marsh, Sponsor	Requiring health care providers to require patients to sign a form upon dispensing controlled drugs, explaining the addictive nature of such drugs. The bill does not add anything to what already exists in rules. Moves rules into statute where they become more difficult to change. Opioid prescription practices have changed over time, and previous practices are not always in ways that are now considered to

			be best practice. This bill does not legislate what has to be done but extends the practice of doctors informing patients. The current rules require an informed consent, even in circumstances such as in the emergency room. This would also apply when in statute. It would not be necessary to add the requirement for a conversation, because the legal definition of informed content includes having a conversation.
		Rep. Magipudi	Spoke about her personal experience refusing pain medication. As a condition of discharge from the hospital in 2015, she was required to purchase ten pills she did not wish to take. If the system is working so beautifully why are we having such a big problem? Does not favor adding another form but does want a real conversation between doctor and patient. Some people cannot advocate for themselves. This bill would provide a tool for patients and doctors.

Respectfully submitted,

Rep. Susan Ticehurst, Clerk

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # AB 638 Date 1/29/19

Committee Health

**** Please Print All Information ****

Name	Address	Phone	Representing	Pro	Con
SEN. CINDY ROSENWALD			DISTRICT #13	✓	
Rep Latha Mangipudi			Hills 35	✓	

Testimony

HB~~509~~ 638

Madame Chairman:

For the record I am Representative William Marsh, representing the towns of Sandwich, Moultonborough, Tuftonboro, Ossipee, Effingham, Wakefield, and Brookfield.

I am pleased today to introduce HB638 requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed for Rep. John Janigian, who is off campus today on committee business.

As many of you know, such a form, entitled an informed consent, is already required under rule MED 502.04 (h) and 502.05 (f). This bill does not require anything not already required by rules, does not add any burden to physicians, and explicitly states that one form may satisfy both. We recognize the great work done by the NHMS in drafting the current rules, and accept their statement that these rules have reduced opioid prescriptions in NH by 30%.

Why then this bill? Quite simply, it moves the requirement from rules into statute, where it becomes far harder to change.

I have the perspective of a physician who has seen opioid prescribing habits change radically over my career. You need to understand that history to know why we ought to fix this rule in statute. When I completed medical school, some pain was always tolerable, and severe pain was a sign of something wrong, like infection. You never wanted to mask pain completely. In the mid-1990s, the American Pain Society aggressively pushed the concept of pain as the fifth vital sign, just as OxyContin became available. A book published by the Joint Commission for Accreditation of Hospitals in 2000 explicitly stated "there is no evidence that addiction is a significant issue when persons are given opioids for pain control." It also called doctors' concerns about addiction side effects "inaccurate and exaggerated." The book was sponsored by Purdue Pharma. By 2001, with the standard "Pain is assessed in all patients" the Joint Commission made pain the 5th vital sign. Purdue Pharma's revenues rose from a few billion in 2007 to $35 billion in 2017. In 2009, the Joint Commission repealed this standard, but by then we all know the opioid epidemic was well underway. In 2012, New England Journal of Medicine published a study that found that "76 percent of those seeking help for heroin addiction began by abusing pharmaceutical narcotics, primarily OxyContin" and drew a direct line between Purdue's marketing of OxyContin and the subsequent heroin epidemic in the U.S. In 2016, the AMA passed a resolution dropping pain as a vital sign. In 2018, Purdue Pharma patented a new form of buprenorphine, currently prescribed in medication assisted treatment programs.

This committee has a long practice of not telling "the experts" how to practice medicine. However, the voters sent us here to do something about the opioid epidemic. This rule belongs under the purvue of the General Court in the RSAs, and not in the rules, where it can easily be changed again by the experts. Let us learn from history, and not repeat it.

Thank you, and I will take questions.

HB 635 — HB 610 Medical Society —

Checklist for the Prescribing of Opioids for the Management or Treatment of Pain

Excludes: Cancer Patients, Terminal Pain Patients
and Patients that have Supervised Administration of Opioids in a Health Care Setting

For ALL Pain Patients (Acute and Chronic)

- ☐ Documented history and physical
- ☐ Complete Board-approved risk assessment tool to determine patient appropriateness for opioids
- ☐ Document opioid prescription and rationale
- ☐ Treatment Plan that includes consideration of nonpharmacological modalities and non-opioid options for pain
- ☐ Written Informed Consent outlining risks and benefits of opioid use (can be combined with treatment plan document)
- ☐ Query* the NH PDMP (Prescription Drug Monitoring Program) by licensee or delegate for initial script
  The prescriber/delegate may print the PDMP query results for review and may reference the report in the client's chart or record.

