



. SPECIAL EDITION .

FIGHTING TENNESSEE'S OPIOID ABUSE EPIDEMIC



A Focus On Service, For All Your Banking Needs



Focus on what truly matters – your patients, and leave the rest to us.

Whether you are relocating your practice, purchasing a home, or managing accounts that utilize higher balances, TMA Medical Banking can assist with all your banking needs – empowering both you and your practice.

- Genuine, authentic customer relationship
- Full range of private banking products tailored specifically to fit the needs of both you and your practice
- Flexible financing options with an expertise in healthcare
- Competitive pricing on both consumer and commercial loan products
- Sophisticated cash management and treasury management solutions



Blake Wilson
bwilson@TMAmedicalbanking.com
615.515.4272 NMLS#809370

Katherine Daniels
kdaniels@TMAmedicalbanking.com
615.515.2284 NMLS#1602483



Volume 110, Number 4 + Special Edition

Tennessee Medicine: Journal of the Tennessee Medical Association (ISSN 10886222) is published Quarterly by the Tennessee Medical Association, 701 Bradford Ave., Nashville, TN 37204. Tennessee Medical Association is a nonprofit organization with a definite membership for scientific and educational purposes, devoted to the interests of the medical profession of Tennessee. This Association is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to *Tennessee Medicine* for publication. The author or communicant shall be held entirely responsible. Advertisers must conform to the policies and regulations established by the Board of Trustees of the Tennessee Medical Association. Subscriptions (nonmembers) \$30 per year for US, \$36 for Canada and foreign. Single copy \$5.00. Payment of Tennessee Medical Association membership dues includes the subscription price of *Tennessee Medicine*. Periodicals postage paid at Nashville, TN and at additional mailing offices.

POSTMASTER: Send address changes to *Tennessee Medicine*, 701 Bradford Ave., Nashville, TN 37204. *In Canada*: Station A, P.O. Box 54, Windsor, Ontario, N94 6J5.

Copyright 2017, Tennessee Medical Association. All material subject to this copyright appearing in *Tennessee Medicine* may be photocopied for noncommercial scientific or educational use only.



PRESIDENT

Nita W. Shumaker, MD

CHIEF EXECUTIVE OFFICER

Russ Miller, CAE

EDITOR

David G. Gerkin, MD

MANAGING EDITOR

Julia Couch

EDITORIAL BOARD

James Ferguson, MD

Karl Misulis, MD

Greg Phelps, MD

Bradley Smith, MD

Jonathan Sowell, MD

Andy Walker, MD

ADVERTISING REPRESENTATIVE

Michael Hurst – 615.385.2100

or michael.hurst@tnmed.org

GRAPHIC DESIGN

The Gray Umbrella, LLC

CONTENTS

5 President's Comments

We had a meeting. Now what? – Nita W. Shumaker, MD

7 Physician Supervision Toolkit

9 Editorials

9 Targeted Pain Treatment

- *Reduce Opioids, Reclaim Relief*

14 Neonatal Opiate Withdrawal

- *A Tennessee Perspective*

16 Where is Tennessee in the Epidemic of Opioid Abuse

18 CDC Guidelines for Chronic Pain

23 Tennessee Chronic Pain Guidelines

28 TMA Continues Leading Role in Fighting Opioid Epidemic



REKINDLE YOUR PASSION FOR HEALTHCARE

with the world's longest-running and most preferred
Physician's Executive MBA

Physician-only
program with
650+ alumni

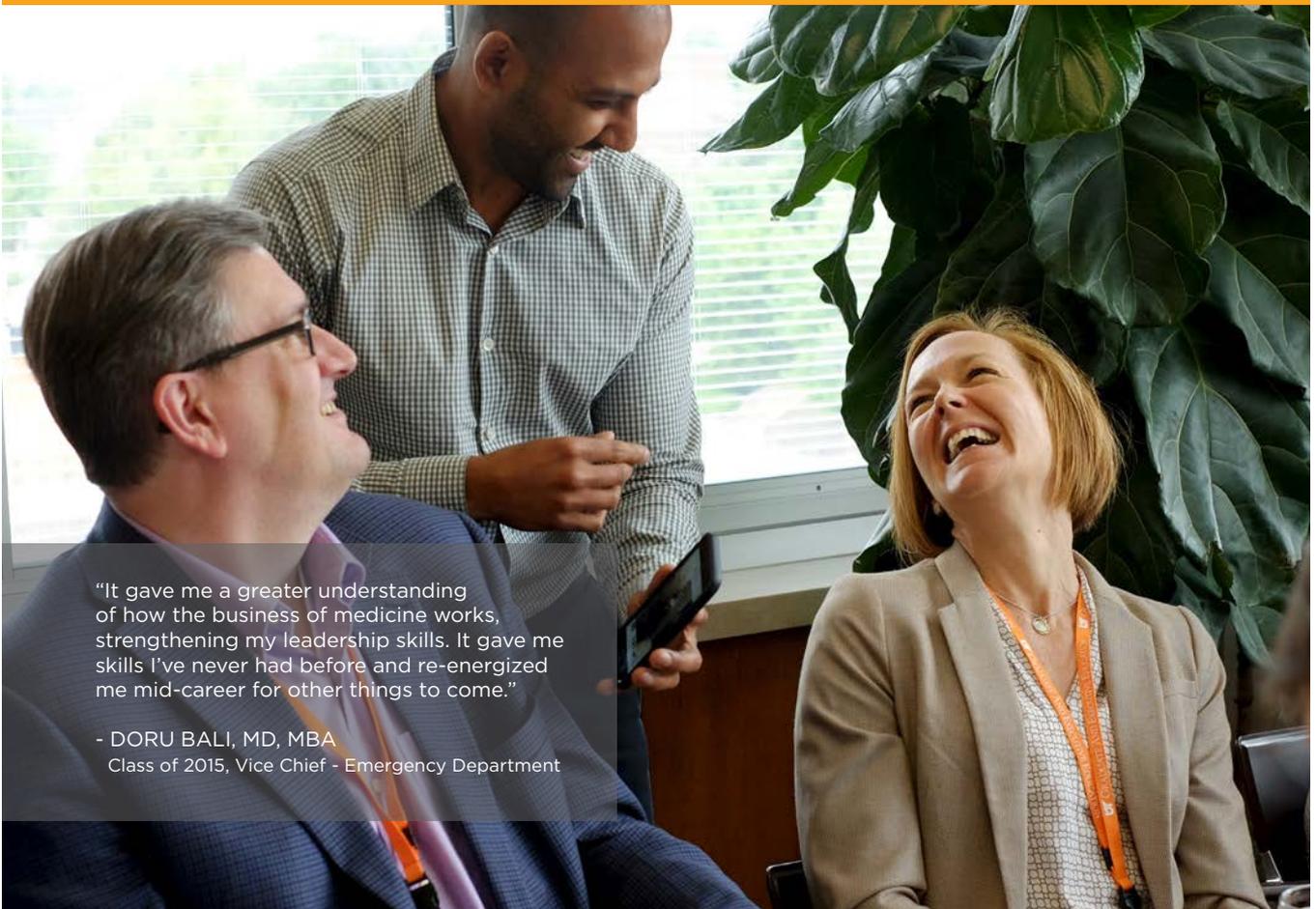
Personalized
leadership
development

Applied
projects
deliver ROI

CME credits
built into
the program

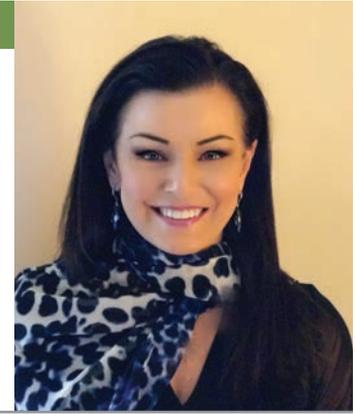
Minimal
number of
days away

No business
pre-requisites
or GMAT



"It gave me a greater understanding of how the business of medicine works, strengthening my leadership skills. It gave me skills I've never had before and re-energized me mid-career for other things to come."

- DORU BALI, MD, MBA
Class of 2015, Vice Chief - Emergency Department



WE HAD A MEETING. NOW WHAT?

By Nita W. Shumaker, MD | TMA President 2017-2018

When my term as TMA President began in April 2017, I made it clear that the opioid abuse epidemic would be my primary focus. Soon after, I began talking to various healthcare stakeholders about a “super summit” where we could bring multiple groups and perspectives together at one place and time to share best practices, develop new ideas and truly begin working together across the state to combat this preventable public health crisis.

The Tennessee Department of Health took the lead in coordinating the two-day event, “Turning the Tide: Collaborating to Prevent Opioid Abuse.” More than 250 people gathered in Franklin in November 2017, including representatives from TDH, the Tennessee Medical Association, Tennessee Hospital Association, Tennessee Nurses Association, Tennessee Pharmacists Association, Tennessee Dental Association, Tennessee Pain Society, addiction specialists, state officials and other interested parties.

At the end of the summit, four actionable initiatives were chosen for the coming year, and into the future.

First, the summit attendees agreed that we need to teach physicians and our extenders how to treat pain without using opioids. I was named physician champion of the “provider education” and charged with identifying, developing and/or disseminating education for physicians, physician assistants and nurse practitioners on the horribly addictive dangers of these medications. We intend to use every avenue possible to make prescribing opioids less frequent by teaching physicians and our extenders how to evaluate and treat pain in other ways, including changing the mandated prescriber education to be less about addictionology and be much more focused on vignettes of pain syndromes and how to treat them differently. SVMIC, the state’s largest medical liability insurance carrier and a longtime TMA corporate partner, has agreed to start teaching a risk seminar about the dangers of opioids, most specifically about the risk to us and our patients if we are not closely following the CDC or Tennessee chronic pain guidelines. This special edition of Tennessee Medicine is also part of the focus on evaluation and treatment of pain without using opioids.

The second project that came out of the super summit was decreasing prescribing in hospital emergency rooms. THA will help with encourage ER doctors and their extenders to prescribe no more than a three-day prescription of opioids from any emergency room, where appropriate.

