

# TN TOGETHER

*ENDING THE OPIOID CRISIS*

## Frequently Asked Questions

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## GENERAL QUESTIONS

### 1. What is TN Together?

TN Together is a multi-faceted plan, comprised of legislation, Governor Haslam's proposed 2018-19 Budget and other executive actions to attack the state's opioid epidemic through three major components: 1) Prevention, 2) Treatment and 3) Law Enforcement.

### 2. What role does the legislation play in the TN Together Initiative?

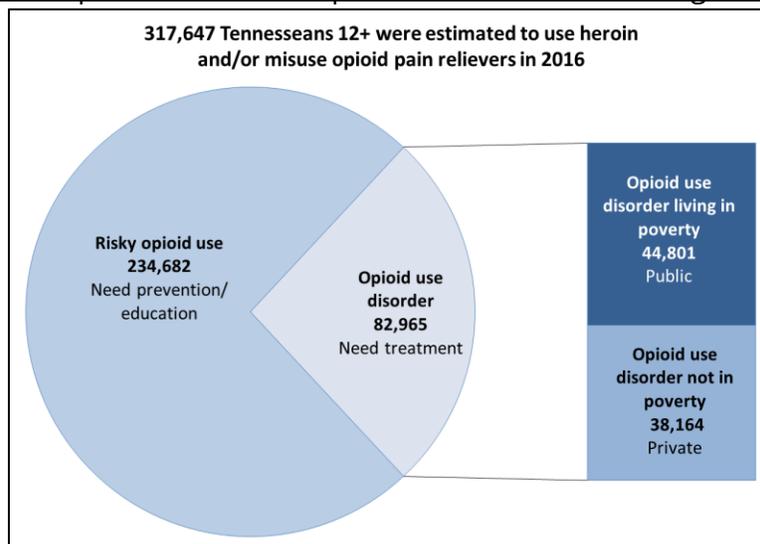
This year's opioid legislation, part of the TN Together plan to attack the state's opioid epidemic, recognizes the work of multiple agencies and stakeholders, and aggressively and comprehensively addresses the issue through prevention, treatment and law enforcement.

### 3. What is an opioid?

An opioid is a class of drugs that is meant to reduce feelings of pain and may also create a state of euphoria. Common prescription opioids include naturally occurring drugs like morphine and codeine as well as synthetic drugs like hydrocodone, oxycodone, fentanyl, and many others.

### 4. How many individuals in Tennessee misuse opioids or have a demonstrated opioid use disorder?

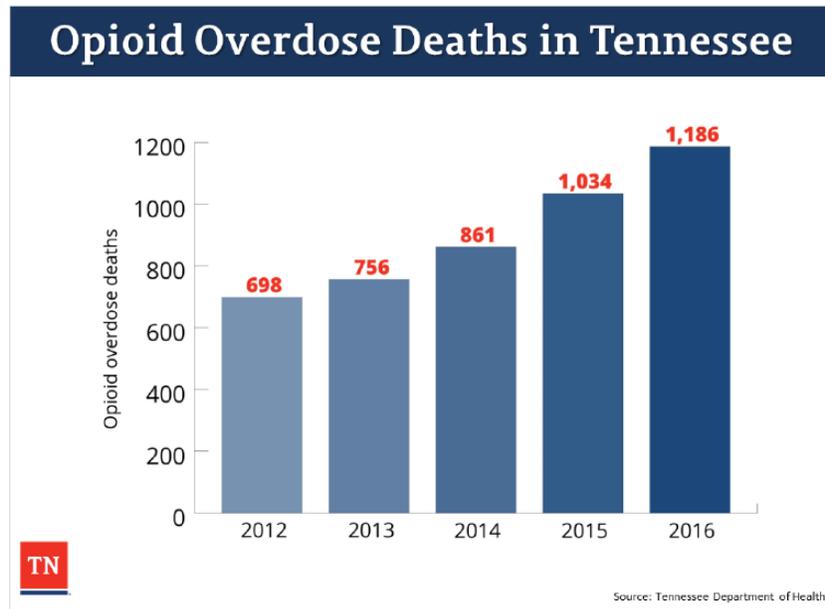
2016 opioid use disorder prevalence estimates for ages 12+



