Progress in Fight Against Prescription Drug Abuse Not Enough
Keith Anderson, MD

Pain Relief Doesn’t Always Come in a Pill
John R. Schneider, MD, MA

Drug Related Deaths: The Medical Examiner Perspective
Amy McMaster Hawes, MD

Tennessee’s Doctors Take On The Opioid Abuse Epidemic
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PAIN PRESCRIBING AND REPORTING

Collective efforts in Tennessee to fight the opioid abuse epidemic are starting to show results. There was a decline of 14.3 percent in opioid morphine milligram equivalents dispensed to patients in Tennessee between 2012 and 2015.

MMEs from the top 50 Prescribers in Tennessee in 2015 decreased by 8.3 percent compared to 2014.

Potential doctor or pharmacy shopping patients have decreased 50.1 percent from 2011 to 2015.

The Tennessee Controlled Substance Monitoring Database is being used more often and impacting on prescriber practices. The number of registrants with the CSMD increased by 10.2 percent in 2015 while the number of patient reports requested rose by 27.3 percent.

OF PRESCRIBERS IN 2015:

73 percent use the CSMD at least monthly.

43 percent were less likely to prescribe controlled substances after checking the CSMD.

35.1 percent said checking the CSMD made them more likely to refer patients to substance abuse treatment.

64 percent said the CSMD helps them identify and cut down on doctor shoppers.

77.9 percent said average response for information from the CSMD was 9 seconds or less when Tennessee data is requested.

Prescribers were asked if they changed their treatment plan after viewing information from the CSMD:

- 35.8% strongly agree
- 33.7% somewhat agree
- 20.3% neutral or no opinion
- 10.2% somewhat disagree
- 10.2% neutral or no opinion

Source: Controlled Substance Monitoring Database Annual Report 2016
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A new report from the National Safety Council lists Tennessee as one in just four states “making progress” in the fight against prescription drug abuse.

Tennessee meets five out of six positive indicators, according to the report, while 46 states were ranked as either failing or lagging behind.

The Tennessee Medical Association and other concerned stakeholders in and outside of the healthcare community have helped create rules requiring pain management education for prescribers, issued state-sanctioned opioid prescribing guidelines, and strengthened laws regulating pain clinics or pain management services.

We have made good progress and can point to some measurable results.

The Controlled Substance Monitoring Act of 2002 allowed the state to implement a database to monitor the dispensing of certain controlled substances. Data collection began in 2006 and subsequent laws in 2012 and 2016 have enhanced its capabilities.

In Tennessee, the Controlled Substance Monitoring Database has reduced the incidence of doctor shopping, the practice of visiting multiple doctors to obtain controlled prescription drugs, by 50 percent since 2011. It’s much harder now for addicted patients to fraudulently obtain prescriptions from a legitimate healthcare provider.

Data also shows a nearly 8 percent drop in the total amount of opioid prescriptions for pain, and a more than 14 percent decrease in Morphine Milligram Equivalents (MME) from 2012 to 2015. Among Tennesseans between the ages of 20 and 30, MME prescriptions have declined nearly 55 percent since 2011.

But we still have a lot of work to do.

As the number of prescriptions goes down, the number of overdose deaths continues to rise. The Department of Health reported that 1,263 Tennesseans died from overdoses in 2014, compared to 1,062 in 2011. That’s a 19 percent increase.

Leading physicians in the TMA have long advocated for increased funding for addiction treatment, which is sorely lacking across the state. Opioid addiction is a disease. Without appropriate medical intervention, our efforts are not enough to reverse and eventually end the epidemic.

The need for treatment is perhaps most vivid in the neonatal units of hospitals around our state, where, in 2014, more than 1,600 babies were born addicted to prescription drugs because their mothers abused drugs during pregnancy. According to the Department of Health, the number of babies born in Tennessee with Neonatal Abstinence Syndrome increased 285 percent in the most recent five-year period for which data is available.

We have to continue identifying, educating and even penalizing healthcare providers who are overprescribing, inadvertently or otherwise, and keep “pill mills,” clinics in operation solely to write prescriptions for controlled drugs, out of operation. The CSMD, along with stronger regulations for pain clinics and pain management services, has helped, but the more we can educate and monitor doctors, nurses and physician assistants on safe and proper prescribing, the better we will control the supply of opioids in our state.

Patients also play a role. According to the state’s “Prescription for Success” report, 71 percent of addicts said they get their drugs from a friend or relative, the practice of conversion. More than half the time they are simply given away for free. Government-run take back programs are a safe, convenient way to dispose of unused or unwanted drugs and avoid contributing to this growing statewide and national problem. Many local law enforcement agencies coordinate take back programs throughout the year.

We are making progress in the fight against prescription drug abuse, but we are far from winning. We must stay the course on the things that are working, fix or replace the methods that aren’t, and continue to look for new strategies to combat this public health plague.

