PRESCRIPTION DRUG AND OPIOID ABUSE COMMISSION
FEBRUARY 8, 2018 MEETING

APPROVED MINUTES

In accordance with the Open Meetings Act, 1976 PA 267, as amended, the Prescription Drug and Opioid Abuse Commission met on February 8, 2018, at the Ottawa Building, Conference Room 3, 611 West Ottawa Street, Lansing, Michigan 48933.

CALL TO ORDER

Judge Linda Davis, Chairperson, called the meeting to order at 2:06 p.m.

ROLL CALL

Members Present:
Judge Linda Davis, Chairperson, Ex-Officio for LARA
Vincent Benivegna
Rebecca Cunningham (Arrived at 2:22 p.m.)
Richard Dettloff (teleconference)
Lisa Gigliotti
Timothy Hurtt
Paul Lauria (teleconference)
Melissa Owings
Michael Paletta
Judge Patrick Shannon
Roy Soto (teleconference)
Larry Wagenknecht
Laurie Wesolowicz (teleconference)

Members Absent:
Stephen Bell
Stephen Lazar
Paula Nelson
Gretchen Schumacher
Adam Wilson

Ex-Officio Members:
Michelle Brya, Assistant Attorney General (Departed at 3:59)
Dr. Debra Pinals, Department of Health and Human Services
Col. W. Thomas Sands, Michigan State Police

Staff:
Cheryl Pezon, Acting Bureau Director, BPL

Kimmy Catlin, Board Support, Boards and Committees Section
Andria Ditschman, Analyst, Boards and Committees Section
Weston MacIntosh, Analyst, Boards and Committees Section

APPROVAL OF AGENDA

MOTION by Benivegna, seconded by Gigliotti, to approve the agenda as presented.

A voice vote followed.

MOTION PREVAILED

APPROVAL OF MINUTES

MOTION by Benivegna, seconded by Gigliotti, to approve the minutes from January 11, 2018 as written.

A voice vote was followed.

MOTION PREVAILED

DHHS Update

Karen Yoder, Steve Sukta, and Mary Teachout introduced themselves to the Commission.

Steve Sukta and Mary Teachout presented a PowerPoint entitled “Michigan Model for Health” to the Commission. (Please see addendum #1).

Pinals advised the following:

MDHHS met with the deans of all medical schools in Michigan last month. The purpose of this meeting was to discuss curriculum for medical school students concerning prescribing practices and medication assisted treatment. A workgroup to continue this discussion will be formed.

Michigan was just accepted into a policy academy from the National Governors Association (NGA) on strategies to reduce infectious disease in individuals with substance use disorders. The policy academy team consists of representatives from MDHHS, the Governor’s office, the Michigan State Police, and a local community organization. This policy academy will develop and implement a strategic action plan for preventing and responding to infectious disease associated with substance use disorder. The two day kickoff meeting with all participating states will occur next month. The NGA will provide technical assistance throughout this process.

MDHHS is hosting an opioid overdose prevention Stakeholders Group on February 26, 2018. This meeting will focus on improving outreach and surveillance.

MDHHS is hosting a Public Safety and Public Health Conference on April 17, 2018 at the Crowne Plaza in Lansing. This one day summit will allow public safety workers, public health workers, and others to strategize, discuss best practices, and network with statewide experts.

MDHHS is working to reduce neonatal abstinence syndrome (NAS) by promoting prevention and wellness, increasing capacity, and improving quality. These efforts include promoting evidence based home visiting and provider education, increasing the number of opioid treatment providers, and child welfare cross-system collaboration.

Discussion was held.

Health Professions Stakeholder Group

Dr. William Morrone introduced himself to the Commission.

Dr. William Morrone presented a PowerPoint entitled “Combating the Opioid Mortality Crisis” to the Commission. (Please see addendum #2)

Discussion was held.

Office of Drug Policy Discussion and Chair Report

Davis explained that the Governor’s Office met with the department directors and stakeholder groups. There are currently 56 independent projects being worked on by several different people. This work needs to be more collaborative. By creating an Office of Drug Policy, the various projects will come together, resulting in a more effective outcome by eliminating duplicative work.

Judge Davis advised the importance of this office because although the specific drug used changes, the problems remain the same. Everyone needs to be educated on this.

MOTION by Shannon, seconded by Wagenknecht, to refer the inquiry of the need for an Office of Drug Policy to all four of the subcommittees under the Prescription Drug and Opioid Abuse Commission and to obtain ideas and direction of how the office should function if established. A formal motion shall be provided to the full Commission from the Policy and Outcomes Subcommittee.

A voice vote was held.

MOTION PREVAILED

Legislative Update

Bryan Modelski, Legislative Analyst for the Bureau of Professional Licensing, discussed

recently introduced bills that impact opioid abuse.

Paletta gave each Commission member a handout regarding Michigan opioid legislation and gave an overview of the document. (Please see addendum #3).

Discussion was held.

OLD BUSINESS

None

SUBCOMMITTEE REPORTS

Treatment

The Commission reviewed the subcommittee report.

Pinals advised that MDHHS is working with the Michigan Association of Treatment Courts Professionals to improve training for judges and other court staff on the treatment of addiction.

Regulation and Enforcement

None

Policy and Outcomes

The Commission reviewed the subcommittee report.

Prevention

The Commission reviewed the subcommittee report.

CHAIR REPORT

Davis advised that peer coaches are not being paid if they have a criminal record. Davis expressed the importance of peer coaches. Pinals discussed what the current federal law states and possible changes to the law. Pinals stated she will give an update at the next regularly scheduled meeting.

DEPARTMENT UPDATE

Pezon advised the Commission that the 2017 draft Annual Report is ready to be voted on. Pezon advised that plans are being developed for requiring prescriber licensees to

have a one-time training on controlled substances. A draft copy of the one-time training requirements were provided to the Commission members for comment.

MOTION by Wagenknecht, seconded Cunningham, to approve the Annual Report.

A voice vote followed.

MOTION PREVAILED

PUBLIC COMMENT

Barry Cargill, Director for Homecare and Hospice Association, recommended acceleration of the legislative process for evaluation of exemptions for hospice care.

Pezon advised the possible use of an “emergency rule” if needed.

ANNOUNCEMENTS

The next regularly scheduled meeting will be held April 12, 2018 at 2:00 p.m. in the Ottawa Building, 611 W. Ottawa Street, Conference Room 3, Upper Level Conference Center, Lansing, Michigan.

ADJOURNMENT

MOTION by Gigliotti, seconded by Hurtt, to adjourn the meeting at 4:33 p.m.

A voice vote followed.

MOTION PREVAILED

Minutes approved by the Commission on: April 12, 2018.

Prepared by:
Kimmy Catlin, Board Support February 13, 2018
Bureau of Professional Licensing

Michigan Model for Health™

Steve Sukta
Michigan Department of Health and Human Services

Mary Teachout
Michigan Department of Education

Comprehensive School Health Education

A **comprehensive health education curriculum** is one that is broad in scope and content; addresses numerous health problems, issues, or topics; and includes a set of instructional strategies and learning activities for students in pre-K through grade 12 to acquire the knowledge, attitudes and skills to address multiple health outcomes.

Standards Inform Curriculum

Health Education Standards

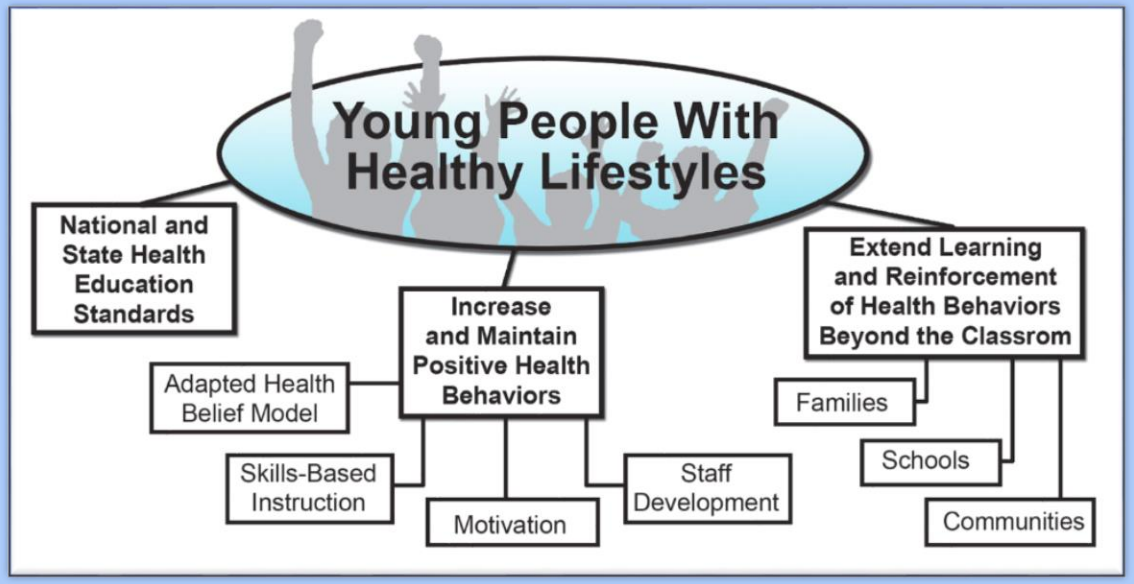
- ✓Core Concepts
- ✓Accessing Information
- ✓Health Behaviors
- ✓Analyzing Influences
- ✓Social Skills
- ✓Goal Setting
- ✓Decision Making
- ✓Advocacy