*Note: Misuse of opioid pain relievers is any use other than prescribed for medical reasons. Fifty-four percent of people with opioid use disorder are estimated to live in poverty and be eligible for public services. Sources: National Survey on Drug Use and Health 2012-2014, 2014, 2014-2015; 2016 U.S. Census 12+ Tennessee population. The above data is based on prevalence data and is expected to be underreported.*

### 5. What data does the state have to support opioid misuse being identified as a crisis?

Each day in Tennessee, at least three people die from an opioid-related overdose, which is more than the number of daily traffic fatalities. Since 1999, the number of opioid-related overdose deaths nationwide, including prescription opioids and heroin, has quadrupled. Each year in Tennessee, enough opioid prescriptions are written for every Tennessean to have one, with more than 1 million prescriptions left over.



If you think of opioid-related overdose deaths in terms of airline crashes, Tennessee experienced the equivalent of **eight fatal 737 crashes in 2016**. That is one crash every 6.4 weeks. If this were happening in the airline industry, the FAA would be taking drastic and comprehensive measures to end these tragedies.

### 6. How does TN Together seek to prevent opioid misuse?

- Through reasonable limits and appropriate exceptions, decreases supply and dosage of prescription opioids with emphasis on new patients – initial prescriptions will be limited to a five-day supply
- Limits coverage of opioids for TennCare enrollees to an initial five-day supply at maximum daily dosage amounts
- Increases prevention education for elementary and secondary schools through revisions to the state’s health education academic standards
- Implements a public awareness campaign to raise awareness about the potential dangers of opioid use and provides resources and support to those struggling with addiction
- Identifies women of childbearing age who are chronic opioid users and provides targeted outreach about risks, contraception and treatment in order to aid in the prevention of Neonatal Abstinence Syndrome (NAS) births
- Establishes a commission to formulate current, evidenced-based pain and addiction medicine competencies for adoption by medical and health practitioner schools
- Creates a collaborative of health care stakeholders to study, formulate and implement best practices around pain management

### 7. How does TN Together seek to treat opioid misuse?

- Provides more than \$25 million in funding (state and federal) for treatment and recovery services for individuals with opioid use disorder. Funding services will include:

- Recovery services for individuals without existing means to acquire treatment;
- Expansion of staffing of peer recovery specialists in targeted, high-need emergency departments; and
- Supplying naltrexone in the state's recovery courts and through a county jail treatment pilot project to decrease opioid dependence and the risk of overdose
- Ensures TennCare members with opioid use disorder have access to high-quality treatment options
- Improves data access and sharing to better and more timely identify critical hotspots for targeting resources and to increase information about patient and community risks
- Creates a statewide public/private treatment collaborative to collectively serve Tennesseans who are struggling with opioid addiction
- Expands residential treatment and services for opioid dependence within the criminal justice system and creates incentives for offenders to complete intensive substance use treatment programs while incarcerated
- Provides funding to the state's zero to three court programs for transportation needs relative to therapeutic and family support services
- Establishes three recovery-oriented compliance courts (one in each grand division) to facilitate accountability in recovery support services for offenders

**8. How does TN Together utilize law enforcement to address community safety issues related to opioid misuse?**

- Increases state funding to attack the illicit sale and trafficking of opioids through additional law enforcement agents and training
- Updates the controlled substance schedules to better track, monitor and penalize the use and unlawful distribution of dangerous and addictive drugs including fentanyl analogues
- Provides every Tennessee state trooper with naloxone for the emergency treatment of opioid overdose prior to paramedic arrival

## LEGISLATION on PRESCRIPTION LIMITS

### 9. What will the new limits be for the initial opioid prescription?

Opioid naïve patients, individuals who have not been prescribed an opioid during the 30-day-period prior to visiting their healthcare practitioner, can receive up to a five-day supply of an opioid with a daily dosage limit of 40 morphine milligram equivalent (MME).

