Digital Health Technologies as an Adjunct to Medication Assisted Therapy for Opioid Use Disorder: Effectiveness and Value

Public Meeting — November 18, 2020

Meeting materials available at: https://icer-review.org/topic/opioids-digital-apps/

Why are we here today?

People who don't have an addiction do not understand what it is like to feel scared and vulnerable. I want to be better and stay better. If you don't suffer from addiction you may not figure out what helps patients like me to not go back, and back, and back to expensive rehab.
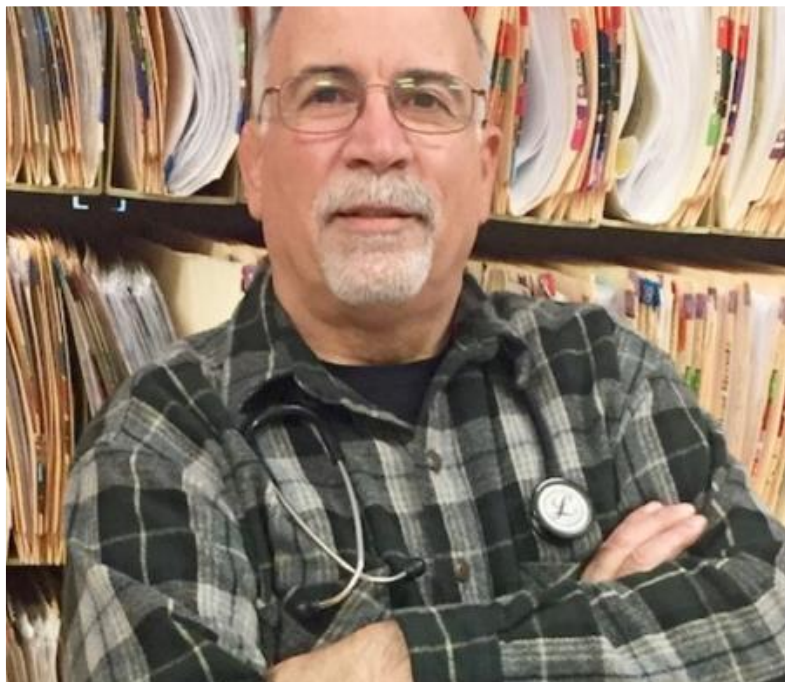
Heidi Hoffman, Patient in Recovery

Why Are We Here Today?

- What happens the day these treatments are approved by the FDA?

- What happens to patients and others in the health care "system"?

When There Isn't Enough Money For Health Insurance
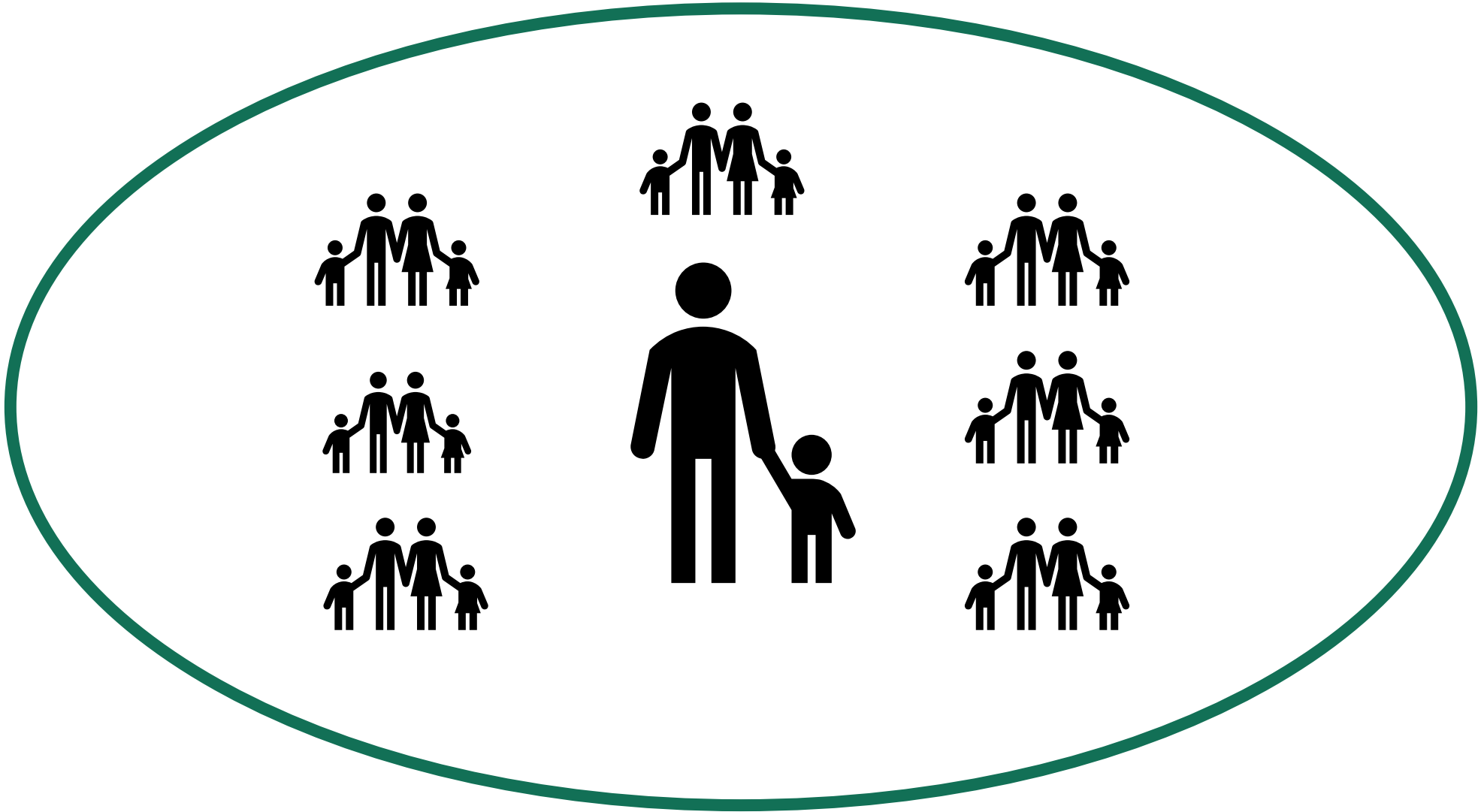

