

FACTSHEET: New Hampshire's Oversight of Opioid Prescribing and Monitoring of Opioid Use

POLICIES AND PROCEDURES

State laws, regulations, guidance, and policies related to oversight of opioid prescribing and monitoring of opioid use (e.g., policies for prescribing opioids).

State-wide Laws, Regulations, and Guidance Related to Opioids

- The Office of Professional Licensure and Certification (OPLC) is responsible for implementing and administering laws related to opioid prescribing. OPLC encompasses the various licensing boards charged with overseeing providers with prescribing authority, including the Board of Dental Examiners, Board of Medicine, Board of Nursing, and Board of Pharmacy. These regulatory boards created and adopted administrative rules for opioid prescribing.
 - House Bill 1423, effective June 2016, requires Board of Dental Examiners, Board of Medicine, Board of Nursing and other boards that fall under the OPLC to adopt rules for the prescribing of controlled substances. This bill contains mandatory standards for the management or treatment of acute and chronic pain. There are exemptions for cancer patients, patients with terminal illness and long-term nonrehabilitative residents of a nursing home facility.
 - The administrative rules on opioid prescribing issued by each regulatory board requires the prescribing provider to document the consideration of nonpharmacological modalities and nonopioid therapy, and an appropriate pain treatment plan which includes the type of drug, the dosage, and the duration of the prescription.
- The New Hampshire Controlled Drug Act, effective January 1, 2009, states, “No prescription shall be filled for more than a 34-day supply upon any single filling for controlled drugs of schedules II or III.” The law does not limit the dosage amount that can be prescribed. The statute in effect prior to this date for an opioid prescription was “34-day supply or 100 dosage units,” whichever is less. The State follows Federal regulations for who can prescribe and specifies how prescriptions for controlled substances are to be issued.
- Senate Bill 158, effective August 2017, declares that if substance use disorder (SUD) services are a covered benefit under a managed care health benefit plan, a health carrier that has authorized or approved medication-assisted treatment (MAT) for such

This factsheet shows New Hampshire's responses to our questionnaire covering five categories related to opioids:

- Policies and Procedures
- Data Analytics
- Outreach
- Programs
- Other

This information is current as of November 2018. See page 15 for a list of State entities involved with oversight of opioid prescribing and monitoring of opioid use. See page 16 for a glossary of terms used in this factsheet.



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services shall not require a renewal of a prior authorization more frequently than once every 12 months.

- The Boards of Licensure have implemented administrative rules for opioid prescribing that are aligned with the Centers for Disease Control (CDC) guidelines, which require the prescriber to:
 - consider nonpharmacological modalities and nonopioid therapies,
 - discuss associated risks with opioid therapy,
 - prescribe minimum amount and lowest dose necessary to treat the patient's condition,
 - check Prescription Drug Monitoring Program (PDMP) prior to prescribing an initial opioid prescription and at least twice a year thereafter, and
 - require random periodic urine drug screens.
- House Bill 270, effective September 2015, provides immunity from arrest, prosecution, or conviction for a person who, in good faith and in a timely manner, requests medical assistance for someone who is experiencing a drug overdose or for themselves if they are experiencing a drug overdose. House Bill 545, effective August 2017, repealed the 3-year sunset provision of this bill.

Medicaid Policies Related to Opioids

- The State has the following Medicaid policies and procedures related to opioids:
 - Medicaid fee for service (FFS) requires prior authorization for long-acting narcotics and methadone when prescribed for pain. Methadone administered at a licensed opioid treatment program (OTP) does not require prior authorization.
 - Medicaid FFS and the Medicaid managed care organizations (MCO) have a dosage accumulation edit built into the claim payment system that monitors the daily morphine milligram equivalent (MME) dose. The policy requires any beneficiary that reaches a daily MME of 100 milligrams or more to receive prior authorization to continue with that dose. Prior authorization is used to ensure prescribed medications are medically necessary and clinically appropriate.
- A SUD benefit has been available to the State's Medicaid FFS plan or managed care populations since July 1, 2016, and includes:
 - screening by behavioral health practitioner for an SUD;
 - screening, brief intervention, and referral to treatment (SBIRT);
 - crisis intervention services provided in an office or community setting;
 - evaluation to determine the level of care and other services needed;
 - medically managed withdrawal management in a hospital setting;
 - medically monitored withdrawal management in an ambulatory or nonhospital residential setting;