At that same visit, if determined necessary, a healthcare practitioner may write a prescription for another five-day supply with a daily dosage limit of 40 MME. The prescription may be filled no less than five days but no more than 10 days from the date it is written. At the point of writing the second prescription, the healthcare practitioner must clearly document in the medical record the reason for the additional prescription and advise the patient on determining if and when it should be filled.

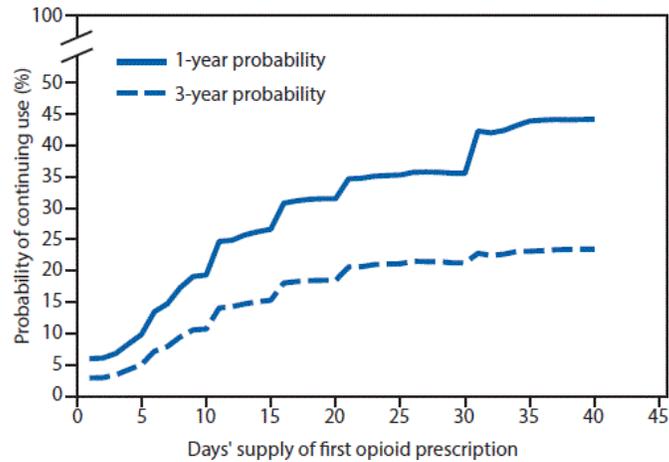
If, after 10 days of opioids, a patient needs an additional prescription, the healthcare practitioner must do a personal reassessment of the patient, discuss the risks of taking additional opioids, attempt non-opioid alternatives to address pain, acquire informed consent detailing the risk of taking opioids, including women of child-bearing age, and provide clear documentation in the record of the medical reasons for prescribing additional opioids. The additional prescription shall not exceed a 30-day supply at 40 MME per day with no refills.

### 10. What is the rationale for setting these specific limits?

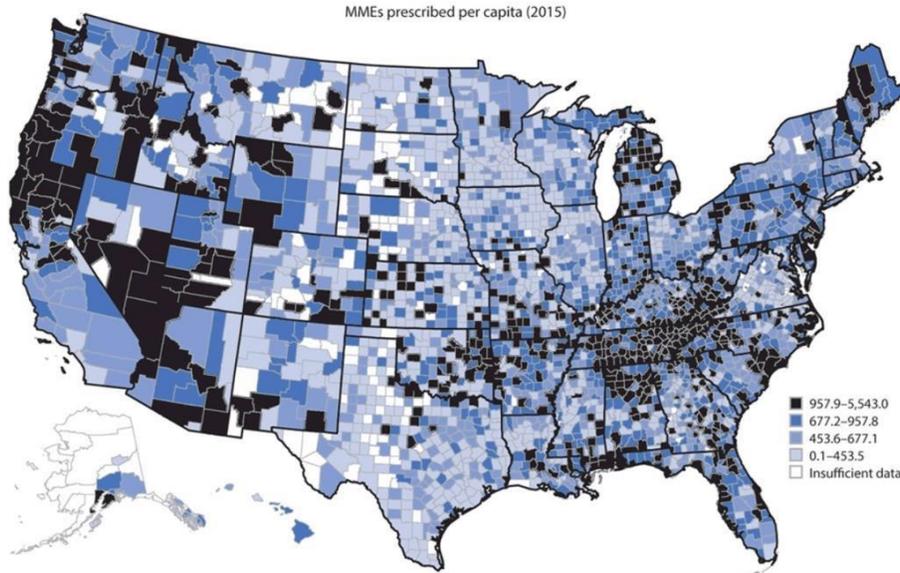
When the opioid epidemic began in the late 1990s and early 2000s, there was not clarity on the risk of substance use disorder and overdose death. At that time, risks were thought to be minimal and could be minimized if medications were taken as prescribed. However, we have now learned that taking opioid medications as prescribed could still result in serious complication, including a substance use disorder or death.