Gustavo Bendeck,
Lubbock, Texas

The Whitmans,
Bird City, Alaska

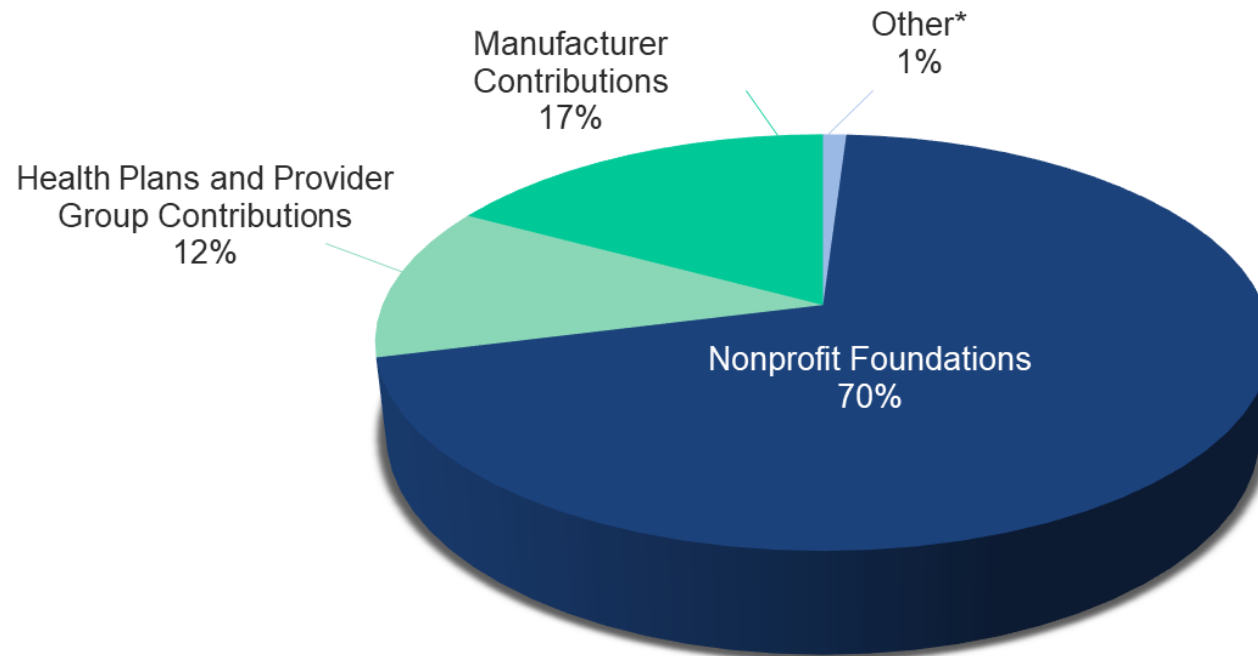Luke Breen,
Minneapolis, Minnesota

Organizational Overview

- Midwest Comparative Effectiveness Public Advisory Council (CEPAC)

- The Institute for Clinical and Economic Review (ICER)

Sources of Funding, 2020
https://icer-review.org/about/support/

Other*
1%

Manufacturer
Contributions
17%

Health Plans and Provider
Group Contributions
12%

Nonprofit Foundations
70%

ICER Policy Summit and non-report activities only
*Individual and matching contributions, government contracts, and speech stipends
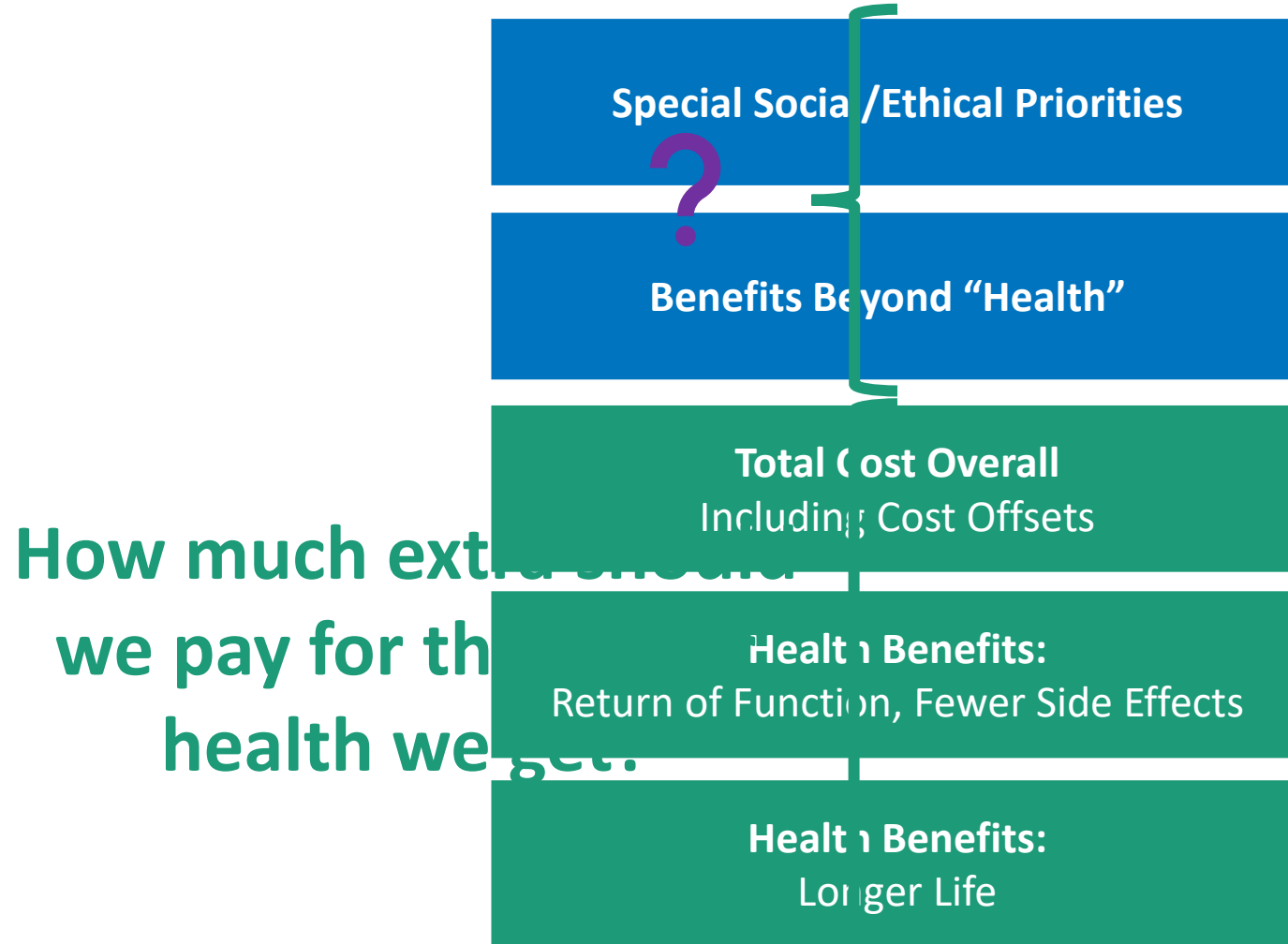
How was the ICER report developed?

- Scoping with guidance from patient groups, clinical experts, manufacturers, and other stakeholders

- Internal ICER staff evidence analysis and cost-effectiveness modeling

- Public comment and revision

- Expert reviewers

  - **Dr. Scott Steiger, MD, FACP, FASAM,** Associate Clinical Professor of Medicine and Psychiatry, University of California San Francisco

  - **Jake Nichols, PharmD, MBA,** President and CEO, Professional Recovery Associates

  - **Sean Murphy, PhD,** Director, Consultation Service, Methodology Core, Weill Cornell Medicine

  - **Danielle Tarino**, President and CEO, Young People in Recovery

- How is the evidence report structured to support CEPAC voting and policy discussion?

Components of Long-Term Value for Money

Special Social/Ethical Priorities

?

Benefits Beyond "Health"

Total Cost Overall
Including Cost Offsets

Health Benefits:
Return of Function, Fewer Side Effects

Health Benefits:
Longer Life

How much extra should we pay for the health we get?

