1. Update on 2017 housekeeping changes to the Medical Practice Act
   - Draft Proposed Revisions to 147.091 Grounds for Disciplinary Action
   - Title Protection

2. Presentation on most recently proposed changes to the Registered Naturopathic Doctors Practice Act
   - Current proposal (pending receipt)
   - Draft legislation presented to Policy & Planning Committee on October 12, 2016 and to full Board on November 12, 2016
   - Enclosed copy of current practice act, Minn. Stat. § 147E (2014)

3. Presentation on proposed changes to Medical Practice Act related to the medical faculty license

4. Attorney General’s report and recommendations on opioid prescribing
   - Attorney General’s press release and report

5. Proposed 2017 Policy & Planning Committee Meeting Dates

6. New Business

7. Additional Agenda Item: Draft Resolution to the Federation of State Medical Boards Regarding Mandatory use of Prescription Drug Monitoring Programs
147.091 GROUNDS FOR DISCIPLINARY ACTION.

Subdivision 1. Grounds listed. The board may refuse to grant a license, may refuse to grant registration to perform interstate telemedicine services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one’s own behalf

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathic medicine. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.

(e) Advertising which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professional superiority to or greater skill than that possessed by another physician.

(f) Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 604.201, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in improper unethical conduct, including without limitation:

(1) Conduct likely to deceive, defraud, harm the public;
(2) Conduct likely to harm the public; or demonstrating a willful or careless disregard for the health, welfare or safety of a patient;

(3) Conduct that demonstrates a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent

(4) Medical practice which is professionally incompetent; and

(5) Conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to provide proper supervision, including without limitation:

(1) supervision of a physician assistant;

(2) supervision of a licensed or unlicensed health care provider; and

(3) or failure to supervise a supervision of a physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication by a court of competent jurisdiction, within or without this state as:

(1) mentally incompetent;

(2) mentally ill; or

(3) developmentally disabled;

(4) or as a chemically dependent person;

(5) as a person dangerous to the public;

(6) as a sexually dangerous person; or

(7) or as a person who has a sexual psychopathic personality by a court of competent jurisdiction, within or without this state.

Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise.

(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any that departure departs from or the failure fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proceeding proof of actual injury to a patient need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients, including without limitation:

(1) by reason of illness;
(2) drunkenness intoxication;

(3) use of drugs, narcotics, chemicals or any other type of material substance;

(4) or as a result of any mental condition;

(5) or physical condition;

(6) diminished cognitive ability, including

(7) loss of motor skills; or

(8) deterioration [or decline] through the aging process or loss of motor skills.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathic medicine to identify the school of healing in the professional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathic medicine, or D.O.

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the referring physician has a “financial or economic interest,” as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician's financial or economic interest in accordance with section 144.6521; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest. The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.
(r) Becoming addicted or habituated to a drug or intoxicant.

(s) Inappropriate prescribing of or failure to properly prescribe a drug or device, including
prescribing a drug or device for other than medically accepted therapeutic or experimental or
investigative purposes authorized by a state or federal agency or referring a patient to any health care
provider as defined in sections 144.291 to 144.298 for services or tests not medically indicated at the
time of referral.

(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the
patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by section 147.111 or to cooperate with an investigation of
the board as required by section 147.131.

(v) Knowingly providing false or misleading information that is directly related to the care of that
patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any
of the following:

(1) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section
609.215, subdivision 1 or 2;

(2) a copy of the record of a judgment of contempt of court for violating an injunction issued under
section 609.215, subdivision 4;

(3) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(4) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board
shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.

(y) Failure to repay a state or federally secured student loan in accordance with the provisions of
the loan.

(z) Providing interstate telemedicine services other than according to section 147.032.
A bill for an act relating to health professions; requiring licensure of naturopathic doctors; modifying scope of practice; amending Minnesota Statutes 2016, sections 147E.01; 147E.05; 147E.06; 147E.10; 147E.15; 147E.20; 147E.25; 147E.30; 147E.35; 147E.40; 151.01, subdivision 23.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 147E.01, is amended to read:

147E.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.


Subd. 3. Approved naturopathic medical education program. "Approved naturopathic medical education program" means a naturopathic medical education program in the United States or Canada and meets the requirements for accreditation by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the naturopathic medical profession recognized by the board. This program must offer graduate-level full-time didactic and supervised clinical training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an institution, or part of an institution, of higher education that at the time the student completes the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting agency recognized by the United States Secretary of Education; or
2.1 (2) a degree granting college or university that prior to the existence of CNME offered
2.2 a full-time structured curriculum in basic sciences and supervised patient care comprising
2.3 a doctoral naturopathic medical education that is at least 132 weeks in duration, must be
2.4 completed in at least 35 months, and is reputable and in good standing in the judgment of
2.5 the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive
2.8 minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines
2.10 prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered Naturopathic doctor. "Registered Naturopathic doctor" means an
2.12 individual registered licensed under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative,
2.14 electrical, or other methods for the repair and care incidental to superficial lacerations and
2.15 abrasions, superficial lesions, and the removal of foreign bodies located in the superficial
2.16 tissues and the use of antiseptics and local topical or injectable anesthetics in connection
2.17 with such methods.

Subd. 9. Naturopathic licensing examination. "Naturopathic licensing examination"
2.19 means the Naturopathic Physicians Licensing Examination or its successor administered
2.20 by the North American Board of Naturopathic Examiners or its successor as recognized by
2.21 the board.

Subd. 10. Naturopathic medicine. "Naturopathic medicine" means a system of primary
2.22 health care for the prevention, assessment, and treatment of human health conditions, injuries,
2.23 and diseases that uses:

(1) services, procedures, and treatments as described in section 147E.05; and

(2) natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. Naturopathic physical medicine. "Naturopathic physical medicine" includes,
2.28 but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold,
2.29 sound, light, and electromagnetic nonionizing radiation and the physical modalities of
2.30 electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon
2.31 hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous
2.32 electrical nerve stimulation, naturopathic musculoskeletal mobilization, and therapeutic
2.33 exercise.
Sec. 2. Minnesota Statutes 2014, section 147E.05, is amended to read:

147E.05 SCOPE OF PRACTICE.

Subdivision 1. Practice parameters. (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

(1) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, and barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;

(2) minor office procedures, including obtaining specimens to assess, diagnose, and treat disease;

(2) (3) performing or ordering physical examinations, including but not limited to and physiological function tests, speculum examinations, orificial examinations, and phlebotomy;

(3) (4) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);

(4) (5) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;

(5) (6) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and

(7) prescribing, dispensing, and administering pharmacological therapies including legend drugs; and

(6) (8) prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor may admit patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

Subd. 2. Prohibitions on practice. (a) The practice of naturopathic medicine does not include:
(1) administering therapeutic ionizing radiation or radioactive substances;

(2) administering general or spinal anesthesia; or

(3) prescribing, dispensing, or administering legend drugs or controlled substances
including chemotherapeutic substances; or

(4) performing or inducing abortions.

(b) A naturopathic doctor registered licensed under this chapter shall not perform surgical
procedures using a laser device or perform surgical procedures beyond superficial tissue
the repair of superficial lacerations and abrasions, superficial lesions, and the removal of
foreign bodies located in superficial tissues.

(c) A naturopathic doctor shall not practice or claim to practice as a medical doctor,
surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice
professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist,
dietitian, nutritionist, or any other health care professional, unless the naturopathic
physician also holds the appropriate license or registration for the health care practice
profession.

Sec. 3. Minnesota Statutes 2014, section 147E.06, is amended to read:

147E.06 PROFESSIONAL CONDUCT.

Subdivision 1. Informed consent. (a) The naturopathic doctor shall present treatment
facts and options accurately to the patient or to the individual responsible for the patient's
care and make treatment recommendations according to standards of good naturopathic
medical practice. The registered naturopathic doctor shall obtain a signed informed consent
from the patient prior to initiating treatment and after advising the patient of the naturopathic
doctor's qualifications including education and registration information; and outlining of
the scope of practice of registered naturopathic doctors in Minnesota. This information must
be supplied to the patient in writing before or at the time of the initial visit. The registrant
shall present treatment facts and options accurately to the patient or to the individual
responsible for the patient's care and make treatment recommendations according to standards
of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor must provide a copy of the informed
consent form to the board.

Subd. 2. Patient records. (a) A registered naturopathic doctor shall maintain a record
for seven years for each patient treated, including:
5.1 (1) a copy of the signed informed consent;

5.2 (2) evidence of a patient interview concerning the patient's medical history and current physical condition;

5.3 (3) evidence of an examination and assessment;

5.4 (4) record of the treatment provided to the patient; and

5.5 (5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor, the patient has been advised to consult with another health care provider.

5.6 (b) A registered naturopathic doctor shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.

Subd. 3. Data practices. All records maintained on a naturopathic patient by a registered naturopathic doctor are subject to sections 144.291 to 144.298.

Subd. 4. State and municipal public health regulations. A registered naturopathic doctor shall comply with all applicable state and municipal requirements regarding public health.

Sec. 4. Minnesota Statutes 2014, section 147E.10, is amended to read:

147E.10 PROTECTED TITLES.

Subdivision 1. Designation. (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," "naturopathic medical doctor," "naturopathic physician," or use, in connection with the individual's name, the letters "R.N.D.," "N.D.," or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered licensed naturopathic doctor unless the individual has been registered licensed as a registered naturopathic doctor according to this chapter.

(b) After July 1, 2009, individuals who are registered licensed under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration license in the place of practice.

Subd. 2. Other health care practitioners. Nothing in this chapter may be construed to prohibit or to restrict:
(1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

(2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

(3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

(4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota licensed naturopathic doctor; or

(5) individuals not licensed by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. Penalty. A person violating subdivision 1 is guilty of a misdemeanor.

Sec. 5. Minnesota Statutes 2014, section 147E.15, is amended to read:

**147E.15 REGISTRATION LICENSURE REQUIREMENTS.**

Subdivision 1. General requirements for registration for licensure. To be eligible for registration licensure as a naturopathic doctor, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

(ii) the name and location of the naturopathic medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;
(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and

(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(2) submit a copy of a diploma from an approved naturopathic medical education program;

(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;

(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

(5) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and

(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 1a. Transition from registration to licensure. (a) An individual registered as naturopathic doctor on or after July 1, 2009, may be granted a license as a naturopathic doctor if the individual:

(1) holds a current, valid registration as a naturopathic doctor that has been issued by the Minnesota Board of Medical Practice; and

(2) is in good standing with the board.

(b) For purposes of this subdivision, "good standing" means that the registered naturopathic doctor is not currently under investigation by the board or advisory council as the result of a complaint, or subject to disciplinary proceedings by the board.

Subd. 2. Registration Licensure by endorsement; reciprocity. (a) To be eligible for registration licensure by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:
8.1 (1) submit the application materials and fees as required by subdivision 1, clauses (1),
8.2 (2), and (4) to (6);
8.3 (2) have successfully passed either:
8.4 (i) the Naturopathic Physicians Licensing Examination; or
8.5 (ii) if prior to 1986, the state or provincial naturopathic board licensing examination
8.6 required by that regulating state or province;
8.7 (3) provide a verified copy from the appropriate government body of a current license,
8.8 registration, or certification for the practice of naturopathic medicine in another jurisdiction
8.9 that has initial licensing, registration, or certification requirements equivalent to or higher
8.10 than the requirements in subdivision 1; and
8.11 (4) provide letters of verification from the appropriate government body in each
8.12 jurisdiction in which the applicant holds a license, registration, or certification. Each letter
8.13 must state the applicant's name, date of birth, license, registration, or certification number,
8.14 date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant,
8.15 and the terms under which the license, registration, or certification was issued.
8.16 (b) An applicant applying for license, registration, or certification by endorsement must
8.17 be licensed, registered, or certified in another state or Canadian province prior to January
8.18 1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.
8.19 Subd. 3. Temporary registration licensure. The board may issue a temporary
8.20 registration license to practice as a registered naturopathic doctor to an applicant who is
8.21 licensed, registered, or certified
8.22 (1) holds a current naturopathic license, registration, or certification in another state or
8.23 Canadian province, the District of Columbia, or territory of the United States, whose
8.24 standards for licensure, registration, or certification are at least equivalent to those of
8.25 Minnesota;
8.26 and (2) is eligible for registration licensure under this section;
8.27 if the application for registration is complete, (3) meets all applicable requirements in
8.28 this section have been met, and a nonrefundable fee has been paid.
8.29 (4) completes an application for licensure; and
8.30 (5) pays the nonrefundable licensure fee.
The temporary registration license remains valid only until the meeting of the board at which time a decision is made on the registered naturopathic doctor's application for registration licensure.

Subd. 4. **Registration License expiration.** Registrations Licenses issued under this chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration license renewal a registrant licensee must:

1. annually, or as determined by the board, complete a renewal application on a form provided by the board;
2. submit the renewal fee;
3. provide evidence of a total of 25 hours of continuing education approved by the board as described in section 147E.25; and
4. submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant licensee who changes addresses must inform the board within 30 days, in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant licensee by the board are considered as having been received by the registrant licensee.

Subd. 7. **Registration License renewal notice.** At least 45 days before the registration license renewal date, the board shall send out a renewal notice to the last known address of the registrant licensee on file. The notice must include a renewal application and a notice of fees required for renewal or instructions for online renewal. It must also inform the registrant licensee that registration the license will expire without further action by the board if an application for registration license renewal is not received before the deadline for renewal. The registrant licensee's failure to receive this notice does not relieve the registrant licensee of the obligation to meet the deadline and other requirements for registration license renewal. Failure to receive this notice is not grounds for challenging expiration of registration licensure status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or before December 31 of the year of renewal the deadline established by the board. If the postmark is illegible, the application is considered timely if received by the third working day after the deadline.
Subd. 9. Inactive status and return to active status. (a) A registrant licensee may be placed in inactive status upon application to the board by the registrant licensee and upon payment of an inactive status fee.

(b) Registrant Licensees seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrant Licensees whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered licensed naturopathic doctor.

Subd. 10. Registration Licensure following lapse of registration licensure status for two years or less. For any individual whose registration licensure status has lapsed for two years or less, to regain registration status a license, the individual must:

1. apply for registration license renewal according to subdivision 5;
2. document compliance with the continuing education requirements of section 147E.25 since the registrant's licensee's initial registration licensure or last renewal; and
3. submit the fees required under section 147E.40 for the period not registered licensed, including the fee for late renewal.

Subd. 11. Cancellation due to nonrenewal. The board shall not renew, reissue, reinstate, or restore a registration license that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant licensee whose registration license is canceled for nonrenewal must obtain a new registration license by applying for registration licensure and fulfilling all requirements then in existence for initial registration licensure as a registered naturopathic doctor.

Subd. 12. Cancellation of registration licensure in good standing. (a) A registrant licensee holding an active registration license as a registered naturopathic doctor in the state may, upon approval of the board, be granted registration license cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant licensee. Such action by the board must be reported as a cancellation of registration licensure in good standing.

(b) A registrant licensee who receives board approval for registration licensure cancellation is not entitled to a refund of any registration fees paid for the registration licensure year in which cancellation of the registration occurred.
To obtain registration licensure after cancellation, a registrant licensee must obtain a new registration license by applying for registration submitting an application and fulfilling the requirements then in existence for obtaining initial registration licensure as a registered naturopathic doctor.

Subd. 13. Emeritus status of registration. A registrant licensee may change the status of the registration license to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant licensee to retain the title of registered naturopathic doctor but restricts the registrant licensee from actively seeing patients.

Sec. 6. Minnesota Statutes 2014, section 147E.20, is amended to read:

147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION LICENSURE.

(a) The board shall act on each application for registration licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration licensure under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration licensure if registration licensure is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration licensure may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration licensure. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration licensure period.

Sec. 7. Minnesota Statutes 2014, section 147E.25, is amended to read:

147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. Number of required contact hours. (a) A registrant licensee applying for registration license renewal must complete a minimum of 25 30 contact hours of board-approved continuing education in the year preceding registration license renewal,
with the exception of the registrant's licensee's first incomplete year, and attest to completion
of continuing education requirements by reporting to the board.

(b) Of the **30** contact hours of continuing education requirement in paragraph (a), at
least **five** hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs
that have been approved for continuing education credit by the American Association of
Naturopathic Physicians or any of its constituent state associations, the American Chiropractic
Association or any of its constituent state associations, the American Osteopathic Association
Bureau of Professional Education, the American Pharmacists Association or any of its
constituent state associations, or an organization approved by the Accreditation Council for
Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve
continuing education programs that do not meet the requirements of subdivision 2 but meet
the following criteria:

(1) the program content directly relates to the practice of naturopathic medicine;

(2) each member of the program faculty is knowledgeable in the subject matter as
demonstrated by a degree from an accredited education program, verifiable experience in
the field of naturopathic medicine, special training in the subject matter, or experience
teaching in the subject area;

(3) the program lasts at least 50 minutes per contact hour;

(4) there are specific, measurable, written objectives, consistent with the program,
describing the expected outcomes for the participants; and

(5) the program sponsor has a mechanism to verify participation and maintains attendance
records for three years.

Subd. 4. Accumulation of contact hours. A registrant licensee may not apply contact
hours acquired in one one-year reporting period to a future continuing education reporting
period.

Subd. 5. Verification of continuing education credits. The board shall periodically
select a random sample of registrants licensees and require those registrants licensees to
supply the board with evidence of having completed the continuing education to which they
attested. Documentation may come directly from the registrants licensees from state or
national organizations that maintain continuing education records.
Subd. 6. **Continuing education topics.** Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. **Restriction on continuing education topics.** (a) A registrant licensee may apply no more than five hours of practice management to a one-year reporting period. (b) A registrant licensee may apply no more than 15 hours to any single subject area.

Subd. 8. **Continuing education exemptions.** The board may exempt any person holding a registration license under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

Sec. 8. Minnesota Statutes 2014, section 147E.30, is amended to read:

**147E.30 DISCIPLINE; REPORTING.**

For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.

Sec. 9. Minnesota Statutes 2014, section 147E.35, is amended to read:

**147E.35 REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, five registered licensed naturopathic doctors who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the board regarding standards for registered licensed naturopathic doctors;
(2) provide for distribution of information regarding registered licensed naturopathic doctors standards;

(3) advise the board on enforcement of sections 147.091 to 147.162;

(4) review applications and recommend granting or denying registration licensure or registration license renewal;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;

(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and

(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Sec. 10. Minnesota Statutes 2014, section 147E.40, is amended to read:

147E.40 FEES.

Subdivision 1. Fees. Fees are as follows:

(1) registration license application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; and

(5) temporary permit fee, $25.

Subd. 2. Proration of fees. The board may prorate the initial annual registration license fee. All registrants licensees are required to pay the full fee upon registration license renewal.

Subd. 3. Penalty fee for late renewals. An application for registration license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. Nonrefundable fees. All of the fees in subdivision 1 are nonrefundable.

Sec. .... Minnesota Statutes 2016, section 151.01, subdivision 23, is amended to read:

Subd. 23. Practitioner. "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed advanced practice registered nurse, or licensed naturopathic doctor. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.
A bill for an act
relating to health professions; requiring licensure of naturopathic doctors; modifying
scope of practice; amending Minnesota Statutes 2016, sections 147E.01; 147E.05;
147E.06; 147E.10; 147E.15; 147E.20; 147E.25; 147E.30; 147E.35; 147E.40;
151.01, subdivision 23.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 147E.01, is amended to read:

147E.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Advisory council. "Advisory council" means the Registered Naturopathic
Doctor Advisory Council established under section 147E.35.

Subd. 3. Approved naturopathic medical education program. "Approved naturopathic
medical education program" means a naturopathic medical education program in the United
States or Canada and meets the requirements for accreditation by the Council on Naturopathic
Medical Education (CNME) or an equivalent federally recognized accrediting body for the
naturopathic medical profession recognized by the board. This program must offer
graduate-level full-time didactic and supervised clinical training leading to the degree of
Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an
institution, or part of an institution, of higher education that at the time the student completes
the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting
agency recognized by the United States Secretary of Education; or
(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered Naturopathic doctor. "Registered Naturopathic doctor" means an individual registered licensed under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical or injectable anesthetics in connection with such methods.

Subd. 9. Naturopathic licensing examination. "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. Naturopathic medicine. "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

1. services, procedures, and treatments as described in section 147E.05; and
2. natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. Naturopathic physical medicine. "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, naturopathic musculoskeletal mobilization, and therapeutic exercise.
Sec. 2. Minnesota Statutes 2014, section 147E.05, is amended to read:

147E.05 SCOPE OF PRACTICE.

Subdivision 1. Practice parameters. (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

(1) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, and barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;

(2) minor office procedures, including obtaining specimens to assess, diagnose, and treat disease;

(2) (3) performing or ordering physical examinations, including but not limited to and physiological function tests, speculum examinations, orificial examinations, and phlebotomy;

(3) (4) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);

(4) (5) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;

(5) (6) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and

(7) prescribing, dispensing, and administering pharmacological therapies including legend drugs; and

(6) (8) prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor may admit patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

Subd. 2. Prohibitions on practice. (a) The practice of naturopathic medicine does not include:
(1) administering therapeutic ionizing radiation or radioactive substances;

(2) administering general or spinal anesthesia; or

(3) prescribing, dispensing, or administering legend drugs or controlled substances including chemotherapeutic substances; or

(4) performing or inducing abortions.

(b) A naturopathic doctor registered licensed under this chapter shall not perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue the repair of superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in superficial tissues.

(c) A naturopathic doctor shall not practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietitian, nutritionist, or any other health care professional, unless the naturopathic physician doctor also holds the appropriate license or registration for the health care practice profession.

Sec. 3. Minnesota Statutes 2014, section 147E.06, is amended to read:

147E.06 PROFESSIONAL CONDUCT.

Subdivision 1. Informed consent. (a) The naturopathic doctor shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice. The registered naturopathic doctor shall obtain a signed informed consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's qualifications including education and registration information; and outlining of the scope of practice of registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing before or at the time of the initial visit. The registrant shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor must provide a copy of the informed consent form to the board.

Subd. 2. Patient records. (a) A registered naturopathic doctor shall maintain a record for seven years for each patient treated, including:
(1) a copy of the signed informed consent;

(2) evidence of a patient interview concerning the patient's medical history and current physical condition;

(3) evidence of an examination and assessment;

(4) record of the treatment provided to the patient; and

(5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor, the patient has been advised to consult with another health care provider.

(b) A registered naturopathic doctor shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.

Subd. 3. Data practices. All records maintained on a naturopathic patient by a registered naturopathic doctor are subject to sections 144.291 to 144.298.

Subd. 4. State and municipal public health regulations. A registered naturopathic doctor shall comply with all applicable state and municipal requirements regarding public health.

Sec. 4. Minnesota Statutes 2014, section 147E.10, is amended to read:

147E.10 PROTECTED TITLES.