The third project centers on perioperative pain medication. The workgroup assigned to the project will work to decrease prescribing of opioids, promulgating use of nerve blocks and

other pain medications in the perioperative period to decrease pain experienced by patients.

The fourth and final project from the summit centers on much-needed patient education. Clearly, physicians need to work with our patients to change expectations of pain management, highlight the dangers of addiction for any prescription written for more than three to five days, and inform patients about the dangers of accidental overdose for anyone prescribed more than 90 Morphine milliequivalents. We need to consider co-prescribing naloxone for those patients, and refuse to prescribe anxiety medications for patients on high dose pain medications. There will be many other efforts once funding is identified.

As you are aware, we in Tennessee write 107 prescriptions for every 100 people in the state. The world around us expects us to police ourselves in decreasing this clearly excess number of prescriptions. But who is writing these prescriptions? Relevant data is amazingly difficult obtain. Those who have data about which providers are writing so many opioid prescriptions – and perhaps why – do not seem willing to share the data with physicians. So those of us who would like to reach out and help decrease prescribing of opioids in such large numbers are blinded to who is actually writing them.

What we do know is that, by far, the largest number of prescriptions written by doctors are written by primary care specialists, with family practice writing slightly more than internal medicine.

We also know that nurse practitioners are writing the most prescriptions for opioids in our state, sometimes as many as family practice and internal medicine combined. And because we cannot identify who or what type of physicians the nurse practitioners are writing for, it is imperative that doctors check the state’s Controlled Substance Monitoring Database to see who is writing in our names and how we compare to our physician colleagues.

I encourage you to use the resources in this special publication to modify opioid-related habits in your day-to-day practice. Look online for videos, webinars or CME. Talk to your colleagues and peers. Reach out to me or one of the subject matter experts who has authored an article in this publication or the TMA staff if you have questions or want to find more information about a specific topic.

We can turn the tide on this epidemic by cutting down the initial supply, preventing misuse and abuse, and decreasing the number of people who become addicted.

Our patients’ lives depend on it. +

Share your thoughts with Dr. Shumaker at communications@tnmed.org.



Better safe than hacked.

Physicians are increasingly exposed to privacy-related claims such as hacking, lost laptops, dishonest employees, and virus attacks, which can result in an embarrassing and costly loss. We offer a Cyber Liability Insurance Plan that provides a comprehensive suite of first-party cyber, third-party cyber, and cyber crime coverages, including:

- Cyber, Privacy & Network Security Liability
- Payment Card Loss
- Regulatory Proceedings
- Media Liability
- Cyber Incident Response Fund
- Business Interruption
- Digital Data Recovery
- Telephone Toll Fraud
- Network Extortion
- Computer Fraud
- Funds Transfer Fraud
- Social Engineering Fraud

Cyber Liability Insurance can make the difference between staying in business or shutting your doors after an attack. Contact us for a professional Cyber Review or for more information on this valuable coverage.

TMA 
Insurance

THE TMA ASSOCIATION
INSURANCE AGENCY, INC.

Exclusive Insurance Plan Administrator
for the Tennessee Medical Association

Contact us today!

800.347.1109

TMAinsurance.com

PHYSICIAN SUPERVISION TOOLKIT

The Tennessee General Assembly has paid more attention to supervision and collaboration in recent years with an abundance of legislation to curb the prescribing of opioids and other addictive medications. Many physicians are not aware of these rules and inadvertently supervise APRNs poorly, thereby allowing APRNs to write too many opioids. Nurses comprise 22% of the prescribers in the state but write 60% of the morphine equivalents **while supervised by physicians.**

TMA encourages members to ensure they are in compliance with supervision regulations. Doing so will help combat the ongoing prescription drug abuse epidemic, and avoid negative consequences and unwanted liability. We in Tennessee are working to lower prescribing opioids in general, and our supervision of extenders is a huge part of that plan.

We also encourage you, for your own protection, to check the Controlled Substance Monitoring Database at least quarterly for prescriptions written under your name to assure that no provider is writing controlled substances under your name without your knowledge.

TMA offers a **physician supervision toolkit** to help our members know and stay in compliance with rules, regulations and protocols governing their supervisory role and to ensure that appropriate and safe medical care is delivered. In the guide you will learn specific requirements in overseeing nurse practitioners and/or physician assistants, and recommendations to ensure that you and your team are ready. TMA also offers supplemental checklists for registered pain clinics, interventional pain, and hormone replacement clinics to comply with additional state rules and statutory requirements. +

TNMED.ORG/TOOLKIT

1. STATE OF TENNESSEE REGULATIONS FOR OVERSIGHT

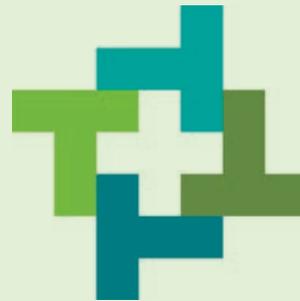
- a. Physician Assistants
- b. Nurse Practitioners from Board of Nursing
- c. Nurse Practitioners from Board of Medical Examiners

2. OFFICE COMPLIANCE CHECKLIST

- a. Supervising Physician's Checklist: Physician Assistant in a Medical Office or a Retail Clinic
- b. Physician Assistants Practicing in a Pain Clinic
- c. Supervising Physician's Checklist: Nurse Practitioner in a Medical Office or a Retail Clinic
- d. Nurse Practitioners Practicing in a Pain Clinic
- e. Nurse Practitioners and Physician Assistants Practicing in a Hormone Replacement Therapy Clinic
- f. Nurse Practitioners and Physician Assistants Practicing Interventional Pain Management

3. TMA LAW GUIDE TOPICS AND ADDITIONAL RESOURCES

- a. TMA Guidelines for Physicians Supervising NPs and PAs in Retail Clinics
- b. Certified Nurse Practitioners
- c. Physician Assistants
- d. Contract: Template Independent Contractor Agreement
- e. Other Resources





Strategic Financial Partners is the Tennessee Medical Association's preferred partner for financial education, comprehensive investment management and financial planning in these areas:

- Retirement
- Estate & Legacy
- Tax Strategies

This partnership was created to address the unique challenges that face physicians and medical practitioners in today's financial environment.

At Strategic Financial Partners we help medical practitioners - in all stages of their careers - plan for their personal financial futures, their practices, and their families.



**STRATEGIC
FINANCIAL
PARTNERS**

For additional information, please contact us.
sfp-md@strategicfinancialpartners.com

615.435.4149

A fee was paid by Strategic Financial Partners to participate as a Corporate Partner. Please note that "Partners" and "Partnership" references does not constitute a legal partnership relationship. Securities, investment advisory and financial planning services offered through qualified registered representatives of MSI Financial Services, Inc. Member SIPC. Tennessee medical Association and Strategic Financial Partners are not subsidiaries or affiliates of MSI Financial Services, Inc., or its affiliated companies. 795 Ridgle Lake Blvd. Suite 200 Memphis, TN 38120. L0416464109[exp1216][TN].

TARGETED PAIN TREATMENT – REDUCE OPIOIDS, RECLAIM RELIEF



By Stephanie G. Vanterpool, MD, MBA

Marcy couldn't comb her hair. She was a 76-year-old grandma whose right shoulder pain had increased progressively over the last three years, to the point where she couldn't lift her arm to do almost anything above her shoulder. Lifting anything heavier than a glass of water caused excruciating shoulder pain. The pain was worse on the anterior right shoulder and extended down her arm to the mid-bicep.

She had tried acetaminophen, ibuprofen (which caused stomach upset), and was now taking hydrocodone 5/325 BID. Her orthopedic surgeon had done two right shoulder joint injections for her; the first one worked for two weeks, the second one didn't help at all. Physical therapy just made it to where she couldn't move her arm at all for two days afterward. Her shoulder x-ray showed "glenohumeral joint arthritis" ... and she couldn't comb her hair.

TN CHRONIC PAIN DILEMMA

Marcy's shoulder pain presented a challenge that is all too common in healthcare today: How do we decrease opioid use, effectively treat pain, and increase function in our patients? This triad of goals is what I have termed the Tennessee Chronic Pain Dilemma. Although it is not unique to our state, we find ourselves at the forefront of the nationwide crisis surrounding opioids. In the middle of this crisis are our patients with pain, many of whom just want to be able to resume the activities they were able to do prior to developing pain. As their healthcare providers, it is our responsibility to help them achieve these goals, but also to first do no harm.

TARGETED PAIN TREATMENT

Pain is a symptom of an underlying condition - and, as such, it is the underlying condition that should be targeted and treated. Too often, unclear targets or untargeted treatment attempts (opioids in particular) lead to inadequate relief, which leads to dose escalation and can ultimately lead to tolerance, dependence, and addiction. In short, a clear understanding of "cause" is often the missing link between the diagnosis and treatment of pain.

Targeted Pain Treatment (TPT) addresses that missing link. TPT is the process of accurately diagnosing the cause(s) of pain and then targeting the treatment to the cause(s).

As an anesthesiologist who specializes in Targeted Pain Treatment (TPT), I have spent my career trying to help my

patients with chronic pain reclaim relief and functional quality of life. By focusing on identifying the cause of pain as specifically as possible, then targeting the treatment to that cause, many patients can achieve their functional goals, often without the need for, or at least with reduced use of, opioids.

In this article, I will share some of the techniques and tools that I have found particularly useful in accurately diagnosing the cause or causes of each patient's pain, and then targeting the treatment to that cause. In addition to refreshing the reader on the different pain states and mechanisms that must be considered in any TPT model, we will review the keys to a pain-specific history (S.C.R.I.P.T), physical exam, and assessment. Finally, we will review a multimodal treatment algorithm (M.I.P.S.) that helps ensure that all components of the causes of pain and dysfunction are appropriately targeted.

PAIN STATES & MECHANISMS

There are often multiple overlapping causes of pain in the same physical location on a patient. Identifying and understanding the unique combination of pain states and mechanisms that are present in your patient's pain complaint is a key component to accurately diagnosing the cause or causes of the pain.