Cost Effectiveness as a Part of Pricing to Value

Maximum Price at Which We Can Do More Good Than Harm

Consider Range of Pricing Linked to Better Health

Consider Benefits Beyond Health and Special Priorities

Price to reach $50k/QALY or evLYG

Price to reach $100k/QALY or evLYG

Price to reach $150k/QALY or evLYG
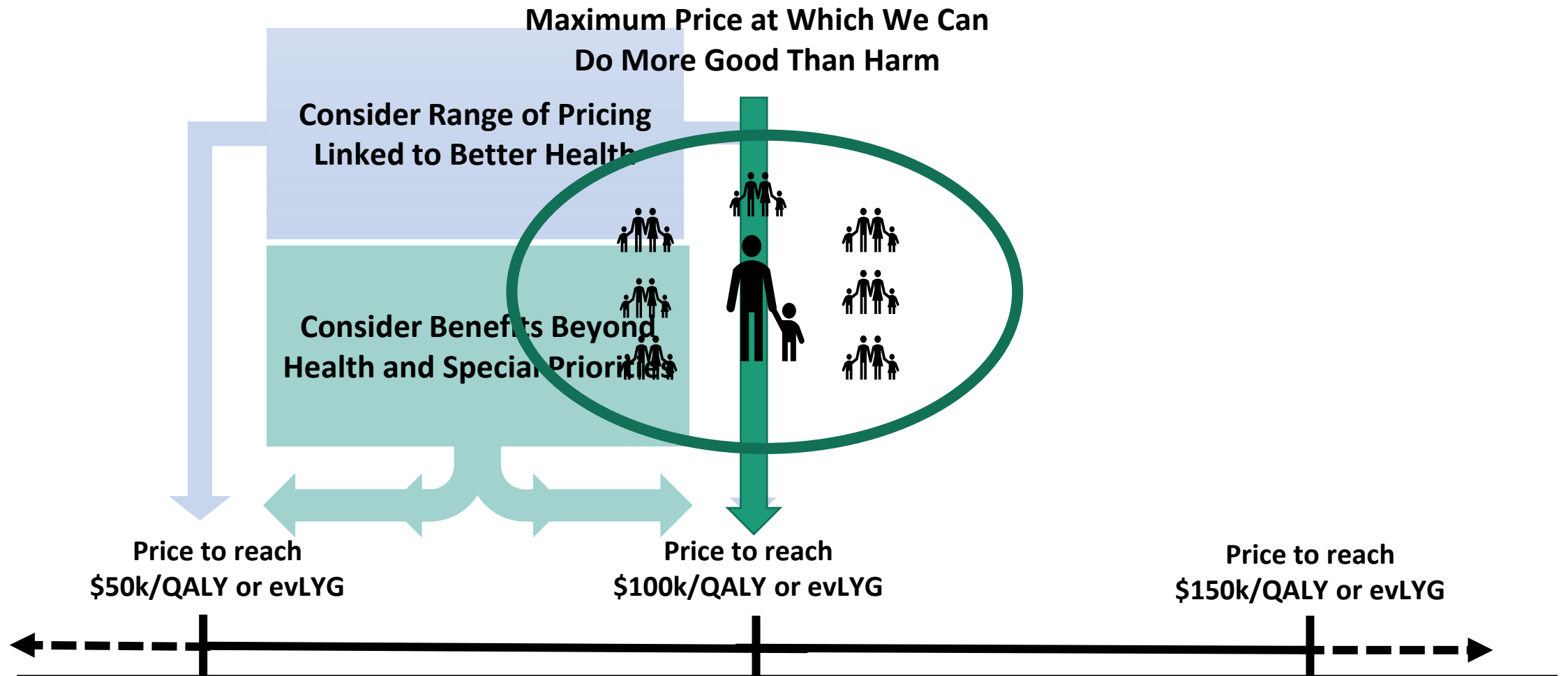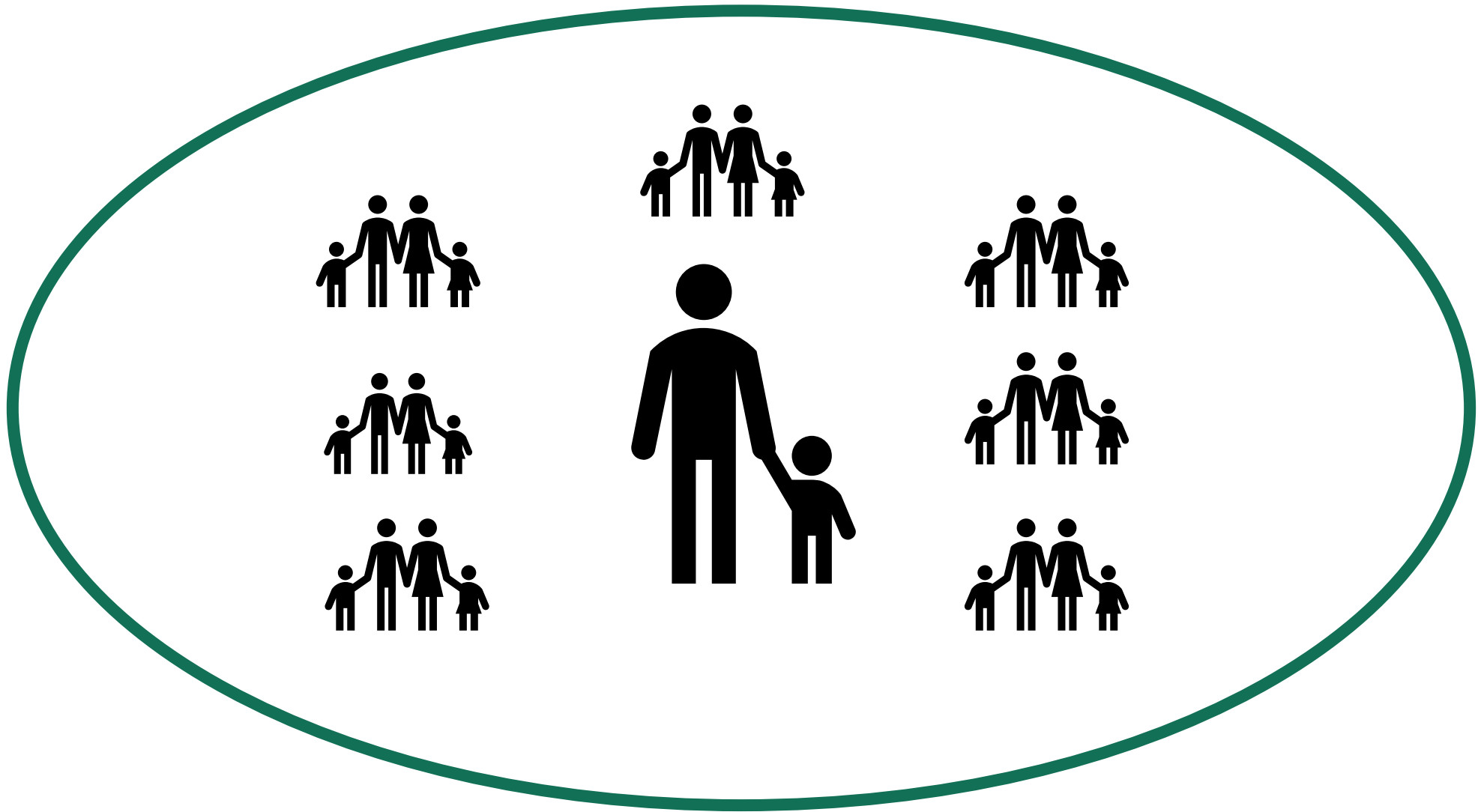
Agenda

Time (CT)	Activity
10:00 am—10:20 am	**Meeting Convened and Opening Remarks** *Steven D. Pearson, MD, MSc, ICER*
10:20 am—10:40 am	**Presentation of the Clinical Evidence** *Jeffrey A. Tice, MD, University of California, San Francisco*
10:40 am – 11:10 am	**Presentation of the Economic Model** *Melanie Whittington, PhD, MS, ICER*
11:10 am – 11:40 am	**Public Comments and Discussion**
11:40 am—12:00 pm	**Break**
12:00 pm—12:50 pm	**Midwest CEPAC Deliberation and Vote**
12:50 pm—1:30 pm	**Lunch**
1:30 pm—2:30 pm	**Policy Roundtable**
2:30 pm—3:00 pm	**Reflections from Midwest CEPAC and Closing Remarks**
3:00 pm	**Meeting Adjourned**