Content Areas

- ✓ Nutrition and Physical Activity
- ✓ **Alcohol, Tobacco and Other Drugs**
- ✓ Safety
- ✓ Social and Emotional Health
- ✓ Personal Health and Wellness
- ✓ HIV Prevention
- ✓ Sexuality Education

The Ultimate Goal of the Michigan Model for Health™ is that young people adopt healthy lifestyles.

Three means of meeting this goal:



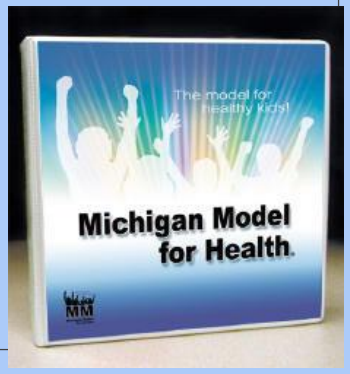
1) Skills-based curriculum that meets Health Education Standards

2) Increase and Maintain Positive Health Behaviors

3) Extend Learning & Reinforcement of Health Behaviors Beyond the Classroom

The Michigan Model for Health™ is:

- A sequential, developmentally appropriate, skills-based, **comprehensive health education curriculum**
- Aligned to Health Education Standards and focused on the six health risk behaviors identified by the CDC
- Research and evidence-based, with numerous studies reporting positive outcomes
- The product of a statewide joint effort of partners from various disciplines, developed and revised since 1984
- A living document that is subject to ongoing revisions

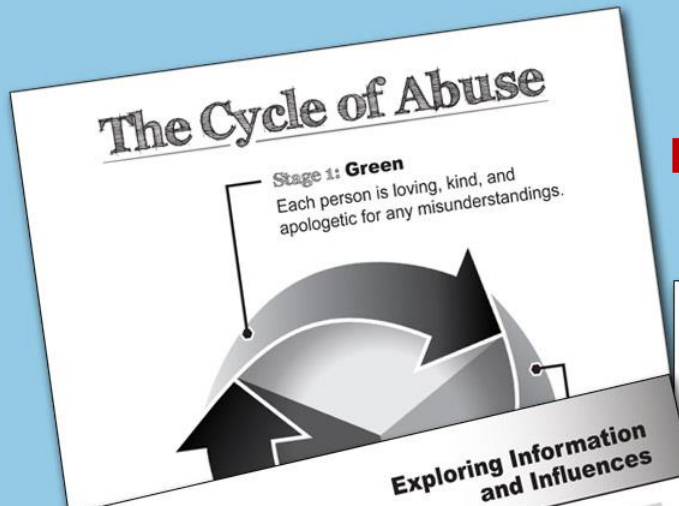


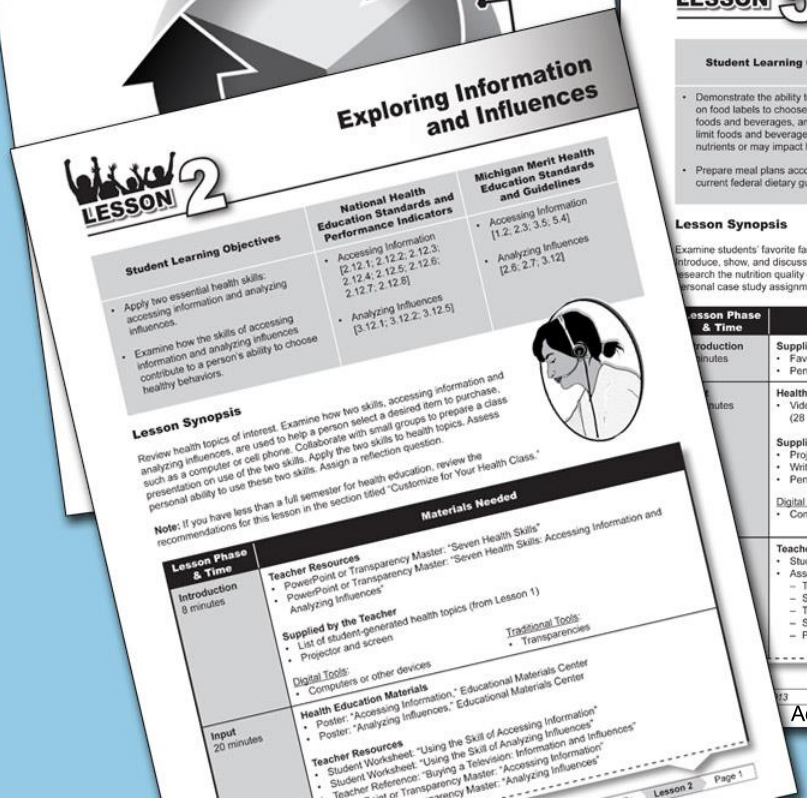
Michigan Model for Health®

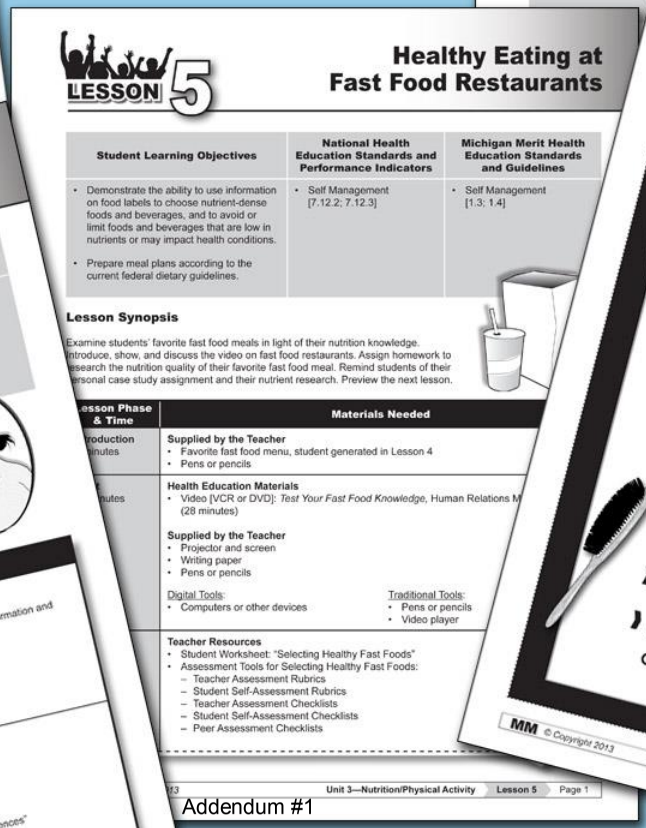
HOME

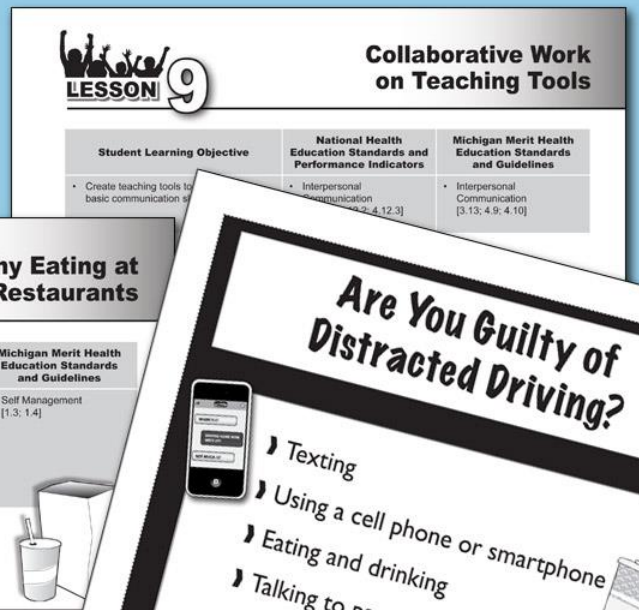
Skills for Health and Life

Printed Lesson Plans in Teacher Manual









Addendum #1

Family Involvement

Family Resource Sheets reinforce concepts at home

Avoid Riding With an Intoxicated Driver

FAMILY RESOURCE SHEET

Do you know that two to four people die every hour from alcohol-related accidents in the United States?

