Opioid Abatement Council Meeting

June 23, 2023

12:00pm – 3:00pm CDT

West Tennessee Healthcare City/ County Boardroom Jackson, TN

Opioid Abatement Council Meeting

- Thank you for joining the Council meeting
- We are recording the meeting

- If you are **Guest**, please turn off your camera and mute yourself
- If you are a **Council member**, please leave your camera on and mute yourself

Introductions & Gratitude

- **Dr. Stephen Loyd** – Chair, Opioid Abatement Council
- **Marie Williams** – Commissioner, Tennessee Department of Mental Health and Substance Abuse Services

Ethics Discussion

Department of Mental Health & Substance Abuse Services

Division of General Counsel

6/21/2023

OPIOID ABATEMENT COUNCIL LEGAL GUIDANCE
Representation, Ethics, Open Meetings, & Open Records

Legal Services. Pursuant to T.C.A. 33-11-104(a)(1)), "[t]he department shall serve as staff to the council…." Accordingly, the Tennessee Department of Mental Health and Substance Abuse Services' Division of General Counsel (DGC) will provide legal services to the Opioid Abatement Council (OAC) so long as doing so does not create a conflict of interest with the State of Tennessee or the department. The council may meet in closed executive session to receive legal advice (T.C.A. 33-11-103(j)). However, matters covered in open sessions are not confidential as there is no expectation of privacy.

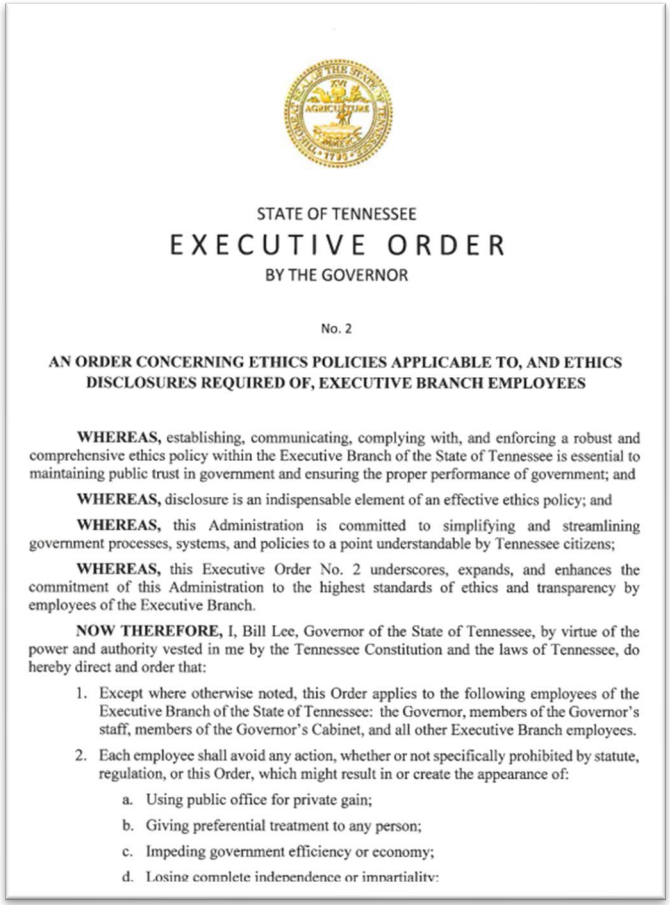
Ethics Guidelines. The council was statutorily created by the State of Tennessee to direct the disbursement of funds held in the state's opioid abatement trust fund. Accordingly, it is expected to meet the highest standards of state ethics and transparency. The department will apply Governor Bill Lee's Executive Order No. 2 when addressing ethics issues. It requires that the business of the state be open and transparent and that those conducting the business of the state will not take any action which could result in or create the appearance of their having a conflict of interests, seeking private gain, showing preference, impeding government efficiency, losing impartiality, or making decisions outside of official channels or which may otherwise cause the public to lose confidence in the integrity of government. The conflicts of interest statement signed by council members requires them to disclose anything which could be seen as a potential violation of these ethical standards.

Open Meetings Act. "Meetings of the council must comply with the open meeting requirements of title 8, chapter 44. Notwithstanding the open meeting requirements of title 8, chapter 44, the council is permitted to meet in a closed executive session for the purpose of obtaining advice from counsel and discussing personnel-related issues in addition to any other purposes allowed by title 8, chapter 44." (T.C.A. 33-11-103(j)). This requires, in part, that (1) council members shall not conduct the business of the council (e.g., deliberations, discussions, etc.) outside of an official meeting of the council, (2) public meetings have a reserved period for public comment, and (3) proper notice shall be given of all public meetings (T.C.A. 8-44-101 et seq., as amended by Public Chapter 300 (2023)). Executive Order No. 2 further requires avoiding any action which could call into question the integrity or impartiality of the council. Accordingly, council members should not discuss the business of the council or do anything which may be considered the business of the council outside of meetings of the council. Questions about meetings, administrative matters, etc., should be referred to the council's website or Executive Director.

Open Records Act. "Records of the council are deemed to be public records for purposes of the open records law, compiled in title 10, chapter 7, subject to the confidentiality provisions of § 10-7-504 and other laws or doctrines." (T.C.A. 33-11-103(k)).

Privacy. The council must conduct meetings and handle any information, documentation, or records in a manner which complies with privacy laws (e.g., HIPAA, 42 CFR Part 2, T.C.A. 33-3-103).

Removal. Pursuant to T.C.A. 33-11-103(f), "[t]he respective appointing authority may remove a member for failure to attend at least one-half (½) of the scheduled meetings in any one-year period or for other cause." Accordingly, the respective appointing authority makes determinations on the conduct of individual council members.



STATE OF TENNESSEE

EXECUTIVE ORDER

BY THE GOVERNOR

No. 2

AN ORDER CONCERNING ETHICS POLICIES APPLICABLE TO, AND ETHICS DISCLOSURES REQUIRED OF, EXECUTIVE BRANCH EMPLOYEES

WHEREAS, establishing, communicating, complying with, and enforcing a robust and comprehensive ethics policy within the Executive Branch of the State of Tennessee is essential to maintaining public trust in government and ensuring the proper performance of government; and

WHEREAS, disclosure is an indispensable element of an effective ethics policy; and

WHEREAS, this Administration is committed to simplifying and streamlining government processes, systems, and policies to a point understandable by Tennessee citizens;

WHEREAS, this Executive Order No. 2 underscores, expands, and enhances the commitment of this Administration to the highest standards of ethics and transparency by employees of the Executive Branch.

NOW THEREFORE, I, Bill Lee, Governor of the State of Tennessee, by virtue of the power and authority vested in me by the Tennessee Constitution and the laws of Tennessee, do hereby direct and order that:

1. Except where otherwise noted, this Order applies to the following employees of the Executive Branch of the State of Tennessee: the Governor, members of the Governor's staff, members of the Governor's Cabinet, and all other Executive Branch employees.
2. Each employee shall avoid any action, whether or not specifically prohibited by statute, regulation, or this Order, which might result in or create the appearance of:
    a. Using public office for private gain;
    b. Giving preferential treatment to any person;
    c. Impeding government efficiency or economy;
    d. Losing complete independence or impartiality;

Please find the complete Executive Order #2:

https://www.tn.gov/content/dam/tn/hr/policy/workforce/Executive%20Order%202.pdf

TENNESSEE OPIOID ABATEMENT COUNCIL
EXECUTIVE ORDER NUMBER 2 STATEMENT

I, (print name)_____, member of the Tennessee Opioid Abatement Council (Council), hereby certify the following:

1. I have received a copy of Governor Bill Lee's Executive Order No. 2, dated January 24, 2019.

2. I understand and agree to abide by Executive Order No. 2 regarding my membership on the Council and any actions taken by the Council.

3. Regarding Executive Order No. 2, I further understand and agree that:

   a. References to employees shall apply to Council members, including myself, regarding all activities, actions, etc., of the Council;

   b. References to financial interests in section 3.a. applies to any contractual or other financial interests related in any way to the Council or Tennessee's Opioid Abatement Fund;

   c. References to the Executive Branch or to the state department or agency in which the individual is employed applies to the Council for this purpose;

   d. References to Chief Ethics Officer will be read as references to the Council's Chair and Executive Director (e.g., ethics related disclosures and record keeping);

   e. The disclosure forms referenced in section 5 of Executive Order No. 2 shall not be used and forms adopted by the Council will be used in their place (e.g., this form); and

   f. Any enforcement issues, such as referenced in section 7 of Executive Order No. 2, shall be directed to the appointing authority who appointed the Council member.

4. I also hereby certify that I have read, understand, and signed the Tennessee Opioid Abatement Council Conflict of Interest Statement.

_____
Council Member Signature

_____
Date

TENNESSEE OPIOID ABATEMENT COUNCIL
INTEREST DISCLOSURE

The purpose of this form is to disclose any potential financial conflict of interest you may have related to your serving as a council member on the Tennessee Opioid Abatement Council (Council) or related to the Tennessee's Opioid Abatement Fund (Trust Fund).