In their 2016 article "Toward a Mechanism-Based Approach to Pain Diagnosis," Daniel Vardeh and colleagues gave an excellent overview of our current understanding of pain states and mechanisms¹. In short, there are **four pain states** which may exist in isolation or in combination in a given patient presentation (*Table 1*): nociceptive pain, inflammatory pain, neuropathic pain, and centralized or dysfunctional pain.

Vardeh and colleagues also highlighted five pain mechanisms which when identified using clinical diagnostic criteria (*Table 2*), give insight into how the pain is being transmitted, and also to possible targeted treatment options. The five mechanisms identified are nociceptive transduction, peripheral sensitization, ectopic activity, central sensitization, and central disinhibition.

THE PAIN FOCUSED HISTORY – S.C.R.I.P.T.

A thorough history coupled with an understanding of pain states and mechanisms will often reveal the most likely diagnoses even before the initial visit is complete. It is often necessary to have a framework in which to gather and process the history for best

Table 1: Accurate Diagnosis - Pain States*

PAIN STATE	PATHOLOGY	SYMPTOMS
Nociceptive	Evidence of noxious (mechanical, thermal, chemical) insult	Pain localized to area of stimulus/ joint damage
Inflammatory	Evidence of inflammation (sterile or infectious)	Redness, warmth, swelling of affected area
Neuropathic	Evidence of sensory nerve damage	Burning, tingling or shock-like, spontaneous pain; paresthesias, dysesthesias
Dysfunctional/ centralized	Pain in the absence of detectable pathology	No identifiable noxious stimulus, inflammation or neural damage; evidence of increased amplification or reduced inhibition

*Modified from Table 1. in Vardeh D, et.al. *J Pain.* 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review.

Table 2: Accurate Diagnosis – Pain Mechanisms*

GENERAL PAIN MECHANISM	CLINICAL DIAGNOSTIC CRITERIA	EXAMPLE
Nociceptive Transduction	Proportionate pain in response to identifiable noxious stimulus	Mechanical nerve root compression
Peripheral Sensitization	Primary hyperalgesia due to decreased transduction threshold of nociceptor terminal	Cellulitis pain
Ectopic activity	Spontaneous pain in the absence of obvious trigger, relieved by local nerve block	Trigeminal neuralgia
Central sensitization	Secondary hyperalgesia; temporal summation, allodynia	Complex Regional Pain Syndrome (CRPS)
Central disinhibition	Secondary hyperalgesia, allodynia	Fibromyalgia

**Adapted from Table 2. in Vardeh D, et.al. *J Pain.* 2016 Sep;17(9 Suppl):T50-69. doi: 10.1016/j.jpain.2016.03.001. Review.

Table 3: Pain Assessment – History (S.C.R.I.P.T.)

S.C.R.I.P.T.	Information to Gather
<u>S</u> tory	- Circumstances of Onset (acute, trauma, insidious, etc) - Details, Details, Details
<u>C</u> urrent Symptoms	-Pain location -Pain description -ROM -Aggravating Factors -Alleviating factors
<u>R</u> x (Relevant Meds)	-Anti-inflammatories, Muscle relaxers, Nerve pain medication
<u>I</u> nterventions	-Previous injections to the area (what was injected, what type of injection was done?)
<u>P</u> hysical Therapy	-Previous PT, Massage, chiropractic, other
<u>T</u> ests	-Imaging of the affected area, NCS/EMG, etc (if done)

results. In my practice, I developed and utilize the **S.C.R.I.P.T.** history template (*Table 3*) – **S**tory, **C**urrent Symptoms, **R**x (Relevant Medications), **I**nterventions, **P**hysical Therapy, and **T**ests.

The story is often the single most illuminating component of the history. It is in this section that one gathers the details about the circumstances of onset, any unique body positions, activities, injuries or other precipitating factors. The story starts with clarification of the pain location - have the patient show you where his or her worst pain is located. Next, ask questions until you understand the mechanism of injury. My favorite question to ask is “Anything out of the ordinary happen prior to onset?” Ask for details until you can visualize - even reenact - the events surrounding the onset of the pain (MVC, fall, etc.).

Next, make sure you understand the current symptoms. What does the pain feel like? Identify aggravating and alleviating factors, or any associated symptoms or circumstance. This will often give clues to the pain states and mechanisms that are in play. For example, burning or tingling pain signifies neuropathic pain mechanisms, whereas aching or throbbing pain may signify nociceptive or inflammatory pain.

Then move on to understanding the Rx (Relevant Medications) that are currently used or have previously been tried. The efficacy of medications such as anti-inflammatories, muscle relaxers, neuromodulators can all help in identifying the target or cause of pain.

Any previous Interventions to address the pain should also be detailed, and the efficacy noted. For example, has the patient with shoulder pain already had a shoulder injection? If so, did it help, for how long? Just as important is noting when interventions have been tried but have not provided relief.

Previous physical therapy for the complaint should also

be documented, along with duration of therapy, efficacy, and whether there was functional or pain improvement.

Finally, review any available tests that have already been conducted to determine any anatomic or physiologic abnormalities that could be contributing to the patients presenting pain complaint.

ACCURATE DIAGNOSIS – PUTTING IT ALL TOGETHER

Once you have gathered the S.C.R.I.P.T. history, the next step is the physical exam. The goal of the physical examination is to determine what functional limitations are most prominent. Essential components of the pain physical exam include observation of the patient (even before the “official” exam begins), making the patient move (assessing gait, range of motion, etc.), and touching the patient (locations of tenderness, muscle tightness, etc.).

At the completion of the evaluation you will have gathered three important components to elucidate the CAUSE or causes of the pain:

From the History: What pain states and mechanisms are present?

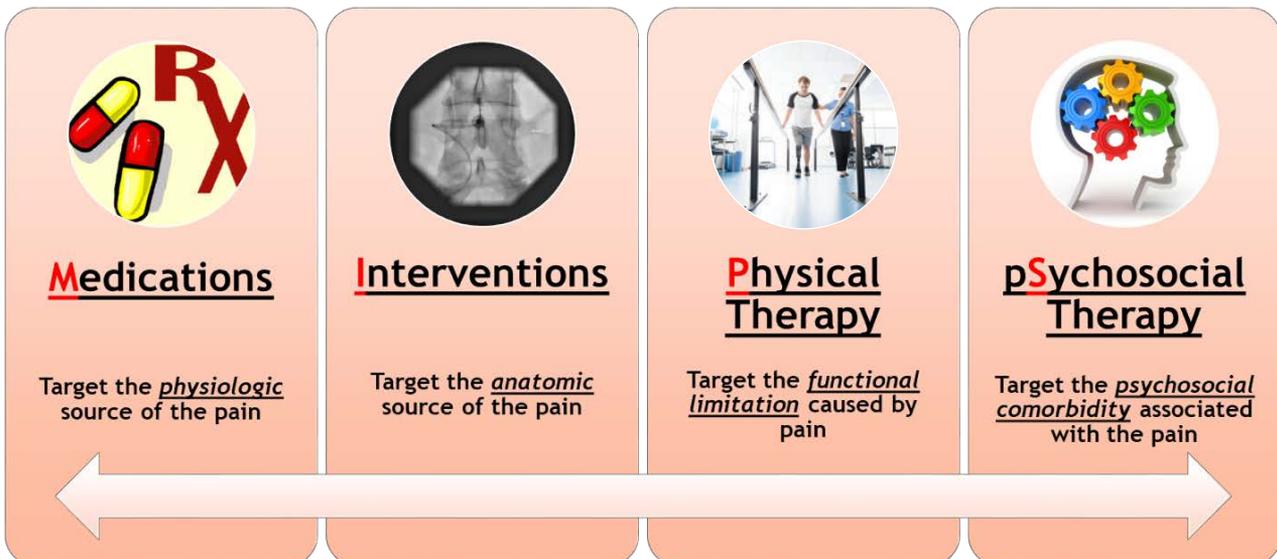
From the Physical Exam: What functional limitations are most prominent?

From the Tests/Studies: What anatomic or neurological pathology is the most likely cause?

Once the accurate cause of pain has been determined, you are now ready to move on to targeting the treatment for the pain.

(continued on page 13)

Figure 1: Target The Treatment – M.I.P.S.

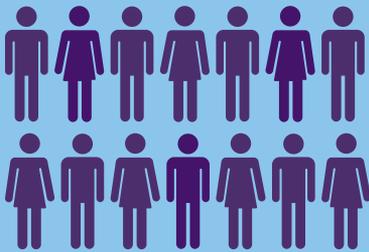


Physicians bring economic health to our communities.

The **2018 AMA Economic Impact Study** demonstrates how physicians contribute mightily to the health of Tennessee's economy.

175,831

JOBS



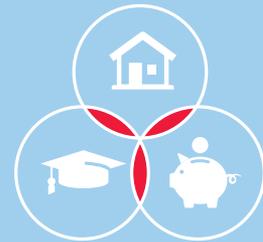
\$29.1 billion

IN ECONOMIC ACTIVITY



\$908.1 million

IN STATE & LOCAL TAX REVENUES



\$13.7 billion

IN WAGES & BENEFITS

Physicians' impact is felt far beyond the exam room, reaching through local communities, producing a network of jobs and spurring local investment.

Learn more at PhysiciansEconomicImpact.org



TARGET THE TREATMENT – M.I.P.S.

To obtain the most successful treatment outcomes, a multimodal approach should be employed³.

The acronym **M.I.P.S.**—**M**edications, **I**nterventions, **P**hysical Therapy, **P**sychosocial Therapy helps to ensure that all components of the pain and functional limitations are appropriately addressed (Figure 1).

Medications – Target the *physiologic source* of the pain – the pain states and mechanisms that have been identified. It is important to note that opioids do not target the physiologic cause of the pain. Therefore, they are not first line options pain treatment, and should almost never be used in isolation². Instead, start with medications that target the identified pain states or mechanisms. **In another article in this issue, Dr. David Edwards reviews the multiple types of targeted, non-opioid medications that can be used in treating the pain.**

Interventions – Target the *anatomic source* of the pain. There are some interventions that can be performed safely and effectively without specialized equipment and training, while others are best performed by specialists. The key to any intervention or series of interventions for pain is that they should be specific, strategic and safe. Specific – meaning targeting the accurate source of the pain (e.g. greater trochanteric bursa vs intra articular hip injection for “hip” pain). Strategic – determine if you should treat the worst pain first, or if multiple sources of pain in the same physical location, do you need to instead start from the “inside” out. Safe – what anatomic, physiologic or pharmacologic factors in this patient are important to consider? What specialized equipment or training is recommended to perform the procedure safely?