According to a [CDC study](#) released in March 2017, opioid dependency can begin within the first few days of an initial opioid prescription. The study was organized by researchers from the University of Arkansas for Medical Sciences and looked at over 1.3 million patient records across the United States during a nine-year span of time. The patients were opioid naïve, cancer-free adults who were on commercial insurance. The lead author of the study, Anuj Shah, found that **after five days of opioids, the probability of long term use had increased to 10 percent, a much higher risk than previously thought** and the biggest increase before hitting the ten-day mark.

Figure 1: One-and three-year probabilities of continued opioid use among opioid naïve patients by number of days' supply of the first opioid prescription – US, 2006-2015.



The purpose of limiting the initial prescription to five days is to place more parameters and checkpoints between practitioner and patient before an individual is put on a chronic regimen of opioids. "Physicians and patients need to discuss the pain management strategy early on," says Shah, "and exhaust all other options before resorting to narcotic or opioid prescriptions." The reality is that chronic use often begins with a prescription for acute pain, so the report suggests that three days is an ideal duration for an initial opioid prescription.



Retrieved from CDC, [Vital Signs: Changes in Opioid Prescribing in the US from 2010-2015, 2017](#)

## 12. What is morphine milligram equivalent (MME)?

Opioid	Dosage	Times per day	MME
Hydrocodone (Lortab, Lorcet, Vicodin)	5 mg	3	15 MME
Oxycodone (Percocet, OxyContin, Roxicotone)	5 mg	4	30 MME
Oxycodone (Percocet, OxyContin, Roxicotone)	10 mg	3	45 MME

Morphine milligram equivalent is a measurement used to equate the strength of various drugs to morphine. One milligram of hydrocodone is equivalent to one milligram of morphine. One milligram of oxycodone is equivalent to 1.5 mg of morphine. For moderate to moderately severe pain, between 2.5 mg and 10 mg, three to four times daily, is a typical range dose. If used four times daily, 2.5 mg of oxycodone, would equate to 15MME. If used four times daily, 10mg of oxycodone would be 60 MME. A 40 MME dose allows a healthcare practitioner to treat patients with mid-range doses of commonly prescribed opioid analgesics for moderate to moderately severe acute pain.

## 13. What is informed consent?

In situations where there are possible risks, a patient may be asked to agree in writing to the health care practitioner's plan for his or her care. Informed consent recognizes a patient's right to know about a procedure, surgery, or treatment before the patient decides whether to receive it.

In most circumstances, the process of informed consent involves the following:

- A healthcare practitioner informs a patient about the possible risks and benefits of the treatment, other options, and of not getting the treatment.
- The patient has the opportunity to ask questions, receive answers and then make decisions that are in his or her own best interest.
- Once a patient and healthcare practitioner go through these steps, and the patient decides to get the treatment, the patient is asked to sign a consent form. The completed and signed consent form is a legal document that permits the healthcare practitioner to proceed with the treatment plan.<sup>1</sup>

*Note: If the patient is a minor (under age), has a serious mental disability, or cannot give consent, then the parent, legal guardian, or a person authorized by the court must give consent before treatment can proceed.*

<sup>1</sup> <https://www.cancer.org/treatment/finding-and-paying-for-treatment/understanding-financial-and-legal-matters/informed-consent/what-is-informed-consent.html>

## Controlled Substance Monitoring Database

### **14. Does this legislation make any exceptions for those currently in pain management or those who are getting recurrent prescriptions for 30 days at a time?**

The legislation provides appropriate exceptions, including exceptions for individuals undergoing active or palliative cancer treatment or who are receiving hospice care for chronic pain.

The primary purpose of this legislation is to prevent additional people from developing opioid abuse issues or becoming chronic care patients. However, the legislation will also increase the frequency with which the CSMD is checked by both the prescriber and the dispenser:

- A prescriber must check the CSMD the first time a controlled substance is prescribed and then at least every six months when the medication remains a part of the patient's treatment plan. For opioid naïve and acute care patients, the CSMD must be checked at the initial prescription and before a third prescription. A prescriber's delegate may check the CSMD on the practitioner's behalf.
- A dispenser of a controlled substance must check the CSMD prior to dispensing a controlled substance for the first time. In addition, the dispenser must check the CSMD every six months for that patient after the first check. For those patients who take schedule II drugs regularly, but who are seen by their prescriber only every 90 days and given three prescriptions per visit, the dispenser will have to check every month, because those scripts say do not fill until a date certain. This is an extra step for the dispenser, who could then refuse to refill the script if they found something suspicious.