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The only exception is for miniature horses. The U.S. Department of Justice provides separate requirements for miniature horses and factors to determine if a miniature horse must be allowed in the office.

There are federal and state laws that require a practice to permit service animals in the office, but nothing regarding other animals or pets.

To fully understand federal and state requirements regarding service animals, service animals in training and the questions you may ask a disabled patient regarding a service animal, please see our Law Guide topic titled Service Animals and the Physician’s Office. If you have any questions, contact legal@tnmed.org or the Legal Department at 800.659.1862, ext. 1645.
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**PHYSICIAN SPOTLIGHT**

**TMA MEMBERS SERVE ON TAGS**

**Physician involvement in Technical Advisory Groups** is a vital part of making sure physician voices are a part of the Tennessee Health Care Innovation Initiative.

TAGs are clinical workgroups including both payer and provider representatives who offer clinical advice on the designs of episodes of care. TMA members have been active in TAGs since the groups first met. More than 70 TMA members have participated in episodes of care TAGs.

Richard Aycock, MD of Germantown has participated in two TAGs — Colonoscopy Wave 2 and Gastrointestinal Hemorrhage Wave 3.

Dr. Aycock is a managing partner at Gastro One in Memphis, and said the opportunity to take part in the TAGs was a perfect fit for him.

“I think it’s critical for physicians to be involved because we’re the ones who are actually delivering the care and are impacted by this kind of change in healthcare payment,” he said.

Dr. Aycock said the goal of episodes of care is to link payment to better health outcomes and good quality of care.

“The only way they can know what quality care is and evaluate outcomes is to have physician input directly into the advisory group,” he said.

The first TAG that Dr. Aycock took part in was for the Colonoscopy Wave 2 episode. Meetings for the TAG were well-attended by individuals from many parts of the healthcare industry, from physicians to insurance providers, he said.

Dr. Aycock said, however, that he was unhappy with the way one measure suggested by the TAG was not included in the final executive summary for the episode. TAG participants agreed that providers needed to be a part of a registry called GIQuIC to participate in gain sharing. The registry is used to collect and report colonoscopy quality indicators.

Quality metrics are not currently included in episode, said Dr. Aycock, who feels the TAG should have been consulted when changes were made. Going forward, he hopes that episodes will have a true commitment to quality.

**PHYSICIAN SPOTLIGHT**

**TMA MEMBERS SERVE ON TAGS**

**Richard Aycock, MD**

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MEMPHIS MEDICAL SOCIETY ANNOUNCES NEW EXECUTIVE VICE PRESIDENT

The Memphis Medical Society has announced Clint F. Cummins as its new executive vice president. Cummins fills the role of Michael Cates, who retired at the end of September. Cates led the Memphis Medical Society staff since 1985.

Cummins has more than 12 years of experience in executive planning, administration, communications and marketing in the nonprofit sector. He was employed for more than six years at the American Cancer Society and has also served as the annual fund manager for Ronald McDonald House Charities of Memphis and as an associate director for organization development for Kappa Alpha Order at the group’s National Administrative Office in Lexington, Va.

“I look forward to serving in my new role at the Medical Society,” Cummins said. “I am dedicated to the organization’s mission of uniting physicians in Shelby County and promoting the highest quality of medical practice and the health of our citizens.”

MMS WELCOMES NEW MEDICAL STUDENTS

In August, The Memphis Medical Society took part in orientation and hosted a welcome reception for incoming M1 students at the University of Tennessee Health Science Center – Memphis. The UTHSC College of Medicine has 170 M1 students this year.

MEMBERS IN THE NEWS

TMA MEMBERS WIN BUSINESS JOURNAL AWARDS

Three TMA members were honored with Health Care Hero Awards by the Memphis Business Journal. The awards were presented in August.

Terry Canale, MD received the Health Care Heroes Lifetime Achievement Award. Canale is a retired professor and chairman of the University of Tennessee-Campbell Clinic Department of Orthopaedic Surgery and president of the Campbell Foundation.

David Stern, MD received the Administrative Excellence award. Stern is chair of the board of University Clinical Health, Robert Kaplan Executive Dean for the College of Medicine and vice chancellor for clinical affairs at the University of Tennessee Health Science Center.

James Eubanks III, MD received the Health Care Provider-Physician Award. Eubanks is chief surgeon and medical director of trauma at Le Bonheur Children’s Hospital.

TMA MEMBERS HONORED AS CHAMPIONS OF HEALTH CARE

Several TMA members were honored by the Chattanooga Times Free Press and Edge Magazine in September as Champions of Health Care. It is the first year the awards have been presented.

Jackson Yiun, MD, FACP and Michael Carr, MD won the Physician Excellence Award for performance considered exemplary by patients and peers.

J. Mack Worthington, MD and Coleman Arnold, MD won the Health Care Volunteer award for serving as the medical director for Project Access.