Physical Therapy – Targets the *functional limitation* associated with the pain. It is important to note that in the chronic pain population, the first goal of physical therapy should not be to “fix” the problem, but rather to improve the patient’s function, focusing on small, achievable goals. Often, this is as simple as helping the patient focus on transition from sitting to standing or improve gait and balance. As pain is improved with the other treatment modalities (M.I.P.S), then the physical therapy can advance to further improvements in function.

Psychosocial Therapy – Targets the *psychological or psychosocial comorbidity* associated with the pain. While every patient may not need formal psychological services, it is very important to be keenly aware of the interplay between psychological or psychosocial comorbidities and pain perception and coping skills. When necessary, appropriately addressing this component of the patient’s diagnosis will often yield great results in improving function and in improving compliance with other treatments.

TPT IN ACTION

Marcy’s shoulder pain was debilitating. From her S.C.R.I.P.T. history, I narrowed down the cause of her pain to the subacromial bursa on her anterior shoulder. This was confirmed on physical exam. This was primarily an inflammatory pain (pain state) with some nociceptive transduction and peripheral sensitization (pain mechanisms). The fact that the pain was coming from her bursa, not her shoulder joint, also explained why the second shoulder joint injection did not work.

Her M.I.P.S treatment plan consisted of adding topical diclofenac to the shoulder 4x/day to target the inflammation (M), performing a subacromial bursa injection in clinic to target the anatomic source of the pain (I), and then sending her to physical therapy to target the functional limitation and improve range of motion and strength in that shoulder and arm (P). Marcy had good insight and social support, so no formal psychological interventions were required.

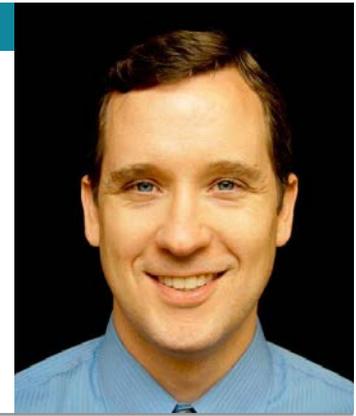
Marcy left my office after her right subacromial bursa injection able to raise her arm above her head without pain. At her follow up six weeks later, she reported continued relief of her shoulder pain and improved strength and range of motion of that arm. She had completely stopped her hydrocodone and was now only using the diclofenac topical gel occasionally if she was very active. She was most happy about the fact that she could now...comb her hair.

TPT - the practice of accurately diagnosing the cause of the pain, then targeting treatment to the cause - enabled Marcy to eliminate the use of opioids and reclaim functional quality of life. By applying the TPT methodology to our patients with pain (eliciting a specific S.C.R.I.P.T. history, doing a thorough exam, and then employing an M.I.P.S. treatment plan), we can work together to address the Tennessee Chronic Pain Dilemma, reduce opioids, effectively treat pain and improve function for our patients. +

REFERENCES:

1. Vardeh D, Mannion RJ, Woolf CJ. Toward a Mechanism-Based Approach to Pain Diagnosis J Pain. 2016 Sep;17(9 Suppl): T50-69. doi: 10.1016/j.jpain.2016.03.001. Review.
2. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65 (RR-1):1-49
3. Roditi D, Robinson ME. The role of psychological interventions in the management of patients with chronic pain. *Psychology research and behavior management*. 2011;4:41-49. doi:10.2147/PRBM.S15375.

NEONATAL OPIATE WITHDRAWAL – A TENNESSEE PERSPECTIVE

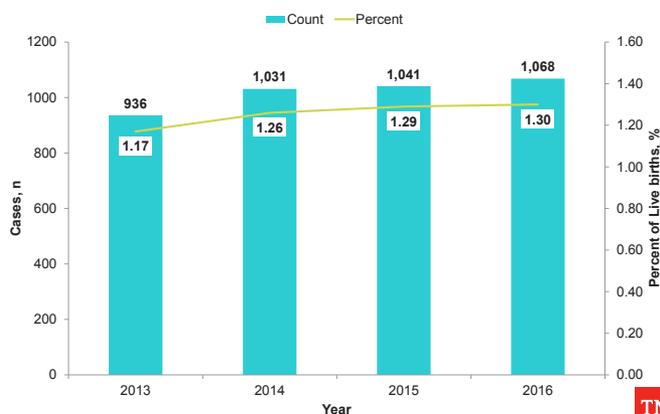


By Jim Batson, MD

In my opinion, watching a newborn experience severe narcotic withdrawal is the most heart-wrenching event in all of medicine. The symptoms include high-pitched screaming, tremors, obsessive scratching, severe diarrhea, excoriating diaper rashes and in extreme cases, seizures. Nothing brings it home more than a visual experience.

When I was in training, neonatal abstinence syndrome (NAS) was quite unusual. In 1999 there were approximately 50 hospitalizations in Tennessee. In 2015, there were more than 1,000.

Annual NAS Surveillance Trends



P-value for trend = 0.08
Source: Neonatal Abstinence Syndrome Surveillance System, Tennessee Department of Health

According to TennCare data, since 2008 the incidence of NAS among enrollees increased from 5.3/1000 to 25/1000 births. More than 3% of babies born in the Upper Cumberland region have a diagnosis of NAS. It is a direct consequence of the exponential rise of opioid addiction and overdoses that plagues our entire country. There are now more overdose deaths in Tennessee per year than those caused by motor vehicle accidents, homicide or suicide. More than 80% of the world's opioid consumption occurs in the United States. How did we get to this point?

Like most complex, ongoing medical crises, the answer is multifactorial. Many experts believe it began with three related trends in the late 1990s. Much of the medical community believed we were undertreating chronic pain and that the risk of addiction was overstated. This led to a concept of pain as the “5th vital sign” that physicians and nurses needed to aggressively

manage. At the same time, several pharmaceutical companies began marketing longer acting versions of narcotics that were supposed to be less addictive. These companies relentlessly pushed their products to be prescribed for any and all types of ongoing pain. In 2007, Purdue Pharma was fined \$600 million after pleading guilty to misleading regulators, doctors and patients about Oxycontin's risk of addiction and abuse. Lastly, many states passed legislation dubbed the “Patient's Bill of Rights.” Tennessee passed a version in 2001 which codified that if a patient requested narcotics for their pain management, the provider either had to prescribe it or refer to someone who did. This opened the door for the rise in the cash-only “pill mills” that continue to plague our communities. The Tennessee legislature unanimously repealed it in 2015 due in part to aggressive lobbying by the Upper Cumberland Medical Society and TMA.

Drug-dependent newborns are a direct result of these trends. In response to the crisis, government and organized medicine have ongoing efforts focused on the overprescribing trend as a whole. There are now many more restrictions on prescribing opiates. Law enforcement has targeted the pill mill industry with some success. The state prescription database makes it much more difficult to shop around for multiple narcotic prescriptions. First responders have become equipped to treat overdoses with naloxone on site. The illicit use of heroin and other synthetic narcotics has skyrocketed in response to these efforts. Some of these synthetics such as carfentanyl are so potent that only a grain or two of the powder is enough to die by overdose.

The short-term health effects of narcotic dependency in newborns are readily apparent. New data from Knoxville shows that NAS babies are at higher risk of significantly smaller head circumference than infants with no fetal exposure to opioids. Not as much is known about the long term health effects, but financially and psychosocially, there is a major impact. The average cost for a normal weight newborn covered by TennCare is about \$4,700, compared to \$44,000 for NAS babies. The risk of DCS placement for NAS babies rises by a factor of 10-15 times. One percent of non-NAS babies spend time in DCS custody as opposed to 15% of NAS newborns. This adds a significant cost and resource burden on an already overworked DCS system. Many of those babies who are not in foster care are raised in an environment with drug dependent family members which can lead to a very chaotic upbringing.

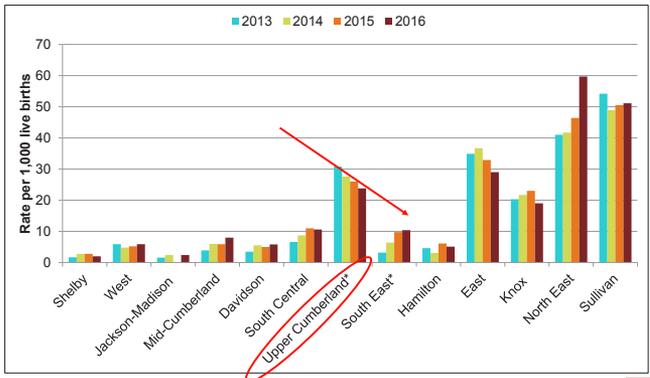
Not much data is available concerning the long-term

physical and psychological effects of constant stimulation of the fetal opioid receptors. However, those born in the early 2000s are now teenagers and I suspect there will be more known in the near future. Pediatric therapists who treat these children have noticed that many have trouble with emotional regulation; their emotions tend to be extreme. A recent Australian study published in the Journal of Pediatrics suggests that a diagnostic code of NAS is strongly associated with poor and deteriorating school performance well through high school. The authors admit that the NAS definition criteria was restrictive and the results should be interpreted cautiously. Many of my colleagues are concerned that teenagers who were exposed to excessive opioids in utero may be more susceptible to addiction if they start to experiment with drugs. This is an area of research that needs further exploration.

Actual treatment of opioid dependent pregnant women is varied. Detoxification during pregnancy has been taboo for decades due to concern for increased risk of fetal demise. This concept is being challenged. An Ob/Gyn in Knoxville has recently had success with an experimental detox program with no evidence of fetal harm in more than 500 pregnancies. ACOG is retreating from the old recommendations and more research is ongoing. Buprenorphine treatment has become a long-term treatment that originally was intended for shorter-term detoxification. It has been shown to reduce the frequency and severity of neonatal withdrawal. Although a safer option than other opioids, when newborns do experience withdrawal, it is usually later onset and for longer duration. Newborns who are at risk are routinely placed on a symptom scoring system after birth and if they meet criteria are usually treated with either oral morphine or methadone.