### **15. Does this require healthcare practitioners to check the CSMD more frequently?**

Yes. There are two changes to the current CSMD checking requirements. Currently, prescribers and dispensers must check the CSMD when starting a new course of treatment and annually thereafter. This bill increases the frequency of checks from annual checks to every six months. Under this bill, dispensers must check all prescriptions that have a "do not fill until date certain" on it, including those written for an opioid naïve patient.

### **16. How many states can Tennessee healthcare practitioners see via the CSMD?**

We are connecting with 13 other states (Alabama, Arkansas, Kentucky, Louisiana, Michigan, Minnesota, Mississippi, North Dakota, Ohio, South Carolina, Texas, Virginia and West Virginia), and we expect to add two more (North Carolina and Georgia) in the next three months. The only contiguous state that we cannot connect with (or are already committed to come on board) is Missouri, which is just now implementing a prescription drug monitoring program.

## LEGISLATION on SENTENCE CREDITS

### **17. Is there more than one type of treatment program for offenders going through a residential program at our correctional facilities?**

The Tennessee Department of Corrections (TDOC) offers several treatment programs; however, only the intensive residential treatment program, which is greater than nine months in length, qualifies for the treatment credit. This program is commonly referred to as Therapeutic Community (TCOM) in TDOC-managed facilities and as Residential Drug and Alcohol Program (RDAP) in privately managed facilities.

Generally, TDOC offers outpatient group therapy and intensive residential treatment in modified therapeutic communities. All substance use disorder programs (outpatient and inpatient treatment) provide the following:

- A multi-disciplinary approach under a Behavioral Health Services Model;
- Substance use treatment counselors, mental health professionals, and medical staff collaborate under one system of care to provide holistic treatment; and
- Evidence-based treatment interventions, such as cognitive behavioral therapy and motivational interviewing, which focus on inmates' criminogenic needs.

All program participants work closely with treatment staff to develop treatment plans that guide and monitor an individual's personal progress while in programming. Treatment plans are developed after staff conducts a thorough medical, psychological, and social assessment. Staff and offenders then identify mutually agreed upon goals to address issues such as addiction severity, criminal thinking errors, dysfunctional relationships, leisure time planning, and pro-social decision making. All programs have treatment staff that monitor individual inmates progress, assure that treatment goals are met, and provide re-entry services.

### **18. Which correctional facility inmates will qualify for treatment credit?**

The treatment credit is not limited to a specific correctional facility. Currently, 9 of the 14 state correctional facilities offer the intensive therapeutic community program. The proposed bed repurposing at the West Tennessee State Prison will increase bed availability for the treatment program and will increase the number of facilities offering the intensive therapeutic community program to 10.

The inmates who have been identified as having a substance use disorder in accordance with TDOC's validated risk and needs assessment will qualify for treatment credit. With the adoption of the Static Risk Offender Needs Guide – Revised (STRONG-R) in Tennessee, a greater focus is being placed on matching offender's needs to services and treatment in order to reduce recidivism and increase treatment completion likelihood. A key element in matching offenders to appropriate interventions is an understanding of programming that is available to those under TDOC's supervision. Through a structured gap analysis procedure, TDOC seeks to identify the:

- Types of programming currently available;
- Quality and evidence-base of said programming;

- Programming capacity; and
- Overall needs of the offender population based on the results of the STRONG-R.

**19. Which inmates will NOT qualify for treatment credit?**

The credit shall not apply to any prisoner convicted of an offense that requires service of at least 85 percent of the sentence under § 40-35-501(i), 100 percent of the sentence under § 39-13-523, or has been convicted of continuous sexual abuse of a child under § 40-35-501(l). This means that most sex offenses and violent felonies will be excluded.