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

Acute Pain Patients (in addition to the items above for ALL Pain Patients)

- ☐ Ensure patient has been provided information on:
  - Risk of side effects, including addiction and overdose resulting in death
  - Risks of keeping unused medications
  - Options for safely securing and disposing of unused medication
  - Danger in operating a motor vehicle or heavy machinery
- ☐ Consider patient's risk for opioid misuse, abuse, diversion and prescribe the lowest effective dose for shortest duration.
- ☐ Prescriptions from Emergency Departments/Urgent Care/Walk-In Care: In most cases, a prescription of 3 or fewer days is sufficient, but no more than 7 days. If a prescription is necessary to exceed the board approved limit, the medical condition and rationale must be documented.
- ☐ For unresolved acute pain where continuity of care is anticipated: No obligation to prescribe opioids for more than 30 days; however, if unresolved acute pain persists beyond 30 days, requires an in-office, follow-up appointment prior to issuing a new script.

Chronic Pain Patients (in addition to the items above for ALL Pain Patients)

- ☐ Prescribe for the lowest effective dose for a limited duration
- ☐ Treatment Plan, includes but not limited to:
  - Goals of treatment in terms of pain management
  - Restoration of function
  - Safety
  - Time course of treatment
  - Consideration of non-pharmacological modalities and non-opioid therapy
- ☐ Written Treatment Agreement** The treatment agreement shall address, at a minimum:
  - Requirement for safe medication use and storage
  - Requirement for obtaining opioids from only one prescriber or practice
  - Consent to periodic and random drug testing
  - Prescriber's responsibility to be available or to have clinical coverage
- ☐ Consideration of consultation with an appropriate specialist for patients:
  - Receiving 100mg morphine equivalent daily dose > 90 days;
  - At high risk for abuse or addiction; or
  - Have a co-morbid psychiatric disorder
- ☐ Re-evaluate Treatment Plan and Re-check PDMP at least twice per year
- ☐ Conduct random and periodic urine drug testing** at least annually for patients taking opioids > 90 days

** Not required for patients with episodic intermittent pain receiving no more than 50 dose units in a 3 month period.

***NH RSA 318-B:41** Rulemaking for Prescribing Controlled Drugs – **Administrative Rules Med 502** Opioid Prescribing*
This checklist is provided only as a tool and does not replace the review by licensees of Administrative Rules Med 502.

Updated 1-17

Board of Medicine

Readopt with amendment Med 502, effective 5-3-16 (Document #11090), to read as follows:

PART Med 502 OPIOID PRESCRIBING

Med 502.01 Applicability. This part shall apply to the prescribing of opioids for the management or treatment of non-cancer and non-terminal pain, and shall not apply to the supervised administration of opioids in a health care setting.

Med 502.02 Noncompliance with Standards as Unprofessional Conduct. Noncompliance with the standards set forth in this part may constitute unprofessional conduct as used in NH RSA 329:17, VI(d).

Med 502.03 Definitions. Except where the context makes another meaning manifest, the following words have the meanings indicated when used in this chapter:

(a) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It can be time-limited, often less than 3 months in duration;

(b) "Administer" means an act whereby a single dose of a drug is instilled into the body of, applied to the body of, or otherwise given to a person for immediate consumption or use;

(c) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include impaired control over drug use, craving, compulsive use, or continued use despite harm. The term does not include physical dependence and tolerance, which are normal physiological consequences of extended opioid therapy for pain;

(d) "Chronic pain" means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that might or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that might require periodic treatment. For the purposes of these rules, chronic pain does not include pain from cancer or terminal disease;

(e) "Clinical coverage" means specified and prearranged coverage that is available 24 hours a day, 7 days a week, to assist in the management of patients with chronic pain;

(f) "Dose unit" means one pill, one capsule, one patch or one liquid dose;

(g) "Medication-assisted treatment" means any treatment of opioid addiction that includes a medication, such as methadone, buprenorphine, or naltrexone, that is approved by the FDA for opioid detoxification or maintenance treatment;

(h) "Morphine equivalent dose (MED)" means a conversion of various opioids to a morphine equivalent dose by the use of board-approved conversion tables;

(i) "Prescription" means a verbal, or written, or facsimile, or electronically transmitted order for medications for self-administration by an individual patient.