Your conduct is subject to the guidelines established by the Executive Order Number 2 Statement, with its attached Executive Order No. 2, and the Conflict of Interest Statement. Both of which you must sign to be a member of the Council. You are not allowed to have a conflict of interest or even the appearance of a potential conflict in regard to anything you do related to the Council or the Trust Fund. The respective Council member's appointing authority will make the final decision regarding any conflict issue.

You must fill out the form below disclosing any potential conflict of interests you may have related to the Council or Trust Fund. Alternatively, you may bring any potential conflicts you are presently aware of to the attention of your appointing authority and the Council's Chair and Executive Director. However, this form will still need to be filled out and provided to the Executive Director before you assume any duties as a member of the Council.

I, (print name)_____, hereby affirm that the answers given to the following questions are true and accurate to the best of my knowledge and belief and, further, that I will immediately notify the Council's Chair and Executive Director of any changes which would require me to amend the following responses.

Regarding the Council and/or Trust Fund:

1. Do you or any of your family members (i.e., parents, siblings, children, or spouse), directly or indirectly, own any shares or have any financial investment or interest in any form in any business, corporation, or other entity which has or may apply for funds or any other benefit from the Council or Trust Fund or which has or may contributed funds into the Trust Fund?

   a. _____ No.

   b. _____ Yes. Please explain:

2. Are you or any of your family members employed by, hold an office or position with (e.g., board member), or have any official relationship to any non-profit enterprise, for-profit enterprise, business, corporation, or any other entity which has or may apply for funds or any other benefit from the Council or Trust Fund or which has or may contributed funds into the Trust Fund?

   a. _____ No.

   b. _____ Yes. Please explain:

3. Have you or any of your family members applied for funds or any other benefit from the Council or Trust Fund or do you have any reason to think you or they will in the future?

   a. _____ No.

   b. _____ Yes. Please explain:

4. Do or have you, any of your family members, or any business partners ever done any form of lobbying for any entity which has or may apply for funds or any other benefit from the Council or Trust Fund or which has or may contributed funds into the Trust Fund?

   a. _____ No.

   b. _____ Yes. Please explain:

5. Are you or any of your family members employed by or have any financial interest in an entity which has done or may do any form of lobbying for any person or entity which has or may apply for funds or any other benefit from the Council or Trust Fund or which has or may contributed funds into the Trust Fund?

   a. _____ No.

   b. _____ Yes. Please explain:

Review & Approval of Minutes

- Dr. Stephen Loyd

Minutes from:

- February 27, 2023
- March 9, 2023 (virtual)
- April 3, 2023 (virtual)
- May 24, 2023 (virtual)

Our Why - Jonah

Administrative Updates

Administrative Updates

- OAC Binders
- OAC Website
- Travel expense form – must be turned in by 6/27
- Technology and emails
  - Requesting your assistant's contact info & your cell number
  - Please check your "junk email" and make sure you are receiving our emails
- Community Grants application update
- County payments and reports update
- New positions – update on contract position

State employee vs. Contract position

We have researched the possibility of hiring the 2 Grants Analysts positions via contract, rather than creating 2 state employee positions:

State Employee	Contract Positions
Positions budgeted for $70,754 ($141,508 for 2 positions)	The hourly rate for a grants analyst is $67. Using 37.5 (hours) x 4.3 (avg # of wks in a month) that would come out to $10,803.75 per month or $129,645
May take 2 months to hire	The process may take 1 month to hire
OAC Office interviews and selects candidate	OAC Office interviews and selects candidate

Fiscal Update

Opioid Abatement Trust Fund

- Each meeting, the OAC Office will share the current monthly Opioid Abatement Trust Fund Statement
- Please note that the information is current to date the statement was created

April Opioid Abatement Trust Fund Statement

Description	Cash
McKinsey Deposit 3.31.2021	12,613,210.59
McKinsey Deposit 4.19.2022	651,080.54
Distributor Settlement 8.12.2022 - AmerisourceBergen Drug Corp., McKesson Corp., Cardinal Health, Inc. and AmerisourceBergen Corp.	14,914,621.88
Distributor Settlement 10.17.2022 - AmerisourceBergen Drug Corp., McKesson Corp., Cardinal Health, Inc. and AmerisourceBergen Corp.	15,674,540.42
Distributor Settlement 11.22.2022 - AmerisourceBergen Drug Corp., McKesson Corp., Cardinal Health, Inc. and AmerisourceBergen Corp.	59,709,854.06
Distributor Settlement 2.09.2023 - Mallinckrodt	4,112,865.67
McKinsey Deposit 4.03.2023	651,080.54
FY 22 Interest Earned	27,134.50
FY 23 Interest Earned	1,886,329.45
County Distributions	(31,425,152.77)
Totals	**78,815,564.88**

Guidance on Web Postings

Guidance on Web Postings

- In an effort to ensure that all relevant information and data is posted on the Opioid Abatement Council's website, the Office is asking the Council to approve the development of Guidance on Web Postings.

- Perhaps include in the policy information from those public records that we can reasonably anticipate that the community may show interest.

Discussion & Decision Point

- Does the Council approve the OAC Office creating a Guidance for Web Postings for the Council to review in a future meeting?

Motion
&
Council Vote

Standards & Metrics Subcommittee

Recovery Housing Definition

- The Standards & Metrics Subcommittee met on 5/31 & 6/13
- We reviewed the Safe Act and discussed the relevance and legal implications with Sam Boukli, OAC Servicing Attorney
- The definition is modeled on language from the Safe Act

Working definition for OAC to review

- The Subcommittee presents this working definition for the OAC to review and discuss:

If applying for recovery housing funding, applicants will be required to show current certification and/or recognition status through a state and/or nationally recognized recovery residence standards organization, any affiliate of any nationally recognized recovery residence standards organization OR the applicant must be currently funded by the State of Tennessee or a federal department or agency to support and/or create a recovery residence.

Discussion & Decision Point

- Does the Council approve the definition of Recovery Housing for the Qualified Applicant List for the Community Grant Applications?

Motion
&
Council Vote

Break

Needs Assessment
Annual Report to the OAC

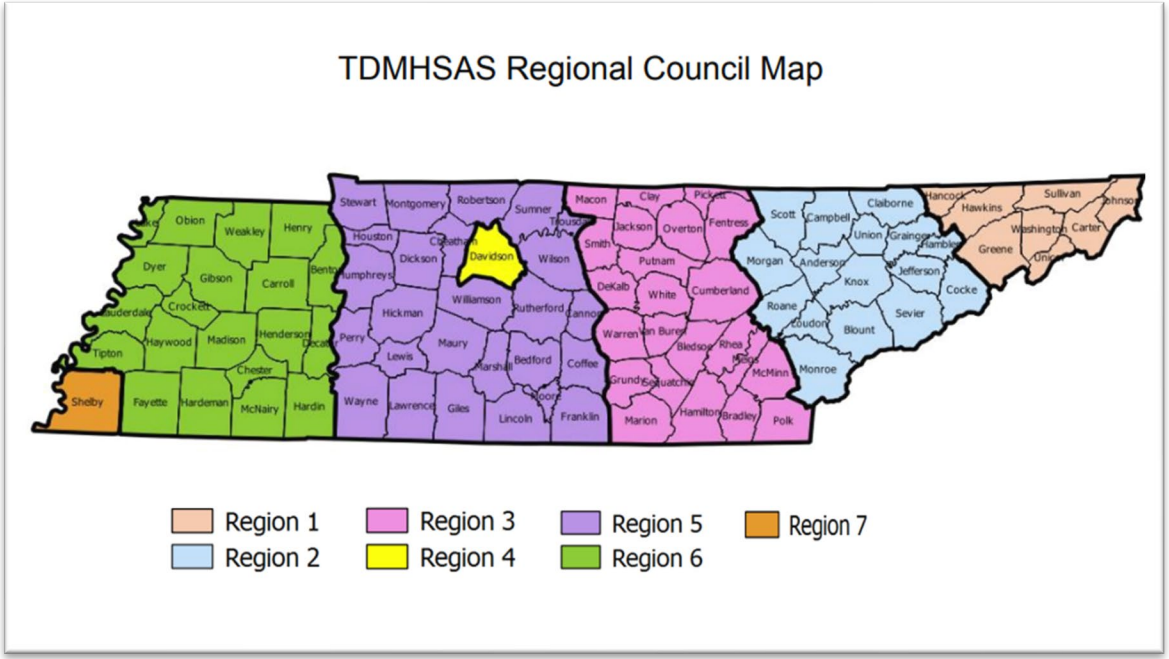
Requirement to hear from the Planning & Policy Council

T.C.A. 33-11-105(b)

- Before rendering decisions regarding the disbursement of funds, the council shall receive input from the department's statewide planning and policy council's need assessment process, which is conducted with the assistance of seven (7) regional planning and policy councils

TDMHSAS Statewide Planning & Policy Council

- Councils and Committees consist of mental health and substance abuse service providers, consumers, family members, advocates and other stakeholders.
- 7 Regional Councils and 1 Statewide Council, which administers/partners with several committees, including the Adult Committee, the Children's Committee, and Consumer Advisory Board.
- All Councils and Committees meet quarterly



Needs Assessment

- The Tennessee Department of Mental Health and Substance Abuse Services completes an annual assessment of need in order to prioritize programming.