**20. What are the anticipated savings from the sentence credit?**

\$2.6 million annually

**21. What is the recidivism rate for those participating in drug treatment while incarcerated?**

Historically, TDOC has not tracked specific recidivism rates for offenders participating in drug treatment while incarcerated. However, after the General Assembly's passage of the Public Safety Act in 2016, TDOC has undertaken the wide scale adoption and reformation of its program delivery to ensure that programming is evidence-based and is consistently applied at all institutions. This was done in conjunction with the adoption of a more advanced assessment tool that allows for the more accurate assessment of offender programming needs and a more advanced mechanism to track whether those needs are addressed during an offender's period of incarceration.

To evaluate the impact of Therapeutic Community (TCOM), TDOC utilized results from 14 quantitative studies in an extensive research review looking at a prisoner population with drug dependence at the time of initial incarceration. Three-quarters of the studies reported TCOM was effective in reducing rates of **re-incarceration**. Other findings included:

- About 70 percent of studies that examined follow-up rates of **drug misuse** relapse found TCOM effective in reducing rates of drug misuse amongst participants.
- TCOM participation reduced **re-arrest** events in 55 percent of the studies.
- Participation in **aftercare** was seen to predict positive outcomes, even when aftercare was randomly assigned.

## LEGISLATION on CONTROLLED SUBSTANCE SCHEDULE CHANGES

### **22. What is the purpose of amending the controlled substance schedule?**

This legislation, in part, updates and modernizes Tennessee's statutory controlled substances schedules, which are some of the state's key tools in combating drug abuse, and more specifically, the opioid epidemic. Specifically, this legislation would give law enforcement an updated statutory list with which to arrest, charge, prosecute, and sentence individuals for knowingly producing, manufacturing, distributing, selling, offering for sale, or possessing controlled substances.

### **23. What does it mean when a drug is added to Schedule I?**

Schedule I means the substance has high potential for abuse and no accepted medical use in treatment or lacks accepted safety for use in treatment under medical supervision.

### **24. What does it mean when a drug is added to Schedule II through V?**

Substances listed in Schedules II through V currently have an accepted medical use but also a potential for abuse with controlled substances in Schedule II being those with a higher risk of abuse and each subsequent schedule being those controlled substances demonstrating a lower risk for abuse.

### **25. Why do fentanyl analogues need to be included as Schedule I drugs?**

The bill adds a number of fentanyl analogues to Schedule I. An analogue is a chemical compound that is structurally similar to another but differs slightly in composition (as in the replacement of one atom by an atom of a different element or in the presence of a particular functional group). While fentanyl and a few analogues have an approved medical use, synthetic versions of fentanyl are linked to an increasing number of illicit drug overdose deaths.

### **26. Does the bill make exceptions for fentanyl analogues with approved medical uses?**

Yes. The language excludes fentanyl and fentanyl-related products that have an approved medical use by the FDA, or if they are listed in another schedule.

## OTHER QUESTIONS

### 27. What is the breakdown of new state funding that will be put toward the opioid initiative?

The total FY19 state funding improvements equate to \$14,523,800 with additional funding from other state sources totaling \$1,575,000.

Initiative	Recurring	Nonrecurring
<b>Substance Abuse Treatment Services</b>	\$8,250,000	
<b>Lifeline Network</b>	\$750,000	
<b>Naltrexone in Recovery Courts</b>		\$750,000
<b>County Jail Treatment Pilot Program</b>		\$300,000
<b>Data Initiatives and Improvements</b>	\$100,000	\$1,500,000
<b>Health Care Collaborative</b>		\$250,000
<b>Special Commission for Improved Prescriber Training</b>		\$7,500
<b>Zero to 3 Courts</b>		\$175,000
<b>Controlled Substances Schedule Update</b>	\$286,300	
<b>TBI Drug Investigation Special Agents (10)</b>	\$1,300,000	\$855,000
	<b>\$10,686,300</b>	<b>\$3,837,500</b>

### 28. How much federal funding will go toward the opioid initiative?

For the second year, Tennessee has received \$13.8M from the Opioid STR grant program created by the 21st Century Cures Act.