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- opioid treatment program: methadone or buprenorphine treatment in a clinic setting;
 - MAT in a physician's office provided in conjunction with other SUD counseling services;
 - outpatient counseling: individual, group, or family counseling for SUDs;
 - intensive outpatient: individual and group treatment and recovery support services provided at least 9 hours per week for adults or 6 hours per week for adolescents;
 - partial hospitalization: individual and group treatment and recovery support services for SUD and cooccurring mental health disorders provided at least 20 hours per week;
 - low, medium, and high intensity residential treatment;
 - recovery support services: community-based peer and nonpeer recovery support services provided in a group or individual setting; and
 - case management: continuous recovery monitoring.
- In 2014, the State expanded its Medicaid population for low income adults by establishing the New Hampshire Health Protection Program (NHHPP), an estimated one in six of whom have extensive mental health or SUD needs. Through the program, the State used Medicaid funds to purchase private insurance for eligible individuals (premium assistance). The State received Federal approval to transition to Medicaid Care Management through a section 1115 demonstration waiver which expires on December 31, 2018 (approximately 53,000 residents covered).
 - Senate Bill 313, enacted June 2018, created a new program called the Granite Advantage Health Care Program which will enroll NHHPP participants in the State's Medicaid Care Management program, beginning January 1, 2019. The Granite Advantage Health Care Program will be implemented by extending and amending the current NHHPP waiver for 5 years, through December 31, 2023.
 - Individuals eligible for the NHHPP Premium Assistance/Granite Advantage Health Care Program are adults with incomes up to 138 percent of the poverty level who are eligible for Medicaid under the Affordable Care Act, are 19 to 64 years old, not pregnant at the time of application, not entitled to or enrolled in Medicare, and not in any other "mandatory Medicaid eligible group." Certain Medicaid expansion adults must participate for greater than or equal to 100 hours per calendar month in work or community service.



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Laws, Regulations, and Guidance on Prescription Drug Monitoring Program Data

- The Controlled Drug Prescription Health and Safety Program, which includes the PDMP was established in 2012.
- According to New Hampshire Revised Statutes 318-B:35, the State can only share PDMP data as follows:
 - The State shares data with other States to identify doctor shopping. The participating states are Maine, Vermont, Massachusetts, Rhode Island, Connecticut, New Jersey, New York and Delaware.
 - The State can only share data with law enforcement when they present a request for information signed by a judge (i.e., court order).

Laws, Regulations, and Guidance Related to Treatment

- The State's approved application for the state opioid response grant through the Substance Abuse and Mental Health Services Administration (SAMHSA) will expand the MAT trainings to increase the number of Drug Addiction Treatment Act waived prescribers in the State and implement a tracking system of those trained to ensure that trained individuals are prescribing and encouraged to serve up to the maximum patient limits.
- The New Hampshire Department of Health and Human Services (DHHS) and Bureau of Drug and Alcohol Services (BDAS) convened a panel of practitioners from health care, behavioral health, specialty SUD treatment services, and the State's Medical Society. This panel reviewed existing MAT models in New Hampshire and other States to identify key components and best practices for the development of a compendium of recommendations and resources for initiating and expanding MAT capacity to serve more patients with opioid use disorders (OUDs). This document is not intended to replace best practice resources, such as the American Society of Addiction Medicine's practice guidelines. The goals of this panel and resulting compendium are to:
 - increase the number of waived buprenorphine prescribers;
 - increase office-based access to MAT programs through multiple settings, including primary care, offices and clinics, specialty MAT programs;
 - increase awareness of, and access to, extended-release injectable naltrexone and other medications by prescription; and
 - include a focus on medications such as buprenorphine (e.g., Suboxone, Subutex, Zubsolv, Bunavail, Probuphine, Sublocade) and naltrexone (extended-release injectable/depot/XR-NTX: Vivitrol) that may be prescribed in an office-based setting, unlike methadone, which per Federal regulation must be dispensed at certified opioid treatment programs.