- TDMHSAS ensures that the most relevant needs are prioritized by asking the Statewide and Regional Planning and Policy Councils to complete an annual Needs Assessment.

- Each Spring, the seven Regional Planning and Policy Councils as well as the Statewide Planning and Policy Council's Committees (Adult, Children's, and Consumer Advisory Board) work independently to identify and prioritize up to three mental health and three substance abuse needs.

- Here is the link to the 2023 Needs Assessment Survey Summary https://www.tn.gov/content/dam/tn/mentalhealth/planning/FINAL%202023%20NA%20Summary.pdf

The process helps in two ways:

1. The planning and policy councils help identify regional needs and assets in order to influence the mental health and substance abuse system; and,

2. It provides a method for the Department to target limited state resources to more effectively and efficiently meet the identified needs.

2023 Needs Assessment – Multiple Region Needs

In 2023, multiple regions identified identical/similar substance abuse-related needs:

- **Increase funding/number of and access to residential & detox beds for adults and children (identified in 2016, 2017, 2018, 2019, 2020, 2021 and 2022)**
  - Regional Councils 1, 2, 5, 6, 7 & Children's Committee
- **Increase prevention and school-based programs for at-risk youth (identified in 2017, 2018, 2019, 2020, 2021 and 2022)**
  - Regional Councils 3, 7
- **Increase recovery housing, including Medication Assisted Treatment (MAT) (identified in 2016, 2017, 2018, 2019, 2020, 2021 and 2022)**
  - Regional Councils 2, 4, 5, 6 & Adult Committee
- **Transportation**
  - Regional Council 1, Consumer's Advisory Board (CAB)

**The TDMHSAS Planning and Budget Committee of the Statewide Planning and Policy Council acknowledges that the department has created or expanded programs to address these needs in the past and on an ongoing basis.*

Work of the Council

Educational Presentations

Dr. Stephen Loyd	Recovery Eco System Medication Assisted Treatment (MAT)
Dr. Clay Jackson	Palliative Care & Pain Medicine
Tommy Farmer	Law Enforcement and Diversion
Karen Pershing	Prevention
Lisa Tipton	Treatment with emphasis on Social Determinants of Health

Unintended Consequences.

Pain, Policy, Pills, and Palliation

W. Clay Jackson, MD, DipTh
West Cancer Center
Director, Palliative Medicine
University of TN College of Medicine
Depts. of Family Medicine and Psychiatry
@mydocjackson

Know the difference in **acute vs. chronic pain** with respect to the **biopsychosociospiritual model**

Be able to explain how administrative categories of **‘cancer pain’** and

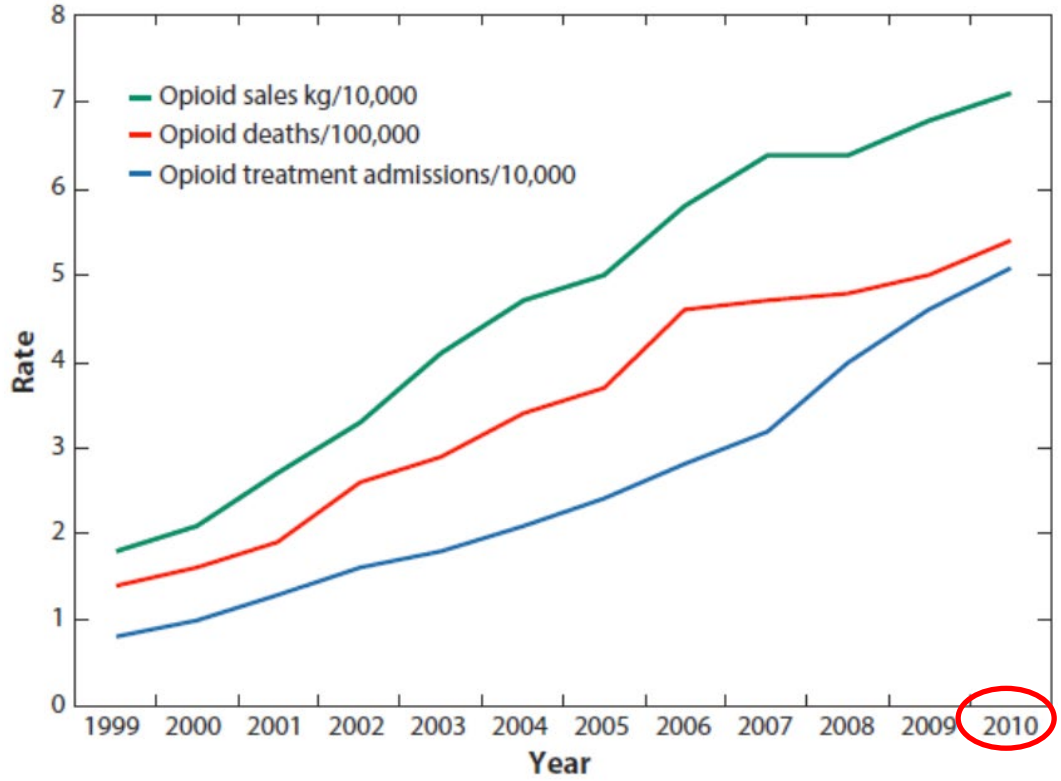
Appreciate ways in which the response to the ‘opioid epidemic’ has led to **unintended consequences**

Contemplate a **‘middle and margins’** strategy to improving public health vis-à-vis the role of opioids in society


50 million
adults have chronic pain
daily or almost daily.
CDC
www.cdc.gov/mmwr


Pain
the 5th vital sign™
American Pain Society

The Graph that Staunched a Thousand Scripts



[1] Kolodny A, Courtwright DT, Hwang CS, *et al*. The prescription opioid and heroin crisis: a public health approach to an epidemic of addiction. *Annu Rev Public Health* 2015;36:559-574.

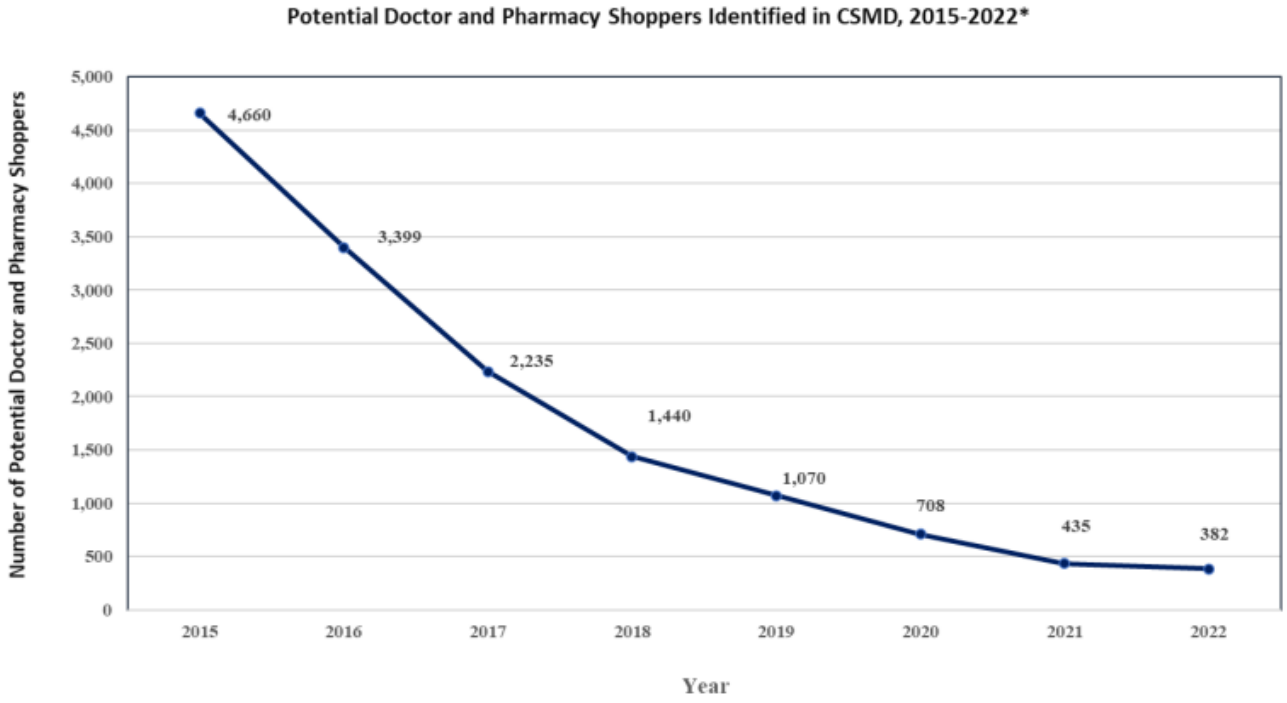
Strategies to Reduce Overprescription of Opioids