Clinical and Patient Experts

Miriam Komaromy, MD, FACP, DFASAM, Medical Director, Grayken Center for Addiction, Boston Medical Center/Boston University

- *No financial conflicts of interest to disclose.*

Scott Steiger, MD, FACP, FASAM, Associate Clinical Professor of Medicine and Psychiatry, University of California San Francisco

- *No financial conflicts of interest to disclose.*

Jake Nichols, PharmD, MBA, President and Chief Executive Officer, Professional Recovery Associates

- *Jake Nichols was previously employed by Pear Therapeutics.*

Kevin Roy, MBA, Chief Public Policy Officer, Shatterproof

- *No financial conflicts of interest to disclose.*

Presentation of the Clinical Evidence

Jeffrey A. Tice, MD

Division of General Internal Medicine

University of California San Francisco

Key Collaborators

- **Noemi Fluetsch, MPH**, Research Assistant, ICER

- **Kanya Shah, PharmD**, Intern, ICER

Disclosures:

We have no conflicts of interest relevant to this report.

Background

- Deaths from OUD continue to increase during the pandemic

- The social and economic consequences of OUD are enormous

  - $2.4 trillion from 2015 to 2018

- Medication assisted treatment (MAT) is the most effective treatment, but fewer than half of patients remain on MAT for six months

- Psychosocial interventions increase retention in some studies

Impact on Patients

- Disrupted relationships with family and friends

- Loss of jobs and housing

- Social stigma

- Health: infections and intermittent adherence to treatment for chronic diseases

Scope of Review

- Population: Adults 18+ years old with OUD

- Intervention: MAT + digital health technologies

- Comparator: MAT

- Outcomes: MAT retention and abstinence

- Time frame: Ideally 1-2 years

Psychosocial Interventions added to MAT

- Cognitive behavioral therapy (CBT) specific to OUD

- Contingency management (CM)

- "Psychosocial interventions were associated with increased likelihood of abstinence from drug use versus control conditions at 3 to 4 months."

- "There was no difference between psychosocial interventions versus controls on drug use days or severity at longer (6 to 12 month) follow up."

Chou et al. Agency for Healthcare Research and Quality (US); 2020 Jun. Report No.: 19-05255-EF-2.

Digital Health Technologies

- reSET-O: an FDA approved digital therapeutic
  - CM, CBT

- Connections
  - Peer support, CBT

- DynamiCare
  - CM, CBT

Insights from Discussions with Patients

- Heterogeneity of patients
  - Age, oral versus IV opioid, prior treatment experience, co-morbidities including other substance use disorders and mental health issues, family support, housing

- "One size does not fit all."
  - Different MAT, different providers, different psychosocial therapies

- The outcome that matters is "getting their life back."
  - Reconnect with family, friends; housing, job, restoration of trust

Clinical Evidence

Randomized Trials

- reSET-O

  - None, but based on the Therapeutic Education System (TES)

- Connections

  - None, but based on A CHESS and CBT4CBT

- DynamiCare

  - None

Clinical Trials of the TES

Study	Arms	N	Length of Follow-Up	Retention (%)
Christensen 2014	• Computer CBT + CM + BUP • CM + BUP	92 78	12 weeks	80.4 64.1
Bickel 2008	• Computer CBT + CM + BUP • Therapist CBT + CM + BUP • BUP	45 45 45	23 weeks	62.2 53.3 57.7
Chopra 2009	• Computer CBT + CM + BUP • Computer CBT + CM* + BUP • BUP	41 42 37	12 weeks	85.4 59.5 75.7
Marsch 2014	• Computer CBT + Methadone • Methadone	80 80	52 weeks	38.8 38.8

BUP: Buprenorphine, CBT: Cognitive behavioral therapy, CM: Contingency management

Christensen 2014

- Single site, unblinded trial with no sham intervention and baseline imbalances between treatment groups

- Different intervention from reSET-O

    - Contingency management

        - Christensen: Consecutive negative urines always led to higher rewards with mean payout $997.50

        - reSET-O: rewards intermittent and based on CBT module completion with mean payout < $300

    - CBT modules

        - Christensen: done in clinic at a computer

        - reSET-O: done out of clinic on a smartphone

Christensen 2014 Outcomes

- Primary outcome: days of continuous abstinence

  - <u>NOT SIGNIFICANT</u>: 55 days versus 59 days, p=0.21

- Retention in treatment at 12 weeks: 80% versus 64%, p=0.02

  - OR 2.3 (95% CI 1.2-4.6)

- GEE analysis* of likelihood of a negative test in weeks 9-12

  - 76% versus 61%, p=0.03

  - Says nothing about total abstinence during the last 4 weeks

Real World Evidence

- 3142 patients who redeemed reSET-O and completed > 1 module
  - No data for 873 (28%) during last 4 weeks
  - 66% abstinent during last 4 weeks (GEE?)

- Claims data on 351 patients using reSET-O

	6 months before initiation	6 months after initiation
Buprenorphine:	from 76.7%	to 72.8%
Hospitalizations:	from 72 (29 patients)	to 27 (13 patients)
ER visits:	from 136 (84 patients)	to 109 (38 patients)

Maricich et al, CMR and Opinion, 2020; Velez et al, Exp Rev Pharm, 2020

Harms

- No harms identified with the digital health technologies

- Theoretical concerns about PHI release

Controversies and Uncertainties

- Lack of RCT evidence of efficacy using the apps

- Lack of medium and long-term outcomes

- No clinical trial evidence on ER visits, hospitalizations, work, and relationship restoration

Potential Other Benefits and Contextual Considerations

- Considerable uncertainty about long-term benefits

- Because of the digital divide, digital health technologies have the potential to increase health disparities

- The potential impact of digital health technologies on family/ caregiver burden and on potential return to work is unknown

Public Comments Received

- New data published November 2020
  - Added to updated report

- CM is accepted as efficacious in SUD
  - Agree, but primarily for alcohol and stimulant use disorder, not opioids

- RCTs of TES present data beyond 12 weeks
  - All of these trials are described in the report. For example, Marsch et al 2014, which has 1-year follow-up found no difference in retention at 1 year (38.8% in both study groups)
  - Christensen 2014 is single site trial done in 2010. They clearly had retention data beyond 12 weeks, but did not report it.

- Evidence base for reSET (predicate for reSET-O) is problematic

Summary

- There is no direct, peer-reviewed randomized trial evidence on the efficacy of any of the apps in the population of interest

- There are randomized trials supporting the short-term efficacy of some of the psychosocial interventions implemented by the apps

- The use of the apps is unlikely to be harmful to patients

- Thus, there is moderate certainty that the digital apps are comparable to MAT alone (due to no identified harms) and there may be incremental benefits

ICER Evidence Ratings for Digital Health Technologies added to MAT versus MAT alone

- reSET-O: C+ Comparable or incremental

- Connections: C+ Comparable or incremental

- DynamiCare: C+ Comparable or incremental

Questions?