Raj Budati, AMA student president at UTHSC – Memphis, Gerald R. Presbury, MD and Janice Cooper of the MMS speak with a new medical student about membership in the MMS, TMA and AMA
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Sharon Duke, DO, PhD, DABAM, FASAM, a partner in East Tennessee Pathways, an addiction recovery center in Morristown, loves to see her patients succeed in their recovery.

“There’s never a dull day,” she said. “My patients are so funny and they’re just so much fun. They just blossom like flowers.”

The success of her practice lies in seeing patients go on to do good things with their lives, like one single mother of four who has regained custody of her children and is in school studying to become a medical coder, Duke said.

“She’s just doing beautifully,” she said.

But addiction is a disease which takes a lifetime to combat, Duke said.

“Every day they have to decide ‘Today I’m going to stay in recovery again,’” Duke said.
FIGHTING PRESCRIPTION DRUG ABUSE IN TENNESSEE

Overuse and abuse of pain prescription medication is a problem throughout the United States. While the country makes up less than 5 percent of the world population, it consumes 99 percent of the world’s hydrocodone, said Mitch Mutter, MD, FACC, State Medical Director for Special Projects.

Tennessee was tied with Alabama for the highest number of filled opioid painkiller prescriptions per capita with 1.2 prescriptions per capita in 2015, according to a report from IMS Health.

But progress is being made.

The National Safety Council, in its report “Prescription Nation 2016,” ranked Tennessee as one of only four states “making progress” in the fight against the prescription drug abuse epidemic along with Kentucky, New Mexico and Vermont. All other states were ranked as lagging behind or failing.

The states were ranked as making progress on six key indicators: mandatory prescriber education, opioid prescribing guidelines, eliminating pill mills, prescription drug monitoring programs, increased access to naloxone and availability of opioid use disorder treatment. Tennessee is considered to be making progress in all of the indicators except the availability of opioid use disorder treatment.

The state was one of the first to mandate prescriber use of its prescription monitoring program, and the result has been a 36 percent reduction in doctor shopping, according to the NSC report. Other data from the state suggests these and other efforts have cut doctor shopping in half.

In 2015, more than 18 million controlled substance prescriptions were reported to Tennessee’s Controlled Substance Monitoring Database, including 8,084,981 opioid prescriptions, according to the CSMD 2016 Annual Report. Those prescriptions are equal to 9,027,110,528 morphine milligram equivalents. MMEs are considered a better measure of prescribing habits than actual prescription numbers because of the variances in potency of different prescription medications. The number of MMEs reported to the CSMD peaked in 2012, when the number reached 9,881,362,610, the same year that the number of opioid prescriptions peaked at 9,279,700.

There has been a drop of about 8.6 percent in MMEs since 2012, when the Prescriptions Safety Act of 2012 passed in the state General Assembly. Between 2010 and 2012, that number went up by about 12 percent.

The number of pain clinics in Tennessee is also decreasing. There are currently 197 pain clinics registered in Tennessee, according to Ashley Dao, board administrator for pain management clinics with the Department of Health. Dr. Mutter said that number peaked at more than 300.

While the state is making progress in its fight against the prescription drug abuse epidemic, that progress is not yet resulting in better outcomes, Dr. Mutter said.

As pill mills are shut down and pain medications become more difficult to get directly, addicts are moving on to other drugs, including heroin and prescription drugs bought on the street. Those drugs have the added danger of being unregulated, and can turn out to be entirely different than what the buyer thinks he or she is getting.

For example, during a two-week period this winter in Winchester 11 people overdosed because they thought they were buying percocet on the street. It turned out to be fentanyl, Dr. Mutter said.

Drug-related deaths in Tennessee are going up. There were 1,166 drug overdose deaths in Tennessee in 2013 and 1,263 drug overdose deaths in 2014, according to the Tennessee Department of Health.

Cases of Neonatal Abstinence Syndrome are also going up, if only slightly. In 2015, there were 1,039 cases of NAS reported to the state, according to the NAS annual report for 2015. The Tennessee Department of Health established NAS as a reportable condition in 2013. The number of NAS cases increased slightly in 2014 and 2015. There were 936 cases reported in 2013 compared to 1,031 reported in 2014 and 1,039 reported in 2015.

Of the infants with NAS, 72 percent were exposed to at least one prescription drug with or without an illicit drug and 48.5 percent of cases were exposed to prescription drugs only, according to the annual report.

“We’re not going to fix it in three years.” he said, noting that the biggest factor is likely just time. “This problem started back in the ‘80s, so we’re talking about 30 years to get in this bad of shape,” Dr. Mutter said. “We’re not going to fix it in three years.”

Dr. Mutter first got involved in fighting the prescription drug abuse problem as a member of the Board of Medical Examiners, where he saw an increasing number of cases of doctors over prescribing or improperly prescribing pain medication. Many of the over prescribers were also abusing medication.

At that point, multiple parties had to come together to combat the problem, including the medical community, the governor and the state legislature.

The result was the Prescription Safety Act of 2012, which made Tennessee one of a limited number of states with mandatory reporting to the Controlled Substance Monitoring Database.