Federal

- Criminal prosecution of illicit prescribers via Controlled Substances Act
  - 32 TN clinicians charged in 2019
  - limited by *Ruan v United States* (2022)
- Reclassification of

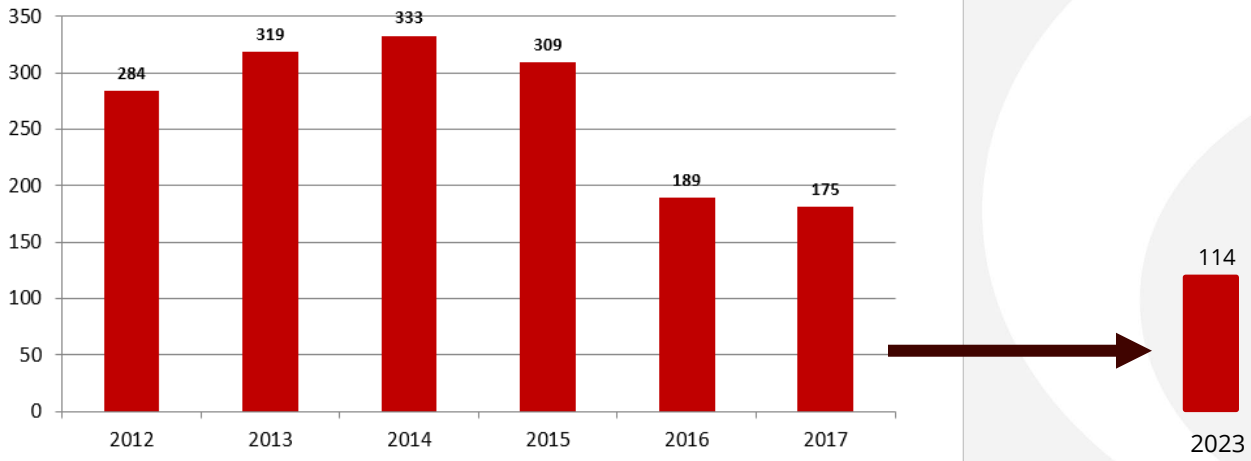
State

- Complaints-based regulatory intervention (*e.g.*, state boards)
- Formative regulatory oversight (*e.g.*, pain clinic registration; 2012)
- Establishing prescription guidelines (2012)
- Database tools (2006;



* 1) Patients that filled controlled substance prescriptions obtained from 5 or more different prescribers at 5 or more dispensers within 90 days; 2) Excluding prescriptions reported from VA pharmacies.

Pain Management Clinics – Number in TN



A “pain management clinic” is a privately owned clinic in which the majority of patients are prescribed or dispensed opioids, benzos, etc. for 90 days or more in a 12-month period for non-malignant pain.

TN

PRESCRIBER GUIDE FOR OPIOIDS IN TENNESSEE

Always consider non-opioid treatment first

is non-opioid treatment effective?

no → is the patient exempt?

yes

no

is surgery an option? — yes →

no

Surgery Patient
30-day opioid | Up to 1200 MME*

Exemption for "more than minimally invasive surgery"

- Check CSMD
- Conduct thorough evaluation of patient
- Document consideration of alternative treatment and why opioid was used
- Obtain informed consent
- Include ICD-10 code on prescription and chart
- Best practice: include "surgery" on prescription to avoid confusion or callbacks

Rx
Patient Name
Address
DEA - BB1234321
ICD-10 CODE
Surgery

TMA™ Tennessee Medical Association

These restrictions do not apply to opioids approved by the FDA to treat upper respiratory symptoms or cough as long as the prescription is for 14 days or less.

Physician may request pharmacy to dispense only 1/2 of the prescription for 10, 20 and 30-day supplies by writing "PF" or "partial fill" on the prescription

3-Day Opioid | Up to 180 MME

No requirements

Rx
Patient Name
Address
DEA - BB1234321

not sufficient

10-Day Opioid | Up to 500 MME*

If necessary for acute pain requires:

- Check CSMD
- Conduct thorough evaluation of patient
- Document condsideration of alternative treatment and why opioid was used
- Obtain informed consent
- Include ICD-10 code on prescription and chart

Rx
Patient Name
Address
DEA - BB1234321
ICD-10 CODE

not sufficient

30-Day Opioid | Up to 1200 MME*

Medical Necessity Exemption

- Check CSMD
- Conduct thorough evaluation of patient
- Document condsideration of alternative treatment and why opioid was used
- Obtain informed consent
- Include ICD-10 code on prescription and chart
- Include "Medical Necessity" on prescription

Rx
Patient Name
Address
DEA - BB1234321
ICD-10 CODE
MEDICAL NECESSITY

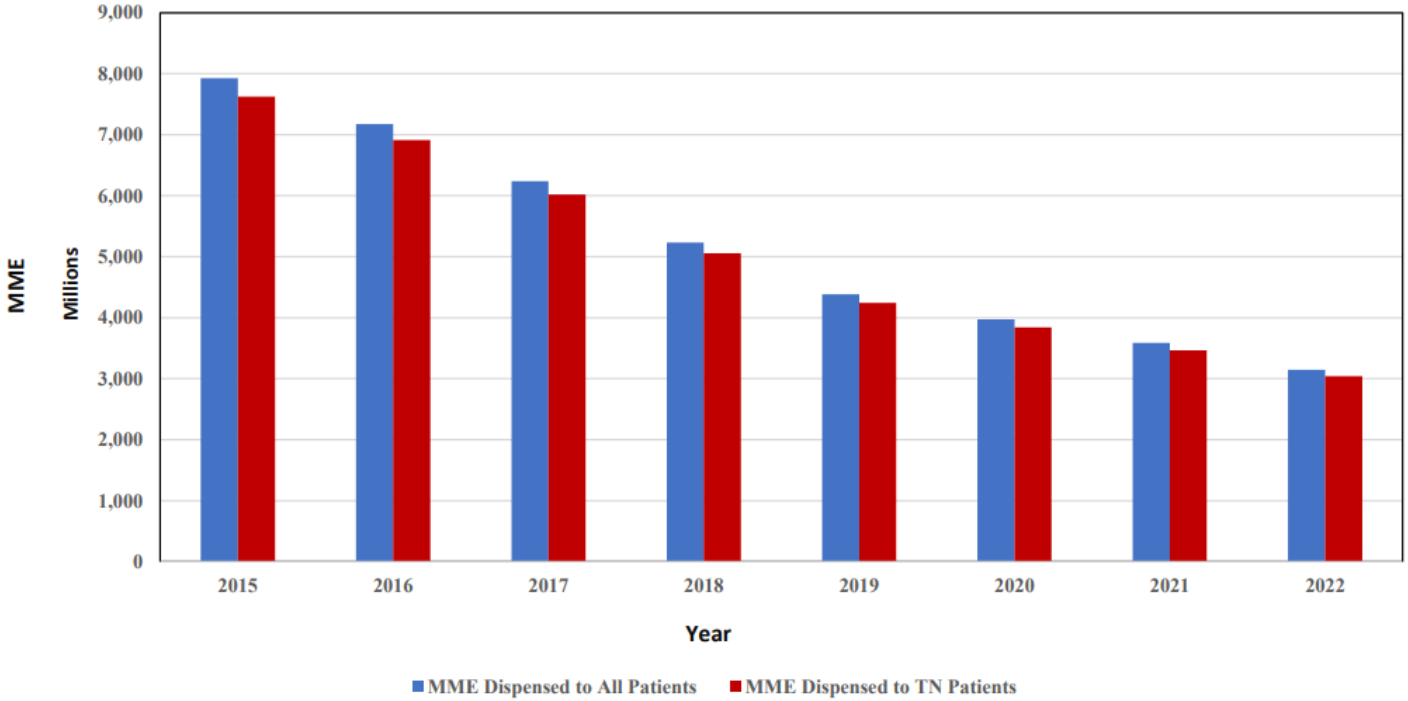
Exempt Patients

Prescription must include the ICD-10 code and the word **exempt**.