The apparent inattention to contraception is concerning. Approximately 86% of pregnancies in opioid dependent women are unintended but only 15% aged 15-44 covered by TennCare were on contraception in 2015. The Tennessee Health Department guidelines specifically cover checking for pregnancy and recommending contraception before prescribing long-term opioids to preconception women. The AAP and ACOG both now recommend long acting reversible contraceptives (LARC) as first line, even in adolescents. The simplest short-term solution to the NAS epidemic is incentivizing preconception women to obtain LARCs.

Annual NAS Case Rate Trends, by Region



*Trend is statistically significant.
Source: Neonatal Abstinence Syndrome Surveillance System, Tennessee Department of Health



We also know that a growing percentage (some estimate as much as 70%) of NAS results from the mother’s use of methadone and/or buprenorphine and naloxone. Any physician or healthcare provider who prescribes these drugs can help reduce risk by encouraging patients to obtain LARCs or prescribing other birth control, especially in the first year of treatment.

The Upper Cumberland region has had some statistically significant success in lowering the number of NAS newborns.

The Power of Putnam is a local task force dedicated to anti-drug education and is very active in the region. Putnam County and surrounding jails have incorporated education programs that encourage LARC options to incarcerated women. These are just some of the ongoing efforts by the medical community, law enforcement and concerned citizens groups attempting to reverse the opioid epidemic.

It is not certain what the future holds. There does appear to be some plateauing of the NAS trend over the last three to four years secondary to multiple ongoing efforts. The Tennessee State Attorney General recently explained his plans for pursuing multi-state litigation against the major drug companies and opioid distributors that have been responsible. This may be the new “Big Tobacco” fight. Hopefully, this will lead to an increase in the money and resources necessary for prevention and treatment of opioid dependency that is sorely needed. +



READ US
ONLINE
tnmed.org/tennesseemedicine

WHERE IS TENNESSEE IN THE EPIDEMIC OF OPIOID ABUSE



By David Reagan, MD, PhD

Where Tennessee sits within the national epidemic of abuse and overdose death is an important and pressing question for those of us who practice medicine in Tennessee, and increasingly affects virtually all of us, our extended families, and our communities. We are not doing well. This epidemic began two decades ago and while the resolution will take years to come, our collective actions now will largely determine how many years it takes. We are uniquely positioned to make the greatest difference in the three most critical areas facing us now: preventing unnecessary exposure to opioids, decreasing the dose and duration of exposure when opioids are needed, and recognizing and responding definitively to signs and symptoms of opioid substance use disorder. Medical evidence is widely available to show us exactly what is needed to curtail this epidemic, but our field is particularly challenged to move evidence into consistent practice. An abundance of research shows us that it takes an average of 17 years to do so. With 1,631 Tennesseans dying of drug overdose in 2016, we must do better.

In the late 1990s, an amazingly small amount of unvalidated medical information was wrapped in well-intentioned desire to relieve those suffering from chronic nonmalignant pain. Overconfidence in the shreds of evidence used and an underappreciation for the history of opioid abuse and magnitude of “unknown unknowns” led to a change in medical practice that initially encouraged and then rewarded liberal prescription of opioids aimed at eliminating patient pain. In Tennessee, this resulted in dramatic increases in opioid dispensing and then benzodiazepine dispensing, so that in 2012 a total of 9.2 billion MME of opioids were dispensed. This is the equivalent of treating every man, woman, and child in Tennessee with oxycodone 5mg TID for nine weeks!

Many efforts have been made to curtail the massive quantities of prescribed opioids and there has been success in several areas: The amount of opioids prescribed has decreased by 32% (with the largest decreases in people 20 to 49 years old). The number of pain clinics has decreased by 48% and the quality of care has improved, the number of doctor shoppers has decreased by 63%, and actions against licensure for prescribing or diversion increased by 150%. However, the number of overdose deaths has continued to increase to 1,631 in 2016, which is a 12% increase over the previous year.

Analysis of overdose death data from 2016 showed that most people who died used multiple drugs; slightly more than

half had no controlled substance dispensed in Tennessee in the 60 days prior to death; increase in deaths due to illicit opioids (illicit fentanyl and heroin) accounted for the lion’s share of the increase in overdose deaths; benzodiazepines were present in 35% of overdose deaths; and stimulant use significantly increased in conjunction with opioids.

Additionally, significant new information about the development of long term opioid use in previously opioid naïve patients became available this year. CDC reported that about 10% of persons taking opioids for 5 days will still be taking opioids a year later. Among patients who get two additional prescriptions within that first episode of care, about 30% will still be taking opioids a year later. So, the risk of chronic opioid use begins much earlier than previously thought.

So, what does this mean? While the question sounds simple, it is deceptively complex in the context of an evolving epidemic.

HERE ARE A FEW CONSIDERATIONS:

1. Tennesseans who end up with the medical condition of substance use disorder were almost always accidentally addicted. Most people obtain their first dose of opioid from friends and family (for which the medical profession provided more opioids than needed, so that the medicine cabinet was stocked). The next most common source is direct prescriptions from a clinician. So, medicine bears some responsibility for the two most common ways that Tennesseans begin the fateful journey to addiction. And medicine can change that in far less than 17 years! Specifically, we can strongly encourage patients to empty their medicine cabinets of old controlled substances (there are takeback sites in every county), educate patients about the dangers of sharing controlled substances with friends and family, and as physicians, we have considerable influence in our communities. We can engage with others to take action to make our communities safer places.
2. While non-pharmacologic and opioid-free pain medications are very important (and underutilized) some patients will reasonably need to continue taking opioids chronically. We can reduce their risk of overdose and overdose death by checking the CSMD more frequently, reducing the dose (remember about the opioid hyperalgesic syndrome), avoiding other respiratory depressants (such as the all too frequently prescribed benzodiazepines),

checking UDS and taking action when unexpected results are present, stopping ineffective treatment (do we really still think that more opioids is better?), and prescribing Voluntary Reversible Long Acting Contraceptives when pregnancy is not desired to help prevent neonatal abstinence syndrome.

3. It is also important to realize that the first overdose appears to be the most dangerous overdose. We should prescribe naloxone earlier than most of us have traditionally done. As we know, naloxone works well, when given in an adequate dose and in time.
4. Substance use disorder (SUD) is the life-threatening condition that is most proximately driving the increase in illicit drug use, overdoses, and overdose deaths in Tennessee. Medically, SUD is an illness of the brain, rooted in an imbalance in neurotransmitters that ultimately affect the activity of the neurotransmitter dopamine. Dopamine helps reinforce behavior to obtain something pleasurable or reinforce behavior to avoid something painful or stressful. In essence, the neurologic changes that accompany exposure to excess

dopamine result in hijacking normal learning processes to reinforce their own acquisition, leading to the multiple self-harming actions so characteristic of addiction. What can we do? We can tirelessly destigmatize SUD, starting in our own practices. We can work to help our patients overcome the hurdles to finding SUD treatment, which is more available than any time in the last seven years. And we can help our patients stop blaming themselves for compulsive behavior when they need treatment. Their road is hard enough without self-denunciation.

In closing, thank you for reading to the end of this piece. Your actions as a clinician are essential to preventing opioid naïve patients from beginning the dangerous journey, preventing patients who need opioids from nonetheless experiencing the pain of addiction, and diagnosing SUD and assisting patients to start the path to recovery. Let's not let this take 17 years to make these changes. Let's do it now! +

David Reagan, MD, PhD is Chief Medical Officer for the Tennessee Department of Health



CDC GUIDELINES FOR CHRONIC PAIN

CDC's Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

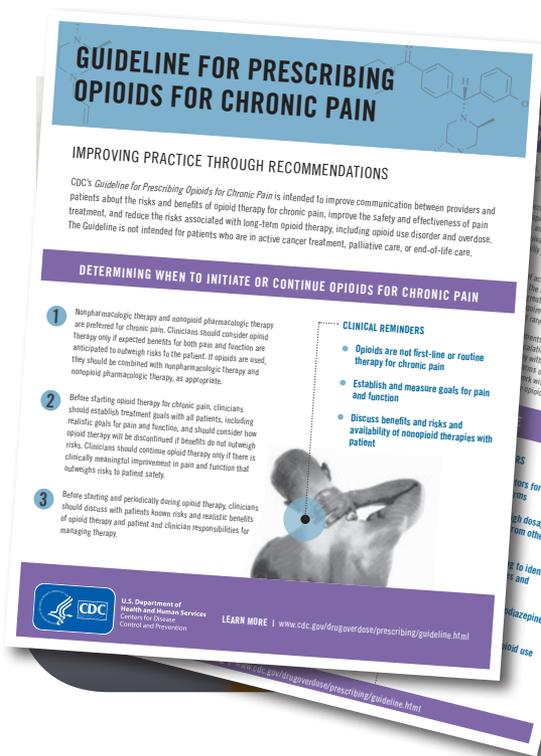
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose, and death. Nearly 2 million Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014.

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- An estimated 1 out of 5 patients with non-cancer pain or pain-related diagnoses are prescribed opioids
- Since 1999, sales of prescription opioids in the U.S. have quadrupled
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids



LEARN MORE

www.cdc.gov/drugoverdose/prescribing/guideline.html

We've got a mortgage
that fits you.



Ask us about our low mortgage rates.

TMA Members and their employees are eligible to receive a \$500.00 discount off closing costs on a home mortgage.

Keith Collison, Managing Director
Finworth Mortgage
keith.collison@finworth.com ♦ 615.345.9905
NMLS #174913



Subject to credit & other restrictions





Already have health insurance?

Tennessee Drug Card can still help! Thanks to the program's unique "**OPEN FORMULARY**" and **LOWEST PRICE LOGIC**, you're guaranteed to get the best deal on your prescriptions, often beating the negotiated rates through your health insurance. Best of all, the card is **FREE TO USE!**

Sample Pricing!