(j) "Risk assessment" means a process for predicting a patient's likelihood of misusing or abusing opioids in order to develop and document a level of monitoring for that patient;

(k) "Treatment agreement" means a written agreement that outlines the joint responsibilities of licensee and patient; and

(l) "Treatment plan" means a written plan that reflects the particular benefits and risks of opioid use for each individual patient and establishes goals, expectations, methods and time course for treatment.

Med 502.04 Acute Pain. If opioids are indicated and clinically appropriate for prescription for acute pain, prescribing licensees shall:

(a) Conduct and document a physical examination and history;

(b) Consider the patient's risk for opioid misuse, abuse, or diversion and prescribe for the lowest effective dose for a limited duration;

(c) Document the prescription and rationale for all opioids according to Med 501.02(d) and (e);

(d) Ensure that the patient has been provided information that contains the following:

(1) Risk of side effects, including addiction and overdose resulting in death;

(2) Risks of keeping unused medication;

(3) Options for safely securing and disposing of unused medication; and

(4) Danger in operating motor vehicle or heavy machinery;

(e) Comply with all federal and state controlled substances laws, rules, and regulations;

(f) Complete a board-approved risk assessment tool, such as the evidence based screening tool Screener and Opioid Assessment for Patients with Pain (SOAPP);

(g) Document an appropriate pain treatment plan and consideration of non-pharmacological modalities and non-opioid therapy;

(h) Utilize a written informed consent that explains the following risks associated with opioids:

(1) Addiction;

(2) Overdose and death;

(3) Physical dependence;

(4) Physical side effects;

(5) Hyperalgesia;

(6) Tolerance; and

(7) Crime victimization;

(i) In an emergency department, urgent care setting, or walk-in clinic:

(1) Not prescribe more than the minimum amount of opioids medically necessary to treat the patient's medical condition. In most cases, an opioid prescription of 3 or fewer days is sufficient, but a licensee shall not prescribe for more than 7 days; and

(2) If prescribing an opioid for acute pain that exceeds a board-approved limit, document the medical condition and appropriate clinical rationale in the patient's medical record.

(j) [~~Prescriptions for Persistent and Unresolved Acute Pain Where Continuity of Care is Anticipated.~~] Prescribers shall not be [~~obligation~~] ***obligated*** to prescribe opioids for more than 30 days, but if opioids are indicated and appropriate for persistent, unresolved acute pain that extends beyond a period of 30 days, the licensee shall conduct an in-office follow-up with the patient prior to issuing a new opioid prescription.

Med 502.05 Chronic Pain. If opioids are indicated and prescribed for chronic pain, prescribing licensees shall:

(a) Conduct and document a history and physical examination;

(b) Conduct and document a risk assessment, including, but not be limited to, the use of an evidence-based screening tool such as the Screener and Opioid Assessment for Patients with Pain (SOAPP);

(c) Document the prescription and rationale for all opioids according to Med 501.02(d) and (e);

(d) Prescribe for the lowest effective dose for a limited duration;

(e) Comply with all federal and state controlled substances laws, rules, and regulations;

(f) Utilize a written informed consent that explains the following risks associated with opioids:

(3) Addiction;

(4) Overdose and death;

(5) Physical dependence;

(6) Physical side effects;

(7) Hyperalgesia;

(8) Tolerance; and

(9) Crime victimization;

(g) Create and discuss a treatment plan with the patient. This shall include, but not be limited to the goals of treatment, in terms of pain management, restoration of function, safety, time course for treatment, and consideration of non-pharmacological modalities and non-opioid therapy. Informed consent documents and treatment agreements may be part of one document for the sake of convenience;

(h) Utilize a written treatment agreement that is included in the medical record, and specifies conduct that triggers the discontinuation or tapering of opioids;

(i) The treatment agreement shall also address, at a minimum, the following:

(1) The requirement of safe medication use and storage;

(2) The requirement of obtaining opioids from only one prescriber or practice;

(3) The consent to periodic and random drug testing; and

(4) The prescriber's responsibility to be available or to have clinical coverage available;

(j) Document the consideration of a consultation with an appropriate specialist in the following circumstances:

(1) When the patient receives a 100 mg morphine equivalent dose daily for longer than 90 days;