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Laws, Regulations, and Guidance on Naloxone

- House Bill 271, effective June 2015, allows pharmacists to dispense opioid antagonists such as naloxone, pursuant to a standing order, to individuals at risk of an opioid overdose or to friends or family members of individuals at risk.
- HB 271 also protects health care professionals and others from criminal, civil liability and professional disciplinary action if they act in good faith and with reasonable care when helping a person they believe is suffering from an opioid-related overdose.
- In 2015, the State launched the “Anyone, Anytime” campaign, which included creation of guidance on naloxone distribution and use. There are four ways New Hampshire residents can get naloxone kits for themselves or someone else:
 - purchase naloxone at a pharmacy using a prescription written by a physician or any licensed prescriber;
 - buy naloxone at a pharmacy, which uses standing orders;
 - receive free kits if the person is (1) a client of a State-contracted health center or treatment provider, (2) at risk for opioid overdose, and (3) does not have insurance that covers the cost or cannot afford to purchase naloxone; or
 - if the person is at risk for opioid overdose and does not have insurance that covers the cost or cannot afford to purchase naloxone, the person may attend an event held by a Regional Public Health Network where the State's free kits are distributed.

DATA ANALYTICS

Data analysis that the State performs related to opioid prescribing and monitoring of opioid use (e.g., analyzing data to determine the number of opioid prescriptions written by providers to detect high-prescribing providers).

- The State performs data analytics related to opioid prescribing:
 - DHHS has periodically analyzed opioid prescribing in the Medicaid FFS and the Medicaid MCO populations.
 - DHHS analysis has focused on member use rates by drug, strength (daily MME dose), supply (days in prescription and annual), and frequency of prescriptions (number in year), and demographics (type of Medicaid and poverty level).
 - Additionally, provider-based reporting has been performed on a pilot basis.
 - DHHS also collects relevant Healthcare Effectiveness Data and Information Set (HEDIS) measures from its Medicaid MCOs.
 - DHHS will use Federal opioid response funding to enhance its data reporting. Specifically, it will be using the State Opioid Response grant to increase data reporting to SAMHSA and will be using CDC opioid funding to integrate data and develop analytic dashboards.



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- The Office of Quality Assurance and Improvement (OQAI) is responsible for data analytics.
 - OQAI performs analysis of Medicaid claims data and Medicaid MCO submitted data.
 - DHHS uses data analytics to monitor policy implementations.
 - Action taken related to the pharmacies, providers, or beneficiaries identified as a result of the data analytics is used to identify the impact of prior authorization policy changes.
- In 2017, the Opioid Task Force completed a process identifying and prioritizing potential action strategies to reduce opioid-related harm in New Hampshire.
- The Medicaid MCOs are required to perform data analytics related to opioids. Specifically, the MCOs:
 - are required to calculate the new opioid related HEDIS measures,
 - use the data for care management, and
 - are required to share new HEDIS measures (the State expects to monitor the new measures relative to policies).
- The Governor's Commission on Alcohol and Drug Use Prevention, Treatment, and Recovery publishes midyear and yearly reports that provides data analytics on:
 - Funding statistics, clinical treatment service outcomes and infrastructure development, the PDMP, peer recovery support services, family peer support services, prevention services, public information campaigns, and other topics.

OUTREACH

Outreach that the State provides related to preventing potential opioid misuse (e.g., opioid-related training for providers).

Outreach to Providers

- The State's Health Alert Network emails and faxes healthcare providers, health departments, and others with important and timely messages on important health topics such as opioid treatment.
- The State distributes additional communications, such as publications, mailings, and bulletins in the form of public service announcements and BDAS website postings.
- The State provides optional training through the BDAS. DHHS and BDAS provide free introductory-level workshops designed for people working in any helping professions whose daily work engages people with SUDs. These organizations also provide advanced training via the New Hampshire Training Institute in Addictive Disorders.



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- The State makes available an expanded array of training and professional opportunities to build on current resources from the Department of Education, the Training Institute on Addictive Disorders, The Center of Excellence in Substance Use Disorders, and other State partners, licensing boards, and departments.