Subdivision 1. Designation. (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," "naturopathic medical doctor," "naturopathic physician," or use, in connection with the individual's name, the letters "R.N.D." "N.D.," or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered licensed naturopathic doctor unless the individual has been registered licensed as a registered naturopathic doctor according to this chapter.

(b) After July 1, 2009, individuals who are registered licensed under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration license in the place of practice.

Subd. 2. Other health care practitioners. Nothing in this chapter may be construed to prohibit or to restrict:
(1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

(2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

(3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

(4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota licensed naturopathic doctor; or

(5) individuals not licensed by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. **Penalty.** A person violating subdivision 1 is guilty of a misdemeanor.

Sec. 5. Minnesota Statutes 2014, section 147E.15, is amended to read:

**147E.15 REGISTRATION LICENSURE REQUIREMENTS.**

Subdivision 1. **General requirements for registration for licensure.** To be eligible for registration licensure as a naturopathic doctor, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

(ii) the name and location of the naturopathic medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;
(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and
(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;
(2) submit a copy of a diploma from an approved naturopathic medical education program;
(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;
(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;
(5) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and
(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 1a. Transition from registration to licensure. (a) An individual registered as naturopathic doctor on or after July 1, 2009, may be granted a license as a naturopathic doctor if the individual:
(1) holds a current, valid registration as a naturopathic doctor that has been issued by the Minnesota Board of Medical Practice; and
(2) is in good standing with the board.
(b) For purposes of this subdivision, "good standing" means that the registered naturopathic doctor is not currently under investigation by the board or advisory council as the result of a complaint, or subject to disciplinary proceedings by the board.

Subd. 2. Registration Licensure by endorsement; reciprocity. (a) To be eligible for registration licensure by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:
8.1 (1) submit the application materials and fees as required by subdivision 1, clauses (1), (2), and (4) to (6);
8.2 (2) have successfully passed either:
8.3 (i) the Naturopathic Physicians Licensing Examination; or
8.4 (ii) if prior to 1986, the state or provincial naturopathic board licensing examination required by that regulating state or province;
8.5 (3) provide a verified copy from the appropriate government body of a current license, registration, or certification for the practice of naturopathic medicine in another jurisdiction that has initial licensing, registration, or certification requirements equivalent to or higher than the requirements in subdivision 1; and
8.6 (4) provide letters of verification from the appropriate government body in each jurisdiction in which the applicant holds a license, registration, or certification. Each letter must state the applicant's name, date of birth, license, registration, or certification number, date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant, and the terms under which the license, registration, or certification was issued.
8.7 (b) An applicant applying for license, registration, or certification by endorsement must be licensed, registered, or certified in another state or Canadian province prior to January 1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.
8.8 Subd. 3. Temporary registration licensure. The board may issue a temporary registration license to practice as a registered naturopathic doctor to an applicant who
8.9 holds a current naturopathic license, registration, or certification in another state or Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota:
8.10 (1) if the application for registration is complete, (2) meets all applicable requirements in this section have been met, and a nonrefundable fee has been paid.
8.11 (4) completes an application for licensure; and
8.12 (5) pays the nonrefundable licensure fee.
The temporary registration license remains valid only until the meeting of the board at which time a decision is made on the registered naturopathic doctor's application for registration licensure.

Subd. 4. **Registration License expiration.** Registrations Licenses issued under this chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration license renewal a registrant licensee must:

1. annually, or as determined by the board, complete a renewal application on a form provided by the board;

2. submit the renewal fee;

3. provide evidence of a total of 25 30 hours of continuing education approved by the board as described in section 147E.25; and

4. submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant licensee who changes addresses must inform the board within 30 days, in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant licensee by the board are considered as having been received by the registrant licensee.

Subd. 7. **Registration License renewal notice.** At least 45 days before the registration license renewal date, the board shall send out a renewal notice to the last known address of the registrant licensee on file. The notice must include a renewal application and a notice of fees required for renewal or instructions for online renewal. It must also inform the registrant licensee that registration the license will expire without further action by the board if an application for registration license renewal is not received before the deadline for renewal. The registrant's licensee's failure to receive this notice does not relieve the registrant licensee of the obligation to meet the deadline and other requirements for registration license renewal. Failure to receive this notice is not grounds for challenging expiration of registration licensure status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or before December 31 of the year of renewal the deadline established by the board. If the postmark is illegible, the application is considered timely if received by the third working day after the deadline.
Subd. 9. Inactive status and return to active status. (a) A registrant licensee may be placed in inactive status upon application to the board by the registrant licensee and upon payment of an inactive status fee.

(b) Registrants Licensees seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants Licensees whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered licensed naturopathic doctor.

Subd. 10. Registration Licensure following lapse of registration licensure status for two years or less. For any individual whose registration licensure status has lapsed for two years or less, to regain registration status a license, the individual must:

(1) apply for registration license renewal according to subdivision 5;

(2) document compliance with the continuing education requirements of section 147E.25 since the registrant's licensee's initial registration licensure or last renewal; and

(3) submit the fees required under section 147E.40 for the period not registered licensed, including the fee for late renewal.

Subd. 11. Cancellation due to nonrenewal. The board shall not renew, reissue, reinstate, or restore a registration license that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant licensee whose registration license is canceled for nonrenewal must obtain a new registration license by applying for registration licensure and fulfilling all requirements then in existence for initial registration licensure as a registered naturopathic doctor.

Subd. 12. Cancellation of registration licensure in good standing. (a) A registrant licensee holding an active registration license as a registered naturopathic doctor in the state may, upon approval of the board, be granted registration license cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant licensee. Such action by the board must be reported as a cancellation of registration licensure in good standing.

(b) A registrant licensee who receives board approval for registration licensure cancellation is not entitled to a refund of any registration fees paid for the registration licensure year in which cancellation of the registration occurred.
To obtain registration licensure after cancellation, a registrant licensee must obtain a new registration license by applying for registration submitting an application and fulfilling the requirements then in existence for obtaining initial registration licensure as a registered naturopathic doctor.

Subd. 13. Emeritus status of registration. A registrant licensee may change the status of the registration license to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant licensee to retain the title of registered naturopathic doctor but restricts the registrant licensee from actively seeing patients.

Sec. 6. Minnesota Statutes 2014, section 147E.20, is amended to read:

**147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION LICENSURE.**

(a) The board shall act on each application for registration licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration licensure under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration licensure if registration licensure is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration licensure may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration licensure. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration licensure period.

Sec. 7. Minnesota Statutes 2014, section 147E.25, is amended to read:

**147E.25 CONTINUING EDUCATION REQUIREMENT.**

Subdivision 1. Number of required contact hours. (a) A registrant licensee applying for registration license renewal must complete a minimum of 25 30 contact hours of board-approved continuing education in the year preceding registration license renewal,
with the exception of the registrant’s licensee’s first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the $25-30$ contact hours of continuing education requirement in paragraph (a), at least $10$ hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

1. the program content directly relates to the practice of naturopathic medicine;
2. each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;
3. the program lasts at least 50 minutes per contact hour;
4. there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and
5. the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. Accumulation of contact hours. A registrant licensee may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.

Subd. 5. Verification of continuing education credits. The board shall periodically select a random sample of registrant licensees and require those registrant licensees to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrant licensees from state or national organizations that maintain continuing education records.
Subd. 6. **Continuing education topics.** Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. **Restriction on continuing education topics.** (a) A registrant licensee may apply no more than five hours of practice management to a one-year reporting period.

(b) A registrant licensee may apply no more than 15 hours to any single subject area.

Subd. 8. **Continuing education exemptions.** The board may exempt any person holding a registration license under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

Sec. 8. Minnesota Statutes 2014, section 147E.30, is amended to read:

147E.30 DISCIPLINE; REPORTING.

For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.

Sec. 9. Minnesota Statutes 2014, section 147E.35, is amended to read:

147E.35 REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.

Subdivision 1. **Membership.** The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, five registered licensed naturopathic doctors who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the board regarding standards for registered licensed naturopathic doctors;
(2) provide for distribution of information regarding licensed naturopathic doctors standards;

(3) advise the board on enforcement of sections 147.091 to 147.162;

(4) review applications and recommend granting or denying licensure or registration license renewal;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;

(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and

(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Sec. 10. Minnesota Statutes 2014, section 147E.40, is amended to read:

14E.40 FEES.

Subdivision 1. Fees. Fees are as follows:

(1) registration license application fee, $200;

(2) renewal fee, $150;

(3) late fee, $75;

(4) inactive status fee, $50; and

(5) temporary permit fee, $25.

Subd. 2. Proration of fees. The board may prorate the initial annual registration license fee. All registrants licensees are required to pay the full fee upon registration license renewal.

Subd. 3. Penalty fee for late renewals. An application for registration license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. Nonrefundable fees. All of the fees in subdivision 1 are nonrefundable.

Sec. .... Minnesota Statutes 2016, section 151.01, subdivision 23, is amended to read:

Subd. 23. Practitioner. "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of...
dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, or licensed advanced practice registered nurse, or licensed naturopathic doctor. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraphs (b), (e), and (f); and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A. For purposes of sections 151.15, subdivision 4; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A.
A bill for an act
relating to health professions; requiring licensure of naturopathic physicians;
modifying scope of practice; amending Minnesota Statutes 2014, sections 147E.01;
147E.05; 147E.06; 147E.10; 147E.15; 147E.20; 147E.25; 147E.30; 147E.35;
147E.40.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 147E.01, is amended to read:

147E.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Advisory council. "Advisory council" means the Registered Naturopathic
Doctor Advisory Council established under section 147E.35.

Subd. 3. Approved naturopathic medical education program. "Approved naturopathic
medical education program" means a naturopathic medical education program in the United
States or Canada and meets the requirements for accreditation by the Council on Naturopathic
Medical Education (CNME) or an equivalent federally recognized accrediting body for the
naturopathic medical profession recognized by the board. This program must offer
graduate-level full-time didactic and supervised clinical training leading to the degree of
Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an
institution, or part of an institution, of higher education that at the time the student completes
the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting
agency recognized by the United States Secretary of Education; or
(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered Naturopathic doctor physician. "Registered Naturopathic doctor physician" means an individual registered licensed under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical or injectable anesthetics in connection with such methods.

Subd. 9. Naturopathic licensing examination. "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. Naturopathic medicine. "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

(1) services, procedures, and treatments as described in section 147E.05; and

(2) natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. Naturopathic physical medicine. "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, manipulation, and therapeutic exercise.
Sec. 2. Minnesota Statutes 2014, section 147E.05, is amended to read:

147E.05 SCOPE OF PRACTICE.

Subdivision 1. Practice parameters. (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

(1) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, and barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;

(2) minor office procedures, including obtaining specimens to assess, diagnose, and treat disease;

(2) (3) performing or ordering physical examinations, including but not limited to and physiological function tests, speculum examinations, orificial examinations, and phlebotomy;

(3) (4) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);

(4) (5) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;

(5) (6) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and

(7) prescribing pharmacological therapies including schedule III, IV, and V legend drugs and controlled substances;

(8) administering vaccinations;

(9) administering intravenous therapies; and

(6) (10) prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor physician may admit patients to a hospital if the naturopathic doctor physician meets the hospital's governing body requirements regarding credentialing and privileging process.
Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not include:

1. administering therapeutic ionizing radiation or radioactive substances;
2. administering general or spinal anesthesia; or
3. prescribing, dispensing, or administering legend drugs or controlled substances including chemotherapeutic substances; or
4. performing or inducing abortions.

(b) A naturopathic doctor registered physician licensed under this chapter shall not perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue the repair of superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in superficial tissues.

(c) A naturopathic doctor physician shall not practice or claim to practice as a medical doctor, surgeon, osteopath, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietician dietitian, nutritionist, or any other health care professional, unless the naturopathic physician also holds the appropriate license or registration for the health care practice profession.

Sec. 3. Minnesota Statutes 2014, section 147E.06, is amended to read:

147E.06 **PROFESSIONAL CONDUCT.**

Subdivision 1. **Informed consent.** (a) The naturopathic physician shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice. The registered naturopathic doctor physician shall obtain a signed informed consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's qualifications including education and registration information; and outlining of the scope of practice of registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing before or at the time of the initial visit. The registrant shall present treatment facts and options accurately to the patient or to the individual responsible for the patient's care and make treatment recommendations according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor physician must provide a copy of the informed consent form to the board.
Subd. 2. **Patient records.** (a) A registered naturopathic doctor physician shall maintain a record for seven years for each patient treated, including:

(1) a copy of the signed informed consent;

(2) evidence of a patient interview concerning the patient's medical history and current physical condition;

(3) evidence of an examination and assessment;

(4) record of the treatment provided to the patient; and

(5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient in writing that, if deemed necessary by the registered naturopathic doctor physician, the patient has been advised to consult with another health care provider.

(b) A registered naturopathic doctor physician shall maintain the records of minor patients for seven years or until the minor's 19th birthday, whichever is longer.

Subd. 3. **Data practices.** All records maintained on a naturopathic patient by a registered naturopathic doctor physician are subject to sections 144.291 to 144.298.

Subd. 4. **State and municipal public health regulations.** A registered naturopathic doctor physician shall comply with all applicable state and municipal requirements regarding public health.

Sec. 4. Minnesota Statutes 2014, section 147E.10, is amended to read:

**147E.10 PROTECTED TITLES.**

Subdivision 1. **Designation.** (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," "naturopathic medical doctor," "naturopathic physician" or use, in connection with the individual's name, the letters "R.N.D.," "N.D.," or "N.M.D.," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered licensed naturopathic doctor physician unless the individual has been registered licensed as a registered naturopathic doctor physician according to this chapter.

(b) After July 1, 2009, individuals who are registered licensed under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration license in the place of practice.

Subd. 2. **Other health care practitioners.** Nothing in this chapter may be construed to prohibit or to restrict:
(1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

(2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

(3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

(4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota registered naturopathic doctor; or

(5) individuals not registered by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. Penalty. A person violating subdivision 1 is guilty of a misdemeanor.

Sec. 5. Minnesota Statutes 2014, section 147E.15, is amended to read:

**147E.15 REGISTRATION LICENSURE REQUIREMENTS.**

Subdivision 1. General requirements for registration for licensure. To be eligible for registration licensure as a naturopathic physician, an applicant must:

(1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

(i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

(ii) the name and location of the naturopathic medical program the applicant completed;

(iii) a list of degrees received from other educational institutions;

(iv) a description of the applicant's professional training;

(v) a list of registrations, certifications, and licenses held in other jurisdictions;

(vi) a description of any other jurisdiction's refusal to credential the applicant;
(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and

(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(2) submit a copy of a diploma from an approved naturopathic medical education program;

(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;

(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

(5) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and

(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 1a. Transition from registration to licensure. (a) An individual registered as naturopathic doctor on or after July 1, 2009, may be granted a license as a naturopathic physician if the individual:

(1) holds a current, valid registration as a naturopathic doctor that has been issued by the Minnesota Board of Medical Practice; and

(2) is in good standing with the board.

(b) For purposes of this subdivision, "good standing" means that the registered naturopathic doctor is not currently under investigation by the board or advisory council as the result of a complaint, or subject to disciplinary proceedings by the board.

Subd. 2. Registration Licensure by endorsement; reciprocity. (a) To be eligible for registration licensure by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:
8.1 (1) submit the application materials and fees as required by subdivision 1, clauses (1),
8.2 (2), and (4) to (6);
8.3 (2) have successfully passed either:
8.4 (i) the Naturopathic Physicians Licensing Examination; or
8.5 (ii) if prior to 1986, the state or provincial naturopathic board licensing examination
8.6 required by that regulating state or province;
8.7 (3) provide a verified copy from the appropriate government body of a current license,
8.8 registration, or certification for the practice of naturopathic medicine in another jurisdiction
8.9 that has initial licensing, registration, or certification requirements equivalent to or higher
8.10 than the requirements in subdivision 1; and
8.11 (4) provide letters of verification from the appropriate government body in each
8.12 jurisdiction in which the applicant holds a license, registration, or certification. Each letter
8.13 must state the applicant's name, date of birth, license, registration, or certification number,
8.14 date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant,
8.15 and the terms under which the license, registration, or certification was issued.
8.16 (b) An applicant applying for license, registration, or certification by endorsement must
8.17 be licensed, registered, or certified in another state or Canadian province prior to January
8.18 1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.
8.19 Subd. 3. Temporary registration licensure. The board may issue a temporary
8.20 registration license to practice as a registered naturopathic doctor physician to an applicant
8.21 who is licensed, registered, or certified
8.22 (1) holds a current naturopathic license, registration, or certification in another state or
8.23 Canadian province, the District of Columbia, or territory of the United States, whose
8.24 standards for licensure, registration, or certification are at least equivalent to those of
8.25 Minnesota;
8.26 and (2) is eligible for registration licensure under this section;
8.27 if the application for registration is complete, (3) meets all applicable requirements in
8.28 this section have been met, and a nonrefundable fee has been paid.
8.29 (4) completes an application for licensure; and
8.30 (5) pays the nonrefundable licensure fee.
The temporary registration license remains valid only until the meeting of the board at which
time a decision is made on the registered naturopath's physician's application for
registration licensure.

Subd. 4. **Registration License expiration.** Registrations Licenses issued under this
chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration license renewal a registrant licensee
must:

1. annually, or as determined by the board, complete a renewal application on a form
   provided by the board;

2. submit the renewal fee;

3. provide evidence of a total of 25 hours of continuing education approved by the
   board as described in section 147E.25; and

4. submit any additional information requested by the board to clarify information
   presented in the renewal application. The information must be submitted within 30 days
   after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant licensee who changes addresses must inform
the board within 30 days, in writing, of the change of address. All notices or other
correspondence mailed to or served on a registrant licensee by the board are considered as
having been received by the registrant licensee.

Subd. 7. **Registration License renewal notice.** At least 45 days before the registration
license renewal date, the board shall send out a renewal notice to the last known address of
the registrant licensee on file. The notice must include a renewal application and a notice
of fees required for renewal or instructions for online renewal. It must also inform the
registrant licensee that registration the license will expire without further action by the board
if an application for registration license renewal is not received before the deadline for
renewal. The registrant licensee's failure to receive this notice does not relieve the registrant
licensee of the obligation to meet the deadline and other requirements for registration license
renewal. Failure to receive this notice is not grounds for challenging expiration of registration
licensure status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or
before December 31 of the year of renewal the deadline established by the board. If the
postmark is illegible, the application is considered timely if received by the third working
day after the deadline.
Subd. 9. **Inactive status and return to active status.** (a) A registrant licensee may be placed in inactive status upon application to the board by the registrant licensee and upon payment of an inactive status fee.

(b) Registrants Licensees seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants Licensees whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered licensed naturopathic doctor physician.

Subd. 10. **Registration Licensure following lapse of registration licensure status for two years or less.** For any individual whose registration licensure status has lapsed for two years or less, to regain registration status a license, the individual must:

1. apply for registration license renewal according to subdivision 5;
2. document compliance with the continuing education requirements of section 147E.25 since the registrant's licensee's initial registration licensure or last renewal; and
3. submit the fees required under section 147E.40 for the period not registered licensed, including the fee for late renewal.

Subd. 11. **Cancellation due to nonrenewal.** The board shall not renew, reissue, reinstate, or restore a registration license that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant licensee whose registration license is canceled for nonrenewal must obtain a new registration license by applying for registration licensure and fulfilling all requirements then in existence for initial registration licensure as a registered naturopathic doctor physician.

Subd. 12. **Cancellation of registration licensure in good standing.** (a) A registrant licensee holding an active registration license as a registered naturopathic doctor physician in the state may, upon approval of the board, be granted registration license cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant licensee. Such action by the board must be reported as a cancellation of registration licensure in good standing.

(b) A registrant licensee who receives board approval for registration licensure cancellation is not entitled to a refund of any registration fees paid for the registration licensure year in which cancellation of the registration occurred.
(c) To obtain registration licensure after cancellation, a registrant licensee must obtain a new registration license by applying for registration submitting an application and fulfilling the requirements then in existence for obtaining initial registration licensure as a registered naturopathic doctor physician.

Subd. 13. Emeritus status of registration. A registrant licensee may change the status of the registration license to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant licensee to retain the title of registered naturopathic doctor physician but restricts the registrant licensee from actively seeing patients.

Sec. 6. Minnesota Statutes 2014, section 147E.20, is amended to read:

147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION LICENSURE.

(a) The board shall act on each application for registration licensure according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration licensure under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration licensure if registration licensure is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration licensure may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration licensure. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration licensure period.

Sec. 7. Minnesota Statutes 2014, section 147E.25, is amended to read:

147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. Number of required contact hours. (a) A registrant licensee applying for registration license renewal must complete a minimum of 25 30 contact hours of board-approved continuing education in the year preceding registration license renewal,
with the exception of the registrant's licensee's first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the 25 30 contact hours of continuing education requirement in paragraph (a), at least five hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

(1) the program content directly relates to the practice of naturopathic medicine;

(2) each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;

(3) the program lasts at least 50 minutes per contact hour;

(4) there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and

(5) the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. Accumulation of contact hours. A registrant licensee may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.

Subd. 5. Verification of continuing education credits. The board shall periodically select a random sample of registrants licensees and require those registrants licensees to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrants licensees from state or national organizations that maintain continuing education records.
13.1 Subd. 6. Continuing education topics. Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

13.2 Subd. 7. Restriction on continuing education topics. (a) A registrant licensee may apply no more than five hours of practice management to a one-year reporting period.

13.3 (b) A registrant licensee may apply no more than 15 hours to any single subject area.

13.4 Subd. 8. Continuing education exemptions. The board may exempt any person holding a registration license under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

Sec. 8. Minnesota Statutes 2014, section 147E.30, is amended to read:

147E.30 DISCIPLINE; REPORTING.

For purposes of this chapter, registered naturopathic doctors, physicians and applicants are subject to sections 147.091 to 147.162.

Sec. 9. Minnesota Statutes 2014, section 147E.35, is amended to read:

147E.35 REGISTERED NATUROPATHIC DOCTOR PHYSICIAN ADVISORY COUNCIL.

Subdivision 1. Membership. The board shall appoint a seven-member Registered Naturopathic Doctor Physician Advisory Council consisting of one public member as defined in section 214.02, five registered licensed naturopathic doctors physicians who are residents of the state, and one licensed physician or osteopath with expertise in natural medicine.

Subd. 2. Organization. The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. Duties. The advisory council shall:
(1) advise the board regarding standards for registered licensed naturopathic doctors;  
(2) provide for distribution of information regarding registered licensed naturopathic doctors;  
(3) advise the board on enforcement of sections 147.091 to 147.162;  
(4) review applications and recommend granting or denying registration licensure or registration license renewal;  
(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors physicians;  
(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and  
(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

Sec. 10. Minnesota Statutes 2014, section 147E.40, is amended to read:

14.16 **147E.40 FEES.**

Subdivision 1. **Fees.** Fees are as follows:

14.18 (1) registration license application fee, $200;  
14.19 (2) renewal fee, $150;  
14.20 (3) late fee, $75;  
14.21 (4) inactive status fee, $50; and  
14.22 (5) temporary permit fee, $25.