		RETAIL PRICE	DISCOUNTED PRICE	% OFF
Xopenex 0.2mg/1ml	1qty	\$261.99	\$15.81	94%
Fluoxetine 20mg TAB (Prozac generic)	30qty	\$21.39	\$9.69	55%
Lipitor 40mg TAB	30qty	\$400.00	\$322.46	19%
Captopril 25mg TAB	30qty	\$29.09	\$24.65	15%

*Discounted prices were obtained from Walgreens pharmacy in January 2016. Prices vary by pharmacy and region and are subject to change.

Pharmacy Coupon Prescription

Coupon MBR ID: Enter Year & Time
(Example: Year 2016; Time 9:14; Enter ID 2016914)
 RxGRP: TNRX
 RxBIN: 610709



This coupon has no expiration date and is reusable on Brand and Generic Rx's. Savings can be as high as 75%.

PATIENT INSTRUCTIONS: This card/coupon is pre-activated and can be used immediately. Present this card/coupon to any participating pharmacy to receive a discount on prescription medications.

PHARMACIST INSTRUCTIONS: Submit as a primary claim (cannot be processed as secondary) using the following pharmacy processing information. For processing questions and comments please call the Pharmacy Helpline below.

Customer Service: 877-321-6755 Pharmacy Helpline: 800-223-2146



This program is not insurance. This is a point-of-sale discount plan.



TENNESSEE DRUG CARD
WWW.TENNESSEEDRUGCARD.COM

compliments of:



For more information or to order free hard cards, please contact:

Natalie Meyer

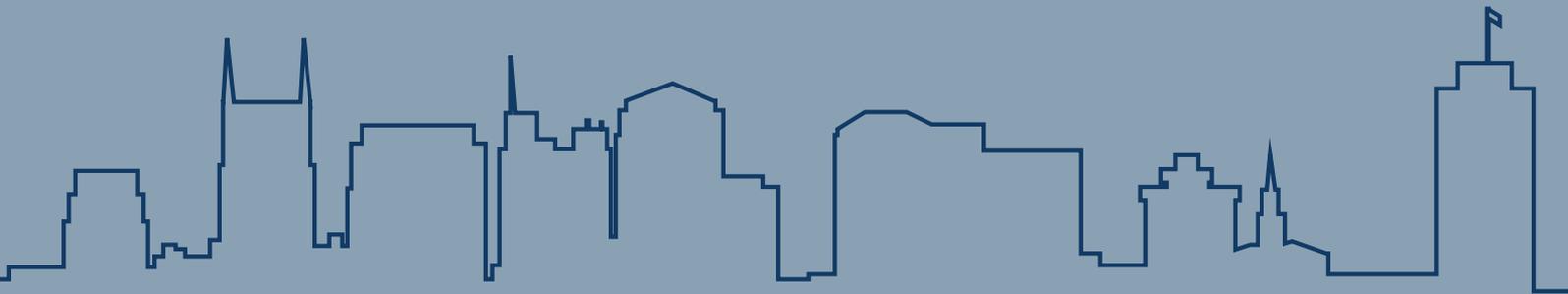
1-888-987-0668 • natalie@tennesseedrugcard.com





HEALTHCARE EDUCATION SUMMIT

SEPTEMBER 14-15, 2018
NASHVILLE | MUSIC CITY CENTER



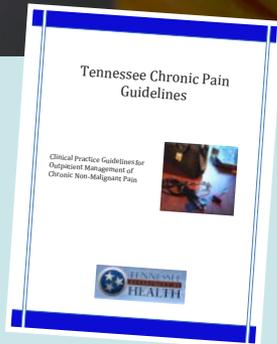
Tennessee's Premiere Medical Education Weekend of the Year

Fighting the Opioid Epidemic
Tennessee's Number One Public Health Crisis



MORE INFORMATION AT trimedtn.com

TENNESSEE CLINICAL PRACTICE GUIDELINES FOR OUTPATIENT MANAGEMENT OF CHRONIC, NON-MALIGNANT PAIN



*Following is an excerpt from the *Tennessee Chronic Pain Guidelines*, which can be accessed on the Tennessee Department of Health Website. https://www.tn.gov/content/dam/tn/health/documents/Chronic_Pain_Guidelines_2016.pdf

The purpose of these guidelines is to define appropriate treatment of chronic pain, a common and often serious condition. We want to foster timely and appropriate treatment for pain, which improves both the ability to function and quality of life. These guidelines are intended to be used to support clinicians in their treatment of patients with chronic pain with particular reference to the prescribing of opioid medications. We want to avoid addiction and adverse outcomes. Optimal treatment of chronic pain, defined as pain lasting longer than 90 days, is an interdisciplinary process that includes many interventions which do not always involve opioid pain medications.

The method used to formulate these guidelines included a review of national expert panel recommendations and state practice guidelines, multiple listening sessions with clinicians in Tennessee, oversight by a multidisciplinary steering committee and recommendations from an advisory committee with strong representation by clinicians with specialty training in pain medicine. Draft clinical guidelines were also circulated to a broader group of professional associations within Tennessee, including but not limited to mental health and substance abuse and workers' compensation programs.

The long term goals of appropriate pain management are to improve symptoms, function and overall quality of life while minimizing adverse effects, addiction, overdose deaths and NAS. These guidelines can help providers reduce problems associated with prescription opiates while maintaining access to compassionate care and appropriate medications for patients living with chronic pain. These guidelines are organized into three sections and appendices contain additional tools and guidance.

I. PRIOR TO INITIATING OPIOID THERAPY FOR CHRONIC NON-MALIGNANT PAIN

A. Key Principles Prior to Initiating Opioid Therapy

1. A patient having been prescribed opioids by a previous provider is not, in and of itself, a reason to continue opioids.
2. Reasonable non-opioid treatments should be tried before opioids are initiated. Opioids should be initiated only after other reasonable, appropriate and available treatments for the pain condition have been considered.
3. All newly pregnant women should have a urine drug test administered by the appropriate women's health provider.
4. The provider should discuss a birth control plan to prevent unintended pregnancy with every woman of child-bearing age who has reproductive capacity when opioids are initiated.
5. The patient's medical history, physical examination, laboratory tests, imaging results, electro-physiologic testing, and other elements supporting the plan of care, should be documented in the medical record prior to initiating opioid therapy.
6. Chronic pain shall not be treated by the use of controlled substances through telemedicine.

B. Initial Evaluation: Steps Prior to Initiating Trial of Opioid Therapy

1. A specific evaluation and history of the patient's pain condition should be obtained. The examination should include the nature and intensity of the pain, past and current treatments for pain, any co-occurring disorders and the effect of the pain on the patient's life functioning,

including but not limited to work, relationships, recreation and sleep.

2. The presence of important co-morbid medical conditions should be assessed and considered when deciding whether to initiate opioids. This includes age of the patient and medical conditions such as chronic obstructive pulmonary disease, sleep apnea, diabetes or congestive heart failure.
3. An initial, condition-appropriate physical examination of the patient should be conducted. A systems review shall be conducted as well.
4. The possible presence of co-occurring mental health disorders should be considered when deciding whether to initiate a trial of opioids. Screening should occur for disorders such as depression, anxiety and current or past substance abuse and, if present, these should be addressed in the creation of a treatment plan (See Mental Health Appendix).
5. A review of prior records directly related to the patient's chronic pain condition is encouraged before opioids are prescribed.
6. Women of child-bearing age who have reproductive capacity should be asked about the possibility of pregnancy at each visit. For women who wish to avoid unintended pregnancy, use of long-acting reversible contraceptives should be discussed, or referral to appropriate high-risk obstetrician made (See Women of Child Bearing Age Appendix and Pregnant Women Appendix).

C. Establishing a Diagnosis

There shall be the establishment of a current diagnosis that justifies a need for opioid medications.

D. Assessment of Risk for Abuse

1. The prescriber shall assess the patient's risk for misuse, abuse, diversion and addiction using a validated risk assessment tool prior to initiating opioid therapy. (See Risk Assessment Tools Appendix)
2. The prescriber should obtain a Urine Drug Test (UDT) (or a comparable test on oral fluids) prior to initiating opioid therapy. (See Urine Drug Testing Appendix)
3. Based on the combined information of the validated risk assessment results, the Controlled Substances Monitoring Database (CSMD) results and the UDT results and past records, an initial assessment should be made about a patient's risk of misuse, abuse or diversion of medications. The prescribing of opioids, if medically indicated, shall take this risk assessment information into account in the prescribing of opioids and the patient's treatment plan. (See CSMD Appendix)

E. Goals for Treatment

1. The primary goal of treatment should be clinically significant improvement in function.
2. A treatment plan should be developed at the onset of treatment and is expected to include other treatments or modalities beyond opioids, both non-pharmacological and pharmacological. The provider should make

reasonable attempts to implement this treatment plan, allowing for barriers such as finances, accessibility and resource distribution.

3. Treatment Plans should establish treatment goals with all patients, including realistic goals for pain and function. One widely used assessment is the 3- item PEG Assessment Scale:
 - a. Pain average
 - b. Interference with Enjoyment of life
 - c. Interference with General Activity
4. The patient should be counseled that the goal of chronic opioid therapy is to increase function and reduce pain, not to eliminate pain. Documentation of this discussion shall be included in the medical record.

II. INITIATING OPIOID THERAPY FOR CHRONIC, NON-MALIGNANT PAIN

A. Key Principles When Considering Prescribing Opioids.

1. National data suggests risk of overdose death starts at 40 MEDD in opioid naive patients with the greatest risk in the population is in the first two weeks of treatment. The risk of overdose for all patient populations increases tenfold at 100 MEDD. Tennessee data suggests the tenfold risk may start closer to 81MEDD.
2. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days in some instances is appropriate and shall be documented in the medical record.
3. When starting opioid therapy as a primary care provider for chronic pain, clinicians should generally prescribe immediate-release opioids instead of extended-release or long acting opioids. Some deviations are expected and the reason should be documented.
4. Any product containing buprenorphine, whether with or without naloxone, may only be prescribed for a use recognized by the federal food and drug administration. Unless there is a documented diagnosis of opiate addiction in medical record, the patient received treatment from a provider practicing under a 21 U.S.C. § 823(g)(2) and who is counted toward the total of number of patients set forth in that statute.
5. Benzodiazepines should be generally avoided in combination with chronic opioid therapy. When the opioid dose reaches 120mg MEDD and the benzodiazepines are being used for mental health purposes, the provider shall refer to a mental health professional to assess necessity of benzodiazepine medication.
6. Buprenorphine/naloxone combinations shall be avoided for the treatment of chronic pain.
7. Should treatment deviate from recommended guidelines, the reasons shall be documented in the medical record.