Outreach to Patients

- The State established a State-wide Addiction Crisis Line (1-844-711-HELP) to help individuals find treatment providers and developed a guidance document on best practices related to MAT. Additional online options include:
 - nhtreatment.org,
 - dhhs.nh.gov/dcbcs/bdas/index.htm, and
 - drugfreenh.org.
- The State provides naloxone kits to providers at their request and through Public Health sponsored community events to beneficiaries or those requesting them.
- The administrative rules on opioid prescribing require that providers ensure that the patient has been provided information that contains the following:
 - risk of side effects, including addiction and overdose resulting in death;
 - risks of keeping unused medication;
 - options for safely securing and disposing of unused medication; and
 - danger in operating motor vehicle or heavy machinery.
- The State uses a written informed consent that explains the following risks associated with opioids:
 - addiction,
 - overdose and death,
 - physical dependence,
 - physical side effects,
 - hyperalgesia,
 - tolerance, and
 - crime victimization.



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PROGRAMS

State programs related to opioids (e.g., opioid-use-disorder treatment programs).

Prevention Programs

- Per the State's Guidance Document on Medication Assisted Treatment Best Practices and the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment, the State strives to focus SUD control initiatives on early identification and overdose prevention using the SBIRT approach at community health centers. SBIRT is an evidence-based practice that has been shown to have a measurable impact on reducing high-risk alcohol and other drug misuse and on increasing utilization of treatment and recovery programs. SBIRT is endorsed by the National Registry of Evidence-based Programs and Practices. Although some service delivery systems, such as the State's community mental health system, conduct brief alcohol and drug screenings of all clients, universal screening is not yet a widespread practice. Attention will be given within other care systems, such as the community health center system and hospital emergency rooms, to implement screening and appropriate interventions more broadly.
- Board of Pharmacy guidelines, and other State laws and regulations, allow drop boxes in certain locations for beneficiaries to discard their unused medication.
- The State has an evaluation system for the effectiveness of opioid-related programs.
 - House Bill 1626 requires DHHS to report on the relative cost effectiveness and outcomes of programs funded in whole or in part by the governor's commission.
 - The State performs compliance audits on its contracted service providers.

Detection Programs

Prescription Drug Monitoring Program

- The PDMP is a web-based data system that contains information on controlled prescription medications dispensed by New Hampshire licensed retail pharmacies and other dispensers. The program monitors controlled drug prescriptions (U.S. Drug Enforcement Administration (DEA) Schedules II through IV) and provides New Hampshire licensed prescribers and dispensers a valuable tool to:
 - improve clinical decision making and patient care in managing their health and prescriptions,
 - promote public health and safety through the prevention and treatment for misuse of controlled substances and assist in the reduction of the diversion of controlled substances.



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- The State uses its PDMP to collect data on controlled prescriptions (schedule II, III, and IV) dispensed in the State and that data is made available to practitioners (prescribers and dispensers) to review to assess and assist in managing the care of their patients.
 - There is a requirement for prescribers to check the PDMP prior to prescribing a schedule II, III, or IV opioid for the treatment and management of pain.
 - Prescribers (e.g., physicians, physician assistants, and dentists) and dispensers (e.g., pharmacist or prescriber delegates) have direct access to the PDMP.
 - Regulatory boards, law enforcement with a court order, and patients have indirect access to the data (must request the information).
 - DHHS does not have access to the PDMP data.
- The Board of Medicine requires that DEA licensed prescribers register with the PDMP and are required to complete 3 contact hours every 2 years of free regulatory-board approved online continuing education or pass an online application in the areas of pain management and addiction disorders.
- Based on recommendations in a performance audit report, the State is making improvements to the PDMP. For example, the audit report recommended developing criteria for reviewing PDMP data, reporting matters for further investigation, and notifying practitioners of concerns.

Lock-In Program

- The State uses a “lock-in” program to restrict recipients who over utilize Medicaid services.
- Beneficiaries that meet lock-in criteria are initially locked into one pharmacy for 12 months. Within the last 3 months of the initial lock-in period, the State determines whether the recipient will be released or continue enrollment in the lock-in program.