Subd. 2. **Proration of fees.** The board may prorate the initial annual registration license fee. All registrants licensees are required to pay the full fee upon registration license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for registration license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.
CHAPTER 147E
REGISTERED NATUROPATHIC DOCTORS

147E.01 DEFINITIONS.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.


Subd. 3. Approved naturopathic medical education program. "Approved naturopathic medical education program" means a naturopathic medical education program in the United States or Canada and meets the requirements for accreditation by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the naturopathic medical profession recognized by the board. This program must offer graduate-level full-time didactic and supervised clinical training leading to the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. The program must be an institution, or part of an institution, of higher education that at the time the student completes the program is:

(1) either accredited or is a candidate for accreditation by a regional institution accrediting agency recognized by the United States Secretary of Education; or

(2) a degree granting college or university that prior to the existence of CNME offered a full-time structured curriculum in basic sciences and supervised patient care comprising a doctoral naturopathic medical education that is at least 132 weeks in duration, must be completed in at least 35 months, and is reputable and in good standing in the judgment of the board.

Subd. 4. Board. "Board" means the Board of Medical Practice or its designee.

Subd. 5. Contact hour. "Contact hour" means an instructional session of 50 consecutive minutes, excluding coffee breaks, registration, meals without a speaker, and social activities.

Subd. 6. Homeopathic preparations. "Homeopathic preparations" means medicines prepared according to the Homeopathic Pharmacopoeia of the United States.

Subd. 7. Registered naturopathic doctor. "Registered naturopathic doctor" means an individual registered under this chapter.

Subd. 8. Minor office procedures. "Minor office procedures" means the use of operative, electrical, or other methods for the repair and care incidental to superficial lacerations and abrasions, superficial lesions, and the removal of foreign bodies located in the superficial tissues and the use of antiseptics and local topical anesthetics in connection with such methods.
Subd. 9. **Naturopathic licensing examination.** "Naturopathic licensing examination" means the Naturopathic Physicians Licensing Examination or its successor administered by the North American Board of Naturopathic Examiners or its successor as recognized by the board.

Subd. 10. **Naturopathic medicine.** "Naturopathic medicine" means a system of primary health care for the prevention, assessment, and treatment of human health conditions, injuries, and diseases that uses:

1. services, procedures, and treatments as described in section 147E.05; and
2. natural health procedures and treatments in section 146A.01, subdivision 4.

Subd. 11. **Naturopathic physical medicine.** "Naturopathic physical medicine" includes, but is not limited to, the therapeutic use of the physical agents of air, water, heat, cold, sound, light, and electromagnetic nonionizing radiation and the physical modalities of electrotherapy, diathermy, ultraviolet light, hydrotherapy, massage, stretching, colon hydrotherapy, frequency specific microcurrent, electrical muscle stimulation, transcutaneous electrical nerve stimulation, and therapeutic exercise.

**History:** 2008 c 348 s 1

147E.05 SCOPE OF PRACTICE.

Subdivision 1. **Practice parameters.** (a) The practice of naturopathic medicine includes, but is not limited to, the following services:

1. ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease;
2. performing or ordering physical examinations and physiological function tests;
3. ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA);
4. referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results;
5. prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and
6. prescribing or performing naturopathic physical medicine.

(b) A registered naturopathic doctor may admit patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

Subd. 2. **Prohibitions on practice.** (a) The practice of naturopathic medicine does not include:

1. administering therapeutic ionizing radiation or radioactive substances;
2. administering general or spinal anesthesia;
(3) prescribing, dispensing, or administering legend drugs or controlled substances including
chemotherapeutic substances; or

(4) performing or inducing abortions.

(b) A naturopathic doctor registered under this chapter shall not perform surgical procedures using a
laser device or perform surgical procedures beyond superficial tissue.

(c) A naturopathic doctor shall not practice or claim to practice as a medical doctor, surgeon, osteopathic
physician, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician
assistant, chiropractor, physical therapist, acupuncturist, dietician, nutritionist, or any other health care
professional, unless the naturopathic physician also holds the appropriate license or registration for the health
care practice profession.

History: 2008 c 348 s 2; 2016 c 119 s 7

147E.06 PROFESSIONAL CONDUCT.

Subdivision 1. Informed consent. (a) The registered naturopathic doctor shall obtain a signed informed
consent from the patient prior to initiating treatment and after advising the patient of the naturopathic doctor's
qualifications including education and registration information; and outlining of the scope of practice of
registered naturopathic doctors in Minnesota. This information must be supplied to the patient in writing
before or at the time of the initial visit. The registrant shall present treatment facts and options accurately
to the patient or to the individual responsible for the patient's care and make treatment recommendations
according to standards of good naturopathic medical practice.

(b) Upon request, the registered naturopathic doctor must provide a copy of the informed consent form
to the board.

Subd. 2. Patient records. (a) A registered naturopathic doctor shall maintain a record for seven years
for each patient treated, including:

(1) a copy of the informed consent;

(2) evidence of a patient interview concerning the patient's medical history and current physical condition;

(3) evidence of an examination and assessment;

(4) record of the treatment provided to the patient; and

(5) evidence of evaluation and instructions given to the patient, including acknowledgment by the patient
in writing that, if deemed necessary by the registered naturopathic doctor, the patient has been advised to
consult with another health care provider.

(b) A registered naturopathic doctor shall maintain the records of minor patients for seven years or until
the minor's 19th birthday, whichever is longer.

Subd. 3. Data practices. All records maintained on a naturopathic patient by a registered naturopathic
doctor are subject to sections 144.291 to 144.298.

Subd. 4. State and municipal public health regulations. A registered naturopathic doctor shall comply
with all applicable state and municipal requirements regarding public health.

History: 2008 c 348 s 3
147E.10 PROTECTED TITLES.

Subdivision 1. Designation. (a) No individual may use the title "registered naturopathic doctor," "naturopathic doctor," "doctor of naturopathic medicine," or use, in connection with the individual's name, the letters "R.N.D." or "N.M.D.,” or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a registered naturopathic doctor unless the individual has been registered as a registered naturopathic doctor according to this chapter.

(b) After July 1, 2009, individuals who are registered under this chapter and who represent themselves as practicing naturopathic medicine by use of a term in paragraph (a) shall conspicuously display the registration in the place of practice.

Subd. 2. Other health care practitioners. Nothing in this chapter may be construed to prohibit or to restrict:

1) the practice of a profession by individuals who are licensed, certified, or registered under other laws of this state and are performing services within their authorized scope of practice;

2) the provision of the complementary and alternative healing methods and treatments, including naturopathy, as described in chapter 146A;

3) the practice of naturopathic medicine by an individual licensed, registered, or certified in another state and employed by the government of the United States while the individual is engaged in the performance of duties prescribed by the laws and regulations of the United States;

4) the practice by a naturopathic doctor duly licensed, registered, or certified in another state, territory, or the District of Columbia when incidentally called into this state for consultation with a Minnesota licensed physician or Minnesota registered naturopathic doctor; or

5) individuals not registered by this chapter from the use of individual modalities which comprise the practice of naturopathic medicine.

Subd. 3. Penalty. A person violating subdivision 1 is guilty of a misdemeanor.

History: 2008 c 348 s 4

147E.15 REGISTRATION REQUIREMENTS.

Subdivision 1. General requirements for registration. To be eligible for registration, an applicant must:

1) submit a completed application on forms provided by the board along with all fees required under section 147E.40 that includes:

i) the applicant's name, Social Security number, home address and telephone number, and business address and telephone number;

ii) the name and location of the naturopathic medical program the applicant completed;

iii) a list of degrees received from other educational institutions;

iv) a description of the applicant's professional training;

v) a list of registrations, certifications, and licenses held in other jurisdictions;
(vi) a description of any other jurisdiction's refusal to credential the applicant;

(vii) a description of all professional disciplinary actions initiated against the applicant in any jurisdiction; and

(viii) any history of drug or alcohol abuse, and any misdemeanor or felony conviction;

(2) submit a copy of a diploma from an approved naturopathic medical education program;

(3) have successfully passed the Naturopathic Physicians Licensing Examination, a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or successor agency as recognized by the board; passing scores are determined by the Naturopathic Physicians Licensing Examination;

(4) submit additional information as requested by the board, including providing any additional information necessary to ensure that the applicant is able to practice with reasonable skill and safety to the public;

(5) sign a statement that the information in the application is true and correct to the best of the applicant's knowledge and belief; and

(6) sign a waiver authorizing the board to obtain access to the applicant's records in this or any other state in which the applicant has completed an approved naturopathic medical program or engaged in the practice of naturopathic medicine.

Subd. 2. Registration by endorsement: reciprocity. (a) To be eligible for registration by endorsement or reciprocity, the applicant must hold a current naturopathic license, registration, or certification in another state, Canadian province, the District of Columbia, or territory of the United States, whose standards for licensure, registration, or certification are at least equivalent to those of Minnesota, and must:

(1) submit the application materials and fees as required by subdivision 1, clauses (1), (2), and (4) to (6);

(2) have successfully passed either:

(i) the Naturopathic Physicians Licensing Examination; or

(ii) if prior to 1986, the state or provincial naturopathic board licensing examination required by that regulating state or province;

(3) provide a verified copy from the appropriate government body of a current license, registration, or certification for the practice of naturopathic medicine in another jurisdiction that has initial licensing, registration, or certification requirements equivalent to or higher than the requirements in subdivision 1; and

(4) provide letters of verification from the appropriate government body in each jurisdiction in which the applicant holds a license, registration, or certification. Each letter must state the applicant's name, date of birth, license, registration, or certification number, date of issuance, a statement regarding disciplinary actions, if any, taken against the applicant, and the terms under which the license, registration, or certification was issued.

(b) An applicant applying for license, registration, or certification by endorsement must be licensed, registered, or certified in another state or Canadian province prior to January 1, 2005, and have completed a 60-hour course and examination in pharmacotherapeutics.
Subd. 3. **Temporary registration.** The board may issue a temporary registration to practice as a registered naturopathic doctor to an applicant who is licensed, registered, or certified in another state or Canadian province and is eligible for registration under this section, if the application for registration is complete, all applicable requirements in this section have been met, and a nonrefundable fee has been paid. The temporary registration remains valid only until the meeting of the board at which time a decision is made on the registered naturopathic doctor’s application for registration.

Subd. 4. **Registration expiration.** Registrations issued under this chapter expire annually.

Subd. 5. **Renewal.** To be eligible for registration renewal a registrant must:

1. annually, or as determined by the board, complete a renewal application on a form provided by the board;
2. submit the renewal fee;
3. provide evidence of a total of 25 hours of continuing education approved by the board as described in section 147E.25; and
4. submit any additional information requested by the board to clarify information presented in the renewal application. The information must be submitted within 30 days after the board's request, or the renewal request is nullified.

Subd. 6. **Change of address.** A registrant who changes addresses must inform the board within 30 days, in writing, of the change of address. All notices or other correspondence mailed to or served on a registrant by the board are considered as having been received by the registrant.

Subd. 7. **Registration renewal notice.** At least 45 days before the registration renewal date, the board shall send out a renewal notice to the last known address of the registrant on file. The notice must include a renewal application and a notice of fees required for renewal or instructions for online renewal. It must also inform the registrant that registration will expire without further action by the board if an application for registration renewal is not received before the deadline for renewal. The registrant's failure to receive this notice does not relieve the registrant of the obligation to meet the deadline and other requirements for registration renewal. Failure to receive this notice is not grounds for challenging expiration of registration status.

Subd. 8. **Renewal deadline.** The renewal application and fee must be postmarked on or before December 31 of the year of renewal. If the postmark is illegible, the application is considered timely if received by the third working day after the deadline.

Subd. 9. **Inactive status and return to active status.** (a) A registrant may be placed in inactive status upon application to the board by the registrant and upon payment of an inactive status fee.

(b) Registrants seeking restoration to active from inactive status must pay the current renewal fees and all unpaid back inactive fees. They must meet the criteria for renewal specified in subdivision 5, including continuing education hours.

(c) Registrants whose inactive status period has been five years or longer must additionally have a period of no less than eight weeks of advisory council-approved supervision by another registered naturopathic doctor.

Subd. 10. **Registration following lapse of registration status for two years or less.** For any individual whose registration status has lapsed for two years or less, to regain registration status, the individual must:
(1) apply for registration renewal according to subdivision 5;

(2) document compliance with the continuing education requirements of section 147E.25 since the registrant's initial registration or last renewal; and

(3) submit the fees required under section 147E.40 for the period not registered, including the fee for late renewal.

Subd. 11. Cancellation due to nonrenewal. The board shall not renew, reissue, reinstate, or restore a registration that has lapsed and has not been renewed within two annual registration renewal cycles starting January 2009. A registrant whose registration is canceled for nonrenewal must obtain a new registration by applying for registration and fulfilling all requirements then in existence for initial registration as a registered naturopathic doctor.

Subd. 12. Cancellation of registration in good standing. (a) A registrant holding an active registration as a registered naturopathic doctor in the state may, upon approval of the board, be granted registration cancellation if the board is not investigating the person as a result of a complaint or information received or if the board has not begun disciplinary proceedings against the registrant. Such action by the board must be reported as a cancellation of registration in good standing.

(b) A registrant who receives board approval for registration cancellation is not entitled to a refund of any registration fees paid for the registration year in which cancellation of the registration occurred.

(c) To obtain registration after cancellation, a registrant must obtain a new registration by applying for registration and fulfilling the requirements then in existence for obtaining initial registration as a registered naturopathic doctor.

Subd. 13. Emeritus status of registration. A registrant may change the status of the registration to "emeritus" by filing the appropriate forms and paying the onetime fee of $50 to the board. This status allows the registrant to retain the title of registered naturopathic doctor but restricts the registrant from actively seeing patients.

History: 2008 c 348 s 5

147E.20 BOARD ACTION ON APPLICATIONS FOR REGISTRATION.

(a) The board shall act on each application for registration according to paragraphs (b) to (d).

(b) The board shall determine if the applicant meets the requirements for registration under section 147E.15. The board or advisory council may investigate information provided by an applicant to determine whether the information is accurate and complete.

(c) The board shall notify each applicant in writing of action taken on the application, the grounds for denying registration if registration is denied, and the applicant's right to review under paragraph (d).

(d) Applicants denied registration may make a written request to the board, within 30 days of the board's notice, to appear before the advisory council or the board and for the advisory council to review the board's decision to deny the applicant's registration. After reviewing the denial, the advisory council shall make a recommendation to the board as to whether the denial shall be affirmed. Each applicant is allowed only one request for review each yearly registration period.

History: 2008 c 348 s 6
147E.25 CONTINUING EDUCATION REQUIREMENT.

Subdivision 1. Number of required contact hours. (a) A registrant applying for registration renewal must complete a minimum of 25 contact hours of board-approved continuing education in the year preceding registration renewal, with the exception of the registrant's first incomplete year, and attest to completion of continuing education requirements by reporting to the board.

(b) Of the 25 contact hours of continuing education requirement in paragraph (a), at least five hours of continuing education must be in pharmacotherapeutics.

Subd. 2. Approved programs. The board shall approve continuing education programs that have been approved for continuing education credit by the American Association of Naturopathic Physicians or any of its constituent state associations, the American Chiropractic Association or any of its constituent state associations, the American Osteopathic Association Bureau of Professional Education, the American Pharmacists Association or any of its constituent state associations, or an organization approved by the Accreditation Council for Continuing Medical Education.

Subd. 3. Approval of continuing education programs. The board shall also approve continuing education programs that do not meet the requirements of subdivision 2 but meet the following criteria:

(1) the program content directly relates to the practice of naturopathic medicine;

(2) each member of the program faculty is knowledgeable in the subject matter as demonstrated by a degree from an accredited education program, verifiable experience in the field of naturopathic medicine, special training in the subject matter, or experience teaching in the subject area;

(3) the program lasts at least 50 minutes per contact hour;

(4) there are specific, measurable, written objectives, consistent with the program, describing the expected outcomes for the participants; and

(5) the program sponsor has a mechanism to verify participation and maintains attendance records for three years.

Subd. 4. Accumulation of contact hours. A registrant may not apply contact hours acquired in one one-year reporting period to a future continuing education reporting period.

Subd. 5. Verification of continuing education credits. The board shall periodically select a random sample of registrants and require those registrants to supply the board with evidence of having completed the continuing education to which they attested. Documentation may come directly from the registrants from state or national organizations that maintain continuing education records.

Subd. 6. Continuing education topics. Continuing education program topics may include, but are not limited to, naturopathic medical theory and techniques including diagnostic techniques, nutrition, botanical medicine, homeopathic medicine, physical medicine, lifestyle modification counseling, anatomy, physiology, biochemistry, pharmacology, pharmacognosy, microbiology, medical ethics, psychology, history of medicine, and medical terminology or coding.

Subd. 7. Restriction on continuing education topics. (a) A registrant may apply no more than five hours of practice management to a one-year reporting period.

(b) A registrant may apply no more than 15 hours to any single subject area.
Subd. 8. *Continuing education exemptions.* The board may exempt any person holding a registration under this chapter from the requirements of subdivision 1 upon application showing evidence satisfactory to the board of inability to comply with the requirements because of physical or mental condition or because of other unusual or extenuating circumstances. However, no person may be exempted from the requirements of subdivision 1 more than once in any five-year period.

**History:** 2008 c 348 s 7

147E.30 DISCIPLINE; REPORTING.

For purposes of this chapter, registered naturopathic doctors and applicants are subject to sections 147.091 to 147.162.

**History:** 2008 c 348 s 8

147E.35 REGISTERED NATUROPATHIC DOCTOR ADVISORY COUNCIL.

Subdivision 1. **Membership.** The board shall appoint a seven-member Registered Naturopathic Doctor Advisory Council consisting of one public member as defined in section 214.02, five registered naturopathic doctors who are residents of the state, and one licensed physician or osteopathic physician with expertise in natural medicine.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059. Section 15.059, subdivision 2, does not apply to this section. Members shall serve two-year terms, and shall serve until their successors have been appointed. The council shall select a chair from its membership.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the board regarding standards for registered naturopathic doctors;

(2) provide for distribution of information regarding registered naturopathic doctors standards;

(3) advise the board on enforcement of sections 147.091 to 147.162;

(4) review applications and recommend granting or denying registration or registration renewal;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action in relation to complaints against registered naturopathic doctors;

(6) advise the board regarding approval of continuing education programs using the criteria in section 147E.25, subdivision 3; and

(7) perform other duties authorized for advisory councils by chapter 214, as directed by the board.

**History:** 2008 c 348 s 9; 2016 c 119 s 7

147E.40 FEES.

Subdivision 1. **Fees.** Fees are as follows:

(1) registration application fee, $200;

(2) renewal fee, $150;
(3) late fee, $75;

(4) inactive status fee, $50; and

(5) temporary permit fee, $25.

Subd. 2. **Proration of fees.** The board may prorate the initial annual registration fee. All registrants are required to pay the full fee upon registration renewal.

Subd. 3. **Penalty fee for late renewals.** An application for registration renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

**History:** 2008 c 348 s 10
Press Release
Wednesday, November 23, 2016

Attorney General Issues Opioid Report Making Policy and Legislative Recommendations to Address Prescription Painkiller Abuse

Attorney General Lori Swanson today issued a report on opioid prescription painkillers that makes wide-ranging legislative and policy recommendations to improve and build on Minnesota’s response to the growing prescription painkiller epidemic.

“Growing addiction to prescription opioid painkillers is devastating families from all walks of life across all parts of our state. We need all hands on deck to push forward solutions, which must involve those in health care, the criminal justice system, patients, families, and policymakers,” said Attorney General Swanson.

The Epidemic
The Report, entitled "Opioids: Preventing and Addressing Prescription Drug Abuse," notes that the United States has less than five percent of the world’s population but uses 80 percent of the world’s painkillers. Prescription opioid painkillers are controlled substances that are sold under brand names like OxyContin, Percocet, or Vicodin. In 2012, 259 million painkillers were prescribed in the United States, enough for every adult to have a bottle of pills. The Centers for Disease Control has called prescription drug abuse the fastest growing drug problem in the United States.

Sales of opioid painkillers have quadrupled since 1999 and so have the number of overdoses from prescription opioids. Nearly 2 million Americans are estimated to be addicted to prescription painkillers. More than 40 people die every day in the U.S. from a prescription opioid overdose. Every 25 minutes a baby is born in this country with opioid withdrawal. More than 1,000 people receive emergency room treatment each day in the U.S. for misused prescription opioids. Withdrawal symptoms from opioid addiction are particularly harsh, causing many patients to relapse.

Nearly 80 percent of heroin users previously abused prescription painkillers. They often turn to heroin or other street drugs when painkillers become too expensive. Prescription opioids contribute to more deaths than heroin and cocaine combined. Prescription painkiller abuse has a significant human and economic toll. For example, prescription opioid abuse costs about $25.6 billion in lost workplace productivity each year.

The Report
Attorney General Swanson said the report relies on a multitude of interviews and contributions from health care professionals, emergency room personnel, government officials, and victims of the opioid epidemic as well as an extensive review of other states’ responses to the epidemic. She added that while the recommendations alone will not solve the prescription opioid epidemic, they hopefully mark the beginning steps of proposals to strengthen Minnesota’s response to the epidemic.

Recommendations in the report (on pages 29-36 (20161123OpioidReport.pdf#page=33)) include the following:
• **Prescription drug monitoring program.** To curb painkiller abuse, Minnesota should require prescribers and dispensers to review a patient’s history in Minnesota’s prescription drug monitoring database before prescribing or dispensing controlled substances. At least eight states appear to require dispensers or prescribers to check the drug monitoring database before filling most controlled substance prescriptions and over 20 more require it to be checked in some circumstances. For example, next year the neighboring state of Wisconsin will require all practitioners and prescribers to review a patient’s history in the monitoring database before prescribing or dispensing a controlled substance. Research indicates that required use of a drug monitoring program is effective in reducing opioid prescriptions. The database should also be modified to reflect whether a prescriber has had restrictions placed on their prescribing authority by the DEA or a health licensing board.

• **Continuing education.** Opioid prescribers and dispensers should be required to take at least two hours of periodic continuing education that addresses pain management, substance abuse disorder, and evidence-based best practices for prescribing and dispensing prescription opioids. At least 10 states require health care professionals to receive periodic continuing medical education on controlled substance prescribing and pain management.

• **Information for patients.** When opioid prescriptions are filled, pharmacies should be required to provide concise, plain-language information developed by the Minnesota Board of Pharmacy on the risks of opioid abuse and the proper disposal of unused medications.