Dr. Mutter said he had initially expected a lot of pushback to mandatory reporting to the CSMD, but symposia hosted across the state in 2012 and 2013 helped gather ideas to improve the database and get more buy-in from healthcare providers.

State government has provided the framework to combat the prescription drug abuse problem with the 2012 act and a...
new bill passed this year to replace it before its sunset date, he said. The new prescription drug abuse law will not sunset. The state has also published the Tennessee Chronic Pain Guidelines for prescribers. The guide was published before the CDC issued its guidelines and will be updated this fall.

Guidelines were needed because doctors weren’t trained in pain management and yet, some were starting pain clinics right after they finished medical training, Mutter said.

“I mean, as a cardiologist I didn’t try to do brain surgery,” he said. “There’s more to treating pain than just giving a pill.”

Going forward, more resources are needed to adjudicate a backlog of BME cases against doctors who have been prescribing pain medications improperly.

“They’ve given us the big tools and we just need the resources, which is money, lawyers and experts,” Dr. Mutter said.

The large majority of doctors are doing things properly when it comes to prescribing pain medication, with only a small percentage who are being motivated purely by profit, he said.

Many physicians who are over prescribers of pain medication are abusers of those medications themselves, and Dr. Mutter says he favors treatment and rehabilitation for those physicians when possible because studies show that the recidivism rate for substance abuse among physicians is less than 10 percent.

“A medical education is a horrible thing to waste, and if we can rehabilitate those physicians and get them back to being responsible prescribers, then we should do so,” he said.

It’s important that physicians have taken an active role in combating the epidemic, Dr. Mutter said.

“If we don’t fix it, people who know nothing about the problem will attempt to fix it, and it really will not be pretty,” he said. “As ugly as it is now, it will be much uglier if we physicians don’t help fix it ourselves.”

THE ROOTS OF PRESCRIPTION DRUG ABUSE IN TENNESSEE

Substance abuse has been a problem in the field of pain management since its inception, said James Choo, MD of Knoxville.

“One way or another, we’ve been dealing with substance abuse probably since man walked upright,” he said.

Dr. Choo, who works at Pain Consultants of East Tennessee, said East Tennessee is a hotbed for prescription drug abuse issues, though it also affects the entire state.

That is partly due to the specific culture of Appalachia, he said. The poor Scots-Irish immigrants who settled in the area brought whisky technology with them. One way for those people to survive and make money was through the commodity of alcohol, which was relatively cheap to make.

Prohibition made that commodity profitable but illegal, and created an ambiguous relationship with the law for the people of the area, Dr. Choo said. Moonshine was transported from hidden stills in rural communities to larger cities in a pipeline called Thunder Road.

Now, pills and other drugs are coming to the area from outside, he said.

“It’s basically Thunder Road in reverse,” Dr. Choo said.

Other factors also contributed to the rise of the state’s prescription drug abuse problem. One issue has been training. Chronic pain management has not historically been a part of the medical training curriculum, though that is starting to change with more aggressive training in pain medicine prescribing through physician continuing medical education and pain management tracks of study, Dr. Choo said.

The introduction of Press Ganey patient satisfaction scores, studies that found that narcotics for pain relief were not generally addictive, and an initiative in the 1990s to treat pain as a fifth vital sign all also contributed to a rise in use of and addiction to opioids.

“It was essentially a false narrative,” Dr. Choo said.

However, physicians now are very aware and sensitive to the opioid problem, he said.

“I’ve seen a huge awareness amongst all providers,” Dr. Choo said. “It is so much better than it has been in the past.”

Promisingly, he has also seen a rise in the number of patients who are willing to work to step down the amount of opioid pain medication they are taking.

“We’re also seeing patients saying ‘Look, I don’t want opioids at all,’ and they are desperately looking for alternatives,” he said.

“One emerging issue that now needs attention is helping primary care physicians understand that it is okay for them to write some prescriptions for pain relief, where appropriate. Pain specialists can’t be responsible for writing prescriptions for all of those medications because there are not enough of them to fill the needs of the state,” Dr. Choo said.

“While it is important to recruit new board-certified pain specialists to come to East Tennessee, coordinating care between primary care physicians and pain specialists remains important,” he said.

SIDE EFFECTS OF BATTLING OPIOID ABUSE

Edward Capparelli, MD, of Oneida said he sees the impact of the crack down on pain medication in his community.

He is the medical director for the community health center, Mountain People’s Health Councils, Inc., and the physician for the Scott and Anderson County jails.

Dr. Capparelli said he is seeing a rise in inmates reporting use of illegal substances, including cocaine and heroin, which is being brought into the area from Cincinnati and Georgia.

“It’s not just a prescription drug problem, it’s an overall addiction problem,” he said.

Still, Dr. Capparelli said he prescribes pain medications for about 20 percent of his patient population.