- is undergoing active cancer treatment
- is undergoing palliative care treatment
- is receiving hospice care
- has a sickle cell diagnosis
- is in a licensed healthcare facility
- is seeing a pain management specialist or supervisee of specialist
- has been treated with an opioid for 90+ days in the last year
- is being treated with methadone, buprenorphine or naltrexone for MAT
- has suffered a severe burn or major physical trauma

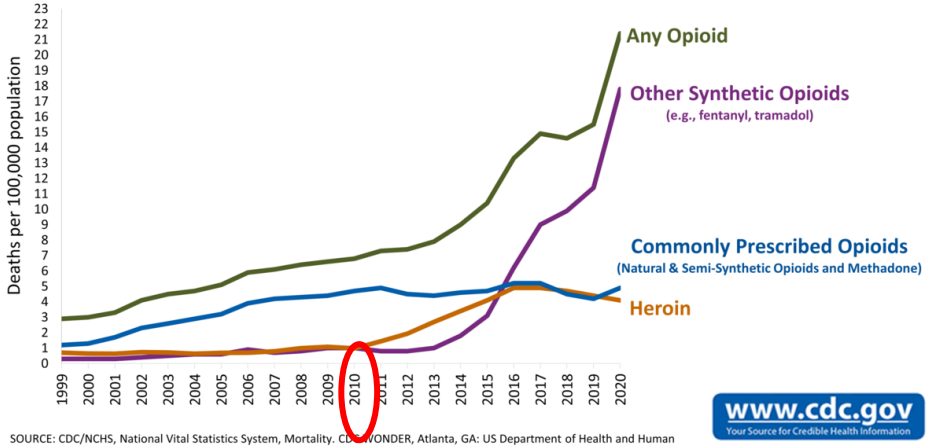
Rx
Patient Name
Address
DEA - BB1234321
ICD-10 CODE
EXEMPT

MME of Opioids Dispensed and Reported to CSMD, 2015-2022*



* 1) Excluding prescriptions reported from VA pharmacies; 2) Excluding buprenorphine products.

Overdose Death Rates Involving Opioids, by Type, United States, 1999-2020



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/.

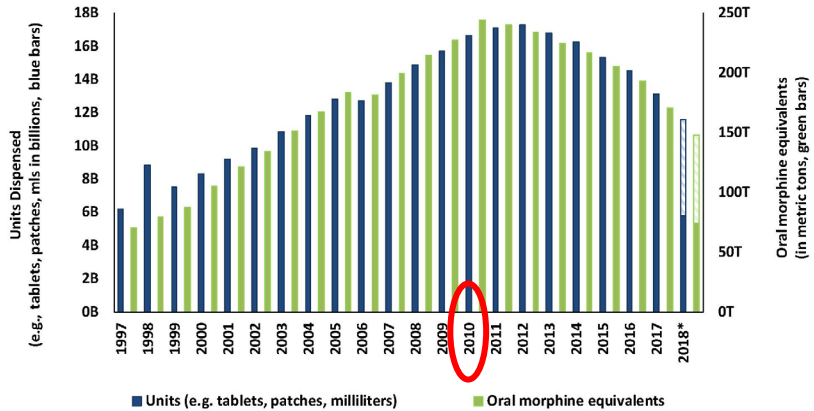
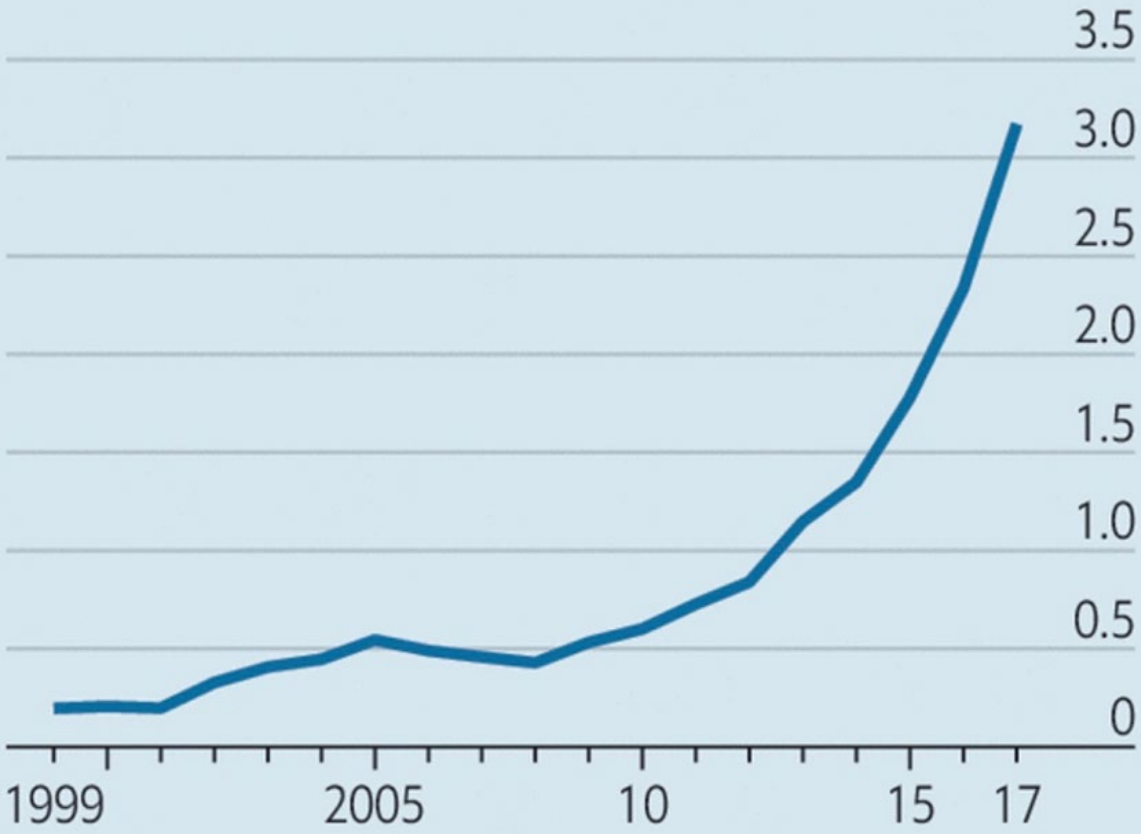


Figure 1: Estimated number of units (e.g., tablets, patches, milliliters) and calculated oral morphine equivalents (in metric tons) dispensed for opioid analgesic products from U.S. outpatient retail pharmacies, 1997 through projected year 2018*

Source: IQVIA, National Prescription Audit™. 1997-June 2018.

One billion MME is equivalent to 1 metric ton of oral morphine equivalents

United States, methamphetamine overdose deaths per 100,000 people

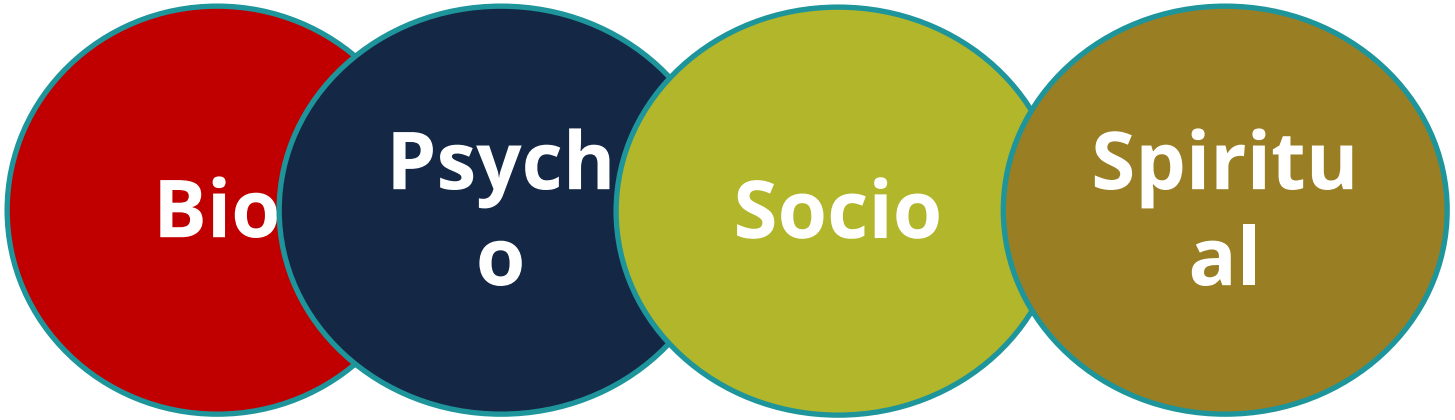


Source: Centres for Disease Control and Prevention

Time for New Models?