B. Upon Initiating Opioid Therapy

1. The initiation of opioids should be presented to the patient as a therapeutic trial.
2. When initiating opioid therapy, the lowest dose of opioids should be given to an opioid naïve patient and then titrated to effect.
3. Informed consent for the use of opioids in treating pain must be obtained prior to initiating treatment. Informed consent documents typically cover: potential risks and anticipated benefits of opioid therapy, potential side effects, likelihood of physical dependence, risk of over-sedation, pregnancy, risk of impaired motor skills, risk of addiction and death. (See Sample Informed Consent Appendix)
4. A written treatment agreement should be used with the patient at the time opioids are first prescribed for chronic pain. Treatment agreements typically cover reasons, for which opioids may be discontinued, the practice policy on early refills, policy on lost prescriptions or medications, expectation for safe storage of medications, use of one pharmacy and expectations about periodic drug testing. The treatment agreement shall include an expectation that a female patient will tell the provider if she wishes to avoid unintended pregnancy and if she becomes pregnant
5. As these new guidelines are implemented, practitioners may provide a bridge of opioids for up to six months while the assessment process is carried out. During this time a patient may be continued on a trial of opioids without a fully completed assessment. No provider is obligated to continue opioid therapy that has been initiated by another provider. If the initial evaluation of the patient does not support the need for opioids, a discussion about risks and possible treatment of withdrawal shall be included in the documentation of clinical reasoning for opioid cessation.
6. Providers must continually monitor the patient for signs of abuse, misuse or diversion. An unannounced UDT (or a comparable oral fluids test) should be done twice a year at a minimum.

C. Women's Health

1. The provider should discuss a method to prevent unintended pregnancy with every woman of child-bearing age who has reproductive capacity before opioids are initiated.
2. The practitioner should obtain a signature indicating that any woman who wishes to become or is at risk to become pregnant has been educated about the risks and benefits of opioid treatment during her pregnancy.
3. Women of child-bearing age who have reproductive capacity shall undergo a pregnancy test prior to the initiation of opioids.
4. Women of child-bearing age who have reproductive capacity should be asked about the possibility of pregnancy at each visit. For women who wish to avoid unintended pregnancy, use of long acting reversible contraceptives should be discussed, or referral to appropriate high risk obstetrician made. (See Women of Child Bearing Age Appendix and Pregnant Women Appendix)

III. ONGOING OPIOID THERAPY FOR CHRONIC NON-MALIGNANT PAIN

A. Key Principles

1. All chronic opioid therapy should be handled by a single provider or practice and all prescriptions should be filled in a single pharmacy, unless the provider is informed and agrees that the patient can go to another pharmacy for a specific reason.
2. Opioids should be used at the lowest effective dose.
3. A provider should not use more than one short-acting opiate concurrently. If a provider deems it necessary to do so then the medical reasons shall be clearly documented.

Documentation of the discussion of the five A's (analgesia, activities of daily living, adverse side effects, aberrant drug-taking behaviors and affect) at initiation of chronic opioid therapy and at follow up visits shall be included in the medical record.

B. Ongoing Therapy

1. Patients on opioid doses of 120mg MEDD or greater should be referred to a pain specialist for a consultation and/or management. If a provider cannot make the required consultation as outlined above, then he/she shall clearly document why not.
2. Clinicians should review the patient's history of controlled substance prescriptions using the Controlled Substance Monitoring Database (CSMD) data to determine whether the patients receiving opioid dosages or potentially dangerous combinations
3. Providers must continually monitor the patient for signs of abuse, misuse or diversion. A UDT (or a comparable oral fluids screen or test) should be done twice a year at a minimum. (See Urine Drug Testing Appendices)
4. Based on the combined information of patient behavior, collateral information, the CSMD results, the UDT (or Oral Fluids Test) results and past records, an ongoing risk assessment should be made about a patient's risk of misuse, abuse or diversion of medications. The prescribing of opioids, if medically indicated, shall take this risk assessment information into account on an ongoing basis. Adjustments to the patient's treatment should occur in a timely manner based on this information. Inconsistent results from the treatment plan should be addressed immediately and documented action taken as appropriate.
5. Emergency department physicians should keep the specialist and the primary care provider informed about changes in a patient's condition and any emergent incidents or conditions.
6. Opioids are to be discontinued when the risks, side effects, lack of efficacy or presence of medication or aberrant behavior outweigh the benefits. Opioids sometimes have to be discontinued due to financial or third-party coverage issues. A taper of opioids may or may not be indicated,

(continued on page 27)

depending on the clinical situation. (see Tapering Protocol Appendix)

7. Appropriate documentation of CSMD query should be included in the medical record. (see CSMD Appendix)
8. Clinicians should offer or arrange evidence based treatment for patients with substance use disorder. Referral to an Addiction Specialist may be appropriate in some cases.

C. Women's Health

1. The provider should discuss a method to prevent unintended pregnancy with every woman of child-bearing age who has reproductive capacity when opioids are initiated. (See Women of Child Bearing Age Appendix and Pregnant Women Appendix).

2. The provider shall advise every woman of child-bearing potential on opioids that she be on a method to prevent unintended pregnancy specifically considering long acting contraceptive methods.
3. The treatment agreement shall include an expectation that a female patient will tell the provider if she becomes pregnant or plans to become pregnant.
4. If she plans to become or becomes pregnant she shall be referred to an obstetrician.
5. When a UDT is performed, results must be documented in the medical record. +

LEARN MORE

https://www.tn.gov/content/dam/tn/health/documents/Chronic_Pain_Guidelines_2016.pdf

**ePrescribing
as efficient
as you are.**



Tennessee Prescribers,

DxScript[®]/+ EPCS is the most secure, easy-to-use and customizable eRx solution on the market. It is HIPAA compliant, cloud based and iPhone and Android compatible. DxScript integrates with third party EHR / Practice Management systems and it also works as a stand-alone module.

Our platform is certified by the EHNAC for EPCS as per DEA rule (75 FR 16236, March 31, 2010) [docket no. DEA-218, RIN 1117-AA61] in accordance with the Tennessee Chronic Pain Guidelines.

For more information visit
www.dx-web.com or
call us at 212-967-1944.



Most physicians enter the profession with a singular motivation: to help others.

Physicians must prove their commitment to that ideal by withstanding years of training and work demands that test their resolve at every turn. And while our medical system often reveals their personal strengths, it also can expose the fragile nature of their humanity.



*I have
learned ...*

“ I have learned it is all right for doctors to ask for help, for we are human beings also - sometimes faulty ones, but still humans.”

- R.B., M.D.



Dr. Michael Baron, Medical Director

5141 Virginia Way, Suite 110 • Brentwood, TN 37027 • (615) 467-6411 • e-tmf.org

TMA CONTINUES LEADING ROLE IN FIGHTING OPIOID EPIDEMIC

TMA has worked for years to turn back the dial on what we initially thought were safe drugs. The state's largest professional organization for doctors has partnered with other stakeholders to promote more effective prescriber education and implement effective public policies to curb the initial opioid supply and help prevent misuse and abuse.

LEGISLATION

TMA was the catalyst to changing the prescribing educational requirements for Tennessee physicians and has led the way on important public policies and other initiatives.

- Creating and distributing Tennessee's opioid prescribing guidelines
- Supporting the Controlled Substance Monitoring Database
- Lobbying for passage of the Safe Harbor Act in 2013 and important changes to subsequent legislation that addressed Neonatal Abstinence Syndrome
- Aiding passage of the original state law requiring pain clinic registration
- Supporting the Addison Sharp act requiring pain clinic guidelines and mandatory CME by prescribers of opioids
- Working to pass legislation to require specialty training for pain clinic medical directors and eliminate dispensing in pain clinics.
- Improving and strengthening physician oversight rules for more collaborative, integrated team-based healthcare delivery

In 2017, TMA successfully defeated two bills that would have negatively impacted pain clinics and pain management physicians. The bills—a product of House Speaker Beth Harwell's opioid task force—would have raised existing tort reform cap limits when a provider is required to be licensed as a pain management clinic, and required referrals to pain management clinics to come only from emergency physicians or primary care physicians. TMA watched for legislation based on those recommendations and worked quickly to make sure the damaging legislation did not go forward.

TMA members served on the physician committee to develop new opioid prescribing guidelines approved by the state licensing boards, and have been instrumental in the development, implementation and improvement of Tennessee's Controlled Substance Monitoring Database. TMA, along with the Tennessee Pharmacists Association, helped pass the original law implementing the CSMD and was the first state medical society in the U.S. to support mandated controlled substance database lookups by prescribers.

EDUCATION

TMA has trained more than 5,000 prescribers in Tennessee in the past five years through its live and online prescription safety

Physicians' and Patients' Strongest Advocate in Nashville

On January 22, 2018, Governor Bill Haslam announced his "TN Together" plan for addressing the state's opioid abuse epidemic with a three-pronged strategy for prevention, treatment and law enforcement. TMA President Dr. Nita Shumaker released a statement in initial reaction to the plan, but important details were unavailable until the following week, when the Haslam administration filed a draft bill that would put new mandates on prescribing, dispensing and reporting of opioids.

Scores of physicians contacted TMA in the ensuing days to express concerns over specific aspects of the proposed law and the practical implications for doctors and patients. The Board of Trustees held an emergency conference call to discuss the bill language, review input from members and other healthcare stakeholders, and issued a public statement outlining TMA's concerns and proposed solutions.

At the time of publication of this special edition of *Tennessee Medicine*, TMA was engaged with legislators to advocate for important changes and ensure physicians continue to have a leading voice in this public health crisis. TMA's primary focus remains educating healthcare providers and reducing initial supply, where physicians have direct influence on patient safety and quality of care.