Presentation of the Economic Model

Melanie D. Whittington, PhD, MS

Associate Director of Health Economics

Institute for Clinical and Economic Review

Team Members

Jonathan D. Campbell, PhD, Senior Vice President, ICER

Rick Chapman, PhD, Director of Health Economics, ICER

Lorenzo Villa Zapata, PhD, PharmD, Post-Doctoral Fellow, University of Colorado Anschutz Medical Campus

Nicholas D. Mendola, MPH, PhD Student, University of Colorado Anschutz Medical Campus

Disclosures:

The economic team reported no conflicts defined as more than $10,000 in health care company stock or more than $5,000 in honoraria or consultancies relevant to this report during the previous year from health care technology manufacturers or insurers.

Objective

To estimate the cost effectiveness of digital health technologies as an adjunct to MAT for OUD

- reSET-O in addition to outpatient MAT (i.e., counseling and pharmacological therapy) vs. outpatient MAT alone

Methods Overview

- **Model**: Two-phase decision analytic model

- **Setting**: United States

- **Perspective**: Health care system perspective

- **Time Horizon**: Five-year

- **Discount Rate**: 3% per year (costs and outcomes)

- **Cycle Length**: Four weeks (Phase 2)

- **Outcomes**: Cost per quality-adjusted life year (QALY) gained; cost per life year (LY) gained; cost per equal value life year gained (evLYG); cost per MAT year

Model Schematic: Phase 1
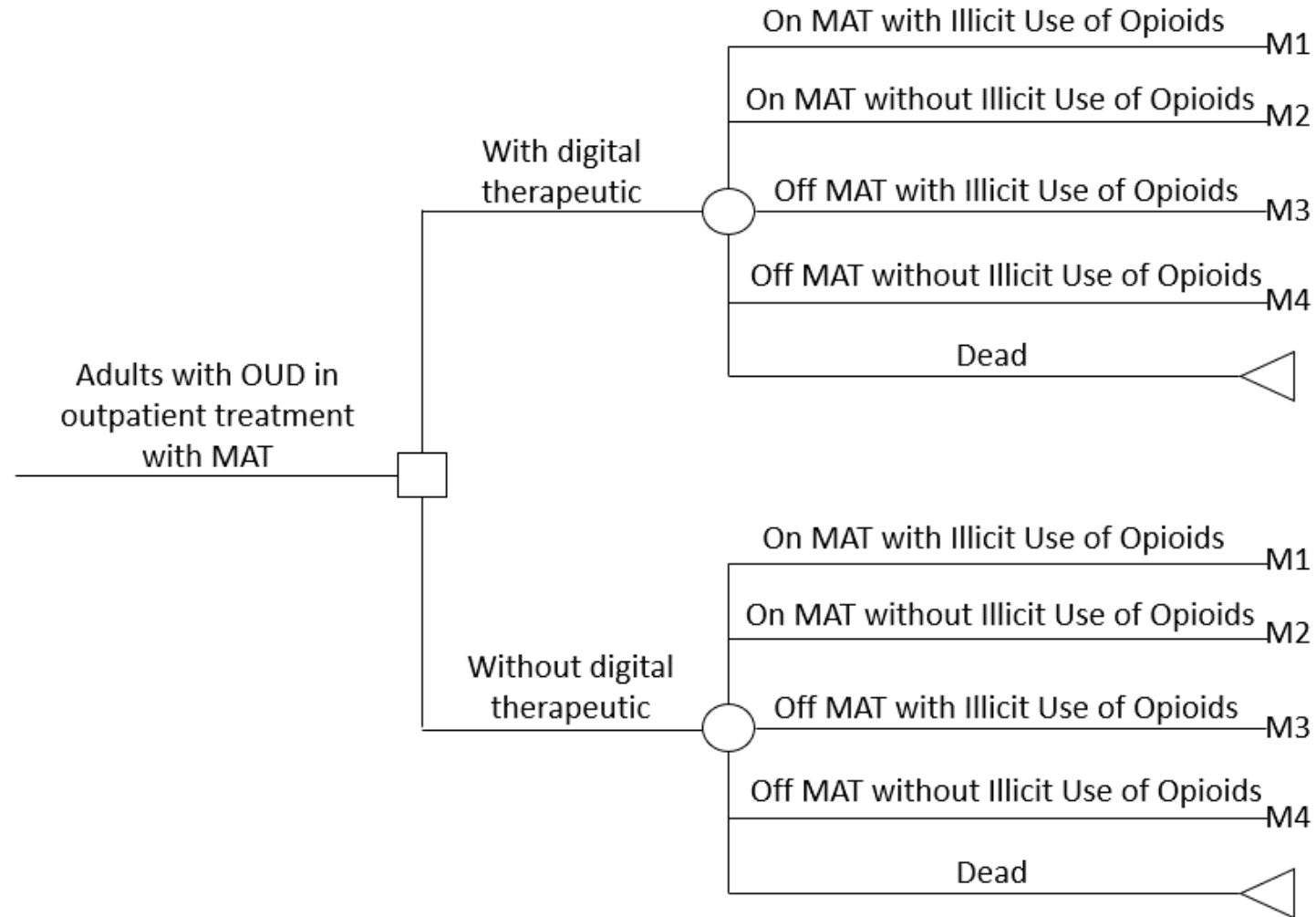
Model Schematic: Phase 2
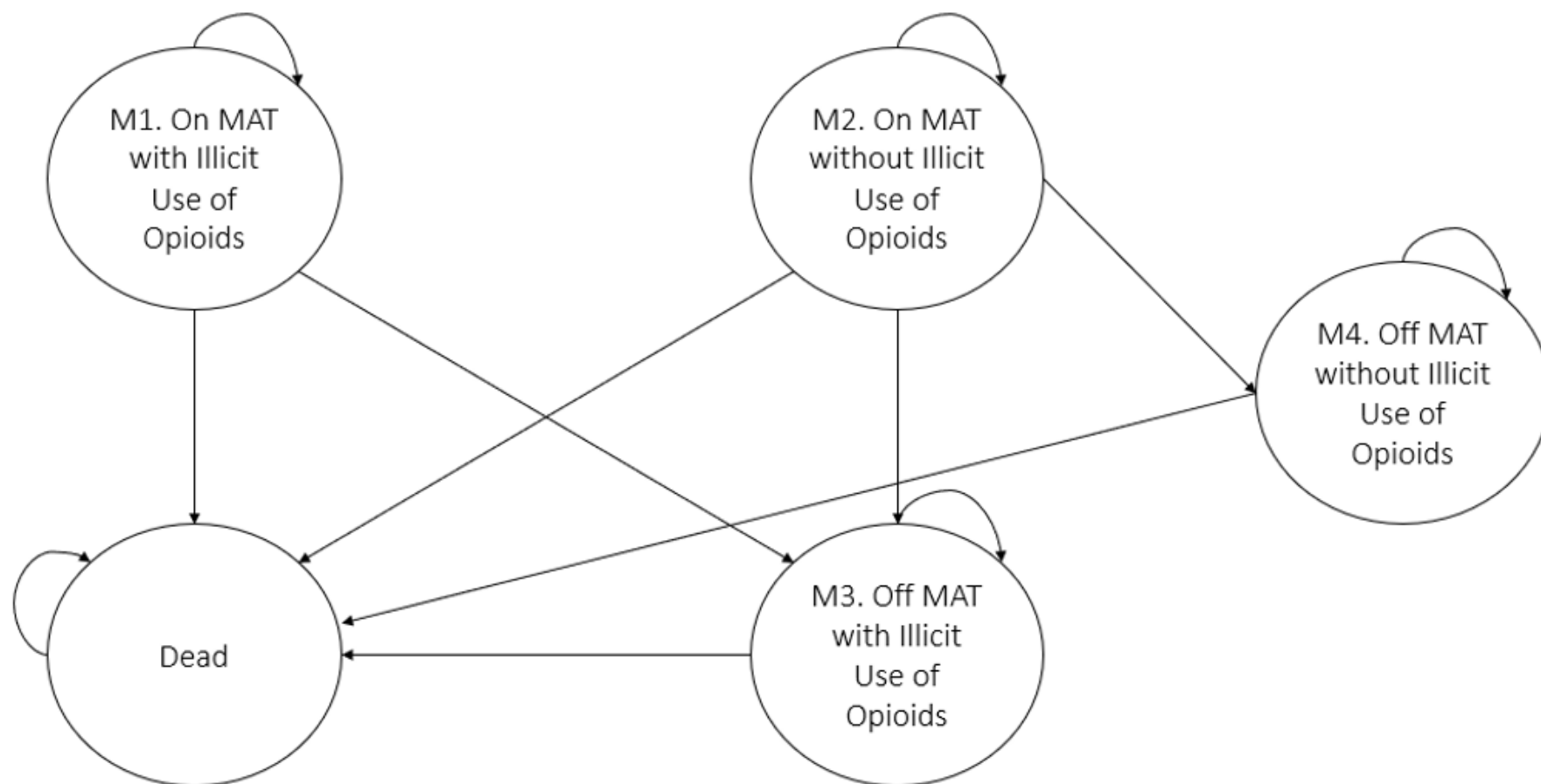
Key Model Assumptions