ACCESS THE TENNESSEE CHRONIC PAIN GUIDELINES AT:

tn.gov/assets/entities/health/attachments/
ChronicPainGuidelines.pdf
The shutdown of numerous pain clinics in the region have left patients who truly struggle with chronic pain to find a new place to go for treatment, he said.

“Even in pain clinics shut down for being pill mills, there are legitimate pain patients,” he said.

Those legitimate patients then have to go somewhere else for the medicine they need, Dr. Capparelli said, which creates a problem because some doctors now refuse to write prescriptions for pain medication and others sometimes have long waiting lists or are charging extremely high prices for visits.

Dr. Capparelli said it is difficult when patients come to him claiming to be in pain because the only way to measure that is by listening to what they tell him.

“Doctors go into medicine because we want to make people better,” he said. “We want to make people happy.”

Dr. Capparelli said that he has worked hard to wean patients that had been taking high doses of narcotics down to levels currently recommended for primary care physicians. This has met with resistance from his currently established patients and has been very difficult. For some new patients coming in already taking high doses of narcotic medications prescribed from other doctors, it has been impossible and those individuals have left his clinic frustrated.

“The ones who are already on it, that’s a really hard question and I don’t have a good answer because there is not a good answer,” he said.

It is far easier to battle opioid abuse by using caution when prescribing pain medications for patients not currently using them, said Dr. Capparelli.

For those patients, it’s important to realize that narcotics are not the answer for every type of pain and, when they are the chosen treatment, and should be prescribed in the lowest effective dose for the shortest time possible, he said.

When making that decision, Dr. Capparelli recommends that, before prescribing pain medications, prescribers review the state CSMD, review a patient’s medical record and compare the results of a CSMD search with a urine drug screen to make sure there are no drugs that have not been prescribed in the patient’s system.

A typical patient will stay under her care for about two years, and most she sees weekly.

But the medication is only a part of treatment.

“We’re working on everything in their lives to help them into a new lifestyle,” she said.

When people go into recovery they often have to change their entire support group because of connections to their substance abuse. For many, treatment also includes psychiatric treatment or counseling.

Dr. Duke also estimates that between 70 and 80 percent of women and between 30 and 40 percent of men with substance abuse disorder have a history of being abused.

“That’s a big reason for their long history of substance use; they find out that when they use drugs it erases those thoughts and memories,” she said. “It numbs the pain. It numbs their mind.”

It can be difficult for people who stop abusing substances and go into recovery to then re-experience the feelings they have been suppressing with drugs.

“The first thing I tell them is, there is not a pill for every feeling in this world,” she said.

Many of the pain medications her patients have abused were never intended to treat the kind of pain for which they were prescribed, Dr. Duke said.

For example, near the end of Dr. Duke’s husband’s struggle with cancer, he was taking methadone to deal with the pain. He died about five years ago.

“Most of these drugs were developed for that kind of problem,” Dr. Duke said. “…You don’t need narcotics for a year for a broken toe.”

There are many other ways to treat pain outside of opioid pain medication, including physical therapy, exercise, milder pain relievers such as ibuprofen, ice, heat, massage and yoga.

Working as both a psychologist and as an emergency room doctor, Dr. Duke has seen a lot of people with drug addictions. People with a history of addiction would come to the ER to see what the new doctor would give them.

“Unfortunately, at that time I didn’t have the appreciation for the disease that I do now and I didn’t give them the help they really needed,” she said.

While working as an ER doctor, a friend who was working at a Johnson City recovery program asked her to join him, thinking she would be an asset. For three years, she worked at both the ER and the recovery program and found it more and more fascinating.

About four years ago she transitioned to working just as a doctor treating substance use disorders.

Dr. Duke said mass education about the nature of addiction is needed in the state, and progress is being made.

“The progress I’ve seen most is that our legal system is making some efforts to treat this as a disease instead of as something that needs to be punished,” she said.

She urges physicians to check the CSMD to see what medications a patient has been on and how many doctors the patient is seeing, consider whether the patient’s complaint and medical history justifies a pain prescription and consider alternate ways of treating pain before writing a prescription.

“The pills should be the last option,” she said. “Controlled substances should be the last option.”

Working Toward Recovery

Anyone who takes a narcotic long term will develop a dependence on the medication, which means that when they stop using it they will experience withdrawal, Dr. Duke said. But those who have what she refers to as the “addiction gene” get a different effect from those medications. Those are the individuals who doctor shop and resort to other illegal actions to obtain drugs.

“We know that addiction is an inherited disease,” she said. “We do not cure it. We bring them off addicting substances and we teach them a lifestyle to stay off it.”

Patients who come to her with a dependency on rather than an addiction to pain medications are much easier to treat, she said. Most of her patients either started using drugs recreationally or were prescribed them to deal with pain.

Dr. Duke treats her patients with various forms of Suboxone, which includes buprenorphine and naloxone. The buprenorphine is a partial antagonist narcotic to fill a patient’s opiate receptors and stop withdrawal while naloxone blocks the effects of all other narcotics.
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As probably everyone knows by now, we are in the middle of the worst and deadliest drug epidemic in our nation’s history. In Tennessee, there is good news and bad news.