(2) When a patient is at high risk for abuse or addiction; or

(3) When a patient has a co-morbid psychiatric disorder;

(k) Reevaluate treatment plan and use of opioids at least twice a year;

(l) Require random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days. Unanticipated findings shall be addressed in a manner that supports the health of the patient;

(m) Have clinical coverage available for 24 hours per day, 7 days per week, to assist in the management of patients; and

(n) The prescriber may forego the requirements for a written treatment agreement and for periodic drug testing for patients:

(1) Who are residents in a long-term, non-rehabilitative nursing home facility where medications are administered by licensed staff; or

(2) Who are being treated for episodic intermittent pain and receiving no more than 50 dose units of opioids in a 3 month period.

Med 502.06 Prescription Drug Monitoring Program.

(a) Prescribers required to register with the program under RSA 318-B:31-40, or their delegate, shall query the prescription drug monitoring program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient's pain and then periodically and at least twice per year, except when:

(1) Controlled medications are to be administered to patients in a health care setting;

(2) The program is inaccessible or not functioning properly, due to an internal or external electronic issue; or

(3) An emergency department is experiencing a higher than normal patient volume such that querying the program database would materially delay care.

(b) A licensee shall document the exceptions described in (a)(2) and (3) above in the patient's medical record.

Med 502.07 Medication Assisted Treatment.

(a) Licensees who prescribe medication assisted treatment shall adhere to the principles outlined in the American Society of Addiction Medicine's National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015) found at http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline as cited in Appendix II.

Appendix I

Rule	Statute
Med 502	RSA 329:9, V and XV-a

Appendix II Incorporated References

Rule	Reference	Obtain at:
Med 502.07 (a)	The American Society of Addiction Medicine's "National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use," adopted on June 1, 2015.	No cost to download from: http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline

BOARD of NURSING: PART Nur 502 OPIOID PRESCRIBING

Nur 502.01 Applicability. This part shall apply to the prescribing of opioids for the treatment of non-cancer and non-terminal pain, and shall not apply to the supervised administration of opioids in a health care setting.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17

Nur 502.02 Noncompliance with Standards as Unprofessional Conduct. The ethical standards set forth in this part shall bind all licensees, and noncompliance with these standards shall constitute unprofessional conduct as used in NH RSA 326-B:37, II(h). The board shall investigate violations of these standards and impose disciplinary sanctions for such violation by following the disciplinary procedures set forth in Nur 402, and the hearings procedures in Nur 207.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17

Nur 502.03 Definitions. Except where the context makes another meaning manifest, the following words have the meanings indicated when used in this chapter:

(a) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It can be generally time-limited, often less than 3 months in duration;

(b) "Administer" means an act whereby a single dose of a drug is instilled into the body of, applied to the body of, or otherwise given to a person for immediate consumption or use;

(c) "Addiction" means a primary, chronic, neuro-biologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include impaired control over drug use, craving, compulsive use, or continued use despite harm. The term does not include physical dependence and tolerance, which are normal physiological consequences of extended opioid therapy for pain;

(d) "Chronic pain" means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that may require periodic treatment. For the purposes of these rules, chronic pain does not include pain from cancer or terminal disease;

(e) "Clinical coverage" means specified and prearranged coverage that is available 24 hours a day, 7 days a week, to assist in the management of patients with chronic pain;

(f) "Dose unit" means one pill, one capsule, one patch, or one liquid dose;

(g) "Medication-assisted treatment" means any treatment of opioid addiction that includes a medication, such as methadone, buprenorphine, or naltrexone, that is approved by the FDA for opioid detoxification or maintenance treatment;

(h) "Morphine equivalent dose (MED)" means a conversion of various opioids to a morphine equivalent dose by the use of board-approved conversion tables;

(i) "Prescription" means a verbal, written, facsimile, or electronically transmitted order for medications for self-administration by an individual patient;

(j) "Risk assessment" means a process for predicting a patient's likelihood of misusing or abusing opioids in order to develop and document a level of monitoring for that patient;

(k) " Treatment agreement" means a written agreement that outlines the joint responsibilities of Advanced Practice Registered Nurse (APRN) and patient; and

(l) "Treatment plan" means a written plan that reflects the particular benefits and risks of opioid use for each individual patient and establishes goals, expectations, methods, and time course for treatment.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17
(from Nur 502.02)

