30-GH1021\O.1
Bruce
4/25/17

AMENDMENT #1

OFFERED IN THE HOUSE BY REPRESENTATIVE FOSTER

TO: CSHB 159(HSS)

Page 11, line 3:

Delete "**for every 40 hours of education received**"

Insert "**in the two years preceding an application for renewal of a license**"

30-GH1021\O.5
Bruce
5/4/17

AMENDMENT #2

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 159(HSS)

Page 1, following line 9:

Insert a new bill section to read:

"* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT. It is the intent of the legislature that the seven-day supply limit for an initial opioid prescription under secs. 5, 16, and 22 of this Act may not be considered as a minimum length of time appropriate for an initial prescription. The United States Centers for Disease Control and Prevention guidelines state that a three-day initial prescription of an opioid is sufficient for most cases of acute pain. The United States Centers for Disease Control and Prevention reported in its March 17, 2017, weekly report that the likelihood of a person's chronic opioid use increases with each additional day of medication supplied after the second day. Practitioners should use their professional judgment in each case and not interpret the seven-day limit as a direction to prescribe the full seven days."

Page 1, line 10:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly.

Page 34, line 10:

Delete "secs. 31 and 42"

Insert "secs. 32 and 43"

Page 34, line 16:
Delete "sec. 34"
Insert "sec. 35"

Page 34, line 17:
Delete "sec. 39"
Insert "sec. 40"

Page 34, line 19:
Delete "secs. 34 and 39"
Insert "secs. 35 and 40"

Page 34, line 24:
Delete "secs. 1 and 2"
Insert "secs. 2 and 3"

Page 34, line 26:
Delete "secs. 1 and 2"
Insert "secs. 2 and 3"

Page 34, line 28:
Delete "secs. 6 - 13"
Insert "secs. 7 - 14"

Page 34, line 30:
Delete "secs. 6 - 13"
Insert "secs. 7 - 14"

Page 35, line 1:
Delete "secs. 18 and 20"

Insert "secs. 19 and 21"

Page 35, line 3:
Delete "secs. 18 and 20"
Insert "secs. 19 and 21"

Page 35, line 5:
Delete "secs. 23 - 25"
Insert "secs. 24 - 26"

Page 35, line 7:
Delete "secs. 23 - 25"
Insert "secs. 24 - 26"

Page 35, line 8:
Delete "Section 27"
Insert "Section 28"

Page 35, line 10:
Delete "Section 32"
Insert "Section 33"

Page 35, line 12:
Delete "Section 33"
Insert "Section 34"

Page 35, line 14:
Delete "Section 35"
Insert "Section 36"

Page 35, line 16:

Delete "Section 36"
Insert "Section 37"

Page 35, line 18:
Delete "Sections 37 and 38"
Insert "Sections 38 and 39"

Page 35, line 20:
Delete "Section 41"
Insert "Section 42"

Page 35, line 22:
Delete "Section 1, 2, 6 - 13, 18, 20, 23 - 25, 34, and 39"
Insert "Sections 2, 3, 7 - 14, 19, 21, 24 - 26, 35, and 40"

Page 35, line 24:
Delete "Sections 31 and 42"
Insert "Sections 32 and 43"

Page 35, line 25:
Delete "secs. 45 - 53"
Insert "secs. 46 - 54"

THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services
OFFICE OF THE COMMISSIONER

Anchorage
3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

Juneau
350 Main Street, Suite 404
Juneau, Alaska 99801-1149
Main: 907.465.3030
Fax: 907.465.3068

May 1, 2017

The Honorable Paul Seaton
House of Representatives
Alaska State Capitol
Room 505
Juneau, AK 99801

Dear Representative Seaton:

Thank you for sharing with me your questions regarding House Bill 159, Opioids; Prescriptions; Licenses; Databases, following the bill's hearing in House Finance on April 27, 2017. Below are responses to these questions, assembled with the help of my colleagues at the Departments of Law and Commerce, Community and Economic Development:

Question 1: The Centers for Disease Control (CDC)guidelines (members have a copy) state that opioid treatment for acute pain will rarely require more than three days' prescription, so physicians should not feel obligated to prescribe opioids for a full seven days.

(a) Would you be comfortable with intent language that would reference the CDC guidelines to clarify that the seven-day limit in the bill is not intended to suggest that opioids be prescribed for all seven days?

Yes, we would be comfortable with such intent language as it is consistent with the bill's goal of keeping amounts of opioids prescribed as low as possible to meet clinical need, while also providing flexibility for the professional judgment of providers.

(b) Would the intent language we are thinking about already be covered by opioid prescription guidelines that have been issued by the licensing board?

The only licensing board that has articulated controlled substance prescribing guidelines is the Board of Examiners in Optometry, which in AS 08.72.272 prohibits optometrists from prescribing a quantity that exceeds four days. Other prescribing boards require licensees to follow generally accepted standards of safe practice. Certain licensing boards are reviewing and adopting recommended prescriptive guidelines; however, none have been codified in regulation.