Opioid-Use-Disorder Treatment Programs

- The State has several SUD treatment programs. All State-funded programs are required to facilitate onsite access to, or outside referral to, MAT for individuals with OUD if deemed clinically appropriate.
 - There are providers that offer outpatient SUD program services. Some of the services provided are partial hospitalization services, crisis intervention, and continuous recovery monitoring.
 - Of these providers, some also offer comprehensive SUD program services. These programs offer both residential and outpatient services. Some of the services are medically monitored withdrawal management; individual, group, and family



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- substance use counseling; and low, medium, and high residential treatment services.
- The State also has nine opioid treatment programs (methadone clinics). The methadone clinics dispense methadone, buprenorphine, and provide drug testing and counseling services.
- Medicaid pays for MAT and peer to peer counseling.
- The State uses SAMHSA grants and the State General Fund to cover treatment and recovery services, including MAT and peer services for individuals who are not insured or are underinsured for the needed service. (SAMHSA funds totaled \$9.8 million for various project periods, September 2016 through August 2019.)
- At the local level, the Manchester and Nashua Fire Departments operate a Safe Station Program in response to the opioid crisis.
 - Fire department personnel quickly assess each walk-in's vital signs to determine the level of medical attention needed.
 - Those seeking treatment are escorted directly to a SUD treatment facility located near the fire station.
 - Since its inception, this innovative program has treated more than 2,000 people in Manchester and more than 1,300 in Nashua.

OTHER

Other State activities related to opioids that are not covered by the other categories in this factsheet.

- New Hampshire has the following Medicaid Waivers and State Plan Amendment related to opioids:
 - As part of its overall approach to addressing the SUD crisis, DHHS applied for and received a 5-year section 1115(a) Demonstration Waiver for SUD treatment and recovery access. This waiver will enable the DHHS to reimburse residential SUD treatment providers with more than 16 beds for Medicaid covered clients. The services proposed will include those that are in alignment with the existing SUD delivery system for residential treatment and expand availability of services for individuals who also have mental health disorders. The adolescent residential treatment program outlined in the waiver is anticipated to begin operations in the fall of 2018 and will allow for 36 beds to serve as residential treatment for individuals 18 and under.
 - DHHS applied for and received in 2016 a 5-year section 1115(a) Demonstration Waiver entitled "Building Capacity for Transformation," which is intended to reform the State behavioral health care system through a State-wide network of regionally based Integrated Delivery Networks (IDN). The IDNs will help the



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State to (1) integrate physical and behavioral health for “whole person” care; (2) expand capacity to address behavioral health issues in appropriate settings; (3) develop new expertise to address the current crises; and (4) reduce gaps in care during transitions through improved care coordination. The State views this demonstration as a vital next-step in behavioral health reformation post-Medicaid expansion under the Patient Protection and Affordable Care Act.

- The 5-year demonstration will operate between January 5, 2016, and December 31, 2020. The State expects the demonstration to affect 140,000 Medicaid beneficiaries. The demonstration does not change Medicaid eligibility and all affected groups will continue to derive their eligibility through the Medicaid State plan and receive benefits and services as they do today, but in a more coordinated fashion. Delivery System Reform Incentive Payment (DSRIP) program funding will enable the State to make performance-based funding to these regionally-IDNs that furnish Medicaid services. The goal of the IDN coalitions is to incentivize the providers to work together to achieve the State’s delivery system transformation and improve health outcomes.
- CMS approved a 1915(i) State Plan Amendment (SPA) in 2018 entitled, “Home and Community Based Care for High Risk Children With Severe Emotional Disturbance.” The goal of this SPA is to meet the needs of children and young adults, many of which have family members with SUD, so they can be more successful in the home, community, and school. An additional benefit is that the child will not be using hospital level of care or going into the child protection and juvenile justice systems. Examples of care include medication and other treatments that may be necessary to stabilize and effectively treat the symptoms the children and youth may be experiencing.
- The State strives to implement additional programs and regulations, and to acquire additional funding to combat the opioid crisis. For example:
 - In fall 2018, the State received a \$46 million SAMHSA State Opioid Response Grant designed to increase options for prevention, treatment, and recovery services. Types of services include MAT, housing, telehealth, peer recovery support services, care coordination, and support services that include transportation, childcare, and overall care coordination.
 - The opioid epidemic continues to have devastating consequences for children and families. One of these consequences is the breakdown of parental protective capacity and the resulting involvement with the child protection agency. Internal Division for Children, Youth, and Families (DCYF) data show that the number of children removed annually from parental care increased by 128 percent between 2010 and 2017, from 302 to 688. In 2017, 461 (67 percent) of the removals had substance misuse as a risk factor. That is up from 44 percent in 2010. When a child is removed from the home and placed in out-of-home care,



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the State prefers to place the child with relatives because the child tends to benefit from maintaining connections with his or her family. In this way, DCYF seeks to prevent placement in foster care. Many relatives, especially grandparents, have stepped forward to care for children when their parents cannot. The percentage of children removed from home but living with a relative increased from 23 percent to 33 percent from 2012 to 2016.