It’s somewhat good that we seem to have plateaued in the number of babies born with Neonatal Abstinence Syndrome (NAS); the bad part is it’s still more than 1,000 babies a year. We also still have more than 1,000 overdose deaths in Tennessee, so we have way too many born dependent on opioids and dying on opioids. I sometimes say if today’s like any other day, we will have four Tennesseans who die of an overdose of prescription drugs, primarily opioids and specifically benzodiazepine.

There’s good news in that we are prescribing significantly fewer opiates in Tennessee; the bad news is they are being replaced by a heroin epidemic. Tennesseans are rapidly turning to those drugs – they’re available on the street and are cheaper and far more powerful than prescription opiates.

NSC Report: Significant Progress in TN

Recently, the National Safety Council released a report on state progress in addressing America’s drug epidemic.* They looked at six key indicators:

1. Mandatory prescriber education
2. Opioid prescription guidelines
3. Eliminating pill mills
4. Prescription drug monitoring programs
5. Increased access to naloxone
   (opioid antagonist, acts to reverse opioid overdose)

No states have met all six criteria, but Tennessee was one of four states mentioned as making the most significant progress, along with Kentucky, New Mexico and Vermont. Physicians have made a lot of progress here; a lot of this was due to the work we’ve done educating physicians about the epidemic, to the development of the Controlled Substance Monitoring Database and the implementation of a proper prescribing CME requirement for physician licensure in Tennessee. The only category we did not do well in was the availability of opioid use disorder treatment; this is primarily due to a lack of funding for such treatment. This is what my recent op-ed in The Tennessean newspaper was all about – getting money set aside by Congress for this type of treatment.

In addition to the four states making progress, the NSC report showed 47 states needing to improve and 28 states failing in strengthening their laws and regulations.

Worst to First

When Dr. Mitch Mutter first assumed the position of Director of Special Projects for the Tennessee Department of Health, he said he wanted Tennessee to go from “Worst to first.” At that time, I thought he was overly optimistic, but now I see he had a vision, and we now have this goal within reach. I was pleased to see we were in the top four; no state has done more than Tennessee. This has been accomplished by coordinated efforts involving the Department of Health, the Tennessee Medical Association, the Tennessee Medical Foundation and State Volunteer Mutual Insurance Company (SVMIC). TMA deserves the credit for taking the initial action on this emerging epidemic in 2007 when it offered the first course to educate physicians about this evolving epidemic. I’ve been honored to work with TMA in developing those CME programs.

I agree with the NSC that there has been a significant change in our state. Our doctors are more aware of the epidemic now. When I used to give talks about over prescribers, one category was the deficient doctor who didn’t keep up with CME or was not aware of prescribing issues or laws. There should not be anybody in the state who falls into that category now. It has also been gratifying to me to see the change in physician attitudes toward these presentations. When I first started teaching the courses in 2007, it was not unusual to be met with comments or questions about why we were doing that, or those indignant that we were telling them how to treat their patients. I never hear that anymore. I would say the majority of doctors in the state are committed to stepping up to the plate and doing whatever we need to do to turn this epidemic around. And we are doing it.

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Over the last couple of decades, the pendulum for opioid prescribing has swung from a more liberal position to a more conservative one. Some cite early research in 1980 as one of the justifications for the upsurge in opioid prescriptions. In that article, “Addiction Rare in Patients Treated with Narcotics,” the physicians reported only four cases of documented addiction in a survey of nearly 12,000 patients. Next came an aggressive push to treat pain in the many years to come by pain specialists, pharmaceutical industry, and pain societies touting pain as the “fifth vital sign.” Although the authors of that original article concluded that addiction is rare in hospitalized medical patients treated for acute pain without a history of addiction, the same cannot be implied for chronic pain sufferers given long-term opioid prescriptions in which they are free to administer at home.

Unfortunately, data from the Centers for Disease Control and Prevention suggests in 2014, 40 percent of drug overdose-related deaths were due to prescription pain relievers. Also note that four out of five heroin addictions begin with opioid prescription pain relievers. Opioids are now prescribed for common injuries such as back and neck pain.

In the midst of the national prescription opioid abuse epidemic, healthcare providers are turning to non-pharmacologic alternatives for the treatment of chronic pain.

One such option, neuromodulation or spinal cord stimulation, has been shown to be superior to conservative medical management and/or reoperation, and more cost effective. The procedure is a two-step process in which patients are initially selected to undergo a temporary trial period generally lasting from three to 15 days. An electrode lead is percutaneously tunneled into the epidural space through a needle targeting the spinal level associated with the painful area. Should the patient report more than 50 percent pain relief and improved functioning upon completion of a trial, consideration for a permanent implantable pulse generator (IPG) is made.

