

# Healthcare Provider Panel

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**Katherine Steuer (“KS”):** Thank you very much. Our panel is focusing on, in significant part, the cycle of addiction and the interventions that may or may not be sufficient from the provider and payer perspective. I first would like each of our panelists to please introduce themselves, give us some background about their work, and how it is affected by the opioid crisis that we are here to discuss today.

**Dakasha Winton (“DW”):** My name is Dakasha Winton, and I am the Chief Government Relations Officer at BlueCross BlueShield of Tennessee. So, when you think about government affairs, you don’t tend to think about how you’re interacting with the opioid crisis. Just to kind of give you some insight, last year, over 600 bills were filed in various legislatures to try to address the opioid crisis. There are constant actions in Congress to try to address the opioid crisis.

At BlueCross BlueShield of Tennessee, on behalf of our 3.4 million members, we paid for about \$18 billion worth of prescription

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drugs last year. That is a phenomenal number. The first thing that we do is determine whether or not something is safe, and then we look at the cost, which is what most people expect for the insurance company to do. How the opioid crisis has impacted our costs is that they've made them rise very significantly. We look at, in a very holistic way, how, as a health plan, we can try to address that crisis. So that's what we do.

**Cassandra Howard (“CH”):** Good morning. I'm Dr., or Colonel, Cassandra Howard. I was an ER doctor at Methodist Germantown for about 15 years. We currently see a population of about 60,000 visits per year. As you know from this symposium and the media, an increasing number of those patients are patients with drug addictions. We treat a lot of overdoses—unfortunately, a lot of return customers, not the best way to rack up frequent flyer miles. But it has impacted our business. It impacts the care we provide to other emergent conditions or patients presenting. Part of our discussion today will kind of give you some insight into my perspective as the provider looking out at the epidemic as I interface with my pre-hospital providers—the EMS, paramedics—that are on the scene treating patients. I will also address how the epidemic affects our ability at the hospital—ER level and in-patient level—how we care for these patients and ultimately get them definitive care and the limitations associated with doing so.

**Shawn Hamm (“SH”):** My name is Shawn Hamm. I finished my residency in family medicine and did a fellowship in addiction medicine. Now I'm happy enough to be a professor at the University of Tennessee, teaching other fellows how to specialize in addiction medicine. At the university, we're involved in the clinical aspects, research. We're also involved in community outreach, as well as prevention. As you can imagine, especially in my clinic—

Let me back up. In addiction medicine, it's more than just the opioid crisis, right? So we see a lot of other addictions as well. But a majority of them right now are people suffering from opioid use disorder. I don't know if you want me to kind of talk a little bit about addiction first. Define it a little bit. So there are lots of different definitions, some of them are longer than others. I usually like to think about it as doing something despite adverse consequences. Keep in

mind, there are behavioral addictions, too, gambling and stuff. But for purposes of this, we're just going to talk substance use.

It's also important to remember that addiction is a chronic relapsing disorder or disease. It is something that is not short-term, so it's compared a lot to diabetes, and I think that kind of analogy fits really well. Somebody who's diagnosed with diabetes, we treat with medication, lifestyle modifications, diet, exercise, education. Addiction is the same way, especially when we're talking about the opioid use disorder. When you're talking about that, it's about using a substance, this compulsion to use a substance, in this case opioids, and then a lack of control on the limit of that substance. Ok? They can't stop using it. And then when they're not using it there's a—it's associated with negative emotions and stress, which kind of also drives more use.

I will have to a little bit talk about one of the main neurotransmitters involved in all addictions, dopamine. That is in our brains. It's there for reward. Everything we do: when you're hungry, you need something to eat, and you finally eat, you get a little hit of dopamine. When you're thirsty, and you finally get something to drink, you get a little hit of dopamine. It rewards us for good and normal behaviors that are necessary for survival. Opioids, in particular, they end up releasing, they're very efficient in releasing, high amounts of dopamine. Higher than a normal physiological level. So, the way I think of it, when someone does heroin—when they first start—they get this huge spike in dopamine. They become euphoric.

Well, doing that a couple of times over and over, your body, your brain tries to put things in homeostasis. They try to put things back in balance, because it needs you sober. So what it will do is downregulate dopamine. It will make less dopamine. It will reset the hedonic tone that is naturally there. Then, what quickly happens with drug addiction, particularly with opioids, the person's drive for use ends up just to feel normal again because they have less dopamine around now that that has been reset. So I think that that's important to kind of consider. Do you want me to keep going?