- Understanding and meeting the needs of grandparents raising grandchildren is important to help stabilize children who have been affected by parental opioid use. To that end, the State has taken the following steps:
 - In June 2017, established a Grand Families Study Commission to review data on grandparents taking over parenting role to study their needs and to recommend strategies and services to meet those needs.
 - DCYF developed a *Resource Guide for New Hampshire Relative Caregivers* to guide grandparents and other relatives in finding the benefits and resources available to children and their caregivers (available at <https://www.dhhs.nh.gov/dcyf/documents/relativecaregivers.pdf>).
 - DCYF also applied for a “Kinship Navigator” grant to build greater capacity in this area.
- Additional regulations are in the process of being developed to enhance State offerings for quality coverage and access for SUD treatment. The rules include:
 - Medicaid service updates and
 - the BDAS’ formulation of program rules to establish a certification process for the overall SUD treatment system and to create standards and revise licensing requirements for SUD residential treatment facilities.
- The staff at the State’s Office of Chief Medical Examiner (OCME) compiles the drug overdose death data, updates it monthly, and distributes it to over 250 local, State and federal agencies as well as numerous media outlets. According to the OCME:
 - In 2013, heroin deaths in the State almost doubled from the previous year. In 2014, the State had another sharp increase in heroin deaths. In the following years, the deaths from heroin started to drop off as the deaths from fentanyl went up.
 - The drug driving the increase in overdose deaths for the past few years has been fentanyl. Fentanyl is a pharmaceutical drug but the fentanyl found at most death scenes is not the prescription medication. According to law enforcement, the type of fentanyl involved with most of the State’s deaths is produced in illicit labs in Mexico and China. There were over 600 fentanyl deaths during the last 2 years.
 - The State has also seen over 80 deaths in the last biennial where fentanyl analogues caused or contributed to the death. Fentanyl analogues are drugs that are chemically similar to fentanyl and affect the human body similarly, but chemists have adjusted the molecular structure so that they do not fall within



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the class of drugs that are scheduled by the Drug Enforcement Agency. Furanyl fentanyl, fluoro-fentanyl, U-47700, and acetyl fentanyl were the analogues seen in New Hampshire.

- The OCMCE reported that approximately 88 percent of all known drug overdose deaths in 2017 are related to opioid overdoses and about 75 percent of all overdose deaths have involved fentanyl.
- The State's Attorney General (AG) is proceeding with actions against opioid pharmaceutical companies.
 - In 2015, the AG initiated a consumer protection suit against OxyContin maker Purdue Pharma for deceptive marketing and business practices by, among other things, significantly downplaying the serious risk of addiction posed by OxyContin and other products, overstating the efficacy of chronic opioid therapy, falsely claiming that its product is tamper resistant and thereby nearly impossible to abuse, and failing to report instances of suspicious dispensing of its products, as required by law.
 - In 2016, the AG joined a 41 State antitrust lawsuit against the makers of opioid treatment brand name drug Suboxone over allegations that the companies engaged in a scheme to block generic competitors and caused purchasers to pay artificially high prices. The States accuse Reckitt Benckiser pharmaceuticals, now known as Indivior, of (1) conspiring with MonoSol Rx to switch Suboxone from a tablet version to a film (that dissolves in the mouth) to prevent or delay generic alternatives and maintain monopoly profits and (2) violating State and federal antitrust laws. The attorney general alleges that consumers have paid artificially high monopoly prices since late 2009, when generic alternatives of Suboxone might otherwise have become available. During that time, annual sales of Suboxone topped \$1 billion.
- In recent years, the State expanded its Department of Justice with "Problem-Solving Courts." These treatment courts combine community-based treatment programs with strict court supervision, progressive incentives, and sanctions. These treatment court programs are designed to promote compliance with treatment programs as an alternative to jail time.
- The State Department of Safety (DOS) administers programs such as:
 - Operation Granite Hammer: The Division of State Police Investigative Services Bureau, in conjunction with the DOS Grants Management Unit, continues to oversee the Substance Abuse Enforcement Program. This resulted in the establishment of an Operation Granite Hammer (\$1.5 million) grant program which was designed to support the implementation of drug enforcement operations/initiatives to combat the misuse of opioids and fentanyl throughout the State. As of October 2017, the State's Information and Analysis Center