### 29. What steps is TennCare taking to decrease the number of NAS births?

- TennCare and each managed care organization (MCO) will be increasing outreach to all women of childbearing age (15-44) who have used opioids in the last year.
- TennCare and each MCO will use predictive analytics to determine clinical risk levels for women ages 15-44 who are using opioids in order to guide targeted engagement and outreach to these members.
- Based on the level of the member's clinical risk, each MCO will use different strategies to engage these women to educate them on the risks of opioid therapy and connect them with appropriate supports.
- These interventions will include connecting members to primary care, mental health, and pain management providers, increasing access to appropriate voluntary reversible

long acting contraception (VRLAC), and support safe tapering of chronic opioid therapy and treatment for opioid use disorder.

## Treatment and Recovery Programs

### **30. What is the recommended length of treatment to overcome an opioid addiction?**

A recommended length of stay is based on an individual's presentation to a treatment or recovery facility. Each individual, when they arrive at a facility, is evaluated using American Society of Addiction Medicine (ASAM) criteria to determine the most appropriate treatment level of care and duration for that individual. Every one year of sobriety enhances a person's likelihood to stay in recovery, according to a recent [National Institute for Health study](#), so the longer a person stays in treatment, the better the chance of improved long-term outcomes.

## Recovery Courts and Recovery Oriented Compliance Courts

### **31. What are recovery courts/drug courts?**

Recovery courts (RCs), also known as drug courts, are special courts willing to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives. The expectations of those willing to participate are intensive, as the road to recovery is not easy. Individuals who complete all the parameters of the Recovery Court graduate with their sobriety and a new lease on life.

Individuals are admitted exclusively on a voluntary basis and must complete an application approved by a judge, district attorney, defense attorney, coordinator, probation officer, treatment professional and law enforcement. All applicants are prioritized based on being a high risk for recidivism and high need for Behavioral Treatment Services, development of life skills and accountability. Applicants accepted to the program are supported with the trained recovery court team. The duration of the 12-24 month program is built on three essential components:

1. Clinical assessments to determine levels of treatment;
2. Accountability that includes frequent drug screens and court appearances; and
3. Leverage of the court to influence behavior by use of incentives or sanctions.

### **32. In order to be admitted to a recovery court, does the crime committed have to be drug related?**

No, in order to be admitted to a recovery court, an individual does not have to commit a drug-related crime. In order to be considered eligible to participate in a drug (recovery) court, a participant must only meet the requirements of T.C.A. § [16-22-113](#), which are: not be a violent offender as defined by T.C.A. § [16-22-103](#); be substance abusing or chemically dependent, or both; and be willing to participate in a treatment program.

### 33. What are Tennessee Recovery Oriented Compliance Courts (TN ROCCs)?

TN ROCC is a dedicated docket for offenders who have been assessed as having a substance use disorder and/or mental health disorder and are considered a low risk for recidivism but still have high need for substance abuse/mental health treatment options.

TN ROCCs serves individuals who do not meet the criteria to enter into the recovery courts. These individuals are likely low risk for recidivism but high/moderate need for treatment for substance abuse and/or mental health disorders. These individuals could be eligible due to pre-trial release, probation violations, either by committing new crimes (usually property crimes) or “technical” violations, or as part of an original sentence.

TN ROCCs allow judges to provide impactful intervention for low risk offenders dealing with substance abuse/co-occurring disorders that do not meet the criteria for the intense programming of recovery courts (RCs). Placement on a TN ROCCs docket is at a judge’s discretion and may be voluntary/involuntary. TN ROCC can intervene early with low risk offenders before they get further into the criminal justice system. TN ROCC may also refer to the recovery court programs for individuals in a TN ROCC program that needs a more intense court program.

<b>Provision</b>	<b>RCs</b>	<b>TN ROCCs</b>
Treats high risks for recidivism	X	
Treats high needs for behavioral health & other services	X	X
Application required (voluntary participation)	X	
No eligibility restrictions for sentences permitting probation except for being at a low risk for recidivism		X
Relies on justice personnel who volunteer to participate as a team member i.e. CJL. (Requires recruitment, training, etc.)	X	