• **Naloxone (e.g. Narcan).** This is a potentially lifesaving drug that can reverse an overdose if quickly administered. But it requires a prescription. At least nine states have or are implementing statewide standing orders for naloxone in which a state public health official authorizes pharmacies to dispense naloxone without an individualized prescription. Minnesota public health officials should do the same and issue a statewide standing order for naloxone, which pharmacies should be required to honor. First responders should be required to carry naloxone, and the Legislature should consider funding sources to defray these costs for responders and low-income Minnesotans.

• **Disposal of opioid painkillers.** Each county law enforcement agency and most pharmacies should be required to maintain collection receptacles for controlled substance drug disposal. Patients often don’t know how to dispose of unused medication. Surveys indicate that more than one-half of the people who abuse prescription drugs get them for free from a family member.

• **Prescription duration.** Under current Minnesota law, a prescription for controlled substances is valid for one year. This time period should be shortened to 30 days to decrease the amount of time that a prescription drug can be diverted or abused.

• **Medical Assistance prior authorizations.** Buprenorphine (e.g. Suboxone) is a drug to treat opioid dependence and it mitigates the otherwise harsh effects of opioid withdrawal. Prior authorization requirements for any form of buprenorphine should be removed from the Medical Assistance program.

• **Pill mills.** In order to identify “pill mill” providers who irresponsibly prescribe opioid painkillers or fraudulently bill government programs for such prescriptions, state government agencies with a legitimate need should be able to access the prescription monitoring database. All prescribers—including those who get paid in cash or don’t accept Medical Assistance—should be required to participate in the Opioid Prescribing Improvement Program.
(OPPI) enacted in 2015 to evaluate opioid prescribing patterns. To aid in the detection and halting of “pill mills,” the OPIP program should be implemented as expeditiously as possible. To curb overprescribing, a number of states have imposed guidelines for the recommended length and/or strength of opioid prescriptions, and the State should give consideration as to the adoption of such guidelines.

- **Drug Courts.** The Legislature should be responsive to the judicial branch’s requests for resources to better address drug addiction within the criminal justice system, including the formation of drug courts, which have shown success. About two-thirds of Minnesota counties have a drug court or plan to establish one but about one-third of counties do not.

- **Expand access to treatment, especially in rural areas.** Drug treatment options should be expanded, especially in rural areas. Every dollar spent on substance abuse treatment saves $4 in health care costs and $7 in criminal justice costs. Of the 122 physicians in Minnesota that are authorized to prescribe buprenorphine to treat opioid dependency, two-thirds are located in the seven-county metropolitan area.
Opioids
Preventing and Addressing Prescription Drug Abuse

Office of Minnesota Attorney General
Lori Swanson
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ACKNOWLEDGEMENT

People are dying from prescription drug overdoses at record levels. The most recent data reflect more than 18,000 deaths in a year in the United States alone. Another 10,000 died from heroin overdoses. Since 1999 the amount of prescription opioids sold in the United States quadrupled, and the fatality rate of opioid painkiller overdoses has similarly quadrupled. The epicenter of the epidemic is the United States, where less than five percent of the world’s population consumes 80% of the global opioid supply. Recent surveys indicate that more than half of the people who abused prescription drugs got them for free from a family member. Other research similarly indicates that the vast majority of heroin users initially used prescription opioid pain relievers.

This Report relies on a multitude of interviews and contributions from health care professionals, emergency room personnel, government officials, and victims of the opioid epidemic. The Report is a compilation of recommendations that can be taken in Minnesota in relatively short order to strengthen efforts to address this crisis.

There are many different approaches to the prescription drug epidemic. Some focus on medical providers, some on pharmaceutical manufacturers, some on treatment and rehabilitation, some on prevention, and some on the criminal justice system. The proposals vary by state and by the impact of the epidemic on a particular community, and there will no doubt be continuing debate as to the most effective approach to the crisis.

This Report does not claim that its recommendations will solve the prescription opioid epidemic. At best, it is hoped that it marks the beginning steps of proposals to build on efforts to address this crisis in Minnesota.
SECTION 1. INTRODUCTION.

You do not have to look further than the daily news to see the devastating effect that opioid abuse is having across the country and in Minnesota. The misuse of opioids, both legally prescribed and illicitly obtained, has become a public health epidemic nationally and in Minnesota. The United States uses 80% of the world’s painkillers, despite having less than 5% of the world’s population. Opioid-related overdoses are the leading cause of drug-related deaths in Minnesota, with prescription opioids contributing to more deaths than heroin. Nationally, 78 people die of an opioid-related overdose every day. More than 40 people die every day from a prescription-opioid overdose.

While illicit drugs like heroin, carfentanil, and synthetic substances are also being used and taking lives at alarming rates, this report focuses on prescription opioids. In many cases, users of illicit substances began by abusing prescription opioids before switching to street drugs that were cheaper and more attainable. Overdose fatalities related to prescription opioids now surpass those from heroin and cocaine combined.

The opioid crisis involves many stakeholders: those struggling with addiction and their friends and families, employers, health care providers, pharmacists, insurers and third-party payors, professional-licensing boards, law enforcement, and the criminal justice system. Federal and state lawmakers have taken steps in recent years to acknowledge and address the growing problems related to opioids. But gaps in the law remain. This Office has met with professionals in the field, consulted with other state attorneys general and government regulators, and communicated with families affected by the opioid crisis. This report provides background on how the opioid crisis evolved; outlines the current state of the problem; discusses federal and state laws, initiatives, and resources related to prescription-opioid abuse; and makes recommendations for further reforms to prevent and address prescription-opioid abuse.
SECTION 2. OPIOID OVERVIEW.

Section 2.1. What Are Opioids? Opioids can be traced to the discovery of opium, which was first discovered and labeled the “plant of joy” by the Sumerians around 3400 B.C. Opium may have been first used for euphoria in religious rituals before eventually spreading throughout the ancient world to every major civilization, where it would be used to treat pain and other ailments.

Opioids are compounds that bind to and stimulate widely distributed receptors in the central nervous system, the peripheral nervous system, and the immune system. Opioids encompass both naturally occurring substances, derived from opium, and synthetic and semisynthetic compounds that, like naturally occurring opioids, act primarily on opioid receptors in the body. Their primary clinical use is as painkillers, where they reduce the intensity of the pain signals that reach the brain. Opioids are susceptible to addiction and abuse because, in addition to reducing pain, they trigger chemical processes in the brain that create intense feelings of pleasure.

Commonly known opioids include both illegal substances like heroin and prescription painkillers like hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin and Percocet), morphine, and codeine.

Section 2.2. Opioid Prescriptions Began Increasing in the Late 1990s. Most of the common prescription-opioid painkillers are schedule II drugs. Any doctor may prescribe an opioid painkiller in the ordinary course of a medical practice when the painkiller is prescribed to treat pain. Prescribing controlled substances requires a registration from the U.S. Drug Enforcement Agency (DEA), which is attainable by completing a simple application form. For most of the 20th century, medical professionals in the United States considered long-term use of opioids to be “contraindicated by the risk of addiction, increased disability, and lack of efficacy over time.” Because doctors generally perceived prescription opioids as dangerously addictive, doctors reserved their long-term use for patients with cancer or other terminal illnesses. A series of studies in the late 1970s and early 1980s explored the effect of opioid treatment on patients with chronic pain, including non-cancer pain. These studies concluded that opioid treatment for chronic pain was largely a safe practice and generated a discussion in the 1990s about prioritizing pain treatment for all patients. One of the more salient elements of the campaign to enhance pain treatment was to describe pain as the fifth vital sign.

Pharmaceutical companies played a significant part in advancing the campaign to prioritize pain treatment as companies aggressively promoted expanded opioid usage. Beginning in 1996, Purdue Pharma began promoting the use of opioids for non-malignant pain in conjunction with the release of its opioid painkiller, OxyContin. “We do not want to niche OxyContin just for cancer pain,” a marketing executive told employees in 1995. In its promotional campaign, Purdue claimed that the risk of addiction from OxyContin was extremely small: Purdue even trained its sales representatives to convey to providers that the risk of addiction to OxyContin was less than one percent. The company promised that one dose could...
relieve pain for 12 hours. As the *L.A. Times* noted, “[o]n the strength of that promise, OxyContin became America’s bestselling painkiller, and Purdue reaped $31 billion in revenue.”

The push for better pain treatment coincided with an exponential increase in opioid prescriptions. Sales of opioid painkillers quadrupled between 1999 and 2010. The Center for Disease Control and Prevention (CDC) estimates that 20% of patients who have pain-related diagnoses or pain unrelated to cancer receive an opioid prescription. Each year between 2000 and 2010 saw a six-percent increase in the likelihood of an individual receiving an opioid prescription. These trends culminated in 259 million prescriptions in 2012, “enough for every adult in the United States to have a bottle of pills.” In 2016, the American Medical Association recommended removing pain as a vital sign.

**Section 2.3. More Prescriptions Result in More Drug Diversion.** The proliferation of opioid prescriptions has fueled increased opportunities for people to divert the painkillers for non-medical uses. According to the John Hopkins Bloomberg School of Public Health, research data strongly indicate that most prescription-drug abuse stems from diversion of legitimate prescriptions. The most common form of diversion involves patients with legitimate opioid prescriptions transferring the drugs to family members or friends trying to self-medicate. According to at least one study, approximately 70% of people who report non-medical use of a prescription opioid obtained the drug from a friend or family member. Given these patterns, it is unsurprising that “many physicians admit that they are not confident about how to prescribe opioids safely, how to detect abuse or emerging addiction, or even how to discuss these issues with their patients.”

**Section 2.4. The Addictive Qualities of Opioids.** The representations from the 1990s and Purdue Pharma’s marketing campaign about the risk of opioid addiction were eventually proved to be false. In 2007, a Purdue affiliate and three company executives pleaded guilty to criminal charges related to their false representations about the risks of OxyContin. Evidence established that clinical trials conducted before the drug hit the market revealed that, not only did it not provide relief for the promised duration, it was addictive. The company and executives paid nearly $635 million in fines.

While opioids are prescribed to relieve pain, they simultaneously activate the brain’s reward systems that trigger the release of dopamine, leading to feelings of intense pleasure. This chemical interaction mimics the same biochemical effect that occurs when people engage in other rewarding life activities, like eating or having sex. The pleasure induced by opioids has been described as being a few hundred times better than the pleasure produced by eating or having sex. Accordingly, in the early stages of opioid abuse, stimulating the brain’s reward system is a primary reason for using opioids in excess. But the compulsion to take opioids evolves with greater exposure and builds with time.
The first clinically significant change in compulsion is opioid tolerance. Over time, increasingly higher dosages are necessary to produce the same amount of dopamine and achieve the same effect because brain cells with opioid receptors become less responsive to opioid stimulation. An increasing tolerance can also lead to withdrawal symptoms that manifest through reduced dopamine releases that previously occurred in response to normally rewarding activities like eating. These withdrawal symptoms exacerbate the compulsion to take opioids.

The second clinically significant change in the transition to opioid addiction is opioid dependence. Typically, opioids initially suppress neurons that stimulate wakefulness and general alertness, resulting in drowsiness, low blood pressure, and slowed breathing. After repeated exposure to opioids, the neurons in the brain that typically stimulate alertness, breathing, and blood pressure adjust by becoming more active. As a result, when opioids are present, their mitigating effect on these neurons is offset by the neurons’ increased activity. But when opioids are absent, the increased activity of these neurons triggers withdrawal symptoms like jitters, anxiety, muscle cramps, and diarrhea. In other words, repeated exposure to opioids alters or “hijacks” the brain so that it functions normally when opioids are present and abnormally when they are not. These brain changes underlie the compulsive drug-seeking behavior associated with opioid addiction. “Chemistry, not moral failing, accounts for the brain’s unwinding.”

Withdrawal itself is not fatal. But its effects have been described as so overwhelming that a relapse is likely if the withdrawal is not addressed immediately. The Pioneer Press once described that individuals in withdrawal “feel like their bones are breaking and fluids leak from every orifice.” A former drug user has stated that, when users are in withdrawal, “They can’t eat. They can’t stand up. They have stomach cramps. They have muscle aches. They can’t think. All they know is what they need to stop the pain.” The director of a treatment program put it more bluntly: “You don’t die from withdrawal. You just wish you would have.”

The structural changes in brain activity associated with opioid addiction and withdrawal symptoms help explain the danger posed by repeated exposure to opioids. By virtue of the effect that opioids have on the brain, greater exposure leads to craving higher dosages to achieve the same effect experienced at lower dosages and to stave off withdrawal symptoms. At the same time, significantly higher risks of overdose are associated with exposure to higher dosages of opioids, with one study finding that the risk of overdose was nine times higher for individuals who received prescribed opioid dosages of at least 100 milligrams compared to individuals receiving lower dosages. Part of this effect is explained by the asymmetry in individuals’ development of tolerance to different effects of opioids. An article in The New England Journal of Medicine noted that tolerance to analgesic (pain-relief) and euphoric effects of opioids develops quickly, while tolerance to other opioid effects, like respiratory depression, develops more slowly. Accordingly, increasing dosages to maintain the painkilling effects of the opioid exacerbate a patient’s risk of overdose. The U.S. Surgeon General recently explained that, “addiction is not a character flaw—it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

“You don’t die from withdrawal. You just wish you would have.” — Treatment program director
No single factor determines who will become addicted to opioids. Community-, family-, and individual-level factors may all may affect individuals’ risk levels. The Surgeon General has stated that factors may include access to substances, family conflict, family history of substance-use disorders, low involvement in school, a history of abuse or neglect, and a history of substance use during adolescence. Adolescence and young adulthood are particularly critical times for being at risk of developing a substance use problem or disorder. Research has indicated that high school students who receive and take a legitimately prescribed opioid are one-third more likely to abuse the drug by age 23 than students who have not taken a prescription. Some recent research has also suggested that the personality traits that make someone most susceptible to addiction are sensation-seeking, impulsiveness, anxiety sensitivity, and hopelessness.

Section 2.5. Opioid Use Disorder. The recent deluge of prescription opioids for pain relief, coupled with opioids’ powerful inducements toward compulsive and addictive behavior, has resulted in an astounding rate of opioid addiction, affecting approximately 2.5 million adults in 2014, with approximately 1.9 million specifically addicted to prescription painkillers. Further, 12.5 million Americans ages 12 and older reported misusing a prescription painkiller in the past year. The Diagnostic and Statistical Manual of Mental Disorders recognizes opioid use disorder as a subset of substance use disorder. The symptoms of opioid use disorder include a strong desire for opioids, the inability to control or reduce use despite interference with other obligations, use of increasing dosages, spending a significant time obtaining and using opioids, and experiencing withdrawal symptoms when reducing use.

Section 2.6. Treating Opioid Dependence. One of the common and effective forms of treating opioid dependency is medication-assisted treatment, which generally consists of a medication in addition to other psychosocial counseling and support. While methadone remains one form of medication-assisted treatment, since 2002 buprenorphine has been one of the more prevalent forms of medication-assisted treatment. Buprenorphine is a schedule III drug that is a partial agonist, whereas methadone is a full agonist like heroin. An agonist is a chemical that binds to a receptor on a nerve cell and produces a response. Subutex consists only of buprenorphine, but one of the more common medications used is Suboxone, which is a combination of buprenorphine and naloxone. Naloxone is primarily used to counteract the effects of an opioid overdose in emergency situations. Unlike buprenorphine, naloxone is not susceptible to abuse because it does not mimic the effects of opioids or address withdrawal symptoms. Other buprenorphine-based drugs that the FDA has approved for treating opioid dependence include Bunavail and Zubsolv. In May 2016, the FDA approved the first buprenorphine implant, Probuphine. Common brands of naloxone include Narcan and Evzio. Because buprenorphine is only a partial agonist and because it can be combined with naloxone, drugs like Suboxone generally present a lower risk of abuse or overdose.
a patient can fill a buprenorphine prescription at a pharmacy and take it at home as opposed to frequently traveling to a methadone clinic—that may be far away—to receive methadone. Research has found that buprenorphine is effective in treating opioid dependence. Because medication-assisted treatment involves using a medication to treat addiction, some providers are resistant to using it even though some research suggests that abstinence-based treatment has difficulty in successfully treating opioid dependence. Physicians with first-hand experience prescribing buprenorphine tend to have a more optimistic view of its efficacy than physicians who have not prescribed it. For example, in a survey of rural Washington state physicians who were currently prescribing buprenorphine, all reported that they were generally satisfied with the effectiveness of buprenorphine for treating opioid addiction, and 95% said they would recommend the use of buprenorphine to their colleagues.

Whereas any doctor can prescribe schedule II opioid painkillers to treat pain, the DEA more strictly regulates distribution of buprenorphine to treat opioid dependence. As discussed in more detail in Section 4 of this report, only physicians who obtain a waiver from the DEA are authorized to prescribe buprenorphine, and most then face strict patient limits. And, as discussed in Sections 5 and 6, barriers to accessing buprenorphine can accumulate due to the limited number of authorized prescribers and to roadblocks imposed by insurers.

Treatment not only benefits the individual with a substance use problem, it makes economic sense. Every dollar spent on treatment for a substance use disorder saves $4 in health care costs and $7 in criminal-justice costs.
SECTION 3. THE CURRENT OPIOID CRISIS.

The United States is facing an unprecedented drug overdose epidemic, driven by the increased availability of prescription opioids. Despite constituting only 4.6% of the world’s population, Americans consume 80% of the global opioid supply. In 2014, a record number of people died from drug overdoses in the United States, and opioids accounted for most of these deaths.

Section 3.1. The National Devastating Toll of Opioid Abuse. According to the American Society of Addiction Medicine, drug overdoses are the leading cause of accidental death in the United States, with 47,055 lethal drug overdoses occurring in 2014. Since 2009, deaths from overdoses have exceeded those from car accidents. Between 2000 and 2014, nearly one-half million people died in the United States from drug overdoses.

As illustrated by the CDC in Figure 1, opioids account for a significant part of the drug overdose epidemic. In 2014, 61% of all drug overdoses involved an opioid. That year, 28,647 people—about 78 people a day—died from an opioid-related drug overdose. In 1999, opioids accounted for just 35% of all drug overdose deaths, and an average of 16 people a day died from an opioid-related overdose. While the death rate for drug overdoses in general has increased by 137% since 2000, the death rate for opioid-related overdoses increased by 200%.

Section 3.2. The Devastating Toll of Opioid Abuse in Minnesota. Minnesota is not immune from these trends. Between 1999 and 2014, the state had 3,262 opioid-related fatalities; 1,767 of these deaths related to prescription opioids, 348 related to heroin, and 1,147 related to other opioids. In 2015, 572 people in Minnesota died from drug overdoses; 216 of the deaths

“The bottom line is that [the prescription opioid epidemic] is one of the very few health problems in this country that’s getting worse.”—Dr. Tom Frieden, CDC director

“Our heroin addicts are now 20-year-old kids... Today’s addicts, many don’t look like your Keith Richards stereotype. They look like your prom queen.”—Minneapolis DEA Agent
related to prescription opioids, while 114 related to heroin.\textsuperscript{95} Between 2014 and 2015, deaths in Minnesota related to drug overdoses increased by 11\%, and these deaths have quadrupled since 2000.\textsuperscript{96} The starkness of these numbers is underscored when considering that, in 2008, fewer than ten people died from a heroin overdose in Minnesota—a number low enough that the CDC did not report the exact number.\textsuperscript{97}

The opioid epidemic stretches across all demographics in Minnesota, but some segments of the population have been hit particularly hard. The opioid-related death rate for Native Americans between 1999 and 2014 was five times higher than that of whites.\textsuperscript{98} The death rate for African Americans was also higher than the rate for whites.\textsuperscript{99} Geographically, the counties with the highest death rates are Anoka, Carlton, Cass, Hennepin, Mille Lacs, and St. Louis Counties.\textsuperscript{100} Cass County and Mille Lacs County have been hit the hardest.\textsuperscript{101} As illustrated by Figure 2, generationally, most opioid-related deaths have occurred in those between ages 45 and 54 (846 deaths), followed by those ages 35 to 44 (750 deaths), those ages 25 to 34 (605 deaths), those ages 55 to 64 (360 deaths), and those ages 15 to 24 (322 deaths).\textsuperscript{102}

![Figure 2. Minnesota Opioid-Related Overdose Fatalities. (Sources MPRNews, CDC)](image)

**Section 3.3. Prescription-Drug Abuse is Driving the Opioid Epidemic.** In 2012, the CDC described prescription-drug abuse as the fastest growing drug problem in the United States.\textsuperscript{103} Analyzing data from 2000 to 2014, the CDC observed a long-term trend in fatal overdoses involving prescription opioids and a more recent increase in deaths from illicit opioids, primarily heroin.\textsuperscript{104}

As to the increase in overdoses from prescription painkillers, a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is part of the U.S. Department of Health and Human Services, found that 4.3 million individuals ages 12 or older reported current non-medical use of prescription painkillers in 2014, meaning that they were using prescription painkillers either without a prescription or without a medical need.\textsuperscript{105} Between
2003 and 2010, the rate of chronic non-medical use of prescription pain relievers—defined as past-year non-medical use for 200 days or more—increased by 74.6%.

Emergency room visits involving misuse or abuse of prescription opioids increased 153% between 2004 and 2011. These trends culminated in nearly 2.5 million Americans ages 12 or older meeting the criteria for a opioid use disorder in 2014, according to SAMHSA.

The increasing number of individuals engaging in non-medical use of prescription opioids and the corresponding addiction rates have resulted in an unprecedented increase in overdose deaths caused by prescription opioids. While representing less than 25% of all drug overdose deaths in 1999, prescription opioids now account for 40% of all drug overdose deaths. Since 2003, prescription opioids have resulted in more overdose deaths than heroin and cocaine combined. The increasing number of prescription-opioid overdose deaths is troubling, with the number of prescription opioid-related overdoses quadrupling since 1999. Of the 28,647 opioid-related deaths in 2014, nearly 19,000 were from prescription opioids. More than 40 people die in the United States each day from a prescription opioid overdose.