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reported the seizure of 1426 grams of fentanyl, 3573 grams of heroin, 6721 grams of heroin/fentanyl mixture, 9741 grams of methamphetamine, 2083 grams of cocaine, and 1162 grams of crack cocaine, and 22 weapons.

- Granite Shield Overview: The Granite Shield program began in October of 2016. It has expanded to include 79 law enforcement agencies across the State. The agencies are working closely with the State Information and Analysis Center to ensure cases are properly deconflicted to maximize officer safety. As of January 1, 2018 (mid-term), the Granite Shield program has reported 285 arrests and the seizure of approximately 23.2 pounds of heroin/fentanyl. This amount contains over 350,000 potentially deadly dosage units. To date, the Granite Shield initiative has been responsible for 1,235 arrests and the seizure of approximately 48.4 pounds of heroin/fentanyl. This total seizure is approximately 747,672 (3/4 of a million) potentially deadly dosage units.



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NEW HAMPSHIRE STATE ENTITIES

New Hampshire Department of Health and Human Services: DHHS is responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors, and administers programs and services such as mental health, developmental disability, substance abuse, and public health.

Bureau of Drug and Alcohol Services: The mission of the BDAS is to join individuals, families and communities in reducing alcohol and other drug problems thereby increasing opportunities for citizens to achieve health and independence.

New Hampshire Office of the Chief Medical Examiner: The OCME is responsible for determining the cause and manner of sudden, unexpected or unnatural deaths falling under its jurisdiction.

New Hampshire Department of Safety: The DOS encompasses protection of the lives and safety and preservation of the quality of life of New Hampshire citizens and visitors.
New Hampshire Division of Children Youth and Families: DCYF manages protective programs on behalf of New Hampshire's children and youth and their families.

New Hampshire Office of Professional Licensure and Certification: The principal mission of the OPLC is to safeguard the public health, safety, welfare, environment, and the public trust of the citizens of the State of New Hampshire.

New Hampshire Department of Justice: The mission of the DOJ is to serve the people of New Hampshire with diligence, independence and integrity by performing the constitutional, statutory and common law duties of the Attorney General.



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GLOSSARY OF TERMS

medication-assisted treatment: Treatment for opioid use disorder combining the use of medications with counseling and behavioral therapies.

morphine milligram equivalents: The number of milligrams of morphine an opioid dose is equal to when prescribed.

naloxone: A prescription drug that can reverse the effects of an opioid overdose and can be life-saving if administered in time. The drug is sold under the brand names Narcan and Evzio.

nonpharmacologic pain management: Management of pain without medications, such as the use of acupuncture or mindfulness-based therapy.

opiate antagonist: Opiate antagonist drugs such as naloxone are used in the treatment of opioid dependence and in the reversal of an opioid overdose.

opioids: Natural or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain and reduce the intensity of pain signals and feelings of pain. This class of drugs includes the illegal drug heroin; synthetic opioids, such as fentanyl; and pain medications available legally by prescription, such as oxycodone, hydrocodone, codeine, and morphine. Opioid pain medications are generally safe when taken for a short time and as prescribed by a doctor, but because they produce euphoria in addition to pain relief, they can be misused.

opioid use disorder: A problematic pattern of opioid use that causes significant impairment or distress. A diagnosis is based on specific criteria, such as unsuccessful efforts to cut down or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria.

Prescription Drug Monitoring Program: A State-run electronic database that tracks controlled substance prescriptions. A PDMP helps providers identify patients at risk of opioid misuse or overdose due to overlapping prescriptions, high dosages, or coprescribing of opioids with benzodiazepines.