**KS:** I thought your water analogy last night was good.

**SH:** Oh right. Last night we were talking, and this was more about the stigma associated with addiction, and we'll probably get into that

a little bit later. A lot of people view addiction as a moral failing. It's a moral failing on the part of the person who has the disorder, or they don't have a strong will. And so, I've even had those arguments at my dinner table and the way that you need to think of it is. This is my—I don't know if I should say this—mother-in-law.

[LAUGHTER]

**CH:** I know his mother-in law.

[LAUGHTER]

**SH:** But it's really common, right? So, it's kind of like, "What, can't they just stop?" The way you need to think about it is—I told her, "Well, you just finish drinking. You just went to the bathroom and everything. You can live four days without drinking anymore water. You know that. You know that. Your prefrontal cortex knows that. That's your thinking part of your brain. I just told you that. Don't drink anything for two days. Do not do it. You'll live. I'm telling you that you'll live. You'll have two days cushion. You're still going to want it. You're going to have that drive to drink." People with addiction, particularly opioids, it is more profound than that, there is a bigger urge to do it. And again, that part of your brain that we're talking about—we really do call it the reptilian brain, the lizard brain. It's really there for these normal maintenance things. And it also never shuts off. You go to bed at night, and it's still there. You can't override with the things that people who suffer from addiction have to learn, in other words coping skills and support systems. We'll probably get into that later.

**KS:** Thank you, that was very helpful. Back to talking about the "revolving door" of what Dr. Howard was saying earlier, with the EMS responding and patients going to the emergency room and getting treated for an addiction before being released, and possibly having not enough treatment or not wanting treatment and returning to the emergency room. I wondered if you could comment a little bit more on that, Dr. Howard, and then we'll move into some thoughts on what led us to the epidemic.

**CH:** It's typical in the life and times of an [emergency room ("ER")] doc. You're in the ER, and part of the rush is you never know what's coming in next. You guys watch *ER*<sup>1</sup> on TV—it's nothing like that. But it gets to the point where, with some of our patients, you don't need a chart. You don't need a medical record number. You know when you see them, you know what your encounter is going to be. And it's going to be, you know, some story about knocking the bottle over and everything falling down the drain and you need a full refill. Or it's the patient who is just very honest, and they're so low in life that they don't care that you know that they're opioid addicted. Or that they're using heroin. Or they're using fentanyl.<sup>2</sup>

I've seen some patients so desperate that they've taken the sustained-release, 72-hour fentanyl patch that is used for patients with chronic pain, say, metastatic cancer to the bone, which I wouldn't wish on worst enemy. It's just a horribly painful existence. One of the ways to give that patient, for example, sustained pain medicine delivery, and get them some day to day relief, just going through life, is to put on this opioid patch, and they'll get sustained delivery of this medication. I have a patient who comes in, and he chews them. He takes them from his grandmother, and he chews her patches because he is just that desperate. So, if her mail order refill doesn't come, and there's a gap in fentanyl patches available at home, he comes to the ER and he wants pain medicine.

So our struggle is how, in the midst of treating the person having an acute MI (heart attack), and the person behind them is having a stroke, you have to stop and deal with—eloquently, we call them “dude,” not to violate HIPAA<sup>3</sup>—you have to stop and treat “dude” [with the acute emergency] and “dude” [the opioid addict] recurrently comes in. You try not to vilify the [addicted] patient, but, unfortunately, in the ED, we get to know these males and females as

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1. See generally *ER*, INTERNET MOVIE DATABASE, [https://www.imdb.com/title/tt0108757/?ref\\_=nv\\_sr\\_1](https://www.imdb.com/title/tt0108757/?ref_=nv_sr_1) (last visited Dec. 2, 2018).

2. “Fentanyl is a synthetic opioid that is 80–100 times stronger than morphine.” *Fentanyl*, U.S. DRUG ENF'T ADMIN., <https://www.dea.gov/factsheets/fentanyl> (last visited Dec. 2, 2018).