We want to protect all family members from being involved in any type of accident, including car accidents. As your child gets older, he or she is more likely to be at risk for riding with a driver who is intoxicated from the use of alcohol or other drugs. Getting a ride home from babysitting is an example of a time when your child might be offered a ride from an intoxicated adult. Riding with a friend's older brother or sister who has been drinking or using other drugs is another possibility.

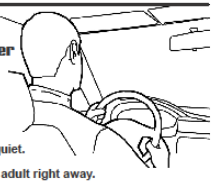
What You Can Do

- Spend time talking with your son or daughter about this issue.
- Make a plan for what to do.
- Identify a person to call if you aren't available.
- Pick a code phrase, such as "Is Grandma still sick?" Your child can use this phrase to let you know he or she needs a ride but cannot say that directly. Perhaps your child is in the same room as the person who is intoxicated.
- Review what your child learned at school. On the right, you will find ideas we discussed in school for how to avoid riding with an intoxicated driver. We also talked about what to do if you can't avoid it.

Ways to Avoid Riding With an Intoxicated Driver

- Say "No" or "No thanks" to the person offering to give you a ride.
- Call your parents immediately and have an emergency plan in place.
- Call another trusted adult if your parents can't be reached.
- Tell the driver you don't feel comfortable riding with him or her.
- Tell the driver your plans changed.
- Find a friend you trust and go home with him or her instead.
- If someone who gives you a ride makes you feel uncomfortable, tell your parents or a trusted adult right away.

If You Can't Avoid Riding With an Intoxicated Driver



- **Sit in the backseat.**
- **Buckle up tight.**
- **Put everything on the floor.**
- **Don't bother the driver. Be quiet.**
- **Tell your parent or a trusted adult right away.**

This can be frightening to think about. But there are ways to help our children know what to do to stay as safe as possible Our children need to know they have our support when taking action to avoid riding with an intoxicated driver.

Want to Know More?

Check out these websites for more information and ideas for helping your child.

- National Safety Council: www.nsc.org
- National Highway Traffic Safety Administration (NHTSA): www.nhtsa.dot.org
- Mothers Against Drunk Driving (MADD): www.madd.org
- Students Against Destructive Decisions (SADD): sadd.org
- Recording Artists, Actors, and Athletes Against Drunk Driving (RADD): www.radd.org

What to Know Before You Go

FAMILY RESOURCE SHEET

Motor vehicle crashes are the leading cause of death for children from 3 to 6 and 8 to 14 years old.

National Highway Traffic Safety Administration, 2007

Children are easily injured in car crashes for two reasons:

- Their bones are developing.
- The size and shape of their bodies make injuries more likely.

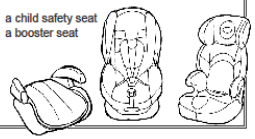
Your child is learning how to be safe while riding in a car or truck. There are two important things to remember:

- Use a safety belt and be sure it fits right. Safety belts save thousands of lives each year.
- Sit in the back seat.

Safety Belts for Everyone!

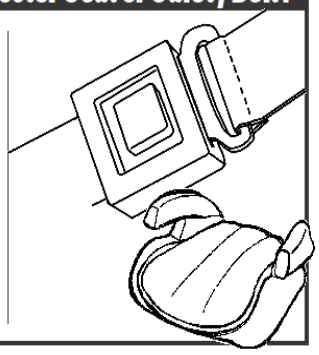
People over 4'9" tall can use the safety belts as they are installed in cars and trucks. For other children, use:

- a child safety seat
- a booster seat



What's Better: A Booster Seat or Safety Belt?

Until children are 4'9" tall they are required by law to use booster seats. An adult safety belt does not properly fit a child under 4'9" tall. In a crash, a safety belt that doesn't fit right can be deadly. Booster seats make the lap and shoulder belts fit properly. The belts protect a child's stomach, chest, and neck in a crash. Booster seats also allow a child's legs to bend normally.



Effectiveness of the *Michigan Model for Health*™: A Randomized Control Study (2011)

4th and 5th Grade Results

Students who received the *Michigan Model for Health*® curriculum showed statistically significant, positive changes compared to a randomized control group.

- Less reported alcohol and tobacco use and aggressive behavior in the past 30 days
- Enhanced knowledge about the hazards of drugs
- Reduced intention to use alcohol and smoke cigarettes
- Increased knowledge and skills in physical activity and nutrition
- Better interpersonal communication skills, social emotional skills, and self-management skills
- Improved pro-health and pro-safety attitudes
- Stronger drug and tobacco refusal skills
- Later age of first cigarette use

Principal Investigator:
Jim O'Neill, Ph.D., Madonna University
Collaborator:
Jeff Clark, H.S.D., Ball State University

Professional Acknowledgements

- Designated as a **"Promising Program"** by the U. S. Department of Education.
- Included on the **Substance Abuse and Mental Health Services Administration's** (SAMHSA) **National Registry of Evidence-Based Programs and Practices** (NREPP), an online registry of evidence-based interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment (2011)
- Included on the Office of Justice Programs' **CrimeSolutions.gov**, an online clearinghouse for promising and effective, quality programs and practices in the areas of criminal justice, juvenile justice, and crime victimization (2013)
- Included on the 2013 **CASEL Guide: Effective Social and Emotional Learning Programs** (Preschool and Elementary School Edition)

Michigan Model for Health™ Implementation

- The Michigan Model for Health™ is implemented state-wide in 87% of public school entities, or five of six public schools in Michigan utilizing the MMH.
- Implementation occurs within non-public schools across Michigan, although to a lesser extent. (*Use of the Michigan Model for Health Curriculum among Michigan Public Schools, Michigan Department of Health and Human Services, 2016).*

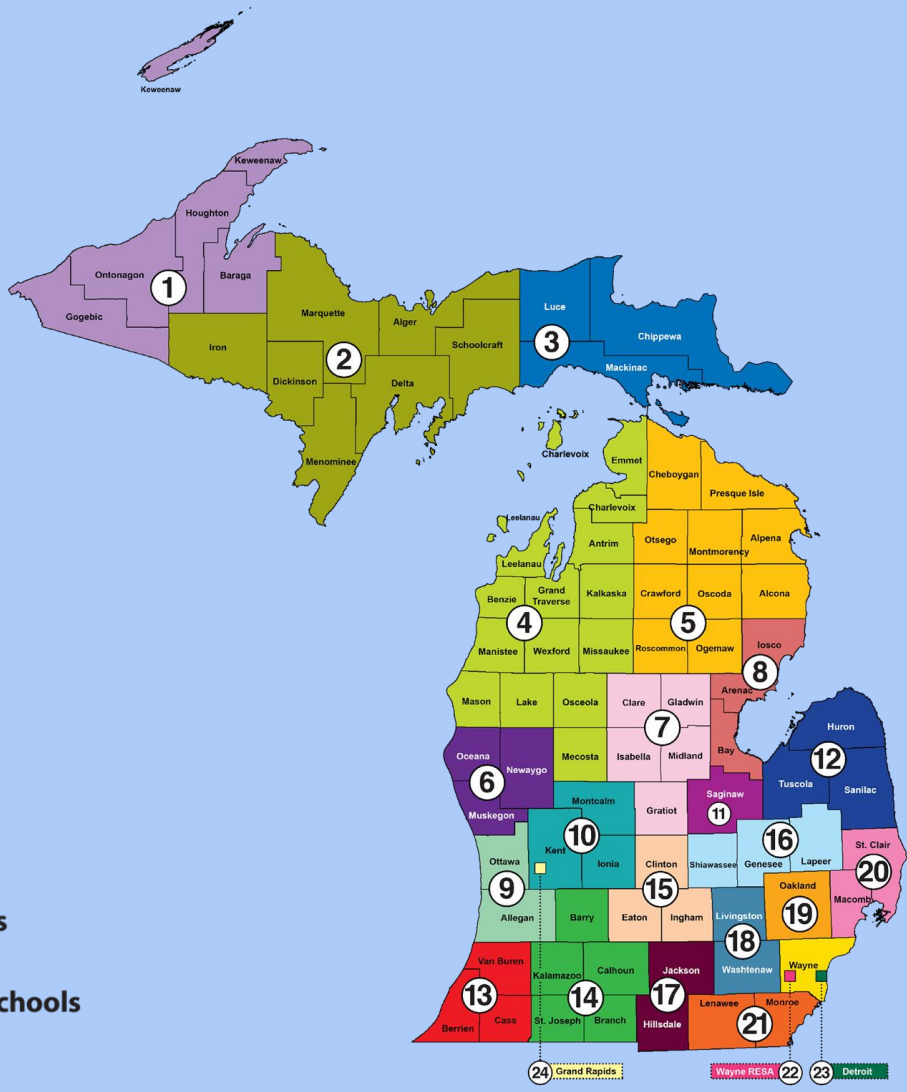
Michigan Model for Health™ Infrastructure