- Individuals with negative urine drug screening tests for all assessment points over the last 4 weeks of reSET-O use entered the On MAT without Illicit Use of Opioids health state in the Markov model

- No incident cases of abstinence in Phase 2

- MAT discontinuation after reSET-O was the same as standard of care

- The clinical outcomes (e.g., abstinence, retention) for standard of care were equivalent to the outcomes from the comparator arm in the reSET-O pivotal trial

Population

Adults 18 years and older with OUD in outpatient MAT

Population Characteristics	Value	Notes/Source
Mean age (years)	34	Weighted average from Christensen et al., 2014
Female (%)	46%	Weighted average from Christensen et al., 2014
Injection drug use (%)	14%	Weighted average from Christensen et al., 2014
Employed full time (%)	37%	Weighted average from Christensen et al., 2014

Key Model Inputs: Abstinence and Retention

	reSET-O	SoC	Source
Abstinence			
Phase 1	67.1 days	57.4 days	Christensen et al., 2014
Phase 2	████████████	████████████	Data on file
Retention			
Phase 1	80.4%	64.1%	Christensen et al., 2014
Phase 2	14.5% discontinue per cycle		Christensen et al., 2014

Key Model Inputs: Health State Utilities

Parameter	On MAT	Off MAT
No Illicit Use of Opioids	0.766	0.852
Illicit Use of Opioids	0.689 - 0.761	0.574 - 0.694

*Lower value of range represents injection drug use; upper value of range represents non-injection drug use
Source: Wittenberg et al., 2016

Key Model Inputs: DHT Costs

	WAC per Download	Net Price
reSET-O	$1,665	$1,219

WAC: wholesale acquisition cost

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Key Model Inputs: Outpatient MAT Costs

	Utilization	Unit Cost
Therapist Counseling	6 visits	$128

Drug	**WAC per Dose**	**Discount from WAC**	**Price per Dose**	**Price per Year**	**Source**
Buprenorphine/ Naloxone	$9.81	N/A due to generic product	$9.81	$3,579	Redbook

WAC: wholesale acquisition cost

Key Model Inputs: Health Care Utilization Costs

Per Cycle Costs (4 weeks)	On MAT	Off MAT with Illicit Use of Opioids
Hospitalizations	$379	$1,033
Emergency Department Visits	$55	$101
Outpatient Visits	$136	$159

Costs reported are per cycle (four weeks) and are reflective of average health care utilization for patients with OUD who are or are not adherent to buprenorphine. These estimates are not unit costs, but reflect the unit cost multiplied by the average rate of use of each service per four-week cycle.

Key Model Inputs: Societal Costs

Societal Cost Type	Per Cycle Value
Productivity Losses (only with Illicit Use of Opioids)	$1,358*
Criminal Justice and Incarceration	
When On MAT (with and without Illicit Use of Opioids)	$1,109¥
When Off MAT (only with Illicit Use of Opioids)	$5,546¥

MAT: medication assisted treatment

*Applied to 37% of patients in applicable health states

¥Applied to 43% of patients in applicable health states

Results

Base-Case Results: Discounted Model Outcomes

| Intervention	reSET-O Download Cost	Total Health System Costs	Life Years	QALYs	evLYGs	On MAT Years
reSET-O	$1,219	$83,332	4.61821	3.152809	3.152812	0.54
SoC	$0	$82,558	4.61820	3.146440	3.146440	0.46
Incremental	$1,219	$774	0.00002	0.006369	0.006371	0.08

QALYs: quality-adjusted life years, evLYGs: equal value life year gained, MAT: medication-assisted treatment, SoC: Standard of Care

Base Case Results: Incremental Cost-Effectiveness Ratios

Comparison	Incremental Cost per Life Year Gained	Incremental Cost per QALY Gained	Incremental Cost per evLYG	Incremental Cost per MAT Year Gained
reSET-O vs. SoC	$48,449,000	$121,500	$121,400	$10,000

evLYG: equal value life year gained, MAT: medication-assisted treatment; QALY: quality-adjusted life year, SoC: standard of Care

One Way Sensitivity Analyses
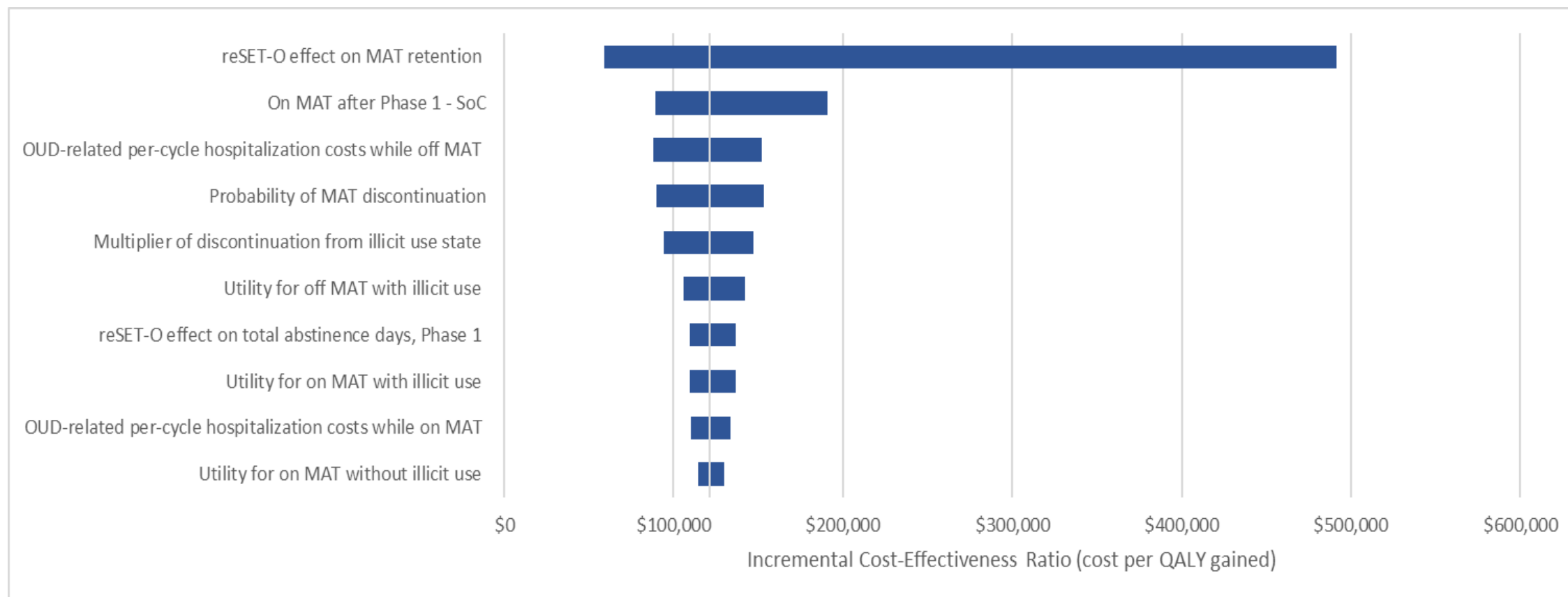
Probabilistic Sensitivity Analysis