Nur 502.04 Acute Pain. If opioids are indicated and clinically appropriate for prescription for acute pain, prescribing licensees shall:

(a) Conduct and document a physical examination and history;

(b) Prescribe the lowest effective dose for a limited duration;

(c) Document the prescription and rationale for all opioids;

(d) Ensure that the patient has been provided information that contains the following:

(1) Risk of side effects, including addiction and overdose resulting in death;

(2) Risks of keeping unused medication;

(3) Options for safely securing and disposing of unused medication; and

(4) Danger in operating motor vehicle or heavy machinery;

(e) Comply with all federal and state controlled substance laws, rules and regulations;

(f) Conduct and document a risk assessment, such as the evidence-based screening tool Screener and Opioid Assessment for Patients with Pain (SOAPP);

(g) Document an appropriate treatment plan and consideration of non-pharmacological modalities and non-opioid therapy;

(h) Utilize a written informed consent that explains the following risks associated with opioids:

(1) Addiction;
(2) Overdose and death;
(3) Physical dependence;
(4) Physical side effects;
(5) Hyperalgesia;
(5) Tolerance; and
(6) Crime victimization;

(i) In an emergency department, urgent care setting, or walk-in clinic:

(1) Not prescribe more than the minimum amount of opioids medically necessary to treat the patient's medical condition. In most cases, an opioid prescription of 3 or fewer days is sufficient, but a licensee shall not prescribe for more than 7 days; and

(2) If prescribing an opioid for acute pain that exceeds a board-approved limit, document the medical condition and appropriate clinical rationale in the patient's medical record; and

(j) Not be obligated to prescribe opioids for more than 30 days, but if opioids are indicated and appropriate for persistent, unresolved acute pain that extends beyond a period of 30 days, the licensee shall conduct an in-office follow-up with the patient prior to issuing a new opioid prescription.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17
(from Nur 502.03)

Nur 502.05 Chronic Pain. If opioids are indicated and clinically appropriate for prescription for chronic pain, prescribing licensees shall:

(a) Conduct and document a history and physical examination;

(b) Conduct and document a risk assessment, including, but not limited to, the use of an evidence-based screening tool such as the Screener and Opioid Assessment for Patients with Pain (SOAPP);

(c) Document the prescription and rationale for all opioids;

(d) Prescribe for the lowest effective dose for a limited duration;

(e) Comply with all federal and state controlled substances laws, rules, and regulations;

(f) Utilize a written informed consent that explains the following risks associated with opioids:

(1) Addiction;
(2) Overdose and death;
(3) Physical dependence;
(4) Physical side effects;
(5) Hyperalgesia;
(6) Tolerance; and
(7) Crime victimization;

(g) Create and discuss a treatment plan with the patient. This shall include, but not be limited to the goals of treatment, in terms of pain management, restoration of function, safety, time course for treatment, and consideration of non-pharmacological modalities and non-opioid therapy. Informed consent documents and treatment agreements may be part of one document and for the sake of convenience;

(h) Utilize a written treatment agreement that is included in the medical record and specifies conduct that triggers the discontinuation or tapering of opioids;

(i) The treatment agreement shall also address, at a minimum, the following:

(1) The requirement of safe medication use and storage;
(2) The requirement of obtaining opioids from only one prescriber or practice;
(3) The consent to periodic and random drug testing; and
(4) The prescriber's responsibility to be available or to have clinical coverage available;

(j) Document the consideration of a consultation with an appropriate specialist in the following circumstances:

(1) When the patient receives a 100 mg morphine equivalent dose daily for longer than 90 days;
(2) When a patient is at high risk for abuse or addiction; or
(3) When a patient has a co-morbid psychiatric disorder;

(k) Reevaluate treatment plan and use of opioids at least twice a year;

(l) Require random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days. Unanticipated findings shall be addressed in a manner that supports the health of the patient; and

(m) Have clinical coverage available for 24 hours per day, 7 days per week, to assist in the management of patients; and

(n) The prescriber may forego the requirements for a written treatment agreement and for periodic drug testing for patients:

(1) Who are residents in a long term, non-rehabilitative nursing home facility where medications are administered by licensed staff; or

(2) Who are being treated for episodic, intermittent pain and receiving no more than 50 dose units of opioids in a 3 month period.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17 (from Nur 502.04)

Nur 502.06 Prescription Drug Monitoring Program.