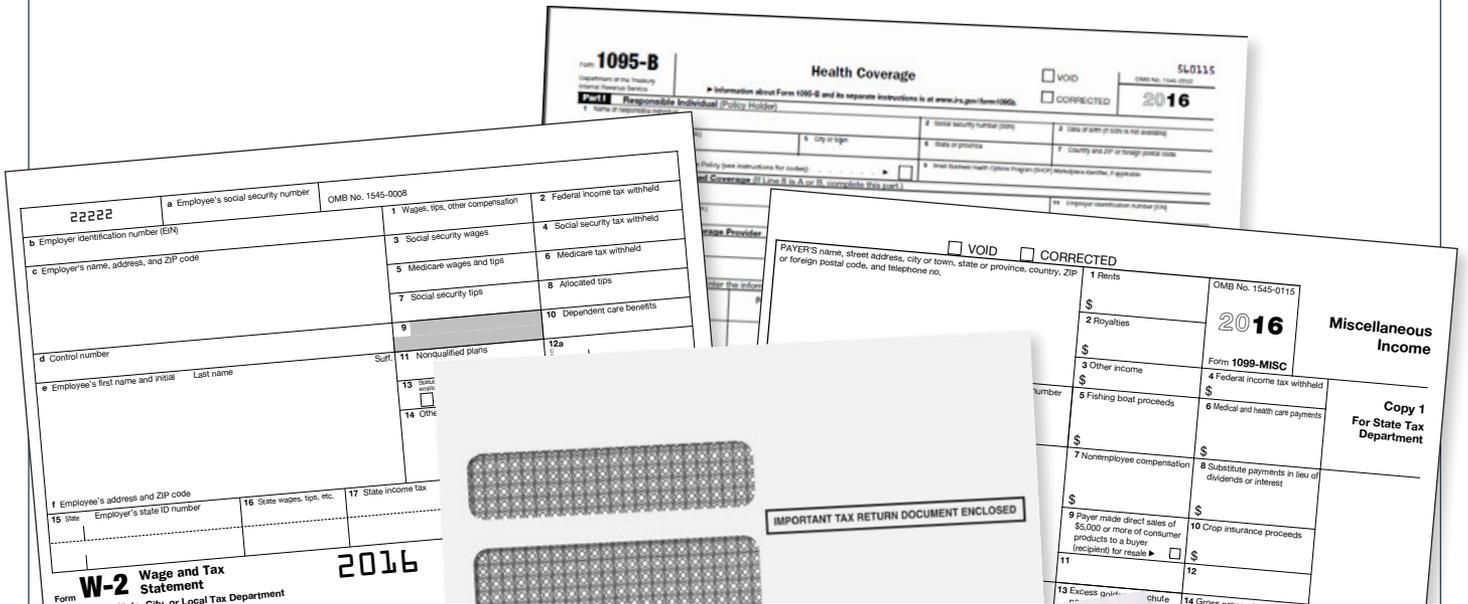
education courses. As the opioid epidemic continues, TMA is committed to providing continuing education for physicians on diagnosis-based screening and treatment protocols and educating patients about the dangers of opioids, including proper storage and disposal. Appropriate patient education is key to prevention and those conversations most often take place between the physician and patient.

We will continue to help promote Take Back programs and other efforts to corral unused and unwanted drugs. The "Prescription for Success" report indicates that 71% of addicts obtain drugs from a friend or relative. During the "National Takeback Day" on Oct. 28, 2017, Tennessee hosted more than 130 collection sites that collected nearly 30,000 pounds of drugs in total.

In November, TMA provided CME credit for the Department of Health's "Turning the Tide: Collaborating to Prevent Opioid Abuse" conference in Nashville. Several TMA physician members attended the summit, collaborating with other healthcare professionals to identify interventions, improve quality of care and patient safety for pain treatment. +

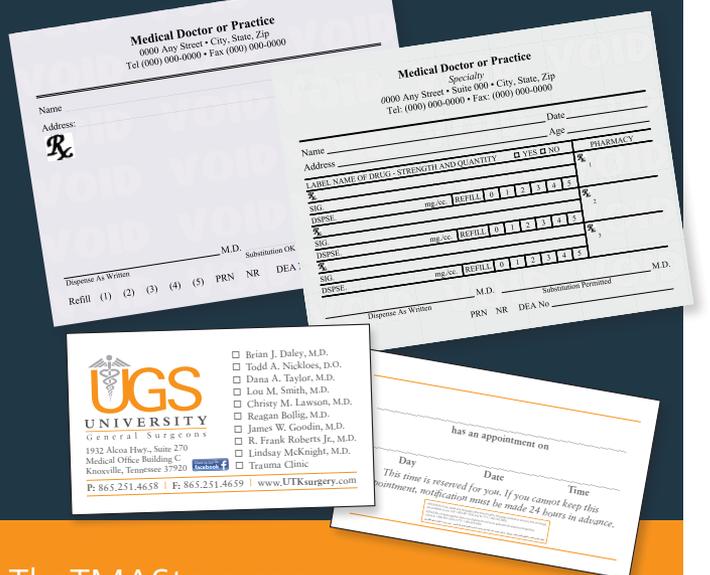


We have the right W-2, 1099 & 1095 options for your practice



ALL THE PRODUCTS YOU NEED

- Software compatible forms
- Blank or preprinted forms
- Compatible envelopes
- Kits with everything you need
- Pressure seal forms
- Tamper resistant prescription pads and paper
- Appointment cards



FOR MORE INFORMATION
OR TO ORDER ONLINE:

ONLINE: TheTMAStore.com
TOLL FREE: 800-800-5876
EMAIL: twopointinc@rjyoung.com

We lean on Lucy!



“The board and I rely on Lucy to take care of all things financial. Accurate, prompt and caring, Lucy knows the healthcare profession.”

Rebecca Leslie, Executive Director
Nashville Academy of Medicine



Lucy
Carter, CPA

Rebecca
Leslie

Need a trusted advisor you can lean on?
Call KraftCPAs! 615-242-7351 • www.kraftcpas.com



Many of the advertisers in this Journal are longstanding patrons of our monthly publication. Don't take them for granted. Read their advertisements, and when you patronize their products and/or services, be sure to tell them you saw their ad in *Tennessee Medicine*.

INSTRUCTIONS FOR AUTHORS

Manuscript Preparation – Electronic manuscripts should be submitted to the Editor, David G. Gerkin, MD, via email at communications@tnmed.org. A cover letter should identify one author as correspondent and should include his/her complete address, phone, and e-mail. Manuscripts, as well as legends, tables, and references, must be typed, double-spaced on 8-1/2 x 11 in. white paper/Word document. Pages should be numbered. The transmittal letter should identify the format used. If there are photos, e-mail them separately in TIF, JPG or PDF format along with the article; photos and illustrations must be high resolution files, at least 300 dpi.

Responsibility – The author is responsible for all statements made in his work. Accepted manuscripts become the permanent property of *Tennessee Medicine*.

Copyright – Authors submitting manuscripts or other material for publication, as a condition of acceptance, shall execute a conveyance transferring copyright ownership of such material to *Tennessee Medicine*. No contribution will be published unless such a conveyance is made.

References – References should be limited to 15 for all papers. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of first three authors (last name first initial[s] with no commas or periods) followed by et al., complete title of article cited, name of journal abbreviated according to Index Medicus, volume number, first and last pages, and year of publication. Example: Olsen JH, Boice JE, Seersholm N, et al.: Cancer in parents of children with cancer. *N Engl J Med* 333:1594-1599, 1995.

Illustrated Material – Illustrations should accompany the emailed article in a JPG, TIF, JPG or PDF format; files must be high resolution, at least 300 dpi. Photos must be identified with the author's name, the figure number, and the word "top," and must be accompanied by descriptive legends typed at the end of the paper. Tables should be typed on separate sheets, be numbered, and have adequately descriptive titles. Each illustration and table must be cited in numerically consecutive order in the text. Materials taken from other sources must be accompanied by a written statement from both the author and publisher giving *Tennessee Medicine* permission to reproduce them. Photos of identifiable patients should be accompanied by a signed release.

Consideration – Please be aware that due to the volume of submissions, article consideration by the Editor and/or Editorial Board may take three months or more.

Publication – Publication of accepted submissions could take up to a year or more; TMA Members enjoy an expedited publication benefit that could reduce the wait time by up to several months. All articles and abstracts will be published in an online forum and open for peer review on our website, and online database for journals, articles, and resources available to TMA members only.

ADVERTISERS IN THIS ISSUE

TMA Medical Banking.....	2
Haslam College of Business.....	4
TMA Insurance.....	6
Strategic Financial Partners.....	8
Finworth Mortgage	20
Tennessee Drug Card.....	21
Tennessee Medical Foundation.....	27
RJ Young.....	29
Kraft CPAs	30
TMA Insurance.....	31
SVMIC.....	32



INSURANCE FOR YOUR PRACTICE? WE'VE GOT YOU COVERED!

Not only do we have you covered with a full line of insurance plans to help protect your practice, but also by working hard to ensure that you have the right plan design, at the best price available, with the carrier that is right for you. And, we've been doing so for over 30 years! Following are just some of the plans we offer:

- Building and/or Office Contents
- Workers' Compensation
- Cyber-Network Security-Data Breach
- RAC Audit Coverage
- Directors and Officers - EPLI
- Commercial Auto & Umbrella

For more information or a quote, contact us.



THE EXCLUSIVE INSURANCE
PLAN ADMINISTRATOR FOR THE
TENNESSEE MEDICAL ASSOCIATION

800.347.1109 • TMA@assoc-admin.com • TMAinsurance.com



SVMICTM
Mutual Interests. Mutually Insured.

Medical Professional Liability Insurance

Now in our fifth decade of insuring physicians, we continue to proudly protect, support and advocate for you.

- Claims handling expertise
- Highly acclaimed policyholder service
- Patient safety education
- Risk evaluation services
- Practice management consulting

SVMIC.com

800.342.2239

ContactSVMIC@SVMIC.com