	Cost Effective at $50,000 per QALY	Cost Effective at $100,000 per QALY	Cost Effective at $150,000 per QALY
reSET-O vs. SoC	4.2%	26.9%	62.0%

QALY: quality-adjusted life year, SoC: Standard of care

Scenario Analysis: Trial Time Horizon Discounted Model Outcomes

	reSET-O Download Cost	Total Health System Cost	QALYs	On MAT Years
Time Horizon: 12 Weeks				
reSET-O	$1,219	$4,540	0.175	0.21
SoC	$0	$3,425	0.173	0.19
Incremental	$1,219	$1,115	0.002	0.02
Time Horizon: 5 Years				
Incremental	$1,219	$774	0.006	0.08

MAT: medication-assisted treatment; QALY: quality-adjusted life year; SoC: standard of Care

Scenario Analysis: Trial Time Horizon, Incremental Cost-Effectiveness Ratios

Comparison	Incremental Cost per QALY Gained	Incremental Cost per Additional MAT Year
reSET-O vs. SoC	$547,000	$59,200

MAT: medication-assisted treatment; QALY: quality-adjusted life year; SoC: standard of Care

Scenario Analysis: Modified Societal Perspective, Discounted Model Outcomes

Intervention	Productivity Loss Costs	Criminal Justice & Incarceration Costs	Total Health System Costs	Total Societal Cost
reSET-O	$27,981	$2,599	$83,332	$113,912
SoC	$28,155	$2,638	$82,558	$113,351
Incremental	-$174	-$39	$774	$561

SoC: Standard of Care

Scenario Analysis: Modified Societal Perspective, Incremental Cost-Effectiveness Ratio

Treatment	Incremental Cost per QALY Gained	Incremental Cost per Additional MAT Year
reSET-O vs. SoC	$88,000	$7,300

MAT: medication-assisted treatment; QALY: quality-adjusted life year; SoC: Standard of Care

Limitations

- Lack of comparative evidence on retention or abstinence after an individual has stopped using reSET-O

- The comparator arm in the pivotal trial for reSET-O was not reflective of standard of care

- The impact of contingency management in addition to MAT versus MAT alone is inconsistent in the literature

Comments Received

- Manufacturer-provided net price

- Provider interactions with the platform occurs with the counseling sessions

- Updated utility values for On MAT to a US population reference

- Recent claims-based analysis of health care utilization

Conclusions

- reSET-O is within commonly used thresholds of $100,000-$150,000 per QALY gained IF a significant impact on MAT retention if extended after the use of reSET-O.

- If individuals immediately revert to outcomes characteristic of standard of care after reSET-O use, the findings from the 12-week time horizon are more indicative of the cost-effectiveness, suggesting reSET-O is not cost-effective.

- Clinical evidence on MAT retention and abstinence after one's use of reSET-O is essential to reduce the uncertainty in the cost-effectiveness findings.

Questions?

Public Comment and Discussion

Yuri Maricich, MD, MBA
Chief Medical Officer & Head of Development, Pear Therapeutics

Conflicts of Interest:

- *Dr. Maricich is a full-time employee of Pear Therapeutics.*

00 : 05 : 00

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Hans Morefield
Chief Executive Officer, CHESS Health

Conflicts of Interest:

- *Hans is a full-time employee of CHESS Health.*

00 : 05 : 00

Heidi Hoffman
Patient Representative

Conflicts of Interest:

- *No financial conflicts of interest to disclose.*

00 : 05 : 00

Andrea Barthwell, MD, DFASAM

**Encounter Medical Group; Founder, Two Dreams; Founder, EMGlobal LLC
Former Deputy Director of Demand Reduction, White House Office of National
Drug Control Policy**

Conflicts of Interest:

- *Dr. Barthwell consults for Ideal Option, the Manor, and Pocket Naloxone*

00 : 05 : 00

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Break

Meeting will resume at 12:00 pm CT

Voting Questions

Patient population for all questions: Adult patients with opioid use disorder who are receiving medication assisted treatment (buprenorphine, methadone)
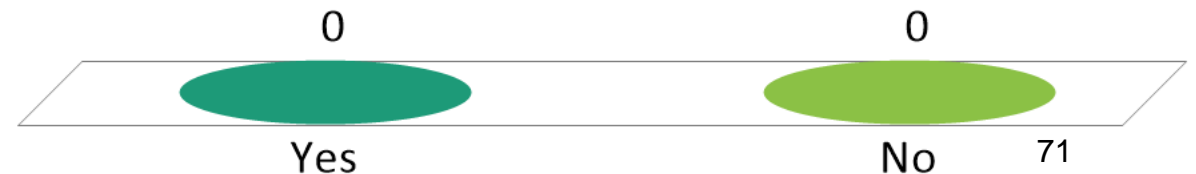
Clinical Evidence
*standard of care includes medication assisted treatment, but not contingency management

1. Given the currently available evidence, is the evidence adequate to demonstrate a net health benefit for the reset-O app added to standard of care compared to standard of care alone?
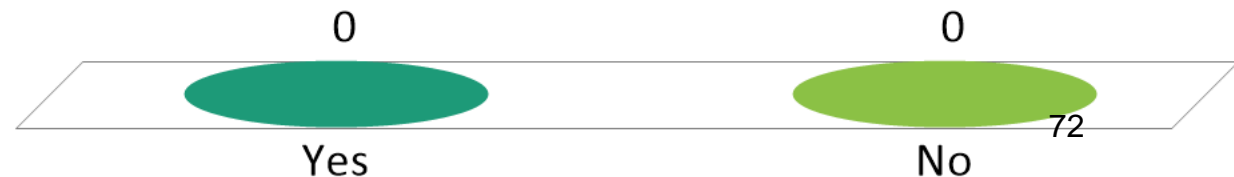
A. Yes

B. No

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Yes

No

2. Given the currently available evidence, is the evidence adequate to demonstrate a net health benefit for the treatment with the Connections app added to standard of care compared to standard of care alone?
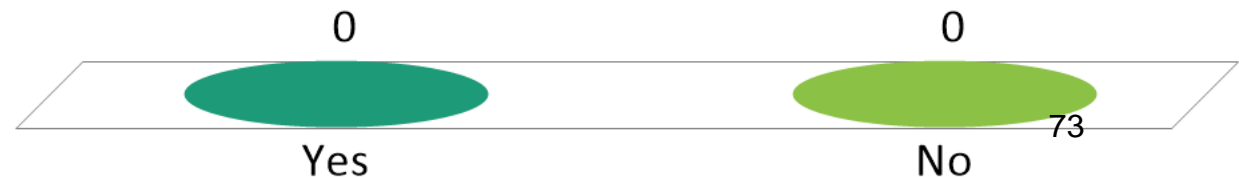
A. Yes