Data indicate that the rate of prescription-opioid overdose deaths strongly correlates with increases in prescription-opioid sales and corresponding prescription abuse and addiction. For example, the CDC reports that, between 1999 and 2008, overdose death rates, sales, and substance-abuse-treatment admissions related to opioid painkillers increased in parallel, as illustrated by the following chart created by the CDC:

These trends led the authors of an article published in *The New England Journal of Medicine* to declare in March 2016 that it “can no longer be questioned” that “the widespread use of [prescription opioids] has resulted in a national epidemic of opioid overdose deaths and addictions.”
Prescription-drug abuse is of particular concern because of its role as a gateway to other opioids. “Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use.”115 A review of research in The New England Journal of Medicine concluded that nearly 80% of heroin users reported previously engaging in non-medical use of prescription opioids before using heroin.116 Another study from SAMHSA found that the likelihood of using heroin was 19 times higher among individuals who reported prior non-medical painkiller use.117 Research has additionally shown significant shifts in the patterns of first opioid use among heroin users entering substance-abuse treatment programs. According to a study published in The Journal of the American Medical Association: Psychiatry, among people who began using opioids in the 1960s, more than 80% reported that their first opioid was heroin; conversely, in the 2000s, 75% of users initiated opioid use with prescription opioids.118 Many individuals reported resorting to heroin because it is cheaper and more accessible.119

The transition from non-medical use of prescription opioids to illicit synthetic opioids like heroin has significant consequences. First, transitioning to heroin exposes users to a cheaper, more accessible source for their opioid addiction.120 Second, once users are in illegal markets, they are exposed to more potent, illicit synthetic opioids. For example, since 2015, the DEA has issued public warnings about the increasing presence of two synthetic opioids, fentanyl and carfentanil, that are often disguised as or combined with heroin.121 Fentanyl is 50 to 100 times more potent than morphine and 30 to 50 times more potent than heroin.122 Carfentanil is 100 times more potent than fentanyl.123 Carfentanil is typically used as a tranquilizing agent for elephants and other large mammals.124 Figure 4 reflects the small amounts of carfentanil and fentanyl needed to achieve the same effect as a larger amount of heroin. Even in this figure, the depiction of carfentanil is exaggerated because it would otherwise be imperceptible.

**Equivalent Strengths of Heroin, Fentanyl, and Carfentanil**

![Figure 4. Relative Potency of Heroin, Fentanyl, and Carfentanil. (Source: DEA.)](source: DEA.)
Carfentanil and fentanyl are particularly dangerous because each can be absorbed through the skin, and a small amount can kill. Carfentanil is so strong that it is difficult to revive someone who has overdosed, even with multiple doses of naloxone. While little data exist on the proliferation of carfentanil due to its recent emergence in illicit markets, CDC data show that the number of drug products seized by law enforcement that tested positive for fentanyl increased by 426% from 2013 to 2014.

The increasing number of individuals using illegal opioids has coincided with a recent and steep increase in deaths related to illicit opioids like heroin and fentanyl. The number of deaths from synthetic opioids increased by 79% between 2013 and 2014, and the increase correlated with the increase in drug products testing positive for fentanyl. Meanwhile, heroin-overdose death rates increased by 26% from 2013 to 2014 and have tripled since 2010. Despite the relatively recent nature of the data, the increasing levels of abuse of, and addiction to, prescription opioids indicate that prescription-opioid abusers are turning to heroin, which in turn is leading to an increase in deaths from both heroin and other synthetic opioids like fentanyl. According to a report published by the CDC, these findings indicate that the opioid epidemic is worsening. Consistent with these trends, Minnesota has experienced a wave of overdose deaths related to fentanyl-laced heroin, including a cluster of deaths alleged to be linked to one metro area drug dealer.

Section 3.4. The Costs of Opioid Abuse. In addition to the rising human and death toll, the opioid crisis imposes significant economic costs on society. Abuse of opioid painkillers costs society billions of dollars each year. Estimates range from $53 to $72 billion a year, when accounting for medical costs, treatment costs, lost productivity, and costs incurred by the criminal justice system. The CDC reports that more than 1,000 people receive emergency-room treatment every day for misusing prescription opioids, and the National Institute on Drug Abuse reports that a baby is born suffering from opioid withdrawal every 25 minutes. Lost workplace productivity alone has been estimated to be about $25.6 billion a year. Seven million men between the ages of 25 and 54 (about 11.4% of the age group) are not in the labor force, meaning that they are unemployed and not seeking work. The percentage has increased from less than 4% in the past two decades. One recent study found that 44% of these men not in the labor force reported taking painkillers on a daily basis, in contrast to about 20% of employed men and those unemployed but looking for work. Some have speculated that the high rate of painkiller use may be connected to being unemployed, as those with few job prospects may be more likely to become depressed and addicted to painkillers.
Household compositions and caretaking responsibilities have also shifted because of the opioid epidemic. In 2015, 2.9 million children were living with grandparents responsible for their care, compared to 2.5 million in 2005. More children are now living with their grandparents because their parents have either died from a heroin or prescription-drug overdose or are struggling with an opioid addiction and unable to care for their children. In addition to changing retirement plans for many grandparents, these dynamics create strains related to finances and health. About one-fifth of grandparents caring for grandchildren live below the poverty line, and more than one-quarter have a disability.
SECTION 4. FEDERAL LAWS, INITIATIVES, AND RESOURCES RELATED TO PREVENTING AND COMBATTING OPIOID ABUSE.

The federal Controlled Substances Act was first enacted in 1970, and the distribution and disposal of controlled substances have been heavily regulated. Since approximately 2000, however, there have been several shifts in federal law aimed at increasing safe and timely disposal of prescription drugs, expanding treatment access for those dependent on opioids, and curbing prescription-drug abuse.

Section 4.1. Proper Disposal of Controlled Substances. Several federal laws affect the disposal of controlled substances. Prompt and safe disposal reduces the risk that prescription drugs will be diverted or otherwise misused.

Section 4.1.a. Federal Controlled Substances Act. The Controlled Substances Act (CSA), 21 U.S.C. §§ 801-971, broadly regulates manufacturing, possessing, using, importing, distributing, and disposing of certain drugs, including opioids approved for medical use. The CSA classifies drugs on one of five schedules depending on whether the drug has an acceptable medical use and whether the drug has the potential for abuse and dependency. Opioids are found in all five of the federal schedules from heroin on schedule I to cough suppressants containing small amounts of codeine on schedule V. Before 2010, the CSA required a person to dispose of a lawfully prescribed controlled substance by either surrendering the medication directly to law enforcement, seeking the DEA’s assistance, or destroying it themselves. The DEA has since recognized that these cumbersome restrictions ultimately deterred safe and timely disposal and led to the accumulation of prescription drugs in medicine cabinets, making them “available for abuse, misuse, diversion, and accidental digestion.”


The DEA’s final rules implementing the Disposal Act took effect in October 2014. The rules expanded disposal options by allowing registered pharmacies, manufacturers, distributors, narcotic treatment programs, and hospitals with on-site pharmacies to provide collection receptacles for controlled substances. These registered collectors may also conduct “mail-back programs” if the collector has the ability to destroy the substance. Long-term care facilities may collect from residents if the collection receptacle is managed and maintained by a registered pharmacy. The rules also allow any person to partner with law enforcement to conduct a take-back event and give law enforcement agencies and other collectors the authority to conduct mail-back programs.
Section 4.1.c. Other DEA tools and resources. The DEA administers the registration of collection sites for controlled substances under the Disposal Act, and local DEA offices partner with participating law enforcement agencies to host National Prescription Drug Take-Back Days. The DEA also maintains a search tool to assist citizens in finding a disposal location in their area at https://apps.deadiversion.usdoj.gov/pubdispsearch/. The database is searchable by zip code or city and state.

In October 2016, the DEA exercised its authority under the CSA to issue a final order reducing the Aggregate Production Quota (APQ) for several schedule II opioid medications in 2017, including oxycodone, hydrocodone, fentanyl, hydromorphone, and morphine. The DEA defines the “APQ” as “the total amount of a controlled substance necessary to meet the estimated medical, scientific, research, industrial, and export needs for the year and for the maintenance of reserve stocks.” Practically, this means that the DEA serves as a gatekeeper, controlling the amount of opioids legally sold each year in the United States.

Section 4.2. Federal Laws Related to Medication-Assisted Treatment. The federal government also plays a significant role in access to medication-assisted treatment because it determines which medications may be used and who may prescribe and administer them.

Section 4.2.a. Drug Addiction Treatment Act. In 2000, Congress enacted the Drug Addiction Treatment Act (DATA) of 2000 as part of the CSA, 21 U.S.C. § 823(g). Before DATA, the only approved medications to treat opioid addiction were methadone and levo-alpha-acetyl-methadol, both schedule II drugs that could be dispensed only through a federally approved opioid treatment program. DATA created a system for some physicians to obtain waivers to prescribe schedule III, IV, and V drugs, including buprenorphine (e.g., Subutex) and buprenorphine/naloxone (e.g., Suboxone), for treating opioid dependence. To qualify for a waiver the physician must generally hold an additional certification in addiction or complete eight hours of training on treating and managing opiate-dependent patients. A physician may treat up to 30 patients for the first year of a waiver, and then may seek a waiver to treat up to 100 patients. Effective August 2016, physicians with 100-patient waivers may seek waivers to treat up to 275 patients.

Access to treatment remains a problem because few providers have obtained a waiver to prescribe buprenorphine. Of the approximately 435,000 primary care physicians in the United States, only about 6.9% have a waiver, and only about one-half of that group actually treats opioid use disorders. As illustrated in Figure 5, of Minnesota’s physicians authorized to prescribe buprenorphine, 50 doctors are certified to treat up to 30 patients and 20 are certified to treat up to 100 patients.
Patient limits do not apply to providers who dispense buprenorphine on site in an opioid treatment program.\textsuperscript{166} SAMHSA data indicate that, overall, only 122 of Minnesota’s 16,804 professionally active physicians are authorized to prescribe buprenorphine.\textsuperscript{167} This amounts to about 0.73% of Minnesota’s physicians.

\textbf{Section 4.2.b. Food and Drug Administration approvals for medication-assisted treatment and opioid antagonists.} The U.S. Food and Drug Administration (FDA) is responsible for approving prescription drugs for use. While buprenorphine has been marketed as an injectable painkiller since 1985, the FDA first approved it for treating opioid dependence in 2002 when it approved Subutex (buprenorphine) and Suboxone (buprenorphine/naloxone) tablets.\textsuperscript{168} In 2010, the FDA approved Suboxone in a sublingual film form for treating opioid dependence.\textsuperscript{169} In 2016, this Office filed an antitrust lawsuit with 41 other states against Indivior, the drug manufacturer that makes Suboxone, based on anticompetitive conduct that has precluded other manufacturers from making competing generic versions of the drug. The FDA approved Bunavail in 2014 and Zubsolv in 2015, both of which are also combinations of buprenorphine and naloxone.\textsuperscript{170}

The FDA first approved naloxone hydrochloride in 1971 for administration by injection.\textsuperscript{171} In 2014, the FDA approved Evzio, an auto injector similar to an EpiPen, as the first naloxone injection approved to address the risk of opioid overdose in all settings.\textsuperscript{172} In late 2015, the FDA approved a nasal spray form of naloxone called Narcan.\textsuperscript{173} Naloxone remains a prescription drug, but the FDA has announced that it is reconsidering its options for making naloxone more accessible.\textsuperscript{174}

\textbf{Section 4.3. Recent Federal Reforms, Proposed Legislation, and Initiatives.} Federal agencies have recently taken more aggressive approaches to curbing painkiller abuse. Several recent federal laws and pending bills are also aimed at further addressing the opioid crisis.
Section 4.3.a. New CDC prescribing guidelines. In March 2016, the CDC issued new opioid-prescribing guidelines for primary care physicians, after concluding that further clinician guidance was needed for opioid prescribing. The new guidelines focus on when opioids should be used for chronic pain, how opioids should be selected, how long opioids should be used, and how physicians should assess risks of opioid abuse. The guidelines advise prescribers to be particularly cautious when prescribing the equivalent of more than 50 morphine milligram equivalents (MMEs) per day and to carefully justify prescriptions exceeding 90 MME per day.

Section 4.3.b. FDA drug rejections and guidance. In recent years, the FDA has stopped several new opioid painkillers from entering the market and has taken action when drug manufacturers have misrepresented the safety of unapproved opioids. For example, in 2014, the FDA denied approval of Moxduo (morphine and oxycodone), concluding that insufficient evidence established that the drug was safer than morphine or oxycodone used independently. In September 2016, the FDA sent a warning letter to DURECT Corporation and Pain Therapeutics, Inc., based on their online representations suggesting that an experimental new drug—Remoxy ER (oxycodone)—was safe and effective. The FDA also recently encouraged opioid drug manufacturers to include abuse deterrents in drugs.

Section 4.3.c. Comprehensive Addiction and Recovery Act of 2016. In 2016, Congress enacted the Comprehensive Addiction and Recovery Act (CARA), Pub. L. No. 114-198. CARA seeks to address the opioid crisis primarily by awarding grants to treat and prevent opioid addiction. This Office was part of a coalition of 38 state attorneys general who supported CARA’s passage, recognizing the devastating effects of opioid abuse and advocating for a strategy that includes prevention, law enforcement, reduction of overdose deaths, evidence-based treatment, and support for people who are in or seeking recovery. While CARA passed with overwhelming bipartisan support, disagreements remain about the level of funding provided to implement the components of the final act. Some of CARA’s major provisions include:

- Focusing on opioid-abuse prevention and education by creating the Pain Management Best Practices Inter-Agency Task Force, directing the U.S. Department of Health and Human Services to conduct an education and awareness campaign, requiring a closer review of applications for new opioid painkillers and prescription-labeling requirements, and providing grants for community-based coalitions to address local drug crises.

- Improving access to overdose treatment by providing grants to health centers and other entities to expand access to overdose drugs such as naloxone and creating grant programs for states to implement strategies for pharmacists to dispense overdose drugs through standing orders.

- Improving information available to opioid prescribers by reauthorizing the National All Schedules Prescription Electronic Reporting Act of 2005, which provides grants for states to maintain or improve prescription drug monitoring programs.

- Assisting law enforcement through grants for developing and implementing alternative incarceration programs (such as drug courts or diversion programs), for facilitating
coordinated between criminal-justice and substance-abuse agencies, for training first responders on administering opioid overdose reversal drugs, for purchasing opioid overdose reversal drugs for use by first responders, and for implementing drug take-back programs.187

- Expanding funding for medication-assisted treatment by providing grants to state substance abuse agencies, local governments, or nonprofit organizations serving those with high rates of opioid use.188

- Expanding access to medication-assisted treatment by allowing nurse practitioners and physicians assistants who meet certain requirements to obtain waivers to prescribe buprenorphine.189

- Providing grants to states for implementing integrated opioid-abuse response initiatives that include educating prescribers, creating or improving comprehensive prescription drug monitoring programs, maintaining opioid- and prescription-drug addiction treatment programs, and preventing overdose deaths.190

- Overhauling the prescribing practices of opioids in the U.S. Department of Veterans Affairs.191 Among other things, the law directs the Department to ensure that providers are educated on current prescribing practices and have access to state prescription drug monitoring programs.192

Section 4.3.d. Public awareness and proposed federal legislation related to opioid addiction and diversion. In 2016, U.S. Surgeon General Dr. Vivek Murthy launched a public awareness campaign about the opioid epidemic. In August 2016, he wrote to 2.3 million health professionals, encouraging them to seek education about safe prescription practices and to screen patients for opioid use disorder and connect them with evidence-based treatment.193 He also launched a website, TurnTheTideRx.org, that has a variety of resources related to opioids.194 Additionally, federal legislators have recently proposed additional measures to combat the opioid epidemic, although many of these proposals have yet to be acted on. Some examples include:

- **Prescription Drug Monitoring Act of 2016 (S. 3209).** In 2016, U.S. Senator Amy Klobuchar introduced a bill that would require doctors to consult their state’s prescription drug monitoring program before prescribing a controlled substance.195 The bill would also require states to share program data with other states through a single technology to be established by the U.S. Attorney General in coordination with U.S. Department of Health and Human Services.196

- **Promoting Responsible Opioid Prescribing (S. 2758 and H.R. 4499).** Both the Senate and House of Representatives have pending legislation to remove consideration of pain-related questions on patient surveys from decisions relating to payment from Medicare.197 Currently, the patient surveys, which are used to calculate Medicare reimbursement rates based on quality measures, ask patients three questions related to pain management, including whether the practitioner did “everything they could to help” with pain.198 Some doctors report being faced with the choice of either prescribing unnecessary narcotics or
risking low patient satisfaction scores on surveys, resulting in cuts to reimbursement rates. Sponsoring legislators hope that this new law would remove an incentive for hospitals to overprescribe opioids.200

• **Carl’s Law (S. 3298, H.R. 5601).** Both Senate and House legislators have proposed Carl’s Law to amend the Federal Food, Drug, and Cosmetic Act to require labels of prescription opioids to state prominently that the drug contains an opioid and that addiction is possible.201 The bill is named after Carl Messinger, a New Hampshire man who, while in recovery for a heroin addiction, was prescribed a cough syrup that contained an opioid. The prescription triggered drug-seeking behavior that eventually led to a fatal overdose.202

**Section 4.3.e. SAMHSA Initiatives and Tools.** SAMHSA provides resources and tools to assist people with opioid addictions to seek help by maintaining on its website the Buprenorphine Physician & Treatment Program Locator and the Opioid Treatment Program Directory.203 SAMHSA also offers trainings for physicians on opioid prescribing and medication-assisted treatment.204
SECTION 5. MINNESOTA AND OTHER STATE LAWS AND INITIATIVES RELATED TO OPIOID ABUSE.

Section 5.1. Minnesota Laws. Since about 2013, Minnesota has enacted legislation specifically related to opioid abuse and treatment. The result of these legislative efforts can be seen in Minnesota’s prescription drug monitoring program and its Opioid Prescribing Improvement Program, as well as in laws relating to prescribing practices, treatment and overdose prevention, and controlled substances disposal. The Minnesota Board of Pharmacy has adopted rules to increase opportunities for intervention in opioid addiction and to help prevent controlled substances diversion. In 2016, the State amended many criminal laws to increase penalties for drug dealers, reduce criminal penalties for individuals with addictions, and facilitate treatment opportunities.

“Health officials and the public were slow to realize the extent of the danger presented by opioids until the problem became widespread enough that it was difficult to turn aside.”—Minnesota Public Radio

Section 5.1.a. Prescription drug monitoring program. Minnesota’s prescription drug monitoring program, administered by the Minnesota Board of Pharmacy, is a tool for prescribers and pharmacists to manage patient care and to identify individuals who may be abusing or diverting controlled substances. All dispensers of controlled substances, including pharmacies and practitioners who dispense from their office, are required to submit data about controlled-substance prescriptions to the prescription drug monitoring database. Effective July 1, 2017, prescribers and pharmacists will be required to register and maintain a prescription drug monitoring program user account. They are not required, however, to actually check or review the database before issuing or filling a controlled-substance prescription. One exception when the prescription drug monitoring system must be accessed and reviewed is before a client is ordered a controlled substance while enrolled in an opioid addiction treatment program licensed by the Minnesota Department of Human Services (DHS).

Dispensers are required to report data about controlled-substance prescriptions into the prescription drug monitoring system daily. Minnesota law requires dispensers to report 14 types of data, including the names of the prescriber and dispenser; patient information, including the patient’s name, address, and date of birth; and information about the prescribed controlled substance, including the medication’s name, strength, and quantity, and the duration of the prescription. The Board of Pharmacy may require dispensers to collect additional data, beyond those listed in the statute. For example, the Board requires dispensers to report the prescriber’s and dispenser’s phone numbers, the patient’s gender, and the patient’s payment method.

The data submitted to the prescription drug monitoring database are classified as private data and not subject to public disclosure. Multiple permissible users may access the data, including prescribers, dispensers, the individual to whom the controlled substance is prescribed, and federal, state, and local law enforcement agencies with a valid search warrant.

The Board of Pharmacy is allowed by statute to participate in an interstate prescription monitoring data exchange system. Currently, Minnesota exchanges data with 26 other states.
Section 5.1.b. Prescribing practices. In 2015, the Minnesota Legislature established the Opioid Prescribing Improvement Program (OPIP) with the goal of reducing opioid dependency by improving opioid prescribing practices by providers who serve Medical Assistance patients. OPIP requires DHS and the Minnesota Department of Health to establish a work group to recommend prescribing protocols for all phases of the prescribing cycle and to develop sentinel measures and educational resources for providers to discuss opioids with their patients. As part of OPIP, DHS is supposed to collect data measuring the prescribing patterns of the prescribers in the program and compares their patterns to those of their anonymized peers. Abnormal patterns can lead to implementation of an improvement plan and ultimately termination from the Minnesota Health Care Program. All prescribers who prescribe opioids to program enrollees are required to participate, but other prescribers may participate voluntarily.

When ordering an opioid prescription, all Minnesota practitioners, regardless of whether they are serving Medical Assistance patients, must establish that the prescription drug order was initially based on a patient examination. When a controlled substance is not covered, in whole or in part, by a health plan company or third-party payor, the person purchasing the drug must present valid photo identification, unless that person is known to the dispenser.

The Minnesota Board of Pharmacy has also promulgated rules to assist with recognizing and intervening in opioid addiction and preventing diversion. For example, upon receiving a prescription drug order, a pharmacist must review the patient’s medication, and verify that the patient is receiving the correct medication in the correct strength and dosage form. Labels on drugs administered as controlled substances must include the phrase: “Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.” Additionally, in an effort to prevent and detect diversion through improper dispensation and theft, each pharmacy must maintain a perpetual inventory system for schedule II controlled substances. The Board also requires all prescriptions to be filled within one year of issuance.

Section 5.1.c. Treatment. All substance-abuse programs licensed by DHS must provide educational information about medication-assisted treatment options. DHS is required by statute to establish a pilot program for treating pregnant women with substance use disorders within limits of federal funds available for such a program, and providers in DHS-licensed opioid treatment and withdrawal-management programs must provide educational information about opioids, including opioid tolerance and overdose risks. To reduce diversion, in addition to other requirements, patients receiving DHS-licensed treatment services who receive more than 24 milligrams of buprenorphine daily must meet face-to-face with a prescribing physician. Minnesota’s Medicaid program does not require preauthorization for Suboxone (buprenorphine/naloxone) film. But preauthorization is required for buprenorphine/naloxone tablets and other forms of buprenorphine like Zubsolv.
Section 5.1.d. Prior authorizations. After hearing from a range of providers—including doctors, nurses, pharmacists, and counselors—this Office reached out to the major private third-party payors in Minnesota to determine their preauthorization practices and asked that they remove any preauthorization requirements for buprenorphine when prescribed to treat opioid dependence. HealthPartners and PreferredOne reported that neither required preauthorization. Medica and Blue Cross Blue Shield of Minnesota each reported that it had preauthorization requirements, but both agreed to remove their preauthorization requirements. Only UnitedHealth Group, which is not licensed as an insurer or HMO in Minnesota, refused to alter its policy of requiring preauthorization for all buprenorphine prescriptions. UnitedHealth Group is an administrator of self-insured employee health plans, and state regulation of such plans is preempted by federal law under the Employee Retirement Insurance Security Act of 1974 (“ERISA”).

Section 5.1.e. Criminal laws and drug courts. Minnesota’s criminal laws also play a role with respect to possessing and selling opioid medications and other opioids such as heroin. Minnesota lists many opioid medications specifically on drug schedules II to V, while heroin and other opioids not used for medical purposes are listed on schedule I. Schedule II contains many opioid painkillers including codeine, fentanyl, hydrocodone (Vicodin), and oxycodone (OxyContin), while schedule III contains narcotic drugs with certain amounts of codeine, opium, and morphine. Selling or unlawfully possessing opioids can range from a first- to a fifth-degree controlled substance crime. Provisions of Minnesota’s fifth-degree controlled substance law also address doctor-shopping by prohibiting the procurement of controlled substances through fraud, deceit, misrepresentation or subterfuge, or by using a false name.