3. Health Insurance Portability and Accountability Act, Pub. L. 104-191, 110 Stat. 1936 (1996). HIPAA's chief statutory purpose was to “protect[] the privacy of health information in the midst of the rapid evolution of health information systems.” *S.C. Med. Ass'n v. Thompson*, 327 F.3d 346, 348 (4th Cir. 2003).

just kind of the revolving-door patient coming in, seeking. Sometimes you'll open a chart and it'll be big, bold, large font, bold, and italicized, "drug seeking behavior." That's the charge diagnosis.

Our EMS partners are plagued with this same thing. What do you do when you respond to an address two and three times in a 3- or 4-hour period, and you're giving an antidote to revive someone, restore their breathing because they've overdosed? Then, before you can make it back to the station, you're being called back again because this patient has overdosed yet again.

One example I shared with the team is that we have an EMS council meeting, where all of the ERs in the city meet up with all of the EMS providers, and we discuss our issues in providing care within the city. They noticed that their cost of Narcan,<sup>4</sup> one of their [overdose] reversal agents, went from \$18,000 at their cheapest year and was up to \$97,000 that they had spent. They said, "We can't sustain this budgetary line item, and we may just need to intubate these people—put a breathing tube down their throat, put them on life support, and deliver them to you, and you guys just have to deal with it." At my facility, we have sixteen [intensive care unit ("ICU")] beds in our medical ICU. We have 16 beds in our critical-care ICU. We're full right now. But if, during every EMS call, they intubated an overdosed person whose brain basically is asleep and not telling them to breathe, and delivered them to my ER, we could not sustain that volume. So, it impacts us to that degree of being able to provide care.

**KS:** And for the non-medical folks, they're intubating instead of giving the narcotic reversal agent?

**CH:** Instead of spending that cost of constantly giving that agent.

**KS:** Even though the cost of having someone in the ICU—

**CH:** Astronomically greater.

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4. Narcan is a brand name of naloxone, an opioid antagonist that is designed to block opioid receptors in the brain to bring an individual out of an opioid overdose. *See generally Opioid Overdose Reversal with Naloxone (Narcan, Evzio)*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio> (last updated April 2018).

**KS:** Yeah.

**CH:** It's a continuum. It's a spectrum. Like Dr. Hamm said, treating these patients on the outside, trying to treat and manage the addiction. Hopefully prevent their recidivism in the ED. But, a lot of times, the easiest thing to do in the ER is to treat their pain, and then try to get them connected to an outpatient treatment option. But if they have no provision of care, if they don't have insurance—they don't have several thousand dollars cash to be enrolled.

**SH:** Right, so that's a really big barrier to care. And she probably sees this more [than I do]. You know, the ER is the perfect place that they're there, and you have this window of time in which they want help. But the difficulty is that the window closes really quickly. It's hard to—there are no warm hand-offs, right? Sometimes you cannot admit for an opioid use disorder just because you're withdrawing from heroin—you will not die. I can't admit for that. They have to have electrolyte disturbances.

**CH:** Something medical.

**SH:** Exactly, something medical. And that's difficult. Therein lies part of the problem. Usually what happens is they want help. They're desperate for help, but you can't help them. And then you can't place them anywhere. Addiction is a career of narrowing options. Usually, there are a lot of times where they've lost their job. They've lost their family, support system. And they don't have insurance. It's definitely something that needs to be addressed.

**CH:** So we call Ms. Winton, and we say, "fix it."

[LAUGHTER]

**DW:** And we say—well, we try to say—we try to get involved into various options. When we talk about [police] officers or individuals that do not have access to naloxone, we provide that to various police agencies across the state through a grant to make sure that those areas do get access to those things. We have to try to do some very non-traditional, out-of-the-box thinking to address those issues because

otherwise we just have a revolving door. Some of those individuals we cannot help. If you do not have insurance or you're not insured by BlueCross, then you may be insured by someone else. You know, there are ways to try to maybe get on Medicaid or other options. But just because you're poor, it doesn't make you qualified for Medicaid. And most people don't really understand that. It's not just access available all the time. So, that's a tough thing. That means that everybody has to think a little bit outside the box and to try to address the issue.

**SH:** Narcan is a drug that is used to try to resuscitate somebody who has overdosed, but it's not a cure. In fact, what usually happens when you hit somebody with Narcan is that they wake up pretty angry because it puts them immediately into withdrawal. And, again, those are not pleasant symptoms. They will probably often get mad and leave the ER.