B. No

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Yes

No

3. Given the currently available evidence, is the evidence adequate to demonstrate a net health benefit for the DynamiCare app added to standard of care compared to standard of care alone?
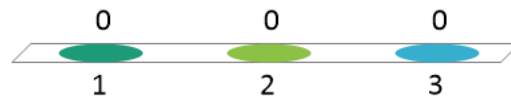
A. Yes

B. No

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Yes

No

4. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
This intervention will not differentially benefit a historically disadvantaged or underserved community		This intervention will differentially benefit a historically disadvantaged or underserved community
Uncertainty or overly favorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too optimistic		Uncertainty or overly unfavorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too pessimistic
Very similar mechanism of action to that of other active treatments		New mechanism of action compared to that of other active treatments
Delivery mechanism or relative complexity of regimen likely to lead to much lower real-world adherence and worse outcomes relative to an active comparator than estimated from clinical trials		Delivery mechanism or relative simplicity of regimen likely to result in much higher real-world adherence and better outcomes relative to an active comparator than estimated from clinical trials
Will not significantly reduce the negative impact of the condition on family and caregivers vs. the comparator		Will significantly reduce the negative impact of the condition on family and caregivers vs. the comparator
Will not have a significant impact on improving return to work and/or overall productivity vs. the comparator		Will have a significant impact on improving return to work and/or overall productivity vs. the comparator
Other		Other

4c. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.
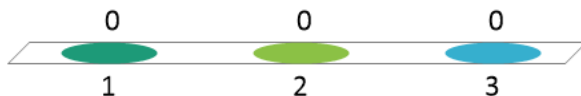
A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
This intervention will not differentially benefit a historically disadvantaged or underserved community		This intervention will differentially benefit a historically disadvantaged or underserved community

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   └─────────────────────────────────┘
       1            2            3
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4d. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

A. 1

B. 2

C. 3

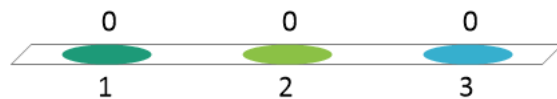| 1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Uncertainty or overly favorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too optimistic		Uncertainty or overly unfavorable model assumptions creates significant risk that base-case cost-effectiveness estimates are too pessimistic

0   0   0

1   2   3

4e. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Very similar mechanism of action to that of other active treatments		New mechanism of action compared to that of other active treatments

0   0   0

1   2   3

4f. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.
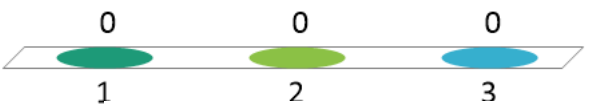
A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Delivery mechanism or relative complexity of regimen likely to lead to much lower real-world adherence and worse outcomes relative to an active comparator than estimated from clinical trials		Delivery mechanism or relative simplicity of regimen likely to result in much higher real-world adherence and better outcomes relative to an active comparator than estimated from clinical trials

0   0   0

1   2   3

4i. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Will not significantly reduce the negative impact of the condition on family and caregivers vs. the comparator		Will significantly reduce the negative impact of the condition on family and caregivers vs. the comparator

0	0	0
1	2	3

4j. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Will not have a significant impact on improving return to work and/or overall productivity vs. the comparator		Will have a significant impact on improving return to work and/or overall productivity vs. the comparator

0   0   0

1   2   3
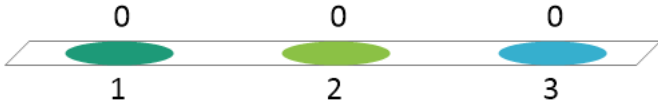
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4k. Please vote 1, 2, or 3 on the following potential other benefits and contextual considerations as they relate to the reset-O app.

A. 1

B. 2

C. 3

1 (Suggests Lower Value)	2 (Intermediate)	3 (Suggests Higher Value)
Other		Other

```
  0         0         0
  ●         ●         ●
  1         2         3
```

Long-term Value for Money

5. Given the available evidence on comparative effectiveness and incremental cost effectiveness, and considering other benefits, disadvantages, and contextual considerations, what is the long-term value for money of treatment at current pricing with reSET-O versus standard care?

A. Low long-term value for money

B. Intermediate long-term value for money

C. High long-term value for money
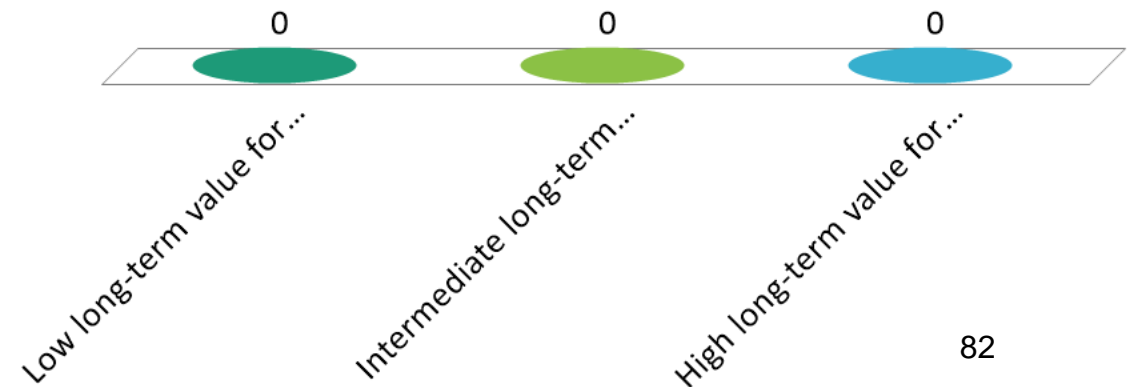
Lunch

Meeting will resume at 1:30 pm CT

Policy Roundtable

Policy Roundtable

Policy Roundtable Participant	Conflict of Interest
Kelcey Blair, PharmD, Vice President, Clinical Solutions at Express Scripts	Kelcey is a full-time employee of Express Scripts.
Anita Ju, Innovation Manager, Blue Shield of California	Anita is a full-time employee of Blue Shield of California.
Miriam Komaromy, MD, FACP, DFASAM, Medical Director, Grayken Center for Addiction, Boston Medical Center, Boston University	No financial conflicts of interest to disclose.
Hans Morefield, Chief Executive Officer, CHESS Health	Hans is a full-time employee of CHESS Health.
Jake Nichols, PharmD, MBA, President and Chief Executive Officer, Professional Recovery Associates	Jake Nichols was previously employed by Pear Therapeutics
Mike Pace, MBA, Vice President and Global Head of Market Access, Value, and Evidence, Pear Therapeutics	Mike is a full-time employee of Pear Therapeutics.
Kevin Roy, MBA, Chief Public Policy Officer, Shatterproof	No financial conflicts of interest to disclose.
Scott Steiger, MD, FACP, FASAM, Associate Clinical Professor of Medicine and Psychiatry, University of California San Francisco	No financial conflicts of interest to disclose.

Next Steps

- Meeting recording posted to ICER website next week

- Final Report published on or around December 11, 2020

    - Includes description of Midwest CEPAC votes, deliberation, policy roundtable discussion

- Materials available at: https://icer-review.org/topic/opioids-digital-apps/

Adjourn

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