In 2016, the Minnesota Legislature enacted the Drug Reform Act, which revised Minnesota’s drug laws and sentencing guidelines with the intent of increasing penalties for drug dealers and kingpins and reducing penalties for individuals with addictions so they can seek treatment. Aggravating factors that can enhance the class of a crime include the involvement of interstate or international drug transfers, the offender’s position within a drug-distribution hierarchy, and the sale or possession of drugs in three or more counties. The law also reduced some classes of crimes. For example, someone with no prior drug convictions would most likely be charged with fifth-degree possession, which was reduced from a felony to a gross misdemeanor. In addition, the law focuses on providing probation and treatment for individuals with an addiction, providing that most cases involving unlawful possession of an opioid painkiller will result in a presumptively-stayed sentence for all but the most recidivistic offenders. The law also appropriated funds for fiscal year 2017 to the Commissioner of Corrections to establish 70 new chemical-dependency or mental-health treatment beds and to hire two chemical-dependency release planners.

Since 2014, the number of treatment courts in Minnesota that focus on specialties like drug addiction has increased. The Minnesota Judicial Branch reports that these courts reduce recidivism and save taxpayers money. As of the date of this report, 57 counties either have an established treatment court or have announced plans to establish one. Counties are largely dependent on obtaining grants from other sources to fund these initiatives.
Recently, Minnesota was approved to design a program, in partnership with Wisconsin, to combat opioid production and trafficking under the federal High Intensity Drug Trafficking Areas (HIDTA) program. The HIDTA program provides resources to law enforcement agencies operating in designated drug-trafficking regions. Minnesota’s recent HIDTA designation is concentrated in Hennepin, Ramsey, Dakota, Anoka and Washington counties and along the I-35 and I-94 corridors.

Section 5.1.f. Access to naloxone. Medical directors of EMTs licensed to provide basic life support may, but are not required to, authorize and allow emergency responders to carry and use naloxone. In 2014, Minnesota enacted Steve’s Law, a pair of Good Samaritan laws that allow non-medical professionals to administer naloxone and to seek medical assistance for an overdose without risking criminal prosecution for participating in drug activity. The laws also authorize a licensed health care professional to prescribe, dispense, distribute, or administer naloxone pursuant to a standing order. Steve’s Law is named after Steve Rummler, a Minnesotan whose life as a successful financial advisor was cut short after he became addicted to prescription opioids he received for chronic pain. When his prescriptions ran out, he turned to heroin and overdosed.

Section 5.1.g. Disposal. Minnesota law allows the collection and disposal of controlled substances in a manner consistent with federal law and state environmental regulations and authorizes pharmacies to collect controlled substances for disposal purposes. County law enforcement, pharmacies (including those operated by EssentiaHealth, HealthPartners, Park Nicollet, and Walgreens), and Minnesota Indian Tribe communities provide permanent disposal sites at multiple locations throughout Minnesota. A list of current drug-disposal locations in Minnesota is attached in the Appendix to this report.

Section 5.1.h. Other public awareness efforts. In response to an increase in heroin overdoses in its communities, including six in one day, Anoka County recently created a public service announcement to display in movie theaters in the county. These efforts are in conjunction with a toolkit it has made available to the public on the county’s website with information about prevention and treatment.

Section 5.2. Other States. Other states are also reacting in varying ways and degrees to the toll of opioid abuse, including mandating use of prescription drug monitoring programs; increasing access to treatment and medication-assisted treatment; increasing access to naloxone; limiting prescribing; encouraging proper disposal of unused opioids; increasing professional continuing education about opioid abuse; and creating public outreach campaigns. Maine, Massachusetts, New York, and Wisconsin recently enacted comprehensive opioid-specific legislative packages in response to increasing opioid abuse and overdose deaths in their states.

Section 5.2.a. Other state prescription drug monitoring programs. All states, with the exception of Missouri, have some form of a prescription drug monitoring program. Not
all states mandate using the program, and those that do have varying requirements, from requiring use for all controlled-substances prescriptions to requiring use under some circumstances. For example, Maine (effective Jan. 1, 2017) and Tennessee require prescribers and dispensers to check the program when initially prescribing an opioid and then at set intervals (Maine, every 90 days; Tennessee, annually) as long as the prescription is renewed. Alaska and New Jersey require pharmacists to review their programs before dispensing. Effective April 2017, Wisconsin will mandate use and require data entry to be complete within 24 hours of issuing a prescription. The following chart summarizes states’ requirements:

<table>
<thead>
<tr>
<th>State</th>
<th>Every Controlled Substance Prescription*</th>
<th>Initial Prescription or New Episode of Treatment*</th>
<th>Drug Seeking Suspected</th>
<th>Admission or Enrollment in Treatment Program</th>
<th>Other</th>
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<td>West Virginia</td>
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<td>Wisconsin</td>
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*Exceptions exist.

Table 1. Circumstances Requiring Use of Prescription Drug Monitoring Programs. (Source: Prescription Drug Monitoring Program Training and Technical Assistance Center.)
Like Minnesota, almost all states with prescription drug monitoring programs allow law enforcement some level of access to its database; only Nebraska and Vermont do not. In Florida, law enforcement may request indirect access to the database during active criminal investigations. Wisconsin law enforcement uploads information into the database when they encounter violations of the law concerning controlled substances.

Most states with prescription drug monitoring programs share data with other states, but to varying extents. As of October 2016, 38 states engaged in some type of interstate data sharing. Minnesota shares data with 26 states. Eight states are in the process of implementing a process for sharing. Only Hawaii, Oregon, and Wyoming are not engaged in, or in the process of implementing, interstate data sharing.

Section 5.2.b. Prescribing restrictions and guidelines. In recent years some states have restricted opioid prescriptions based on the length of the prescription or on daily
morphine milligram equivalents (MMEs). For example, with some exceptions (such as for cancer treatment or other palliative care), Connecticut limits opioid prescription supplies to seven-days for both minors and first-time adult outpatients, and further requires prescribers to discuss the risks of opioids with minors and their parents before prescribing; Maine prohibits opioid prescriptions exceeding 100 MMEs per day and, effective January 2017, prescriptions will generally be limited to a seven-day supply within seven days, and prescriptions for chronic pain may not exceed a 30-day supply within 30 days; Massachusetts imposes a seven-day limit on first-time opioid prescriptions for adults and on all opioid prescriptions to minors; New York limits opioid prescriptions for acute pain to a seven-day supply; and Rhode Island limits first-time opioid prescriptions to outpatients for acute pain to 30 MMEs per day and to 20 dosages.263

Other states have issued opioid-prescribing guidelines. For example, the Medical Board of California cautions prescribers to consider referring to a specialist at 80 MMEs per day; earlier this year, the Massachusetts Department of Public Health reduced its suggested limit from 240 MMEs per day to 120 MMEs per day, which had been reduced from 360 MMEs per day in 2014; the Ohio Boards of Medicine, Pharmacy, Dentistry, and Nursing jointly adopted guidelines encouraging prescribers to reevaluate pain management plans that exceed 80 MMEs; the Utah Department of Health advises prescribers to “increase clinical vigilance” at 120 to 200 MMEs per day; and Washington State’s medical directors’ group suggests referring to a specialist at 120 MMEs per day.264

Section 5.2.c. Access to treatment and medication-assisted treatment. The number of certified physicians authorized by the Drug Addiction Treatment Act (DATA) to provide buprenorphine as a medication-assisted treatment option varies widely by state. California has 428 physicians certified to treat up to 30 patients, compared to North Dakota having one, while Pennsylvania has 117 physicians certified to treat up to 100 patients while both North and South Dakota having none.265 The following table identifies the top and bottom five states relative to how many DATA-certified physicians each state has:

<table>
<thead>
<tr>
<th>Top 5 States</th>
<th>DATA-Certified (30)</th>
<th>Top 5 States</th>
<th>DATA-Certified (100)</th>
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<tbody>
<tr>
<td>California</td>
<td>428</td>
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<td>80</td>
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<table>
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<tr>
<th>Bottom 5 States</th>
<th>DATA-Certified (30)</th>
<th>Bottom 5 States</th>
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<td>Hawai i/ D.C.</td>
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<td>Montana/Wyoming</td>
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<td>North Dakota</td>
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Table 2. Top and Bottom States for DATA-Certified Physicians. (Source: SAMHSA.)

Some states are beginning to prioritize removing roadblocks to treatment, especially relating to awareness of, and access to, medication-assisted treatment. For example, Massachusetts requires that patients being discharged from treatment programs receive information on FDA-approved medication-assisted therapies.266 New York requires hospital staff

26
to provide services to connect patients with treatment options. Once an individual has completed treatment in New York, they are provided multiple services, including education and employment resources, legal and social services, and assistance with transportation and childcare services. The New York State Department of Health also produced a brochure encouraging physicians to become qualified and obtain DEA authorization to treat opioid dependence.

Massachusetts and New York are also removing insurance-related barriers to treatment. Massachusetts requires private insurers to pay for substance abuse evaluations without prior authorization, and New York is requiring insurers to abolish prior authorizations for inpatient treatment and for emergency supplies of medications used for treating opioid addiction.

Section 5.2.d. Access to naloxone. States are expanding access to naloxone (the drug that can reverse an overdose) through standing-order prescriptions and by equipping first responders with the life-saving drug. For example, eight states (Alabama, Indiana, Maryland, New Mexico, North Carolina, Pennsylvania, Vermont, and Wisconsin) have statewide standing orders for naloxone, and a ninth (Iowa) is in the process of implementing one. Standing orders allow a doctor to issue a general prescription authorizing dispensal of a medication to anyone who satisfies particular criteria without an individual prescription. Statewide standing orders in other states have generally been signed by officials in states’ health departments.

In addition to state-specific efforts, as illustrated by the following table, Walgreens makes naloxone available without an individual prescription to more than 2,600 of its pharmacies in 16 states, and CVS has expanded its naloxone access program to 30 states.

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<thead>
<tr>
<th>STATE</th>
<th>CVS</th>
<th>WALGREENS</th>
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</table>

Table 3. National Pharmacy Standing Orders for Naloxone. (Sources: CVS and Walgreens.)
Massachusetts recently authorized law enforcement to establish a training course on drug-related overdoses. Similarly, Wisconsin provides training opportunities for all first responders to administer naloxone.

Similar to the Minnesota laws discussed in Section 5.1.f., to encourage the use and administration of naloxone, most states have immunity and Good Samaritan laws that limit the liability of a person who administers naloxone in emergency situations and limit exposure to criminal charges for people who seek assistance from law enforcement or medical professionals for another person who has overdosed.

Section 5.2.e. Disposal. Many states take part in DEA National Take Back Days and hold their own take back events and work with local law enforcement to provide permanent disposal sites. Both CVS and Walgreens have implemented disposal programs. Walgreens has installed disposal kiosks at 288 of its pharmacies throughout 21 states, and CVS has donated more than 600 drug collection containers to law enforcement agencies in 42 states.

Section 5.2.f. Continuing education. Because most physicians receive little training in medical school regarding pain management and substance abuse disorders, some states are beginning to look for ways to fill these gaps with continuing medical education (CME) requirements specifically focused on controlled substance prescribing. Forty-six states and the District of Columbia have general CME requirements for licensed physicians. Until recently, however, only eight states (Delaware, Kentucky, Massachusetts, Mississippi, New Mexico, Utah, Vermont, and West Virginia) required all physicians licensed to prescribe or dispense controlled substances to obtain CME hours on the topics of controlled substance prescribing, pain management, or substance abuse disorders. In 2016, both Maine and New York added opioid-specific CME requirements, bringing the total number of states to 10.

Section 5.2.g. Public awareness. Some states have implemented programs to educate the public about the risks associated with opioid abuse. For example, New York requires pharmacists to include educational materials with prescriptions that include information about addiction risks, local treatment services, and proper disposal. Massachusetts requires that information on opiate use and misuse be distributed at annual head-injury safety programs for high school athletes, that public schools educate students about substance abuse prevention, and that all driver-education programs address addiction. Some states have also developed public awareness and outreach campaigns. Indiana, Montana, and Massachusetts, for example, have launched public service campaigns.
SECTION 6. BARRIERS TO AND RECOMMENDATIONS FOR ADDRESSING OPIOID ABUSE.

While strides have been made at the federal and state levels in recent years to combat the opioid crisis, gaps in the law remain, and further reforms are needed. Outlined below is a list of some of the areas where further action should be discussed. Not all goals are achievable at the state level. In some cases, Congress should act. And, in others, a cultural shift in how prescription drugs are prescribed and how addiction is treated is necessary.

Reforms will not come easily. Across the country, efforts to tackle factors contributing to the opioid crisis have been met with opposition from the pharmaceutical industry, which devotes significant resources to preventing reform. A joint investigation by the Associated Press and the Center for Public Integrity found that, between 2006 and 2015, the pharmaceutical industry and its supporters spent more than $880 million on lobbying and campaign contributions to oppose stricter regulations. This was more than 200 times the amount spent by those seeking reforms.

Section 6.1. The Legislature Should Require Health Care Professionals to Use the Prescription Drug Monitoring Program. Minnesota has a prescription drug monitoring program established in Minn. Stat. § 152.126, but its utility is limited by the program’s voluntary nature. Most pharmacies must report to the Minnesota Board of Pharmacy information on controlled substances they dispense each day. Neither prescribers nor dispensers are required to check the database before prescribing or dispensing controlled substances. Under current law, the only time they must check the database before issuing or filling a prescription is when they prescribe controlled substances to clients in DHS-licensed opioid-addiction programs. Although prescribers and dispensers must register for the prescription drug monitoring program beginning in July 2017, they may still prescribe and dispense opioids without verifying the patient’s prescription drug history in the database. Data-sharing programs that are meant to prevent doctor-shopping are less effective when prescribers and dispensers do not check them. Research indicates that mandated use of a prescription drug monitoring program is effective in reducing opioid prescriptions.

“I couldn’t save my own son… We are not equipped to handle this epidemic, and thousands of kids need help… Someone needs to help now, we are losing our future generation daily!”—Jennifer, Minnesota mother whose 19-year old son died from a heroin overdose

“The makers of prescription painkillers have adopted a 50-state strategy that includes hundreds of lobbyists and millions in campaign contributions to help kill or weaken measures aimed at stemming the tide of prescription opioids…”—Associated Press and Center for Public Integrity

“People are going to doctors, getting scripts, and selling them on the street to survive.”—Jeff, patient in opioid treatment program

In some cases, the DEA may revoke a provider’s registration to prescribe controlled substances or a health-related licensing board may impose discipline that restricts a provider’s
authority to prescribe controlled substances. It appears that this information may not always be readily available to a dispenser, and the information does not appear in the state’s prescription drug monitoring program.

**Recommendations:**

- The Minnesota Legislature should require prescribers and dispensers to review a patient’s history in Minnesota’s prescription drug monitoring database before prescribing or dispensing controlled substances.

- The Legislature should require prescribers and dispensers to maintain contemporaneous documentation that they checked the program before prescribing or dispensing a controlled substance.

- As an additional safeguard against dispensing unauthorized prescriptions issued by providers who have lost authority to prescribe controlled substances, either because of a DEA or licensing-board restriction, the Legislature should amend Minn. Stat. § 152.126 to require the prescription drug monitoring program to contain a field with information about any restrictions on a prescriber’s authority to prescribe controlled substances. This presumably will require the Minnesota Board of Pharmacy to coordinate with the DEA and health-related licensing boards to periodically determine the status of the ability of Minnesota providers to prescribe controlled substances so the information can be included in the database.

- Current law imposes significant restrictions on access to the prescription drug monitoring program database. These restrictions may impede the ability of appropriate state boards and agencies to study the data and to proactively identify overprescribing patterns, fraudulent billing of state Medicaid programs, and geographical or demographical areas of concern. The Legislature should consider amending Minn. Stat. § 152.126 to allow the Board of Pharmacy and other appropriate government agencies to access the prescription drug monitoring program’s data when they have a legitimate government purpose for accessing the data.

To make prescription drug monitoring programs most effective, all states should be required to share program data. Bills have been introduced in Congress to require all states that have a prescription drug monitoring program to share data, but thus far these measures have not been enacted.
Section 6.2. Continuing Education Requirements Should Address the Risks Associated with Prescription Opioids. Minnesota doctors currently must complete 75 hours of continuing education every three years, dentists must complete 50 hours every two years, and pharmacists must complete 30 hours every two years. The Board of Medical Practice does not require any specific coursework. The Board of Dentistry requires dentists to take two credits in certain “core” subjects, but requires no coursework specific to prescription. Similarly, pharmacists are generally directed to include courses geared toward the “properties and actions of drugs and drug dosage forms,” but are not required to take coursework specifically addressing the risks of prescription opioids.

Recommendation:
- The Legislature should require opioid prescribers and dispensers—including doctors, dentists, and pharmacists—to take at least two hours of periodic continuing education that addresses proper pain management, the risks associated with prescription opioids, and current evidence-based practices of prescribing and dispensing prescription opioids and identifying opioid use disorder and opioid dependence. Given the established addictive nature of opioids and the role of prescription opioids in the opioid crisis, it is imperative that those involved in prescribing and dispensing these drugs remain up to date on current research and best prescribing and dispensing practices.

Section 6.3. Pharmacists Should Provide Clear and Conspicuous Information About the Proper Use and Disposal of Prescription Opioids. State law currently requires prescription containers to be labeled with directions for use. One of the problems with prescription opioids is that consumers may assume they are safe because a doctor prescribed them. While an opioid painkiller may be appropriate for an individual’s circumstances, no one should be lulled into a sense of safety simply because the medication was legitimately prescribed. The Board of Pharmacy currently requires pharmacists to warn that controlled substances may impair driving abilities and that federal law prohibits transferring the drugs. No law, however, requires dispensers to warn of the risks of addiction or to provide information on how to safely dispose of unneeded medications.

Recommendations:
- When opioid prescriptions are filled, the Legislature should require pharmacists to provide clear and conspicuous notice about the risks of opioid abuse and addiction. This information need not be specifically provided on the medication label, but should be provided contemporaneously with the prescription.

“"The drug is so physically addicting that I equate it with the devil because it's that evil of a drug. It steals your values, your morals, your family, and your self-esteem and you become a shell of your own."—PJ, mother of daughter with opioid addiction
Similarly, greater awareness is needed about how Minnesotans can safely dispose of prescription medications that are no longer needed. The Legislature should require pharmacists to provide information about the proper disposal of prescription medications. Providing this information will aid in increasing awareness about the addictive nature of opioids and the importance of disposing of unneeded medications.

The Legislature should direct the Board of Pharmacy to develop concise, plain-language materials that dispensers can distribute to comply with these obligations.

Section 6.4. The Minnesota Department of Health Should Issue a Statewide Standing Order for Naloxone. Naloxone, commonly known as Narcan, is an opiate antagonist that can safely reverse an overdose. State law already provides authority for the issuance of “standing orders,” which allow a doctor to issue a general prescription authorizing dispersal of a medication to anyone who satisfies particular criteria without requiring an individual prescription for a particular patient. State health officials in at least eight other states have issued standing orders for naloxone. No evidence suggests that access to naloxone increases the prevalence or frequency of opioid use.

Recommendation:

A qualified staff member of the Minnesota Department of Health should issue a statewide standing order for naloxone. Given the indisputable effectiveness of naloxone in curbing the death toll associated with the opioid epidemic, the State should take this important step to increase access to this life-saving medication.

Section 6.5. Pharmacists Should be Required to Fill Prescriptions Under Standing Orders Authorizing Them to Dispense Opiate Antagonists. Minnesota law permits pharmacists to dispense medications pursuant to standing orders or other treatment protocol agreements. It has been a growing practice to use these tools to authorize pharmacists to dispense naloxone. This Office has nonetheless heard from providers that some pharmacists remain reluctant to dispense naloxone even when a standing order or other prescribing protocol is in place.

Recommendation:

The Legislature should amend Minn. Stat. § 151.34 to prohibit pharmacists from refusing to dispense an opiate antagonist for which a standing order or other prescribing protocol is in place and the prescribing criteria are satisfied.

Section 6.6. Law Enforcement Agencies and Retail Pharmacies Should Maintain Collection Boxes for Proper Drug Disposal. Proper and timely destruction of prescription medications lowers the risk of those drugs being abused or diverted. As reflected in the Appendix to this report, a couple of counties have no collection boxes and some have only a handful.
Recommendations:

- The Legislature should require each county’s law enforcement agency to maintain at least one collection receptacle for controlled-substance drug disposal as allowed by federal law.

- The Legislature should also require retail pharmacies and on-site pharmacies at clinics and hospitals to register as authorized collectors under federal law and to maintain collection receptacles for controlled substances.

Section 6.7. The Time for Filling Opioid Prescriptions Should be Shortened. Currently, the State’s rules provide that a prescription for a controlled substance remains valid for one year. Allowing unfilled prescriptions to remain active increases the risk of the prescription being abused or diverted.

Recommendation:

- The Legislature should shorten the timeframe for filling a prescription opioid to 30 days. If an opioid is legitimately prescribed for current pain, presumably the prescription should be filled quickly to address that pain. Shortening the timeframe for filling a prescription would decrease the amount of time a prescription drug can be diverted or abused.

Section 6.8. Minnesota’s Medicaid Program Should Eliminate Unnecessary Preauthorization Requirements. As previously discussed, the effects of opioid withdrawal are severe. Any delay in obtaining medications meant to treat opioid dependence increases the chances that the person will instead turn to more painkillers or heroin to fill the void, thereby increasing the risk of a fatal overdose. Buprenorphine and buprenorphine/naloxone (e.g., Suboxone) are the common medications prescribed to assist in treating opioid dependence, and they have been effective. As noted, this Office has received assurances or commitments from Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, and PreferredOne that they either do not or will not impose preauthorization requirements for buprenorphine. Nationally, Cigna also recently agreed to end preauthorization requirements. Minnesota’s Medicaid program requires preauthorization for all forms of buprenorphine except Suboxone film.

Recommendation:

- The Legislature should eliminate preauthorization requirements in the Medical Assistance Program for medications containing buprenorphine that are prescribed to treat opioid dependence.

A White House task force recently reminded insurers of their legal obligation to treat drug addiction the same way as other medical conditions, specifically noting that an insurer cannot require prior authorization for buprenorphine if the insurer does not impose similar restrictions on medications prescribed for physical illnesses. Federal law requires parity in these circumstances, but the law is still limited in that preauthorization is prohibited only when the insurer does not impose a similar requirement for treating other conditions. While the State’s authority is limited by the federal Employee Retirement Income Security Act of 1974 (ERISA) with respect to the administration of self-funded insurance plans, Congress should eliminate
unnecessary preauthorization requirements in self-funded plans that may delay access to important medications to treat opioid addiction.