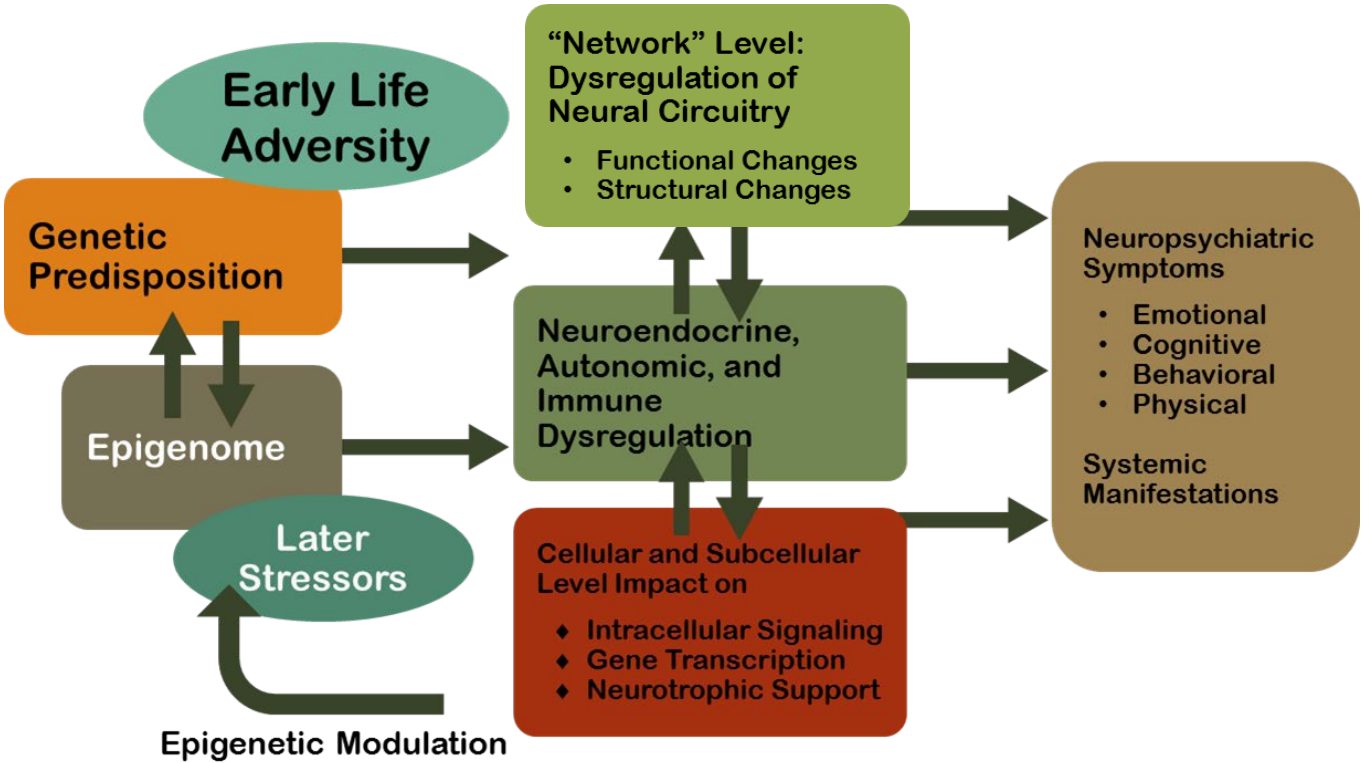
- Pain is a symptom, not a sign[1]
  - Quantification of subjectivity does not objectivity make
  - There is no algometer
- Chronic pain is not acute pain with Groundhog Day syndrome
  - Acute pain is predominantly a biologic phenomenon
  - Chronic pain is predominantly a psychosociospiritual phenomenon[2]
  - 'All symptoms are a product of an inferential process' utilizing[3]
    - Sensory inputs
    - Prior experience
    - Contextual clues

[1] Ballantyne JC, Sullivan MD. NEJM 2015; 373(22):2098-99.
[2] Hashmi JA, Baliki MN, Huang L*, et al. Brain* 2013; 136:2751-68.
[3] Ongaro G, Katpchuk TJ. *Pain* 2019; 160: 1-4.



Acute Pain

Chronic Pain



Maletic V, Raison CL. *Front Biosci*. 2009;14:5291-5338.

Freud was right—you should choose your parents well

- Adverse childhood experiences contribute downstream risks
  - Chronic pain[1]
  - Substance use disorders[2]
  - Mental illness[3]
- Likely high levels of inflammation, due to epigenetic effects, link multiple medical disorders in those exposed to ACE's[4]

[1] Edwards RR, Dworkin RH, Sullivan MDm Turk DC, Wasan AD. *J Pain*. 2016; 17(9 Suppl): T70–T92.
[2] Wolitzky-Taylor K, Sewart A, Vrshek-Schallhorn S. *J Youth Adolesc*. 2017; 46(1): 15–27.
[3] Danese A, Moffitt TE, Harrington H, *et al*. *Arch Pediatr Adolesc Med*. 2009; 163(12): 1135–1143.
[4] Maletic V, Raison CL. *Front Biosci*. 2009;14:5291-5338.

mental Health Matters

- Correlation between mental illness, chronic pain is bidirectional[1]
  - (+) Mental illness: 2x OR of chronic pain
  - (+) Chronic pain: 2x OR of mental illness
  - Of patients on chronic opioids, 47% use benzodiazepines (BZD's) also[2]
  - Boxed warning from FDA regarding co-prescribing (Aug 2016)
- Mental illness increases risk of misuse, overdose
  - Opioid users with anxiety 5x more likely to misuse opioids[3]

[1] Bondesson E, Pardo FL, Stigmar K, *et al. Eur J Pain.* 2018; doi:10.1002/ejp.1218.
[2] Zah V, *et al.* Use of co-medications in chronic pain patients on opioids. AIPM 28th Ann Mtg; San Diego (CA); Oct 2017.
[3] Feingold D, *et al. Gen Hosp Psychiatry* 2017; 47: 36-42.

The Bottom Line on Prescription Opioids

- The overwhelming majority of patients exposed to opioids (98.7%) do **not** progress to long-term use within 18 mos[1]
- Addiction occurs in a sizeable minority of chronic pain patients who use opioids (8%)[2]
- Non-medical use of prescription opioids may lead to abuse of heroin—but not often (< 4% in 5 years)[3]
- Long-term oral opioids are neither intractable nor infallible[4]
  - ~40% reduction in pain scores (7 studies; N=1504)
  - 33% of patients discontinued, owing to adverse events

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[1] Kroenke K, Cheville A. *JAMA.* 2017; 317(23):2365-2366.
Quinn PD, Hur K, Chang Z, *et al*. *Pain* 2017;158(1):140-148.
[2] Volkow ND, McLellan T. *NEJM* 2016; 374(13):1253-63.
[3] Muhuri PK, Gfroerer JC, Davies MC. *SAMHSA CBHSQ Data Review*; August 2013; 16.
[4] Noble M, *et al. J Pain Symptom Manage* 2008; 35:214e228.

- Subjectivity does not become objectivity because you have a metric
  - Complex problems do not admit to simple solutions
    - The Law of Unintended Consequences is a tough customer
- Overprescribing facilitated a crisis, but did not cause it; therefore, right-sizing (or under-sizing) prescribing will not solve it
  - Biology is a great place to start… but a poor place to finish
    - Patients should precede protocols, but not principles