Traditionally, the stimulation causes the patient to feel slight paresthesias in the painful area, thus replacing the feelings of pain. Some patients report that the sensation is unpleasant, predominantly with changes in body position. One IPG now has the ability to adjust the stimulation based on sensing body position (adaptive stimulation) thereby reducing the unwanted paresthesias. These traditional devices deliver pulse frequencies in the range of 2 to 1,000 Hz. Technological advances have produced three novel therapies in recent years. We now have the ability to target a specific dorsal root ganglion for near pinpoint pain control in previously difficult to treat areas such as groin and foot pain. Furthermore, advances in stimulation frequency have shown promise for high rate (10,000 Hz) and burst stimulation, providing reduced or paresthesia-free pain relief. Also on the horizon is a wireless pulse generator in which the energy source is external and transmitted via microwave technology.

Although the true mechanism of action is not known, one possibility is thought to derive from Melzack and Wall’s gate control theory. The idea in which large myelinated fibers are turned on, thereby closing the gate on small unmyelinated pain fibers, blocking transmission of pain to the brain. Both research and personal experience have shown neuromodulation to be more effective in patients with failed back surgery syndrome, radicular pain, peripheral neuropathy and complex regional pain syndrome (CRPS). Neuromodulation has also been shown to be effective in patients with limb ischemia, phantom limb pain and refractory angina pectoris. Importantly, identifying the right candidate/diagnosis early in the treatment process is integral for successful outcomes.

Current data suggest the therapy has long-term efficacy. Traditional stimulation has shown significant evidence for treatment of lumbar failed back surgery syndrome where conventional management has failed. Furthermore, in a recent meta-analysis of traditional stimulation, more than half of all patients experienced significant pain relief and the relief was maintained in follow up at 24 months. In a recent analysis of high frequency stimulation, patients reported significant decreases in opioid use, improvement in Oswestry Disability scores, improved sleep and sustained back pain relief with a baseline scores decreasing from 8.4 to 3.3 at 24 months. Like any medical treatment, neuromodulation is not without complications. Turner et al. site common complications in permanently placed units identified as: need for revision (23.1 percent), hardware malfunction (10.2 percent), infection (4.6 percent), local pain (2.5 percent), pain at IPG site (5.8 percent) and stimulator removal (11 percent).

Although opioid medications have been traditional treatments for chronic neck and back pain, they are not without controversy. Significant evidence shows neuromodulation...
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Tennessee, like many other states, is in the midst of an unprecedented drug death epidemic. This epidemic is largely preventable, and accurate and comprehensive mortality data are integral to prevention efforts. President Obama’s National Drug Control Strategy, which outlines the Administration’s policy to reduce illicit drug use and its consequences in the United States, emphasizes that mortality information is a critical measure of the consequences of opioids. Since county medical examiners are responsible for conducting investigations to accurately determine cause and manner of death of drug-related deaths in Tennessee (TCA §38-7-108), our medical examiners are integral in the local and national drug-related death public health imperative.

National guidelines for drug death investigation by medical examiners have been established and promulgated by several agencies, including the National Association of Medical Examiners (NAME), Substance Abuse and Mental Health Services Administration, American College of Medical Toxicology, and National Institute of Justice. The guidelines all emphasize the importance of integrating death scene investigation, autopsy, medical history and toxicology for accurate and reliable death investigation and certification. They also provide specific guidance for the type of examination, what constitutes an adequate scene investigation, ordering and interpretation of toxicology, and how to certify properly, a drug-related death.

For potential drug-related deaths, an on-scene investigator (ideally a certified medical death investigator) should document many important death scene details. These may include the presence or absence of evidence of drug use, including opioid and other scheduled medications, drug paraphernalia (needles, spoons, cut straws, crushed tablets, pill crushers, etc.), packets of powder or crystals, overlapping prescriptions for the same medication from different prescribers, prescriptions in other people’s names, mixed pills in pill bottles, the presence of naloxone and altered transdermal patches. All of the decedent’s prescription medication should be collected, documented and inventoried.

To accurately determine a cause of death, these scene findings should be considered in conjunction with the autopsy results, decedent’s medical history, and toxicology. Medical history is obtained from provider medical records and through the Controlled Substance Monitoring Database (CSMD). The medical history and CSMD will provide information about a decedent’s prescription medication history, which is one component of assessing opiate tolerance. Tolerance is an important consideration in interpretation of postmortem opiate concentrations.

A complete autopsy is considered best practice for optimal interpretation of toxicology in the context of other investigative findings. Toxicology results cannot be considered alone. However, due to fiscal constraints primarily, autopsies are often not ordered for suspected drug-related deaths in many Tennessee counties. A comprehensive toxicology panel, including but not limited to opiates, benzodiazepines, fentanyl and its analogues, stimulants, depressant and anti-depressant medications should be ordered in every potential drug-related death. The postmortem toxicology must be interpreted with the knowledge of specific drug metabolism, consideration of tolerance, and with the understanding of postmortem redistribution (the well-recognized phenomenon that drug levels change in the body after death). Recognition of heroin in postmortem specimens is a pressing concern. Heroin metabolizes very quickly in vivo. Other specimens, such as urine and vitreous fluid, often must be tested to confirm heroin use. However, these specimens are not routinely collected or tested by most county medical examiners. Currently, the type of toxicology panel ordered, and its interpretation varies by county and even within county jurisdictions.