Section 6.9. First-Responders and Emergency Medical Technicians Should Carry Naloxone. State law permits an EMT’s medical director to authorize the use of intravenous infusion, including opiate antagonists. Naloxone is a proven life-saving tool for reversing opioid overdoses and recent FDA approvals have made it even easier to administer, no longer requiring an injection. Costs can be an impediment to accessing naloxone, both for first responders and for individuals. The cost of naloxone can range from $20 to $40 per dose. The cost of naloxone has been increasing in recent years, prompting Congress to question drug makers on the pricing.

Recommendations:
- As an additional tool in fighting the opioid epidemic, the Legislature should require Minnesota’s first responders and EMTs to carry naloxone and receive training on how to administer it.
- If cost is an impediment, the Legislature should consider funding sources to reimburse local governments for the costs of purchasing naloxone.
- The Legislature should also consider funding sources that can assist low-income patients who are not in government health insurance programs to access this life-saving drug.

Section 6.10. The Legislature Should Take Further Measures to Address Overprescribing. One of the contributing factors to the opioid crisis is overprescribers, or so-called “pill mills,” in which doctors irresponsibly and continuously prescribe high quantities and dosages of opioids in a manner that is not medically appropriate. There are impediments in current law that make it difficult to preemptively identify these providers. For example, the current system often relies on a licensing board to receive a complaint about an inappropriate prescriber, but patients who are drug-addicted typically don’t file such complaints. Even when the boards receive a complaint, they often must engage in lengthy proceedings requiring a “battle of the experts” to determine whether the provider inappropriately prescribed medication.

In 2015, the Minnesota Legislature directed the creation of the Opioid Prescribing Improvement Program (OPIP), under which DHS is instructed to collect data measuring opioid prescribing patterns, compare prescribers to their anonymized peers, and share abnormal patterns with prescribers. While the Legislature mandated participation by prescribers who prescribe

“The only time I touched heroin was whenever I couldn’t find pills. There were times where I did it for a couple days at a time until I found pills, then I would just do the pills. If you were doing painkillers, you’d never be thinking, ‘I’m going to be shoving a needle in my arm.’”—Kevin, Patient in opioid treatment program
opioids to *Minnesota Health Care Program* (e.g., Medical Assistance and MinnesotaCare) enrollees, it gave other prescribers the option to voluntarily participate.

**Recommendations:**

- The Legislature should require all opioid prescribers to participate in the OPIP, regardless of the entity from which the patient receives health coverage. Most doctors treat all patients, including those enrolled in the Minnesota Health Care Program. Some providers, however, do not treat Medical Assistance or MinnesotaCare patients or only accept cash payments. For example, the Kaiser Family Foundation reported that many dentists do not accept insurance and that many who accept insurance do not accept Medical Assistance. Requiring prescribers of controlled substances to participate in the OPIP for monitoring purposes will provide all opioid prescribers an opportunity to align their prescribing practices with community standards.

- In its recent legislative report on the OPIP, the Opioid Prescribing Work Group reported that the Minnesota Department of Human Services is about two years away from having a working program. It would be helpful for the detection of improper prescribing patterns for the program to be implemented as expeditiously as possible. In designing the OPIP’s monitoring program, the Work Group should be cognizant of maintaining patient privacy and design the program to collect data in a way that detects improper prescribing patterns but does not compromise the privacy of patient data.

- As set forth in Section 6.1, allowing appropriate government agencies to access the prescription drug monitoring program database to identify overprescribing patterns would also help in the detection of so-called “pill mill” physicians.

- As noted in Section 5.2.b, a number of states have imposed guidelines for the length and/or the strength of opioid prescriptions. The State should give consideration to adopting such guidelines.

**Section 6.11. The Legislature Should Be Responsive to the Judicial Branch’s Need for Resources for Drug-Related Cases in the Criminal Justice System.** While drug and specialty treatment courts are new in Minnesota, they have shown success. It appears that these specialty courts generally form on a county-by-county basis and that counties are dependent on grants to establish and maintain the courts.

**Recommendation:**

- The Office defers to the Judicial Branch to determine its needs, but recommends that the Legislature be responsive to its requests for resources to better address drug addiction within the criminal justice system, including through the expansion of drug courts.
Section 6.12. Access to Treatment Needs to Expand, Particularly in Rural Areas. The opioid crisis reaches all corners of the state, but few doctors in Minnesota are authorized to prescribe buprenorphine and most treatment resources are concentrated in the Twin Cities metropolitan area. For example, of the 122 physicians that SAMHSA identifies as authorized to prescribe buprenorphine in Minnesota, more than one-third are in Hennepin County, and about 64% are in the seven-county metropolitan area. Treatment not only aids individuals, it saves money in the long run by reducing health-care and criminal-justice costs.

**Recommendation:**
- The Legislature should review options for expanding treatment resources in greater Minnesota.

“We want people to know that this can happen to anyone. Nobody is immune.”
—Rosemary, mother whose 21-year-old daughter died of an opioid overdose

“I will never let his death be for nothing, there are so many things that need to change.”—Jennifer

“I don’t know what to do, I don’t have a place to live, I don’t have a job, I don’t have any money, I don’t have insurance. If you send me out of here I’m going to go to a bridge and jump off.”—Kevin, describing an emergency-room visit

2 Id.


7 Brownstein, supra note 6, at 5391; Rosenblum et al., supra note 6, at 2.

8 Rosenblum et al., supra note 6, at 3.

9 Id.


11 Id.


14 Rosenblum et al., supra note 6, at 2.


17 Id.
18 Id.


20 Ryan et al., supra note 15.

21 Van Zee, supra note 19, at 223.

22 Ryan et al., supra note 15.

23 Id.

24 Ctrs. for Disease Control & Prevention, supra note 3, at 1487.


27 Ctrs. for Disease Control & Prevention, supra note 25, at 1.


32 Volkow & McLellan, supra note 10, at 1253.

33 Ryan et al., supra note 15.

34 Van Zee, supra note 19, at 223; Ryan et al., supra note 10.


36 Id.


38 Kosten & George, supra note 35, at 14.

39 Id.

40 Id.
41 Id. at 15.
42 Id.
43 Id.
44 Id. at 14.
45 Id. at 15.
46 Id.
47 Id.
48 Id.
53 Id.
54 Kosten & George, supra note 35, at 16.
55 Kate Dunn et al., Overdose and Prescribed Opioids: Associations Among Chronic Non-Cancer Pain Patients 6 (Nat’l Inst. Health author manuscript 2010), published in 152 ANNALS INTERNAL MED. 85 (2010).
56 Volkow & McLellan, supra note 10, at 1256.
57 Id.
59 Id. at 1-15-16, 2-21-24.
60 Id. at 1-15.
61 Id.
62 Id. at 1-16.

67 Diagnostic and Statistical Manual of Mental Disorders 481-82, 541-49 (Am. Psychiatric Ass’n 5th ed. 2013).

68 Id. at 541.


70 OFF. OF THE SURGEON GEN., supra note 49, at 4-22-23; Volkow et al., supra note 69, at 2065; Buprenorphine, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., http://www.samhsa.gov/medication-assisted-treatment/treatment (last visited Nov. 8, 2016);

71 OFF. OF THE SURGEON GEN., supra note 49, at 4-23; Buprenorphine, supra note 70.

72 Buprenorphine, supra note 70.


75 Buprenorphine, supra note 70.


77 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 74, at 6.

78 Kosten & George, supra note 35, at 19; Rosenblum et al., supra note 6, at 11-12.

79 Buprenorphine, supra note 70.


82 DeFlavio et al., supra note 81, at 7.

83 Quest et al., supra note 80, at 6.

84 OFF. OF THE SURGEON GEN., supra note 49.

86 Rose Rudd et al., Increases in Drug and Opioid Overdose Deaths—United States, 2000-2014, 64 MORBIDITY & MORTALITY WKLY. REP. 1378, 1378-79 (2016).


89 Rudd et al., supra note 86, at 1379.

90 Id.

91 Id.

92 Nat’l Ctr. for Health Stat., supra note 1.

93 Rudd et al., supra note 86, at 1378.


96 Id.

97 Collins, supra note 94.

98 Id.

99 Id.

100 Id.

101 Id.

102 Id.


104 Rudd et al., supra note 86, at 1379.


Nat’l Ctr. for Health Stat., *supra* note 1.

Ctrs. for Disease Control & Prevention, *supra* note 103, at 10.

Nat’l Ctr. for Health Stat., *supra* note 1.

*Id.;* Rudd et al., *supra* note 86, at 1378.


Rudd et al., *supra* note 86, at 1379.


Muhuri et al., *supra* note 5.

Cicero et al., *supra* note 5, at 823.

*Id. at* 824; see also NAT’L INSTITUTE ON DRUG ABUSE, *supra* note 116, at 3.

Cicero et al., *supra* note 5, at 824-25.


DEA Issues Carfentanil Warning to Police and Public, *supra* note 121.

*Id.*

*Id.;* DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety, *supra* note 121.

Gladden et al., *supra* note 122, at 838.

*Id.*

Rudd et al., *supra* note 86, at 1378-79.

*Id.* at 1379, 1381.

*Id.* at 1382.


Birbaum et al., *supra* note 134, at 661.


*Id.*


*The Men Missing from the Job Market*, *supra* note 137.


*Id.*

*Id.*


*Id.* § 812(c).

147 Id.


152 Id. § 1317.70 (2016).

153 Id. § 1317.80(b) (2016).

154 Id. §§ 1317.65, .70 (2016).


157 Id.


161 Id. § 823(g)(2)(G).

162 Id. § 823(g)(2)(A)(i).


164 OFF. OF THE SURGEON GEN., supra note 49, at 4-23.


visited Nov. 6, 2016); Total Professionally Active Physicians, KAISER FAMILY FOUND. (Sept. 2016), http://kff.org/other/state-indicator/total-active-physicians/ (last visited Nov. 9, 2016).


169 Nat’l Alliance of Advocates for Buprenorphine Treatment, supra note 168.

170 Id.

171 CTR. FOR DRUG EVALUATION & RESEARCH, U.S. DEP’T OF FOOD & DRUG ADMIN, APP. NO. 208411ORIG1S000 SUMMARY REVIEW FOR REGULATOR ACTION 1, (Nov. 18, 2015), http://www.accessdata.fda.gov/drugsatfda_docs/nda/2015/208411Orig1s000SumR.pdf (last visited Nov. 9, 2016).

172 Id.


175 Ctrs. for Disease Control & Prevention, supra note 25, at 2.

176 Id. at 15.

177 Id. at 23-24.


185 Id. § 107, 130 Stat. at 703-05, 709-10.

186 Id. § 109, 130 Stat. at 706-09.
187 *Id.* §§ 201-03, 130 Stat. at 711-17.

188 *Id.* § 301, 130 Stat. at 717-18.

189 *Id.* § 303, 130 Stat. at 720-23.

190 *Id.* § 601, 130 Stat. at 732-34.

191 *Id.* §§ 901-43, 130 Stat. 755-78.

192 *Id.*


196 *Id.* § 4.


199 *Id.*

200 *Id.*


205 MINN. PRESCRIPTION MONITORING PROGRAM, HTTP://WWW.PMP.PHARMACY.STATE.MN.US (LAST VISITED Nov. 9, 2016).
206 MINN. STAT. § 152.126, subd. 6(c) (2016).

207 MINN. STAT. § 152.126, subd. 4(a) (2016); General Program FAQs, MINN. PRESCRIPTION MONITORING PROGRAM, http://pmp.Pharmacy.state.mn.us/assets/files/PDFs/FAQ's/2016/2015_FAQ_General_Program.pdf (last visited Nov. 9, 2016).

208 MINN. STAT. § 245A.192, subd. 11(b)(2) (2016).


210 MINN. STAT. § 152.126, subd. 4(a).

211 Id., subd. 4(b) (2016).

212 MINN. BD. OF PHARMACY PRESCRIPTION MONITORING PROGRAM, supra note 209, at 3-4.

213 MINN. STAT. § 152.126, subd. 6(a) (2016).

214 Id., subd. 6(b) (2016).

215 Id., subd. 6(h) (2016).

216 MINN. PRESCRIPTION MONITORING PROGRAM, supra note 205.


218 MINN. STAT. § 256B.0638, subds. 3-4 (2016).

219 Id. § 256B.0638, subds. 4-5 (2016).

220 Id. § 151.37, subd. 2(d)-(e) (2016).

221 Id. § 152.11, subd. 2d (2016).

222 MINN. R. 6800.3100, subp. 3 (2015).

223 Id. 6800.4150 (2015).

224 Id. 6800.4600 (2015).

225 Id. 6800.3510 (2015).

226 MINN. STAT. § 245A.1915 (2016).

227 Id. §§ 254B.16, 245F.08, subd. 4 (2016).

228 Id. § 245A.192, subd. 3a (2016)

229 Id. § 256B.0625, subd. 13(f)(a); MINN. DEP’T OF HUM. SERVS., MINNESOTA FEE-FOR-SERVICE MEDICAID PREFERRED DRUG LIST (2016).

230 Letter from Minnesota Attorney General to Blue Cross and Blue Shield of Minnesota (Sept. 13, 2016); Letter from Minnesota Attorney General to Blue Cross and Blue Shield of Minnesota (July 6, 2016).
Letter from HealthPartners to Minnesota Attorney General’s Office (July 20, 2016); Letter from PreferredOne to Minnesota Attorney General’s Office (July 20, 2016).

Letter from Blue Cross and Blue Shield of Minnesota (Oct. 3, 2016); Letter from Medica to Minnesota Attorney General’s Office (Sept. 28, 2016).


MINN. STAT. § 152.02, subds. 2-6 (2016).

Id. § 152.02, subds. 3-4.

Id. §§ 152.021-.025 (2016).

Id. § 152.025.


Id. ch. 160, § 2, at 576-77.

Id. ch. 160, § 7, at 583-85.

MINN. SENT. GUIDELINES IV.C.


Drug Courts, MINN. JUDICIAL BRANCH, http://www.mncourts.gov/Help-Topics/DrugCourts.aspx (last visited Nov. 9, 2016); see also OFF. OF SURGEON GEN., supra note 49, at 4-39 (highlighting effectiveness of drug courts in increasing completion of treatment programs and reducing recidivism and later drug use).


Id.


Chanen, supra note 246.

MINN. STAT. § 144E.101, subd. 6(d) (2016).


MINN. STAT. §§ 151.37, subd. 6a, 152.105 (2016).


258 FLA. STAT. § 893.055, subd. 7(c) (2016).


261 *Id.*

262 *Id.*


268 *Id.* ch. 69, pt. C, § 1.


277 Corey S. Davis, Derek Carr, Physician Continuing Education to Reduce Opioid Misuse, Abuse, and Overdose: Many Opportunities, Few Requirements, 163 DRUG AND ALCOHOL DEPENDENCE 100, 101 (2016).

278 Id. at 102.

279 Id.


283 BITTERPILL, HTTP://WWW.IN.GOV/BITTERPILL/ (LAST VISITED Nov. 10, 2016); RESOLVE, HTTP://RESOLVEMONTANA.ORG/ (last visited Nov. 10, 2016); WCVB Launches Public Service Campaign on Opioid


285 Id.

286 Id.

287 MINN. STAT. § 152.126, subd. 4 (2016)

288 MINN. STAT. § 245A.192, subd. 11 (2016).


290 MINN. STAT. § 152.126, subds. 5-6 (2016).


292 MINN. R. 5605.0300.


295 MINN. STAT. § 152.11, subd. 1(e).

296 MINN. R. 6800.4150.

297 MINN. STAT. § 151.37, subd. 2(a) (2016).

298 OFF. OF THE SURGEON GEN., supra note 49, at 4-12.

299 MINN. STAT. § 604A.04.

300 MINN. R. 6800.3510.


302 MINN. STAT. § 256B.0625; MINN. DEP’T OF HUM. SERVS., supra note 229.


304 MINN. STAT. § 144E.101, subd. 6(d).


306 Id.

OFF. OF THE MHCP MED. DIR., supra note 217, at 5.

Buprenorphine Treatment Physician Locator, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=MN (last visited Nov. 6, 2016); see also John A. Gale, Rural Communities in Crisis: Strategies to Address the Opioid Crisis, NAT’L RURAL HEALTH ASS’N POL’Y BRIEF 3 (2016) (discussing gaps in availability of medication-assisted therapy in rural America); Jon Collins, Feds OK Expanded Access to Key Opioid Treatment, MPR NEWS, Jul. 6, 2016 (noting limited access to buprenorphine waiver doctors in greater Minnesota), www.mprnews.org/story/2016/07/06/buprenorphine-opioid-treatment-increase-gets-federal-ok (last visited Nov. 6, 2016).

Sidebar Quotations by Section


APPENDIX

Drug Disposal Locations in Minnesota by County

Anoka County
Anoka County Sheriff’s Office // 13301 Hanson Blvd. NE, Andover, MN 55304
Blaine Human Services Center // 1201 89th Ave NE, Blaine, Minnesota 55434
Blaine Police Department // 10801 Town Square Drive NE, Blaine, MN 55449
Centennial Lakes Police Department // 54 North Road, Circle Pines, MN 55014
Columbia Heights Police Department // 825 41st Avenue NE, Columbia Heights, MN 55421
Fridley Police Department // 6431 University Avenue NE, Fridley, MN 55432
Lino Lakes Police Department // 640 Town Center Pkwy, Lino Lakes, MN 55014
Ramsey Police Department // 7550 Sunwood Drive NW, Ramsey, MN 55303
Spring Lake Park Police Department // 1301 81st Avenue NE, Spring Lake Park, MN 55432
St. Francis Police Department // 4058 St. Francis Blvd. NW, St. Francis, MN 55070
Walgreens Pharmacy // 10686 University Ave NW, Coon Rapids, MN

Becker County
Becker County Sheriff’s Department // 925 Lake Ave, Detroit Lakes MN 56501
City Of Becker // 12060 Sherburne Ave, Becker, MN, 55308-469
Essentia Health DL Pharmacy // 211 Frazee St E., Detroit Lakes, MN 56501

Beltrami County
Paul Bunyan Drug Task Force // Law Enforcement Center, 613 Minnesota Ave NW, Bemidji, MN

Benton County
Benton County Sheriff’s Department // 581 Hwy 23, Foley, MN
City of Rice // 205 Main St E, Rice, MN, 56367-4522
Sauk Rapids Police Department // 250 Summit Ave N, Sauk Rapids, Minnesota 56379

Big Stone County
Sauk Rapids Police Department // Sauk Rapids Government Center, 250 Summit Ave N, Sauk Rapids, MN

Blue Earth County
Blue Earth County Justice Center // 401 Carver Road, Mankato, MN
Mankato Public Safety Center // 710 S Front St, Mankato, Minnesota 56001
Walgreen Co // 1270 Madison Avenue, Mankato, MN 56001

Brown County
New Ulm Police // 15 S Washington, New Ulm, Minnesota 56073
Sleepy Eye Police Department // 130 2nd Ave NW, Sleepy Eye, Minnesota 56085
Springfield Police Department // 16 N Marshall Ave, Springfield, Minnesota 56087

1 Information in this appendix was taken from the DEA’s searchable online database at https://apps.deadiversion.usdoj.gov/pubdispsearch/. The Minnesota Pollution Control Agency also has a searchable list of drug-disposal locations at https://www.pca.state.mn.us/living-green/managing-unwanted-medications.
Carlton County
Carlton County Sheriff’s Department // 317 Walnut Avenue, Carlton, MN 55718
Cloquet Police Department // 508 Cloquet Ave, Cloquet, Minnesota 55720
Moose Lake Police Department // 600 Highway 73, Moose Lake, MN 55767

Carver County
Carver County Sheriff’s Office // 606 E 4th Street, Chaska, MN 55318
Chanhassen City Hall // 7700 Market Blvd, Chanhassen, MN 55317
Waconia City Hall // 201 Vine Street S, Waconia, MN 55387

Cass County
Cass County Sheriff’s Department // 300 Minnesota Ave W, Walker, MN 56484
Cass County Sheriff’s Department // 330 Second St NW, Cass Lake, Minnesota 56633
Pine River Police Department // 200 Front St, Pine River, Minnesota 56474

Chippewa County
Montevideo Police Department // 103 Canton Ave, Montevideo, Minnesota 56265

Chisago County
Chisago County Sheriff’s Department // 313 N Main St, Rm 100, Center City, Minnesota 55012
Chisago County Sheriff’s Department // 325 S Eliot, Rush City, Minnesota 55069
North Branch Police Department // 6408 Elm St, North Branch, Minnesota 55056

Clay County
Barnesville Police Department // 101 Front St S, Barnesville, Minnesota 56514
Dilworth Police Department // 500 Center Ave W, Dilworth, Minnesota 56529
Glyndon Police Department // 218 Parke Ave S, Glyndon, Minnesota 56547
Hawley Police Department // 319 8th St, Hawley, Minnesota 56549
Moorhead Police Department // 915 9th Ave N, Moorhead, Minnesota 56560

Clearwater County
Clearwater County Sheriff’s Department // 213 Main Ave N, Dept 102, Bagley, Minnesota 56611

Cook County
Cook County Law Enforcement // 143 Gunflint Trail, Grand Marais, Minnesota 55604

Cottonwood County
Cottonwood County Sheriff’s Department // 902 5th Ave, Windom, Minnesota 56101
Sterling Long Term Care Pharmacy #32 // 607 10th Street, Worthington, MN 56187

Crow Wing County
Breezy Point Police Department // 8361 Co Rd 11, Breezy Point, Minnesota 56472
City of Nisswa // 5442 City Hall St, Nisswa, MN, 56468-2478
City of Pequot Lakes // 4638 County Road 11, Pequot Lakes, MN, 56472-3385
Crosby Police Department // 2 2nd St SW, Crosby, Minnesota 56441
Crow Wing County Sheriff’s Department // 304 Laurel St, Brainerd, Minnesota 56401
Essentia Health Brainerd Pharmacy // 2024 S. 6th Street, Brainerd, MN 56401
Essentia Health Baxter Pharmacy // 13060 Isle Dr., Baxter, MN 56425

Dakota County
Apple Valley Police Department // 7100 147th St. W., Apple Valley, MN
Burnsville Police Department // 100 Civic Center Pkwy., Burnsville, MN
Dakota County Law Enforcement Center (Hastings) // 1580 Highway 55, Hastings, MN
Eagan Police Department // 3830 Pilot Knob Rd., Eagan, MN
Farmington Police Department // 19500 Municipal Drive, Farmington, MN
Farmington Police Department // 3830 Pilot Knob Rd, Eagan, Minnesota 55122
Inver Grove Heights Police Department // 8150 Barbara Ave., Inver Grove Heights, MN
Lakeville Police Department // 9237 183rd St. W., Lakeville, MN
Mendota Heights Police Department // 1101 Victoria Curve, Mendota Heights, MN
Rosemount Police Department // 2875 145th St. W., Rosemount, MN
South St. Paul Police Department // 125 Third Ave. N., South St. Paul, MN
Walgreens Pharmacy // 15250 Cedar Ave, Apple Valley, MN
West St. Paul Police Department // 1616 Humboldt Ave., West St. Paul, MN