- State Agencies: MDHHS and MDE
  - Writers, Reviewers/Content Experts, Pilot Teachers, Evaluators
- State Steering Committee
- Michigan School Health Coordinators Association (MiSHCA)
  - Training and Technical Support
- Michigan Model for Health Clearinghouse
- School administrators and teaching staff
  - Pre-Kindergarten through 12th grade students
- Multiple Partners

Addendum #1

MiSHCA School Health Coordinator Regions

1. Copper Country ISD
2. Marquette-Alger RESA
3. Eastern UP ISD
4. Traverse Bay Area ISD
5. COP ESD
6. Muskegon Area ISD
7. Gratiot-Isabella RESD
8. Bay-Arenac ISD
9. Ottawa Area ISD
10. Kent ISD
11. Saginaw ISD
12. Tuscola ISD
13. Van Buren RESA
14. Calhoun ISD
15. Eaton RESA
16. Genesse ISD
17. Jackson County ISD
18. Livingston ESA
19. Oakland Schools
20. Macomb ISD
21. Monroe ISD
22. Wayne RESA
23. Detroit Public Schools
24. Grand Rapids Public Schools



Current ATOD Content and Concepts

Alcohol, Tobacco & Other Drugs:

- **Medicines/Prescription Drugs**
- Poisons/Inhalants
- Caffeine
- Tobacco
- Alcohol
- Marijuana

Specific Concepts:

- Safe use of OTC and Prescription medicines
- Refusal skills to take any drugs
- Influence of family and peers on drug use
- Impact of drug use on goals

Michigan Model for Health Revision Process

- Administrative meeting - MDE, MDHHS, Writer
- Writer researches and revises
- Subject Matter Expert review
- Edits incorporated
- Second review – Subject Matter Experts, MDE, MDHHS
- MMH Clearinghouse - format and design
- MMH Clearinghouse - produces and disseminates lessons
- Training of Trainers held for School Health Coordinators
- School Health Coordinators train classroom teachers

Opioid Misuse Prevention Suggested Revisions

- Lesson Modifications
- New Lessons
- Teacher References
- Family Resource Sheets

Questions?

Contact Information

Michigan Department of Health and Human Services
Karen Krabill Yoder
Adolescent & School Health Unit Manager
517-335-8908
yoderk@Michigan.gov

Michigan Department of Education
Mary Teachout, Health & Physical Education Consultant
517-335-1730
teachoutm@Michigan.gov

Combating the Opioid Mortality Crisis

Health Professions Stakeholder Group

Michigan Academy of Family Medicine

Michigan Academy of Physician Assistants

Michigan Chapter American Academy of Pediatrics

Michigan College of Emergency Physicians

Michigan Council of Nurse Practitioners

Michigan Dental Association

Michigan Health & Hospital Association

Michigan Pharmacists Association

Michigan Psychiatric Society

Michigan Osteopathic Association

Michigan State Medical Society

Michigan Society of Addiction Medicine

Michigan Society of Interventional Pain Physicians

Michigan Veterinary Medical Association

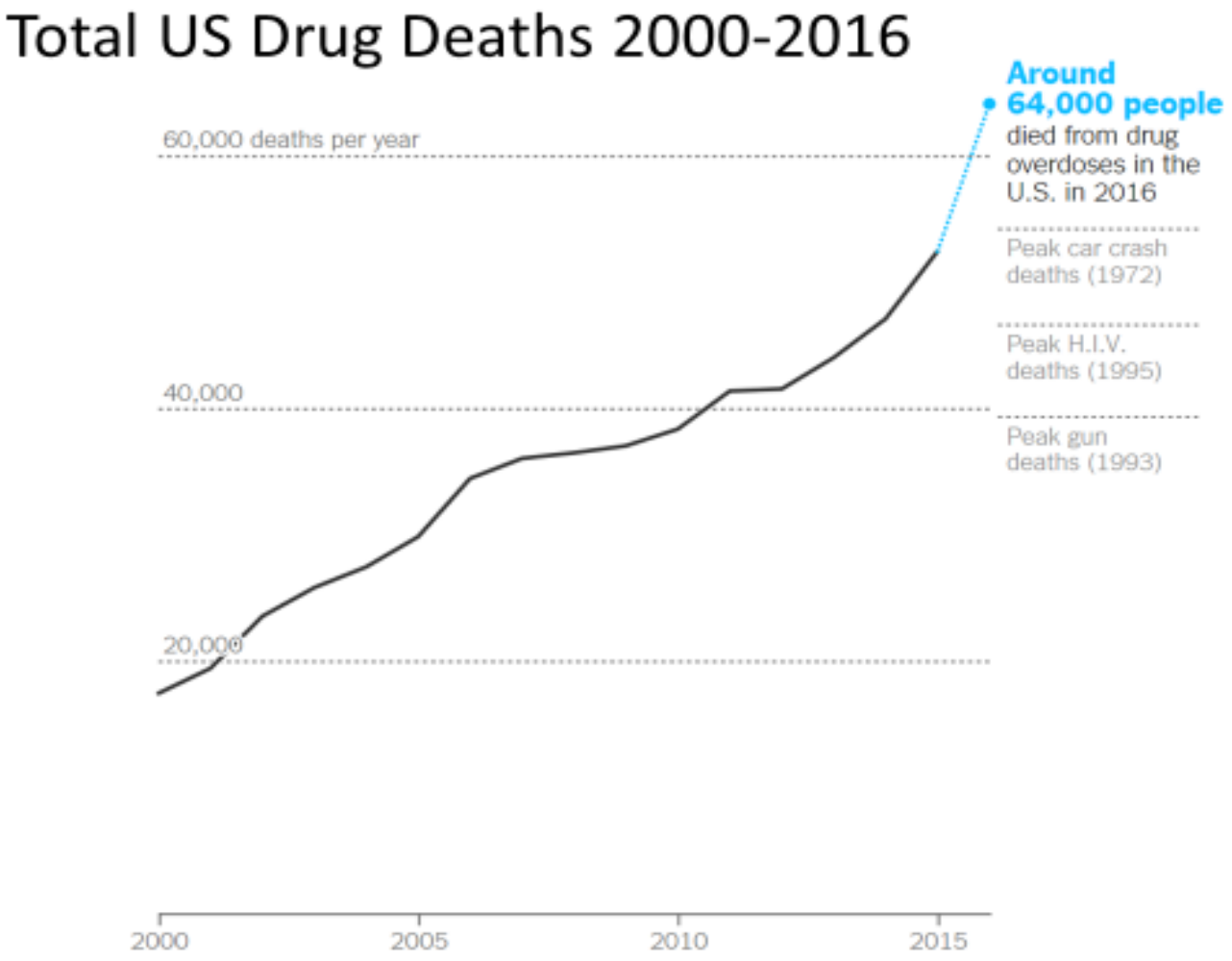
Who We Are

- A coalition of health care professional societies whose members include medication prescribers and dispensers
- Dedicated to…
  - Preventing prescription opioid overuse, addiction and overdose
  - Supporting alternative therapies and multiple modalities to treat pain
  - Improving access to treatment for persons addicted to prescription opioids, heroin and/or fentanyl analogues
  - Simultaneously shrinking supply and demand for both prescribed opioids and illegally trafficked opioids
  - Enhanced training options for health care professionals
  - Expanding community engagement with local leaders
  - Improving public health surveillance and research activities

Our Guiding Principles

- First do no harm
  - Ensure appropriate access to care through the use of evidence-based therapies for people suffering from pain, addiction to opioids and/or multiple substances
- Work collaboratively to develop a comprehensive, multi-faceted statewide strategy
  - Foster strong partnerships and regular dialogue with stakeholders and recognize that different problems require different approaches
- Embrace a “learning health system approach”
  - Leverage teachable moments for health care professionals and other stakeholders