The cause of death reported on death certificates provides valuable information about drug deaths. National guidelines suggest that, when certifying a drug death, the specific drug names causing or contributing to death should be listed in the cause of death statement. Approximately 15 percent of overdose deaths in Tennessee fail to indicate the drugs involved in the death. It is still common practice for physicians to simply list “drug overdose,” “multiple drug intoxication” or “opiate overdose” as the cause of death. Identifying specific drugs on death certificates is imperative for stakeholder agency responses, as law enforcement and public health responses will differ if mortality trends indicate increases in illicit drug use or deaths from pharmaceutical use and abuse. This information can also aid in identifying epidemics of new and emerging drugs such as synthetic fentanyl analogues.

The medical examiner offices in the Tennessee counties housing the five Regional Forensic Centers (Shelby, Davidson, Knox, Hamilton, and Washington) are accredited by the National Association of Medical Examiners, utilize certified medicolegal death investigators and follow best practice guidelines established by NAME and other agencies. But adherence to these drug death investigation guidelines in Tennessee markedly varies among other counties. This variation in death investigation practices creates disparity in the completeness and accuracy of identification and certification of drug overdose deaths. As a result, drug deaths are likely significantly underreported.

In addition to standardized drug death investigation, developing local, regional and national incident surveillance systems to improve outbreak detection of deaths involving illicit opioids (including heroin and illicit fentanyl) is suggested. Medical examiner participation in multiagency, cross-disciplinary data sharing and investigatory initiatives (e.g. New York’s RxStat Initiative and Maryland’s Local Overdose Fatality Review Team)

(Continued on p. 28)
to be an effective and safe alternative with long-lasting results. Technological advances in neuromodulation have improved patient outcomes and functional status. Furthermore, neuromodulation should no longer be considered salvage therapy as evidence has shown improved outcomes with earlier implementation. If you are interested in more information or have a patient whom you feel would benefit, consider referral to a Board Certified Pain Specialist in your area. 

REFERENCES


DRUG-RELATED DEATHS

(Continued from p. 27)

should be developed and supported locally to enhance coordination, data collection and data sharing. This will allow timely reporting and monitoring of specific drugs, provide better information about drug use trends and vulnerable populations and facilitate a rapid and effective response by all stakeholders.

Our medical examiner community is in a unique position to help define the drug death epidemic and is a vital resource to inform about fatal drug use and abuse. Our dedicated medical examiners and medicolegal death investigators must have resources, including funding, education, IT infrastructure, and political support, needed to help mitigate this public health crisis.

REFERENCES


NEW MEMBERS

BLOUNT COUNTY MEDICAL SOCIETY
Jason M. Eskew, DO, Knoxville
Bhavin C. Patel, MD, Maryville
David R. Skinner, DO, Alcoa
Aaron Smyth, DO, Maryville

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY
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Sarah A. Harris, MD, Chattanooga
Alfred E. Paige, MD, Chattanooga
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Mohammed J. Quraishi, MD, Chattanooga
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Barrett G. Haik, MD, Hixson

FOR THE RECORD

Bennett F. Horton, MD, age 88. Died June 27, 2016. Graduate of Medical College of Georgia. Member of the Nashville Academy of Medicine.

Thomas M. Jackson, MD, age 95. Died July 17, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Ira M. Long, MD, age 90. Died July 5, 2016. Graduate of Vanderbilt University School of Medicine. Member of the Chattanooga-Hamilton County Medical Society.

Barney E. McLarty, MD, age 98. Died August 4, 2016. Graduate of Loma Linda University School of Medicine. Member of The Memphis Medical Society.

Robert A. Peterson, MD, age 49. Died May 24, 2016. Graduate of the University of Tennessee Center for Health Science. Member of the Chattanooga-Hamilton County Medical Society.

IN MEMORIAM

Joseph Acker, MD, age 97. Died August 7, 2016. Graduate of the University of Tennessee College of Medicine. Member of the Knoxville Academy of Medicine.

John M. Appling, MD, age 83. Died June 23, 2016. Graduate of Virginia Commonwealth University School of Medicine. Member of the Bradley County Medical Society.

Mary E. Bouldin, MD, age 85. Died July 22, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Denise C. Cantwell, MD, age 58. Died June 14, 2016. Graduate of Wright State University School of Medicine. Member of the Knoxville Academy of Medicine.

Edgar R. Franklin, MD, age 82. Died July 1, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Barrett G. Haik, MD, age 64. Died July 22, 2016. Graduate of Louisiana State University School of Medicine. Member of The Memphis Medical Society.

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