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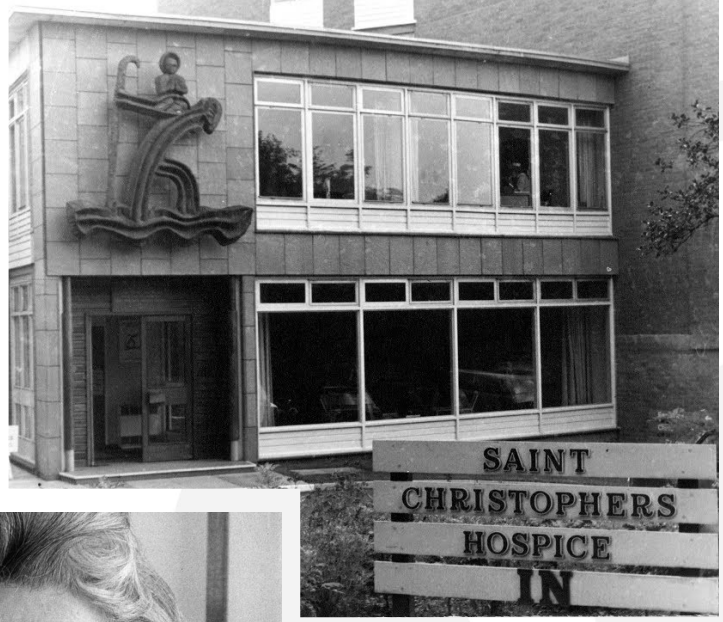
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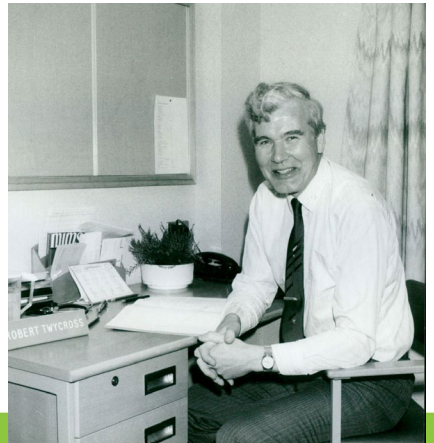
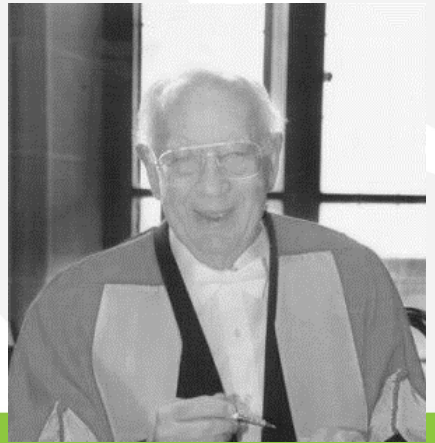
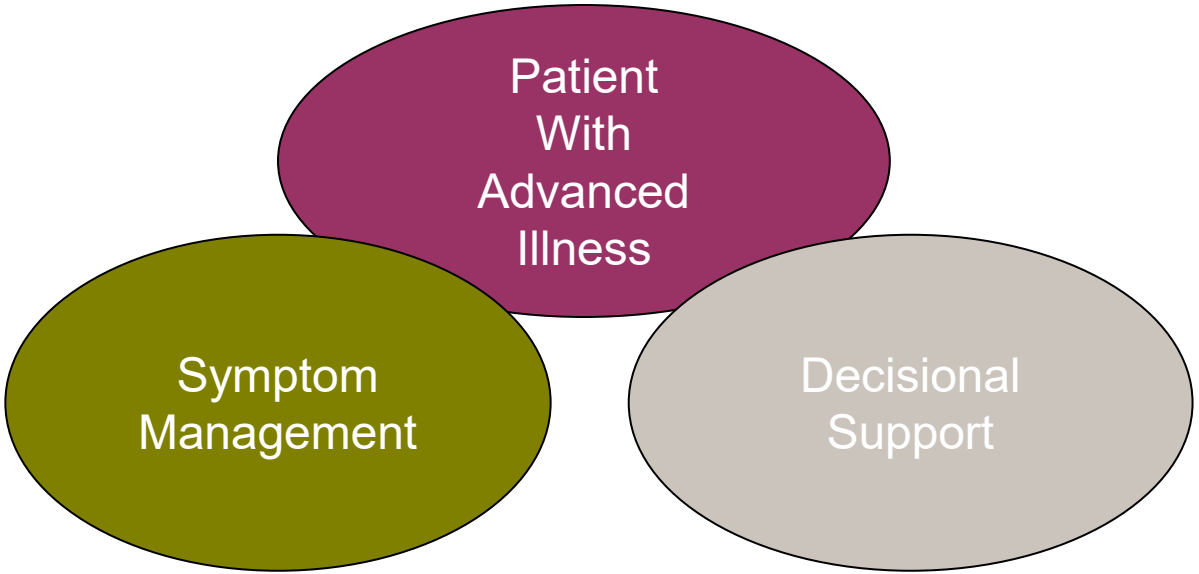




What is Palliative Care?

- Management of symptoms, chiefly in patients with advanced disease in whom medical recovery is not expected
- Latin *pallus:* ‘cloak’

What Does Palliative Care Do?



Prevalence of Pain in Cancer Patients

- 2016 meta-analysis: 55%
  - Included advanced stage, palliative patients
  - Broader range of malignancies
- 2021 meta-analysis[2]: 40%
  - Included patients in active treatment, up to 90d after tx
  - Only included lung, breast patients (with intent to cure)
  - Excluded Stage IV, palliative patients
- 75-80% of advanced cancer report pain[3]

[1] Van Den Beuken-Van Everdingen MHJ, *et al. J Pain Symptom Manage* 2016;51:1070-1090.
[2] Evenepoel M, *et al. J Pain Symptom Manage* 2022;63(3) e317-e335.
[3] van den Beuken-van Everdingen MH, *et al. Ann Oncol* 2007;18:1437-1449.

A National Survey of 5,139 Survivors[1]

- Pain prevalence in cancer patients
  - 60% in active treatment[2]
  - 35% in survivors (16% high-impact pain)[3]
- Opioid use, misuse in last 12 mos:
  - No cancer: 31%
    4.3%
  - Recent cancer (< 12 mos) 54%
    3.5%
  - Remote cancer (> 12 mos) 39%
    3.0%
  - Opioid use back to baseline at year 6 of survivorship

[1]Jairam V, *et al. JAMA Network Open* 2020;3(8)e2013605
[2]van den Beuken-van Everdingen MH, *et al. Ann Oncol* 2007;18(9):1437-1449
[3]Jiang C, *et al. JAMA Oncol* 2019;5(8):1224-1226

A National Survey of 5,139 Survivors[1]

- Cancer survivors are more likely to *use* opioids, but *not* more likely to *misuse* opioids, than the non-cancer population
- Cancer survivors are *less* likely to use opioids than patients with other active, chronic diseases
  - Cancer survivorship 43%
  - Cirrhosis 56%
  - COPD 53%
  - CKD 51%
- Among chronic disease patients, rates of misuse *lowest* among cancer survivors (3.1%), except for Type 2 DM (2.9%)
- Risk factors for opioid *misuse* (among survivors)
  - Young age (35-64 yo vs. >64 yo) OR 7.1
  - EtOH use OR 3.2
  - Non-opioid SUD OR 14.8

[1]Jairam V, *et al. JAMA Network Open* 2020;3(8)e2013605

About that line between cancer pain & chronic pain…

- ASCO defines chronic pain as >90d[1]
- Opioid use that begins upon treatment, and extends >90d beyond treatment completion, would seem to be an appropriate definition of prolonged pain in cancer patients[2]
- Chronic pain is common in cancer survivors[3]
  - 35% of survivors have chronic pain (5.4M US pts)
  - 16% have high-impact chronic pain (2.5M US pts)
    - HICP: chronic pain with major activity restriction
  - Higher incidence with lower SES factors
  - Higher incidence in certain cancers
    - Bone, kidney, throat/pharynx, uterine
  - No correlation with time from diagnosis

[1]Paice JA, *et al. J Clin Oncol* 2016;34:3325-3345.
[2]Check DK, *et al. J Pain Symptom Manage* 2022;63(4):e397-e416.
[3]Jiang C, *et al. JAMA Oncology* 2019;E1-E2.

Shifting Practices and Guidelines

Opioids in the Palliative Care Oncology Space[1]

Recognition of prevalence of aberrant behaviors (non-medical opioid use)

Recognition of potential harms from opioids

Recognition of 'blurring of lines' between malignancy-related pain, chronic pain

Reduction in prescribed opioids

Oncologists,[2] 2013-2017:	-20%
US total,[3] 2013-2017:	-26%

Calls for universal screening (via risk stratification tools, potentially UDS)

[1] Dalal S, Bruera E. *2019 ASCO Educational Book*; 24-35.

[2] Enzinger AC, Wright AA. *J Natl Cancer Inst* 2021;113:225-226.

[3] https://www.fda.gov/files/about%20fda/published/FDA-Analysis-of-Long-Term-Trends-in-Prescription-Opioid-Analgesic-Products--Quantity--Sales--and-Price-Trends.pdf; accessed 23 Oct 2021

Less Opioids Prescribed for Inpatients With Advanced Cancer

Patterns of Opioid Prescription, Use, & Costs Among Patients With Advanced Cancer & Inpatient Palliative Care Between 2008 & 2014

N=714; inpatients with advanced cancer who received PC consult

Median age 57; 55% women; 61% white

12% had history of illicit drug use

ESAS pain score 6.0 (of 10) at admission

MLOS 5d; median time to consult 1d

ESAS pain score 5.0 on discharge

Median f/u in outpt PC clinic 13d

	2008	2014	change
OME at admission	60	50	-16%
Daily OME (PC consult)	150	83	-45%
OME at discharge	75	60	-20%
Total opioids Rx in US	217 B	221 B	+2%

The evidence suggests that palliative consultants became reluctant to escalate dosing in the inpatient setting for severely ill cancer patients.

Yennurajalingam S, *et al. J Oncology Practice* 2018;15(1) e74-e83.

Fewer Opioids Prescribed for Patients With Advanced Cancer, and It's Not Risk-Stratified

Has Declining Opioid Dispensing to Cancer Patients Been Tailored to Risk of Opioid Harms?

N=32,789; claims data analysis

Patients ≥18 yo

breast (72%), colorectal (21%) head & neck (5%) sarcoma (2%)

Variable	2008	2018	Change
≥1 opioid fill per 90d	30%[1]	20%	-33%
Daily OME (those on Rx)	65	41	-38%
High-dose Rx (≥90 OME)[2]	35%	15%	-55%
Concurrent opioid/BZD Rx[3]	21%	20%	-5%
Opioids Rx/100 in US[4]	78	51	-34%

Comparison of 2018, 2008 data showed same declines in Rx rates for patients with, without SUD/OUD/mental health diagnosis

[1]82% in those with OUD

[2]70% in those with OUD

[3]BZD's added to MCR coverage in 2013

[4]CDC.gov

The evidence suggests that those treating cancer patients have reduced opioid treatment at about the same rate as in non-oncology settings, and that they do not risk-stratify Rx strategies well.