The Opioid Crisis



https://www.nytimes.com/interactive/2017/09/02/upshot/fentanyl-drug-overdose-deaths.html?_r=0

Adapted from CDC • National Center for Health Statistics • National Vital Statistics System as of 8/16/17

The Opioid Crisis

Addendum #2

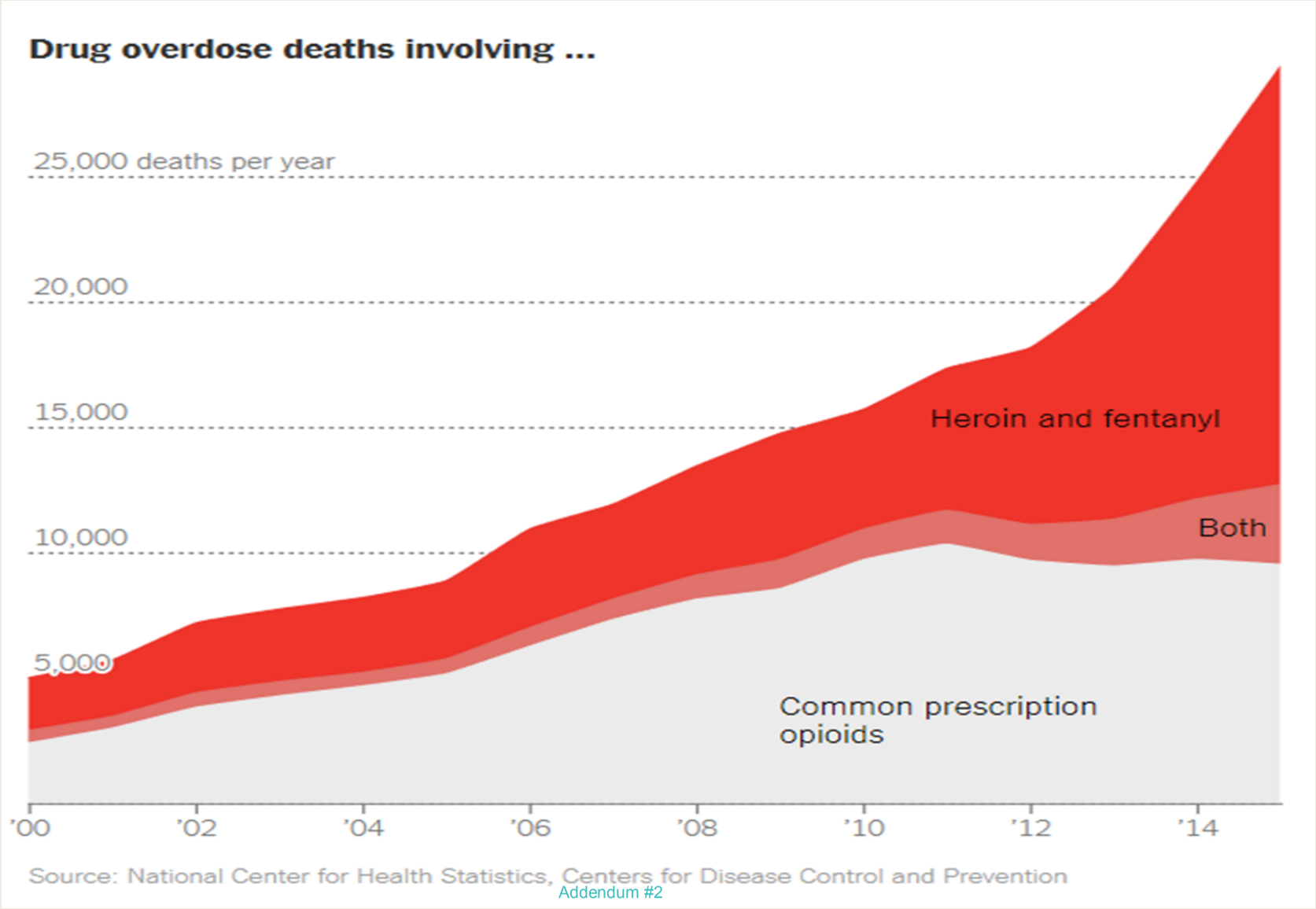
The Changing Landscape: Positive Trends

- Prescription rates have gone down in the past several years
- In 2015, prescription opioids were down by 25% from 2010
- Since 2010, the availability of controlled prescription drugs (CPDs) on the Black Market dropped by approximately one-third

The Changing Landscape: Negative Trends

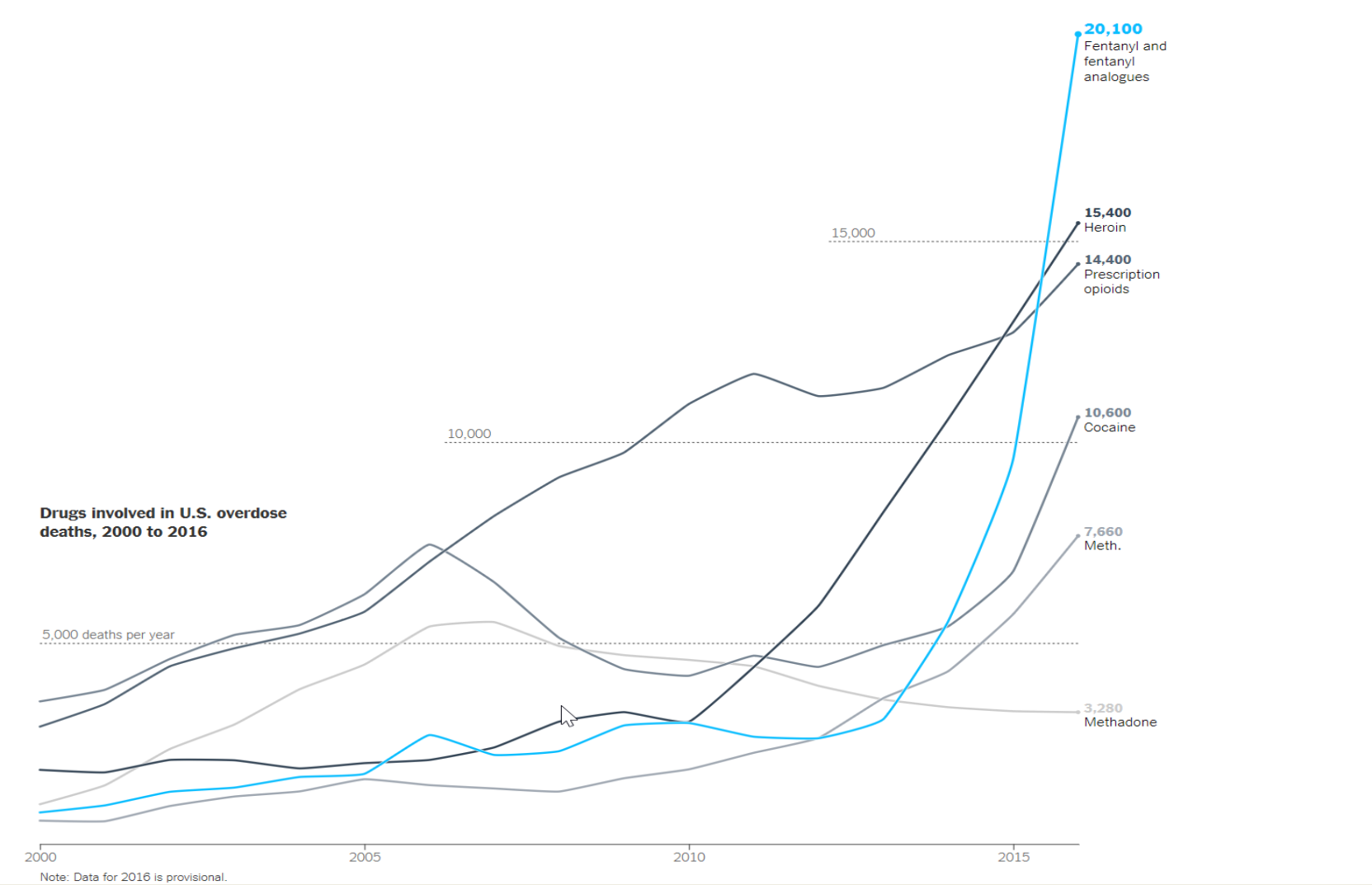
- Death rates in 2016 went up
- In 2015, opioids were still being prescribed 3x greater than they were in 1999
- Shift over the last three years with heroin and fentanyl analogues significantly outpacing opioid related deaths
- 55% of the current opioid-related death rate now driven by the use of illegal heroin, fentanyl and fentanyl analogues whereas 22.5% is due to prescription opioids