Question 2: As part of the continuing education (CE), what are your thoughts on requiring education on alternative pain management options?

The bill intends to encourage continuing education for all health care providers to improve basic knowledge of pain management practices and the basics of addiction medicine in order to advance patient safety and improve quality of care for persons with addictions or in recovery without being overly proscriptive. A number of clinical guidelines for chronic pain, including those from the American College of Physicians and the Centers for Disease Control and Prevention, now encourage non-pharmaceutical management.

Question 3: Bill includes a non-opioid directive for patients that do not want to be prescribed opioids along with a hold-harmless clause for the attending physicians. According to the bill a guardian of a patient may retract the directive, but cannot institute the directive.

You are correct that the bill as drafted provides that a guardian can revoke but not execute a directive. We drafted it this way with these thoughts in mind:

- Power to revoke a directive is premised upon those situations where there is catastrophic illness or injury where the person is unable to say whether they would want to revoke the directive.
- Power to not execute a directive is premised upon similar provision under AS 13.26.301, which limits a guardian's ability to act on behalf of a ward in limited circumstances related to health care. The thinking is that this type of decision should not be left solely to the guardian.

(a) Does this impact parental rights for those under the age of 18?

No, parental rights as to medical treatment for their children, including consent are not changed by this legislation.

(b) Can a parent issue a directive for their child?

Technically as drafted the directive would not be available to a parent; but a parent could discuss treatment options, including declining an opioid prescription at the time of treatment.

(c) Can a parent refuse opioids for their child at the time of treatment?

Yes, this would be done in consultation with a provider at the time treatment is discussed.

Question 4: Definitions - (back up attached). The definitions are outdated and have not been updated since 1993. Rather than updating the entire chapter I would like to update the name of the board from "National Board of Osteopathic Physicians and Surgeons" to "National Board of Osteopathic Medical Examiners." Do you see any problem with this name change?

Amending AS 08.64.205(3) would be detrimental to licensure of osteopaths in Alaska. The current licensure examination that is administered by NBOME is authorized under 08.64.210, which gives the Board the authority to specify exam requirements, satisfying the first part of that subsection. The second part allows for an alternative - being certified to practice by that older organization. Although that organization has been reorganized, and may no longer issue certifications, there may still be osteopaths practicing in Alaska that would want to apply under that provision.

Once again, thank you for your questions. We look forward to continued discussion on this important piece of legislation.

Sincerely,

Jay C. Butler M.D.
Chief Medical Officer

CC: Darwin Peterson, Legislative Director, Office of Governor Bill Walker
Valerie Nurr'araaluk Davidson, Commissioner, Department of Health & Social Service
Sara Chambers, Deputy Director, Division of Corporations, Business & Professional Licensing, Department of Commerce, Community & Economic Development
Stacie Kraly, Chief Assistant Attorney General, Department of Law

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

30-GH1021\O.6
Bruce
5/4/17

AMENDMENT #3

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 159(HSS)

Page 8, line 27, following "Surgeons":

Insert "**or by the National Board of Osteopathic Medical Examiners**"

30-GH1021\O.7
Bruce
5/9/17

AMENDMENT #4

OFFERED IN THE HOUSE BY REPRESENTATIVE SEATON

TO: CSHB 159(HSS)

Page 26, line 10, following "older":

Insert "or an emancipated minor, a parent or legal guardian of a minor, or an individual's guardian or other person appointed by the individual or a court to manage the individual's health care"

Page 26, line 12, following "individual":

Insert "or the minor"

Page 26, line 18, following "individual":

Insert ", a parent or legal guardian of a minor, or an individual's guardian or other person appointed by the individual or a court to manage the individual's health care"

Page 26, lines 24 - 30:

Delete all material and insert:

"(c) An individual who is 18 years of age or older or an emancipated minor, a parent or legal guardian of a minor, or an individual's guardian or other person appointed by the individual or a court to manage the individual's health care may revoke a voluntary nonopioid directive at any time in writing or orally."

Page 26, line 31, following "individual":

Insert ", a parent or legal guardian of a minor, or an individual's guardian or other person appointed by the individual or a court to manage the individual's health care"

Page 27, line 7:

Delete "who has executed"

Insert "or a minor who has"

Page 27, line 11:

Delete "a controlled substance"

Insert "an opioid"

Following "individual's":

Insert "or a minor's"

Page 27, following line 24:

Insert a new paragraph to read:

"(2) "emancipated minor" means a minor whose disabilities have been removed for general purposes under AS 09.55.590;"

Renumber the following paragraphs accordingly.

Page 27, following line 26:

Insert a new paragraph to read:

"(5) "minor" means an individual who is under 18 years of age and is unemancipated;"

Renumber the following paragraphs accordingly.