Townsend TN, *et al. J Pain Symptom Manage* 2022;63(2):179-188.

OUD Patient With Cancer? No Additional Opioids for You, Unless Pain Specialist Is Consulted

Compassion Inequities & OUD: A Matched Case-Control Analysis Examining Ipatient Management of Cancer-Related Pain for Patients with OUD

West Virginia; 80 hospitalizations

N=25 pts with OUD; 31 pts without

Median age: 38 yo

Median survival: 2.3 mos

OUD pts	non-OUD pts
55% male	55% female
Admit/PM: -3 OME	Admit/PM: +37 OME
58% PC consult	20% PC consult
+27% OME w/PM	+27% OME w/PM

Patients with OUD were 90% less likely to receive dose escalation of opioids on admission, regardless of OUD remission status.

One patient with OUD was on TPN; denied IV opioids for 'drug-seeking behavior.' She died 7 days later.

Singh SA, *et al. J Pain Symptom Manage* 2021;62(3):e156-e163.

Going to Hospice? Less Opioids for You

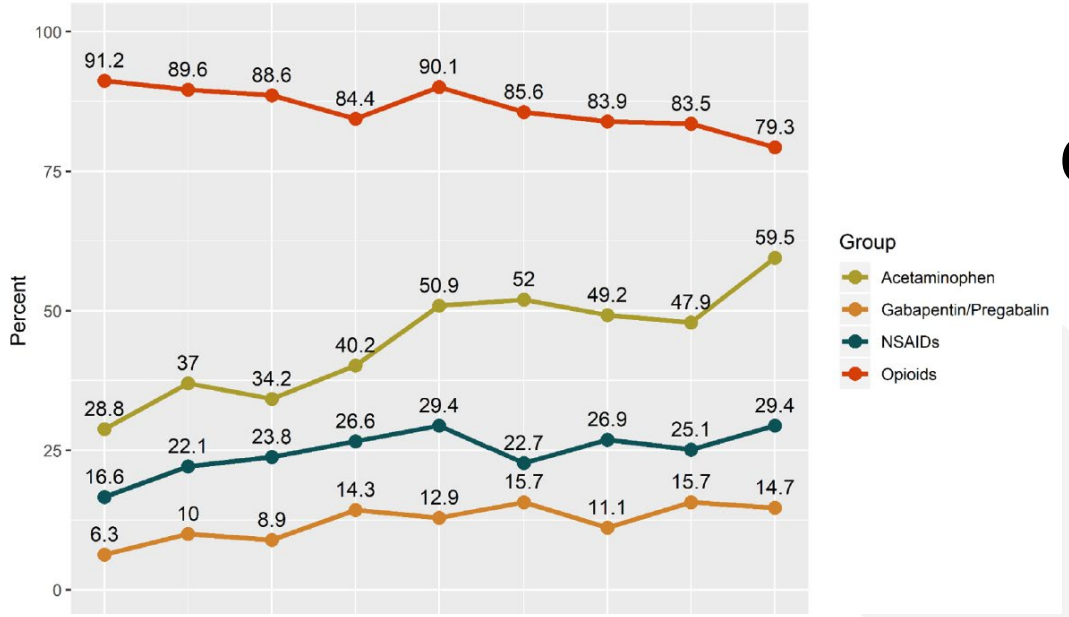
Decreasing Trends in Opioid Prescribing on Discharge to Hospice Care

Oregon (550-bed hospital);

2,6

Me er

dia



Furono JP, *et al. J Pain Symptom Manage* 2021;62(5):1026-1033.

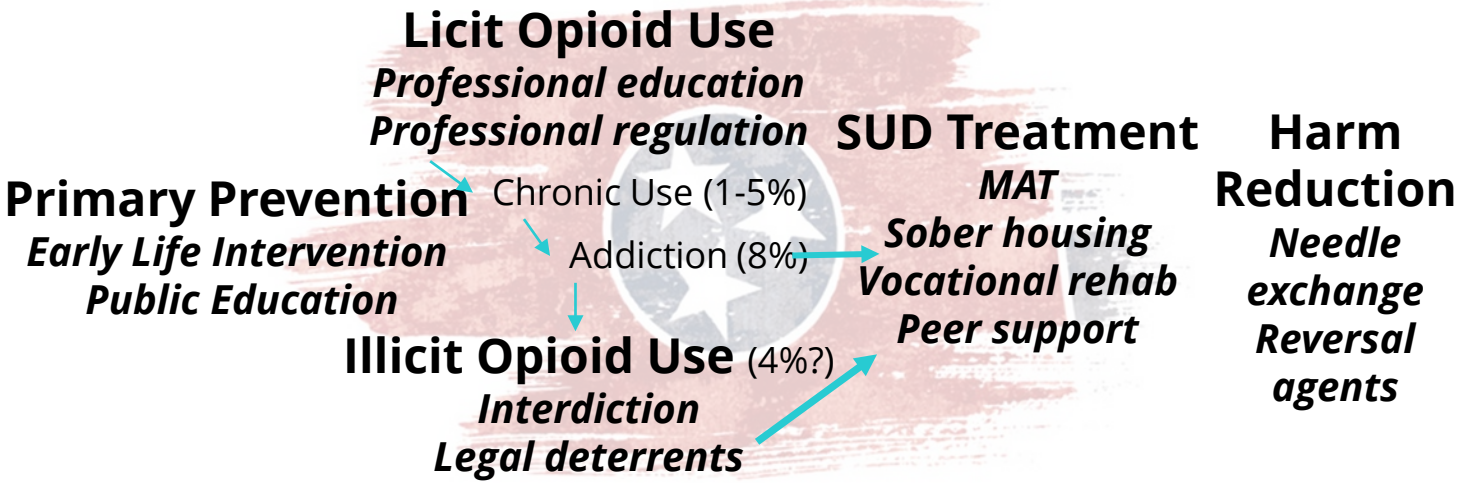
When You Drain the

- Survivors face difficulty in procuring opioid treatment[3]
- Patients in treatment, survivors have employment, financial difficulties in proportion to uncontrolled pain[4]

[1] Shi Q, *et al. Cancer* 2011;117(12):2779-2790.
[2] Sanford NN, *et al. Cancer* 2019;125(23):4310-4318.
[3] Nijs J, *et al. Pain Physician* 2021;24(5):309-317.
Jensen MP, *et al. Pain Med* 2010;11:1099-1106.
Davidsen M, *et al. Scan J Public Health* 2011;39(7 Suppl):131-35.
van den Beuken-van Everdingen MH, *et al. J Pain Symptom Manage* 2016;51:1070-1090.
Schenker Y, Merlin JS, Quill TE. *JAMA* 2018;320(9): 871-2.
[4] Halpern MT, de Moor JS, Yabroff R. *J Clin Oncol* 2021;40:24-41.

Meet Monique,
Who Lives on the Business End of Unintended Consequences

A Modest Proposal: the Middle & the Margins



proactive	proactive and reactive	reactive
long-term changes	intermediate changes	short-term changes
ROI difficult to measure	ROI simpler to measure	ROI simple to measure

The best time for planting a tree is 20 years ago. The second-best time is now.

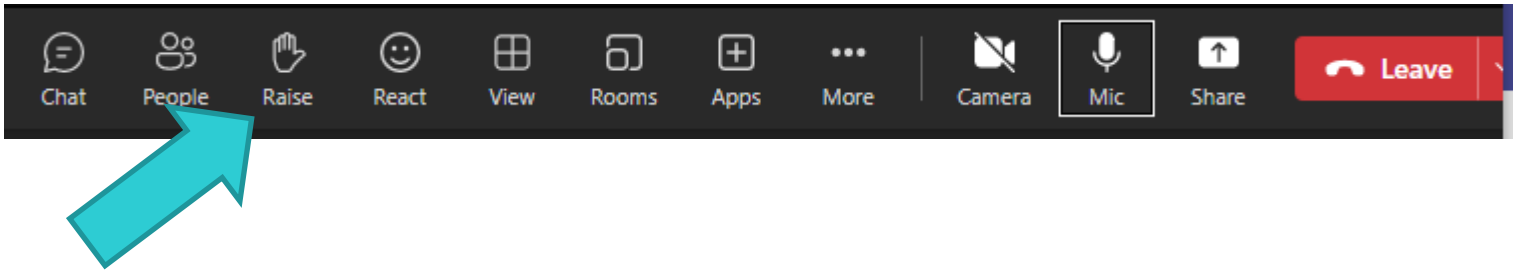
Chinese proverb

Public Comment

- Does anyone wish to comment or address the Opioid Abatement Council?

In-Person: please raise your hand

Virtual: please click the "**raise your hand**" icon located on the top menu bar (3rd from the left)



Thank you