Drug Overdose Deaths



Addendum #2

Drug Overdose Deaths in the US 2000-2016



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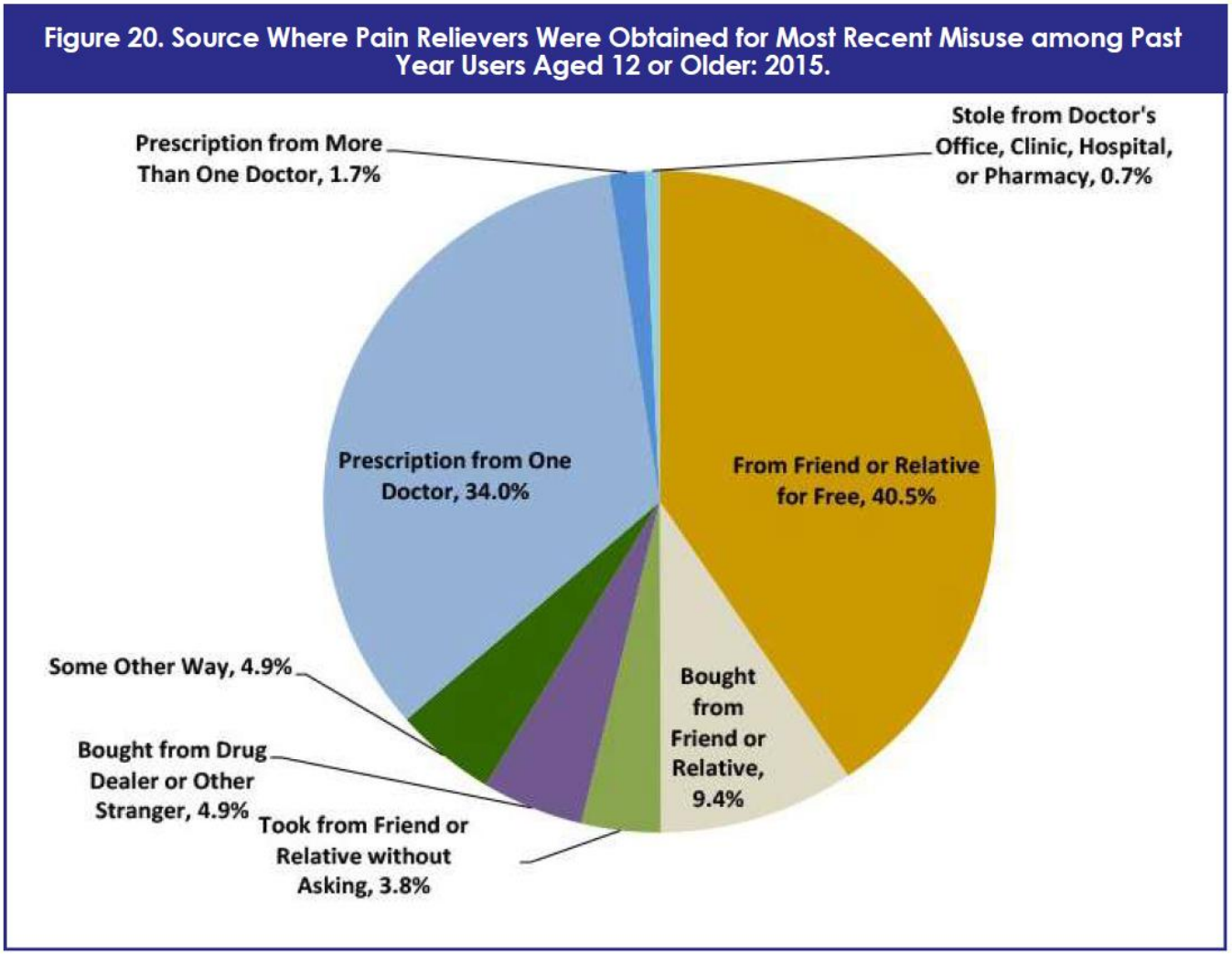
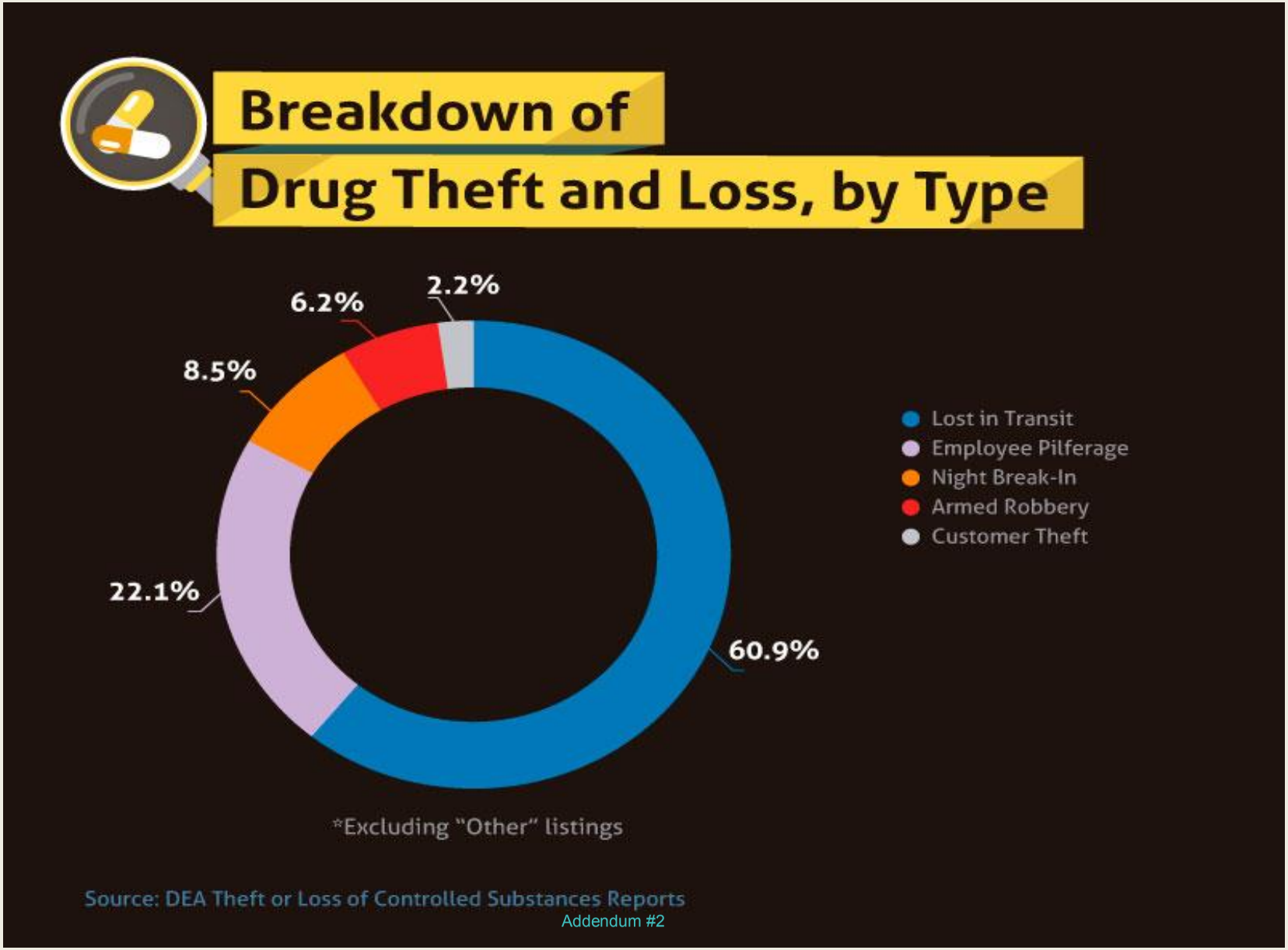
Two-Thirds of Prescription Opioids Were Obtained For Free, Bought or Stolen



Source: Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH)