Dodge County
Dodge County Sheriff's Office // 22 East 6th Street, Mantorville, MN
Kasson Police Department // 19 E Main Street, Kasson, MN

Douglas County
Alexandria Police Department // 501 3rd Ave W, Alexandria, Minnesota 56308
City of Brandon // 115 E Front St, Brandon, MN, 56315-4502
Pope and Douglas Solid Waste Management (PDSWM) // 2115 Jefferson St, Alexandria, MN, 56308

Faribault County
Faribault County Sheriff's Department // 320 Dr. H. Russ Street, Blue Earth, MN 56013
Wells Police Department // 125 South Broadway, Wells, MN 56097

Fillmore County
Fillmore County Detention Center // 901 Houston Street NW, Preston, MN 55965

Freeborn County
Freeborn Law Enforcement Center // 411 S Broadway, Albert Lea, Minnesota 56007
Curt's Long Term Care Pharmacy // 1615 W Main St, Suite B, Albert Lea, MN 56007

Goodhue County
Cannon Falls Police Department // 918 River Road, Cannon Falls, Minnesota 55009
City of Kenyon // 709 2nd Street, Kenyon, MN, 55946-1339
Goodhue Law Enforcement Center // 430 W 6th St, Red Wing, Minnesota 55066
Goodhue County Sheriff's Department // 401 Main Street, Wanamingo, Minnesota 55983
Goodhue County Sheriff's Department // 430 West 6th Street, Red Wing, Minnesota 55066
Wanamingo City // 401 Main St, Wanamingo, Minnesota 55983
Zumbrota Police Department // 50 West Second Street, Zumbrota, Minnesota 55992

Grant County
Grant County Sheriff's Department // 10 2nd St. NE, Elbow Lake, MN 56531

Hennepin County
Eden Prairie City Center (free medication disposal bags) // 8080 Mitchell Road, Eden Prairie, MN 55344
Golden Valley Police Department // 7800 Golden Valley Rd, Golden Valley, MN 55427
HealthPartners Bloomington Clinic // 8600 Nicollet Ave S, Bloomington, MN 55420-2855
HealthPartners Brooklyn Center Clinic // 6845 Lee Ave N, Brooklyn Center, MN 55429
HealthPartners Riverside Clinic // 2220 Riverside Ave, Minneapolis, MN 55454
HealthPartners West Clinic // 5100 Gamble Drive, Ste 100, St. Louis Park, MN 55416
Hennepin County District Court Brooklyn // 6125 Shingle Creek Pkwy, Brooklyn Center, MN 55430
Hennepin County District Court Ridgedale // 12601 Ridgedale Drive, Minnetonka, MN 55305
Hennepin County Library - Southdale // 7001 York Ave. S., Edina, MN 55435
Hennepin County Public Safety Facility // 401 4th Ave. S., Minneapolis, MN 55415
Hennepin County Sheriff's Department // 9401 83rd Ave. N., Brooklyn Park, MN 55445
Maple Grove Police Department // 12800 Arbor Lakes Parkway N, Maple Grove, MN 55369
Osseo Police Department // 415 Central Ave., Osseo, MN 55369
Park Nicollet Clinic-Bloomington // 5320 Hyland Greens Drive, Bloomington, MN 55437
Park Nicollet Brookdale // 6000 Earle Brown Drive, Brooklyn Center, MN 55430
Park Nicollet Clinic-Maple Grove // 9555 Upland Lane N, Maple Grove, MN 55369
Park Nicollet-Minneapolis // 2001 Blaisdell Ave S // Minneapolis, MN 55404
Park Nicollet-Minnetonka // 15111 Twelve Oaks Center Dr, Minnetonka, MN 55305
Park Nicollet- Meadowbrook // 3931 Louisiana Ave S, St. Louis Park, MN 55426
Park Nicollet Clinic-St. Louis Park // 3800, 3850 and 3900 Park Nicollet Blvd, St. Louis Park, MN 55416
Park Nicollet Clinic-Wayzata // 250 Central Ave. N, Wayzata, MN 55391
Rogers Police Department // 21860 Industrial Court, Rogers, MN 55374
St. Louis Park Nicollet Methodist Hospital // 6500 Excelsior Blvd, St. Louis Park, MN 55426
Walgreens Pharmacy // 7700 Brooklyn Blvd, Brooklyn Park, MN
Walgreens Pharmacy // 540 Lake Rd N, Hopkins, MN
Walgreens Pharmacy // 4547 Hiawatha Ave, Minneapolis, MN

Houston County
Houston County Sheriff’s Department // 306 S Marshall Street, Caledonia, MN 55921

Hubbard County
Hubbard County Sheriff’s Department // 301 Court Ave, Park Rapids, MN 56470

Isanti County
Isanti County Sheriff’s Department // 509 18th Avenue SW, Cambridge, MN 55008

Itasca County
Grand Itasca Pharmacy // 1601 Golf Course Road, Grand Rapids, MN 55744
Itasca County Sheriff’s Department // 440 1st. Ave. NE, Grand Rapids MN 55744

Jackson County
Jackson County Sheriff’s Department // 400 Sherman St, Jackson, MN 56143

Kanabec County
Kanabec County Jail // 100 South Vine, Mora, MN

Kandiyohi County
Kandiyohi County Sheriff’s Department // 2201 23rd St. NE, Willmar, MN 56091

Kittson County
None listed

Koochiching County
Essentia Health International Falls Pharmacy // 2501 Keenan Drive, Suite A, International Falls, MN 56649
Koochiching County Law Enforcement Center // 715 4th Street, International Falls, MN 56649

Lac qui Parle County
Lac Qui Parle County Sheriff’s Department // 600 6th Street, Madison, Minnesota, 56256

A-4
Lake County
Essentia Health Silver Bay Pharmacy // 99 Edison Blvd, Suite L, Silver Bay, MN 55614
Essentia Health Two Harbors Pharmacy // 802 11th Street Suite C, Two Harbors, MN 55616
Lake County Sheriff’s Department // 7 Davis Drive, Silver Bay, Minnesota 55614
Lake County Sheriff’s Department // 613 3rd Ave, Two Harbors, Minnesota 55616

Lake of the Woods County
Lake of the Woods County Law Enforcement Center // 206 8th Ave SE, Suite #300, Baudette, MN 56623

Le Sueur County
Le Sueur County Sheriff's Department // 130 South Park Avenue, Le Center, MN 56057

Lincoln County
None listed.

Lyon County
Lyon County Law Enforcement Center // 611 West Main Street, Marshall, MN 56258

Mahnomen County
Mahnomen County Sheriff's Department // 311 North Main St., Mahnomen, MN 56557

Marshall County
Marshall County Sheriff’s Department // 208 E. Colvin Ave. Suite 1, Warren, Minnesota 56762

Martin County
Martin County Law Enforcement Center // 201 Lake Avenue, Fairmont, MN

McLeod County
Hutchinson Police Department // 10 Franklin St. South, Hutchinson, MN 55350
McLeod County Sheriff's Department // 801 East 10th St., Glencoe, MN 55336
Winsted Police Department // 201 1st St. North, Winsted, MN 55395

Meeker County
Meeker County Sheriff’s Department // 460 3rd St S, Dassel, Minnesota 55325
Meeker Law Enforcement Center // 326 N Ramsey Ave, Litchfield, Minnesota 55355

Mille Lacs County
City of Isle // 285 2nd Ave S, Isle, MN, 56342-4594
Mille Lacs Sheriff’s Department // 640 3rd St SE, Milaca, Minnesota 56353
Mille Lacs Sheriff’s Department // 305 21st Ave S, Princeton, Minnesota 56371

Morrison County
Little Falls Police Department // 207 1st Street NE, Little Falls, MN 56345
Pierz Police // 101 Main St S, Morrison, Minnesota 56364
Ramsey Police Department // 7550 Sunwood Drive, Ramsey, Minnesota 55303

Mower County
Mower County Sheriff’s Department // 201 1st St NE, Austin, Minnesota 55912

Murray County
Murray County Sheriff’s Department // 2500 28th St, Slayton, Minnesota 56172
**Nicollet County**
City of North Mankato // 1001 Belgrade Ave, Mankato, MN, 56003-3501
Nicollet County Sheriff's Department // 501 S. Minnesota Ave., St. Peter, MN 56082

**Nobles County**
Nobles County Sheriff's Department // 1530 Airport Rd, Suite 100, Worthington, Minnesota 56187
Sterling LTC Pharmacy // 607 10th Street, Worthington, MN 56187

**Norman County**
Norman County Sheriff's Department // 15 2nd Avenue East, Ada, MN 56510

**Olmstead County**
Olmsted County Sheriff's Department // 151 4th St SE, Rochester, Minnesota 55904

**Otter Tail County**
Battle Lake Police Department // 108 E. Main, Battle Lake, MN
Henning Police Department // 607 2nd Street, Henning, MN
New York Mills Gov't Ctr. // 118 N Main, New York Mills, Minnesota 56567
Ottertail County Sheriff's Department // 417 Court St S, Fergus Falls, Minnesota 56537
Ottertail County Sheriff's Department // 469 Main St W, Ottertail, Minnesota 56571
Parkers Prairie Police Department // 102 N Otter Ave, Parkers Prairie, Minnesota 56361
Pelican Rapids Police Department // 315 N Broadway, Pelican Rapids, Minnesota 56572
Perham Police Department // 525 W Main St, Perham, Minnesota 56573

**Pennington County**
Thief River Falls Police Department // 102 W First St, Thief River Falls, Minnesota 56701

**Pine County**
Pine County Sheriff's Department // 106 1st Street SE, Hinkley, MN 55037
Pine County Sheriff's Department // 635 Northridge Dr. NW, Suite 100, Pine City, MN 55063
Pine County Sheriff's Department // 1602 Hwy 23 N, Sandstone, MN 55072

**Pipestone County**
Pipestone County Sheriff’s Department // 416 Hiawatha Ave S, Pipestone, MN 56164

**Polk County**
Benton County Sheriff’s Department // 581 Hwy 23, Foley, MN 56329
Crookston Police Department // 321 W Robert Street, Crookston, MN 56716
East Grand Forks Police Department // 520 Demers Ave, East Grand Forks, MN 56721

**Pope County**
Pope County Sheriff’s Department // 130 E Minnesota Ave, Glenwood, MN 56334

**Ramsey County**
East Side Family Clinic Pharmacy // 895 East 7th Street, Saint Paul, MN 55106
HealthPartners Arden Hills Clinic // 3930 Northwoods Dr, Arden Hills, MN 55112
HealthPartners Maplewood Clinic // 2165 White Bear Ave N, Maplewood, MN 55109
HealthPartners Como Clinic // 2500 Como Ave, Saint Paul, MN 55108-1494
HealthPartners St. Paul Clinic // 205 S Wabasha St, St. Paul, MN 55107
HealthPartners Specialty Center // 401 Phalen Blvd, St. Paul, MN 55130
HealthPartners Midway Clinic // 451 N Dunlap St, St. Paul, MN 55104
HealthPartners White Bear Lake Clinic // 1430 Hwy 96 E, White Bear Lake, MN 55110
Law Enforcement Center // 425 Grove St., St. Paul, MN
North Saint Paul City Hall // 2400 Margaret Street, North St. Paul, MN
Ramsey County Sheriff's Patrol Station // 1411 Paul Kirkwold Dr., Arden Hills, MN
Regions Hospital // 640 Jackson Street, St. Paul, MN 55101
Walgreens Pharmacy // 1075 Hwy 96 E, St. Paul, MN
Westside Community Health Services Pharmacy // 153 Cesar Chavez St., St Paul, MN 55107

**Red Lake County**
None listed

**Redwood County**
Redwood County Sheriff's Department // 303 E 3rd Street, Redwood Falls, MN 56283

**Renville County**
Buffalo Lake Police Department // 301 N Main St, Buffalo Lake, MN 55314
City of Bird Island // 660 Birch Ave, Bird Island, MN, 55310
City of Morton // Medication Disposal, 220 W 2nd St, Morton, MN, 56270
Fairfax Police Department // 103 2nd Ave NW, Fairfax, MN, 55332
Renville County Sheriff’s Department // 24 SE 2nd Ave, Fairfax, MN 5632
Renville County Sheriff’s Department // 105 S 5th St, Suite 210, Olivia, MN 56277
Renville County Sheriff’s Department // 221 Main St N, Renville, MN 56284

**Rice County**
Faribault Police Department // 25 4th St. NW, Faribault, MN 55021
Northfield Police Department // 1615 Riverview Drive, Northfield, MN 55057
Northfield Safety Center // 300 5th Street W, Northfield, MN 55057
Rice County Sheriff’s Department // 118 NW 3rd St., Faribault, MN 55021

**Rock County**
Rock County Sheriff's Department // 1000 North Blue Mound Ave., Luverne, MN 56156

**Roseau County**
City of Roseau // Roseau City Center, 114 2nd St NE, Roseau, MN, 56751-1110
Warroad Police Department // 802 Cheme Dr NW, Warroad, MN 56763

**Scott County**
Bell Plaine Police Department // 420 E Main St, Belle Plaine, MN 56011
Jordan Police Department // 210 East First St, Jordan, MN 55352
New Prague Police Department // 118 Central, Ave N, New Prague, MN 56071
Prior Lake Police Department // 4649 Dakota St SE, Prior Lake, MN 55372
Savage Police Department // 6000 McColl Drive, Savage, MN 55378
Scott County Sheriff’s Office // 301 Fuller Street S, Shakopee, MN 55379
SMSC Pharmacy // 15045 Mystic Lake Drive, Prior Lake, MN 55372

**Sherburne County**
Becker County Sheriff’s Department // 925 Lake Ave, Detroit Lakes, MN 56501
Big Lake Police Department // 160 Lake St N, Big Lake, MN 55309
Sherburne County Sheriff’s Department // 4180 105th Ave SE, Clear Lake, MN 55319
Sherburne County Sheriff // 13880 Business Center Drive, Elk River, MN 55330

**Sibley County**
Sibley County Sheriff's Department // 419 Harrison Street, Gaylord, MN 55334
**St. Louis County**
Babbitt Police Department // 71 South Drive, Babbitt, MN 55706
Chisholm Police Department // 301 W. Lake St., Chisholm, MN 55719
Duluth City Police Department // 5830 Grand Ave, Duluth, MN 55807
Ely City Hall // 209 East Chapman Street, Ely, MN 55731
Essentia Health Lakeside Pharmacy // 4621 East Superior Street, Suite A, Duluth, MN 55804
Essentia Health Duluth 1st Street Pharmacy // 420 East First Street, Suite A, Duluth, MN 55805
Essentia Health West Duluth Pharmacy // 4212 Grand Ave, Suite A, Duluth, MN 55807
Essentia Health Duluth 3rd Street Pharmacy // 400 East Third Street, Suite A, Duluth, MN 55805
Essentia Health Lakewalk Pharmacy // 1502 London Road, Suite 101, Duluth, MN 55812
Essentia Health Hermantown Pharmacy // 4855 W Arrowhead Rd, Suite A, Hermantown, MN 55811
Essentia Health Hibbing Pharmacy // 730 E. 34th St., Suite A, Hibbing, MN 55746
Essentia Health Virginia Pharmacy // 101 9th St No. Suite A, Virginia, MN 55792
Eveleth Police Department // 415 Pierce Street, Eveleth, MN 55734
Floodwood City Hall // 111 8th Ave West, Floodwood, MN 55736
Gilbert Police Department // 16 Broadway St South, Gilbert, MN 55741
Hermantown Police Department // 5111 Maple Grove Rd, Hermantown, MN 55811
Hibbing Sheriff’s Department // 1810 12th Ave East, Hibbing, MN 55746
Proctor Police Department // 100 Pionk Dr Suite 1, Proctor, MN 55810
Sheriff’s Department // 300 South 5th Ave, Virginia, MN 55792
St. Louis County Sheriff’s Department // 2020 N Arlington Ave, Duluth, MN 55811
Virginia // 327 1st St S, Virginia City Hall, Virginia, MN 55792
Walgreens Pharmacy // 1131 E. Superior St, Duluth, MN

**Stearns County**
Albany Police Department // 400 Railroad Avenue, Albany, MN 56307
Avon Police Department // 140 Stratford Street E, Avon, MN 56310
Belgrade Police Department // 120 Washburn Avenue, Belgrade, MN 56312
Cold Spring Police Department // 27 Red River Avenue S, Cold Spring, MN 56320
Kimball Police Department // 1 N Main Street, Kimball, MN 55353
Melrose City Hall // 225 E First St N, Melrose, MN 56352
Paynesville Police Department // 221 Washburne Avenue, Paynesville, MN 56362
Sartell City Police Department // 310 2 St S, Sartell, MN 56377
Sauk Centre Police Department // 320 Oak Street S, Sauk Centre, MN 56378
St. Joseph Police Department // 25 College Avenue N, St Joseph, MN 56374
Stearns Law Enforcement Center // 807 Courthouse Square Rm S100, St Cloud, Minnesota 56303
Waite Park City Police Department // 19 13th Ave N, Waite Park, MN 56387
Walgreens Pharmacy // 2505 W Division St, St. Cloud, MN

**Steele County**
Astrup Drug Inc. Pharmacy // 1601 State Ave N, Owatonna, MN 55060
Blooming Prairie Police Department // 138 Hwy 218 S, Blooming Prairie, MN 55917
Paynesville City Police Department // 221 Washburne Ave, Paynesville, MN 56362
Steele Law Enforcement Ctr., 204 E Pearl Street // Owatonna, MN 55060

**Stevens County**
Stevens County Sheriff’s Department // 400 Colorado Ave, Morris, MN 56267

**Swift County**
None listed
Todd County
Eagle Valley Clinic // 815 Hwy 71 S, Eagle Bend, MN 56446
Long Prairie City Hall // 615 Lake Street South, Long Prairie, MN 56347
Staples Police Department // 301 2nd Ave NE, Staples, MN 56479

Traverse County
Traverse County Sheriff’s Department // 203 7th Street N, Wheaton, MN 56296

Wabasha County
Lake City Police // 209 S High St, Lake City, MN 55041
Wabasha County Sheriff’s Department // 848 17th St E Suite 1, Wabasha, MN 55981

Wadena County
Wadena County Sheriff’s Department // 415 S Jefferson St, Wadena, MN 56482

Waseca County
Waseca County Sheriff’s Department // 122 3rd Ave NW, Waseca, MN 56093

Washington County
Cottage Grove Service Center // 13000 Ravine Pkwy. S, Cottage Grove, MN
HealthPartners Woodbury Clinic // 8450 Seasons Pkwy, Woodbury, MN 55125
Lake Shore Police Department // 8583 Interlachen Rd, Lake Shore, MN 56468
Lakeview Community Pharmacy // 1500 Curve Crest Blvd, Stillwater, MN 55082
Walgreens Pharmacy // 7135 E Point Douglas Road S, Cottage Grove, MN
Walgreens Pharmacy // 1965 Donegal Dr., Woodbury, MN 55125
Washington County Service Center // 19955 Forest Rd N, Forest Lake, MN
Washington County Law Enforcement Center // 15015 62nd St N, Stillwater, MN

Watonwan County
Watonwan County Sheriff’s Department // 715 3rd Street S, Saint James, MN 56081

Wilkin County
Wilkin County Sheriff’s Department // 515 Dacotah Ave, Breckenridge, MN 56520

Winona County
Winona Law Enforcement Center // 201 W 3rd St, Winona, MN 55987

Wright County
Annandale Police Department // 30 Cedar St E, Annandale, MN 55302
Buffalo Police // 215 1st Ave NE, Buffalo, MN 55313
Howard Lake Police Department // 625 8th Ave PO Box 736, Howard Lake, MN 55349
Walgreens Pharmacy // 135 E Broadway St, Monticello, MN
Wright County Sheriff’s Department // 3800 Braddock Ave NE, Buffalo, MN 55313
Wright County Sheriff’s Department // 11800 Town Center De NE, St Michael, MN 55376

Yellow Medicine
Yellow Medicine County Sheriff’s Department // 930 4th St, Ste 1, Granite Falls, MN 56241
**Tribal Communities**

Grand Portage Health Service // 62 Upper Rd, Grand Portage MN 55605
Leech Lake Tribal Police Department // 6242 U.S. Hwy#2, Cass Lake, MN 56633
Lower Sioux Community // None listed
Mille Lacs Band Government Center // 43408 Oodena Dr, Onamia, MN 56359
Prairie Island Tribal Public Safety // 1960 Island Blvd, Welch, MN 55089
Policy & Planning Committee Meeting
Proposed Meeting Dates
for 2017

Wednesdays:
• February 8
• April 12
• June 14
• August 9
• October 11
• December 13

Previous meetings have been scheduled for 4:30 pm. The Committee should determine if the above dates are acceptable and determine a meeting time or meeting times for the meetings.
Federation of State Medical Boards
House of Delegates Meeting
April 22, 2017

Subject: Mandatory Use of Prescription Drug Monitoring Programs

Introduced by: Minnesota Board of Medical Practice

Approved:

Whereas, Prescription drug monitoring programs (PDMPs) are widely recognized as effective tools utilized by government entities to assess prescription drug abuse and diversion by collecting controlled substance data; and

Whereas, Prescription data collected by PDMPs are used to support states' efforts in education, research, enforcement and abuse prevention; and

Whereas, 49 states, the District of Columbia and one U.S. Territory, Guam, have enacted PDMPs to collect, monitor and analyze prescribing and dispensing data submitted by pharmacies and dispensing practitioners; and

Whereas, Not all licensed prescribers are enrolled in PDMPs and not all enrolled prescribers regularly use PDMP data; and

Whereas, 22 of 49 states with PDMPs require prescribers and/or dispensers to access the PDMP database before writing for controlled substances in certain circumstances; and

Whereas, Proponents of mandatory PDMP use argue that required use is necessary to decrease opioid overdose deaths, reduce “doctor-shopping” and prescription drug abuse, modify prescribing behavior, and communicate effectively with patients about their histories and the risks associated with polypharmacy; and

Whereas, Opponents of mandatory PDMP use argue that required use is burdensome, the technology is sometimes unreliable and is not integrated into clinical workflow, data is incomplete and creates ambiguity for prescribers, mandatory use invites substantial punitive consequences for prescribers, and there is inadequate evidence that mandatory use lowers rates of prescription drug abuse and altered prescribing practices;

Therefore, be it hereby

Resolved, That the Federation of State Medical Boards (FSMB) will establish a task force to study PDMP use in the United States and its territories; and

Resolved, That the FSMB task force will evaluate whether mandatory PDMP use positively impacts patient outcomes and prescribing practices; and

Resolved, That the FSMB task force will evaluate the feasibility of incorporating the PDMP into an electronic medical record system; and

Resolved, That the FSMB task force will develop recommendations regarding mandatory use of PDMP data by licensed prescribers and dispensers.