(a) Prescribers required to register with the program under RSA 318-B:31-40, or their delegate, shall query the Prescription Drug Monitoring Program to obtain a history of schedule II-IV controlled substances dispensed to a patient, prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of this patient's pain and then periodically and at least twice per year, except when:

(1) Controlled medications are to be administered to patients in a health care setting;

(2) The program is inaccessible or not functioning properly, due to an internal or external electronic issue; or

(3) An emergency department is experiencing a higher than normal patient volume such that querying the program database would materially delay care.

(b) A licensee shall document the exceptions described in (a)(2) and (3) above in the patient's medical record.

Source. #11117, eff 6-9-16; ss by #12070, eff 1-1-17
(from Nur 502.05)

Nur 502.07 Medication Assisted Treatment. Licensees who prescribe medication assisted treatment shall adhere to the principles outlined in the American Society of Addiction Medicine's National Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015) found at http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline as cited in Appendix II.

Checklist for the Prescribing of Opioids for the Management or Treatment of Pain

Excludes cancer and terminal pain and does not apply to the supervised administration of opioids in a health care setting.

_____

Patient name & date

For ALL Pain (Acute and Chronic)

- ☐ Documented history and physical
- ☐ Complete Board approved risk assessment tool to determine patient appropriateness for opioids
- ☐ Treatment Plan that includes consideration of nonpharmacological modalities and non-opioid options for pain
- ☐ Lowest effective dose for fewest number of days
- ☐ Informed Consent outlining risks and benefits of opioid use
- ☐ Query the NH PDMP* (Prescription Drug Monitoring Program) Initial script: _____ (date)
  Prescriber may want to print the PDMP query results/screen shot for the medical record

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

Acute Pain

- ☐ Document opioid prescription and rationale
- ☐ Prescription limited to 7 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 30 days; however, if unresolved acute pain persists beyond 30 days, requires an in-office, follow-up appointment _____ prior to issuing a new script.
  (date)

Chronic Pain

- ☐ Written Treatment Agreement **
- ☐ Consideration of pain consultation for patients receiving 100mg morphine equivalent daily dose > 90 days
- ☐ Reevaluate Treatment Plan and use of opioids at least twice per year: _____ (date) _____ (date)
- ☐ Re-check PDMP, at least twice per year: _____ (date) _____ (date)
- ☐ Urine Drug Screens ** at least annually for patients taking opioids > 90 days:
  _____ (date) _____ (date)

** Not required for patients in long-term, non-rehab facility when opioid is administered or for patients with episodic intermittent pain receiving no more than 50 dose units in a 3 month period.

NH RSA 318-B:41 Rulemaking for Prescribing Controlled Drugs
Administrative Rules Med 502 Opioid Prescribing

Bill as Introduced

HB 638 - AS INTRODUCED

2019 SESSION

19-0746
01/05

HOUSE BILL ***638***

AN ACT requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

SPONSORS: Rep. Janigian, Rock. 8; Rep. Gay, Rock. 8; Rep. Marsh, Carr. 8; Sen. Rosenwald, Dist 13

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill requires health care providers to require patients to sign a form upon dispensing controlled drugs explaining the addictive nature of such drugs.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 638 - AS INTRODUCED

19-0746
01/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT requiring health care providers to provide an opioid disclosure form to patients for whom an opioid is prescribed.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Intent. The general court hereby recognizes that the opioid crisis continues to grip our communities. Many persons become addicted after being prescribed opioid pain killers by their health care provider for an injury they have sustained. Patients are often given a choice to take an alternative pain killer or the opioid pain killer the health care provider has prescribed. This may give the patient a false sense of security that either is fine to take. Unfortunately, depending on the patient, he or she may become addicted to the opioid that was prescribed.

2 New Section; Controlled Drug Act; Opioid Disclosure. Amend RSA 318-B by inserting after section 1-c the following new section:

318-B:1-d Disclosure Form for Opioid Prescriptions. Licensed health care providers shall require patients to sign a disclosure form informing the patient that taking opioid drugs could possibly lead to addiction and that such drugs should only be taken if pain is severe. If the patient may be able to use an alternative medication, the form shall include a statement to that effect and that it would be a preferable course of action. The form required under this section may be used to satisfy the requirements of RSA 318-B:41, II(a)(5). The commissioner may adopt rules, pursuant to RSA 541-A, relative to the form and content of the form required under this section.

3 Effective Date. This act shall take effect 60 days after its passage.