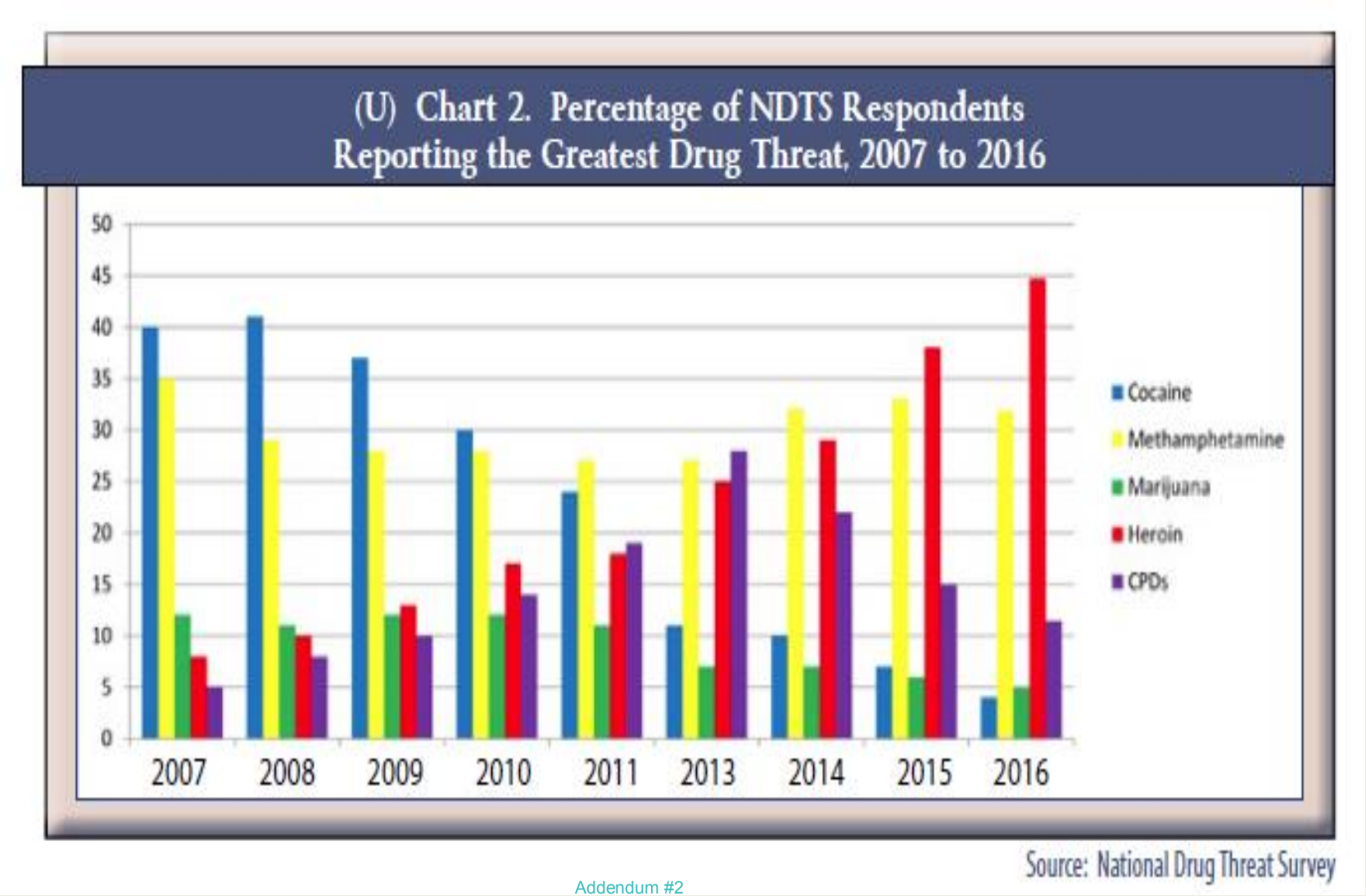
Addendum #2

Other Sources of Diversion of Prescription Opioids



Addendum #2

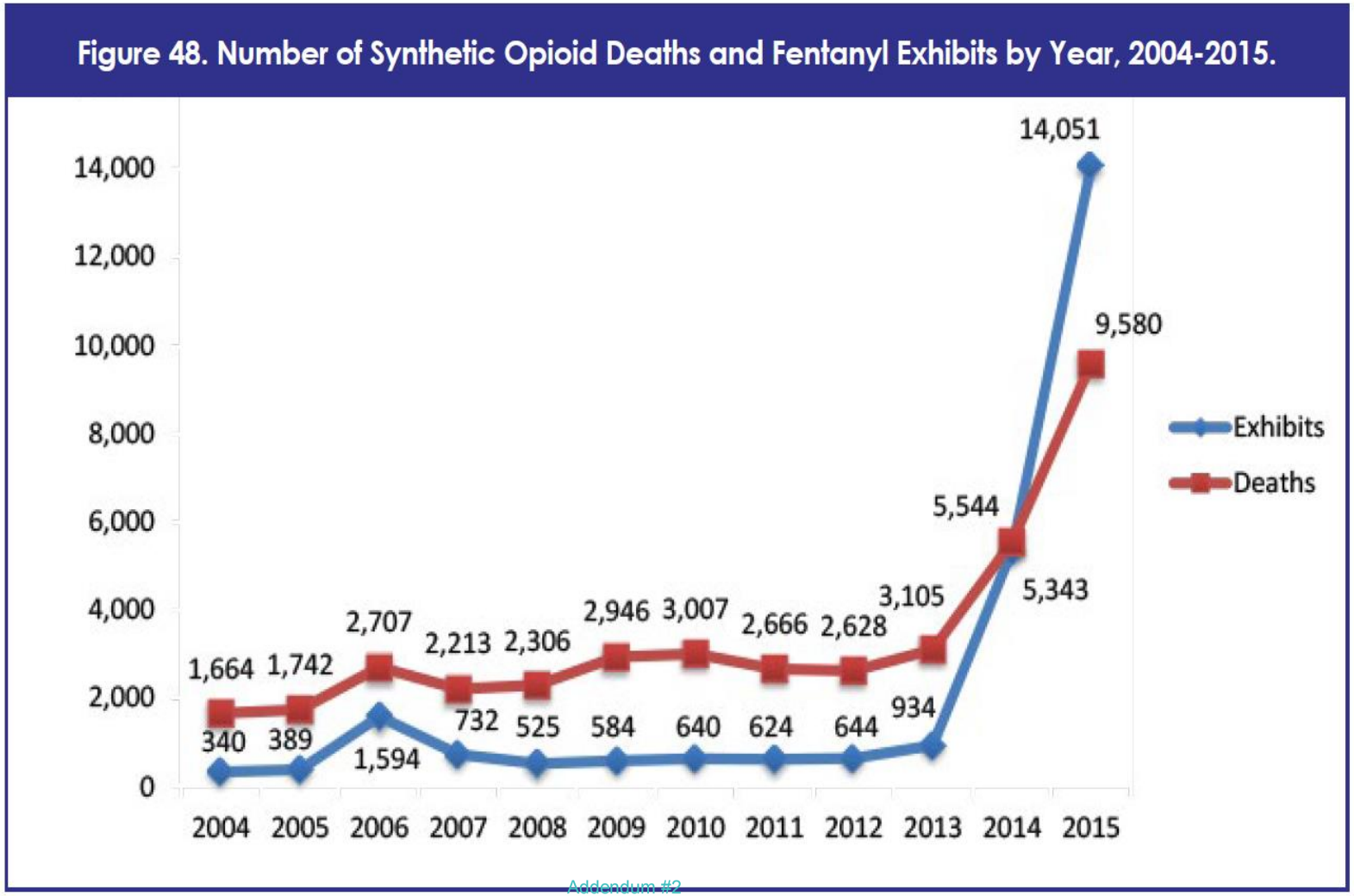
Drug Threat - Controlled Prescription Drugs Declined and Heroin Increased 2013-16



Addendum #2

2016 National Drug Threat Assessment

Fentanyl Confiscations and Deaths on the Rise



Source: Center for Disease Control and DEA National Forensic Laboratory Information System

Availability of Fentanyl Analogues is Increasing

- Growing problem in Michigan
  - Carfentanyl first identified in a fatal overdose case in Kent County (September 2016)
  - Nineteen confirmed carfentanyl cases identified in Wayne County (October 2016)
  - U47700 (aka, U4, Pink) first identified in SE MI (October 2016)
- And, elsewhere
  - “Gray death,” a combination of heroin, fentanyl, and/or carfentanyl possibly mixed with cocaine, identified in Indiana, Ohio, West Virginia and Georgia (May 2017)

Prioritizing Data Collection

- Per the CDC, more precise mortality estimates are possible by using more advanced analytic techniques to include 12 fentanyl analogs
  - >90% of unintentional deaths examined in 24 Ohio counties during January-February 2017 involved fentanyl and fentanyl analogues such as carfentanyl and several others
  - Heroin was seen in 6% of these cases
  - Any prescription opioid (other than fentanyl) was seen in 22.8% of these cases
- The advanced analytics for fentanyl analogues are **not** commonly available in MI, so similar deaths are **not** detectable in most instances and are **not** included as opioid-related death estimates

Bay County Health Department (BCHD)
Office of the Medical Examiner - BCHD, Bay County, Michigan.

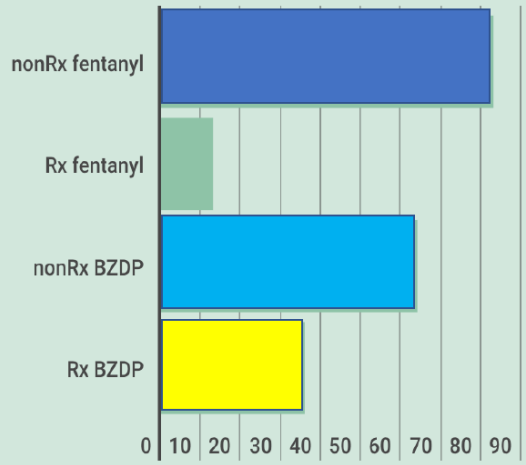
OD deaths 2017

When Fentanyl Analogues Were Found - What Was Prescribed?

30 deaths that were overdose of any kind

- 28 had opioid
- One death 100% benzo
- One death psuedoephedrine + grain alcohol
- 17 of 28 (60%) opioids were fentanyl or fentanyl family
- 14 of 17 (80%) fentanyl deaths were bootleg non pharmaceutical fentanyl
- ZERO fentanyl 4 years ago

Nonprescription fentanyl (nonRx fentanyl) is detected in 15 out of 18 (84%) reports. Rx fentanyl was verified by Rx in the last 30 days of a PDMP report. A prescription Benzodiazepine (Rx BZDP) was present in a total of 8 of 22 drug overdose deaths (36%). Nonprescription benzo (nonRx BZDP) 14/22 (64%) were detected in toxicology data.



Addendum #2

Courtesy of William Morrone, DO, Bay County Medical Examiner

Our Next Steps

- Develop a comprehensive strategy that embraces a learning health system approach and leverages teachable moments for health care professionals in order to:
  - Reduce supply and demand for prescription opioids
  - Improve access to evidence-based pain management and addiction therapies
  - Reduce mortality rates

Our Next Steps

- Prioritize good data collection
  - Disseminate accurate data to policymakers, providers, the public
  - Improve surveillance and detection of opioid related deaths including improved toxicology screening for previously undetectable fentanyl analogues
- Engage communities in education efforts to prevent inappropriate drug use and eliminate illicit drugs from communities

Our Next Steps

- Improve practice patterns based on evidence-based recommendations and with health professional input
  - Widely disseminate CDC and Michigan Quality Improvement Consortium (MQIC) Opioid Prescribing Guidelines
  - Develop evidence-based opioid CME curricula and interventional peer mentoring opportunities
  - Develop referral and consultation resources to ensure open access care when specialized treatment services are necessary and appropriate
  - Leverage analytics available via MAPS

Summary

- We cannot totally legislate, regulate, arrest or spend our way out of this dilemma
- The root causes for the opioid epidemic are complex and multifactorial
- Recently passed legislation represents the first step by adopting strategies when the prescription is the problem
- It is imperative to shrink supply and demand for **both** prescription opioids **and** heroin/fentanyl analogues
- Focusing **only** on prescription opioids without simultaneously addressing "heroin and fentanyl trafficking" **will dramatically shrink probability of success**

Summary

- Health professionals are well positioned to help lead the way and want to work collaboratively with the Commission to:
  - Get heroin and fentanyl analogues off the street
  - Ensure patients with chronic pain and/or addiction aren't abandoned and forced to self-medicate
  - Improve access to addiction treatment before abruptly restricting supply
  - Address diversion so that medication is used for its intended purpose
  - Bolster work force and infrastructure to ensure access to care for those who suffer from opioid tolerance and addiction

Questions?

MICHIGAN HomeCare & Hospice ASSOCIATION

February 8, 2018

Response to PA 247 - 249, of 2017 by the Michigan HomeCare & Hospice Association (MHHA). Michigan Opioid Legislation.

To protect the public health, Public Acts 248 and 249 were written to mitigate the number of deaths due to opioid overdoses in our state. While many states are enacting legislation aimed at preventing these deaths, Public Acts 248 and 249 may put hospice and palliative care patients at greater risk of harm. In the states that have enacted similar legislation, hospice and end-of-life practitioners are exempt from the restrictions on opiate prescribing, due to the intense immediate medical needs of patients at the end of life.

Hospice care provides care and comfort to an individual with a life limiting condition during their last days of life. One of the greatest benefits, and challenges for a hospice is keeping patients comfortable and managing pain in keeping with their wishes. In the last days of life, pain can become unbearable intractable and difficult to manage, even with ready access to class 2-5 controlled substances. While in hospice care, controlled substances often need to be immediately added and adjusted rapidly to keep the patient comfortable.

The State of Michigan Public Act 249, which was signed on December 27, 2017, stipulates that a prescriber who wishes to provide more than a three-day prescription of a schedule 2-5 controlled substance must first ask a patient about other controlled substances that they may be using, review an electronic report of the patient's past usage of scheduled drugs, and be in a "bona-fide patient prescriber relationship". In the Act of a "bona-fide" relationship is described as follows:

> *The prescriber has reviewed the patient's relevant medical or clinical records and completed a full assessment of the patient's medical history and current medical condition including a relevant medical evaluation of the patient conducted in person or via telehealth.*

This public act is designed to prevent an escalation in the opiate crisis but will inadvertently hamper normal hospice patient care. At the end of life, almost all health care is provided in the patient's home or place of residence, by licensed nurses using schedule 2-5 medications to prevent pain and suffering. Doctors are contacted in person, by phone or during the interdisciplinary team consultations to provide the medication orders.

(Continued)

Hospice patients are generally not able to travel to a doctor to have a personal visit, thus under the new law, the doctor would have to go to them – in every case, without exception. Hospices in Michigan will sometimes care for patients that are hours away from their offices. Hospices could not staff the army of doctors needed to make all these personal visits and therefore would not be able to care for patients at the most fragile time in their life under this new law.

Pain and symptom management in a hospice setting is currently managed in patients' homes 24 hours a day, 7 days a week. The ability to respond to a patient's immediate pain crisis would cease under the new law. If a doctor is called on by a visiting nurse to care for a new homebound patient, or if one doctor is covering for another doctor's patient, this law would allow that the covering physician to start or change scheduled medications. Under the stipulation of this new law the physician could also not prescribe scheduled medications that were ordered by a different doctor in the same practice until another personal visit. These changes would create undue pain and suffering for those facing the end of their life.

Public Acts 247, 248 and 249 include all Schedule 2-5 medications in its restrictions. These scheduled medications are used in hospice, not just to treat pain, but also to treat coughing, fatigue, difficulty breathing, depression, seizures, anxiety, insomnia, and other distressing physical symptoms. **This law effectively deprives hospices of the ability to care for and manage patients with dignity at the end of life. These acts threaten to disable hospice care across our state.**

Hospice Care in the home also offers greater accountability than in the office when offering prescribing scheduled medications to terminally ill patients. Nurses and other staff members are present weekly (or more often as needed) to observe the use of these medications and count the number of pills that are in the home. Social workers are involved in every hospice case and frequently visit the home. They assess and observe for possible misuse or diversion of the drugs by the patient or by other members of the household.

The Michigan HomeCare and Hospice Association (MHHA) supports efforts to strengthen regulations designed to protect our citizens and safeguard public health. We would also like to highlight the reality that within the scope of the current challenges with the opioid crisis, hospice and palliative patients do not represent the population of individuals for whom addiction and misuse of opioids is an issue.

Many other states have recently enacted similar types of legislation to address the ongoing opioid abuse epidemic in the United States including: Kentucky's House Bill 333 (2017). Ohio's Rule 4729-5-30 (12/29/2017, and Tennessee's Senate Bill 2552 (4/27/2016). However, while all three of these bills restrict the use of scheduled medications in their respective states, they have also included exemptions for people at end of life and for providers, who are in hospice care. Michigan's Public Act 249, and its companion 248, fails to offer any exemptions. Public Acts 247, 248, and 249 will protect and promote public health by effectively controlling the misuse of scheduled 2-5 controlled substances in the physician's office, but for all the reasons stated here, these acts will only harm those in hospice care. **We request that these public acts be immediately amended to exempt hospice prescribers and patients from their restrictions.**