**CH:** We are not their heroes when we do that.

**SH:** No, not at all.

**CH:** And, unfortunately, there's nothing that I can do legally to force that person into treatment. I can't force them to want addiction treatment. I can't force them not to leave the ED.

There was a patient who went to a local restaurant in Germantown went and ordered lunch. While his sandwich was being made, he went to the bathroom, like most of us do to wash our hands before eating. His girlfriend noticed that he didn't return to get his sandwich. When she went to the bathroom to check on him, he was lying on the floor unconscious. If you're an ER doc, you assume it's an overdose. If you're a soccer mom, you might not assume that everybody that has collapsed in a restaurant bathroom has overdosed.

The paramedics arrive and that's her differential diagnosis of one—he's overdosed—and they're like, "How do you know?"

"Because he just did it a couple of hours ago."

So, this fire unit arrives. Brings the patient to Germantown. By then, he's awake and alert because they've given him three doses of Narcan. There's not a look of satisfaction. They're not ripping their shirt open. Superman, they've saved a life. They're very disgusted



and pretty much tired of this guy because they're constantly having to do the same thing. So, he gets to me. He doesn't even want to be registered. We're wasting his time and he's pretty upset that we've interrupted a very expensive high. So he leaves, and within an hour and a half, he's back. He went to a different location. Overdosed yet again. And the same unit brought him. That was the threat: if he does again, we're going to intubate him and just put him down, and then you can watch him in the ICU.

So that's the cycle that we're seeing. But, legally, I can't strap this guy down and force him to get treatment. I'm actually at fault, and that's abuse because he has the right to refuse care. At that point, he's fully decisional and able to say he wants care or he doesn't.

Now, on the flip side, there are some people who wake up and they're kind of, "Man, I'm in a really bad state. I need to do something about this, doc. I need help." That's that moment of surrender. That's that window of time, that short-lived opportunity where it's not a battle. It's a partnership. But then the record scratches and you wake up and you're back in reality because the music stops playing. And it's, "do you have insurance?"

"No."

"Do you have how many thousands up front to register?"

"How much does it normally cost?"

**SH:** If you go to a lot of these facilities—residential, in-patient treatment facilities—they're private pay or private insurance. It's pretty expensive, and it's just thirty days. Again, we're dealing with a chronic problem, and that's just short-term.

**CH:** For this one I think it was going to be \$5,000 out-of-pocket that he would have had to pay.

**SH:** That's right.

**CH:** That he would have had to pay to leave my ER and go to treatment for thirty days.

**DW:** And as a result of that, you've had some people come in. They've been very entrepreneurial in the sense of creating this whole situation. We see this in Florida and California, where these "addiction

centers” are not actually addiction centers at all. They prey on someone going to the emergency room, and they can’t get into a real addiction center, so they say, “Hey, you have private insurance. Let us help you.” And they put them on the plane. They take them to either Florida or California. They pump them full of more drugs, and the minute that the insurance company figures out that, “hey, this person shouldn’t be there, and we’re not going to cover that individual anymore,” they ship them back. They put them on a bus and they say, “sorry, you gotta go figure it out.” These are the types of things that are happening, and it’s such a terrible cycle that we’re trying to address. But even sometimes we can’t get it fast enough.

**SH:** Interesting. So, when you’re treating opioid use disorder, it’s essential—now, there’s not a one-size-fits-all—but typically it’s essential to put the person on what’s called “medically assisted treatment.”<sup>5</sup> There are three FDA-approved medications for that.<sup>6</sup> But it’s not just the medicine alone, right? It’s that *plus* the behavioral. It’s about cognitive behavioral therapy. It’s Twelve Step support groups.<sup>7</sup> I can go on and on. It’s those things together that equal more sustained recovery or more chance of recovery. Some people are able to do just abstinence right. But what we’re finding with the opioid use disorder, in a year, there’s only 10% that actually are able to achieve that.

So, there are three different medications that you probably hear about. One is methadone.<sup>8</sup> That’s been around for 40 years. It’s a full *mu* agonist—that’s an opioid receptor.<sup>9</sup> You also hear about

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5. See generally, e.g., U.S. Dep’t of Health & Human Servs., *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment> (last updated Feb. 7, 2018).

6. Methadone, buprenorphine, and naltrexone are three FDA-approved drugs for treating substance abuse disorders. U.S. Dep’t of Health & Human Servs., *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat> (last updated Sept. 28, 2015).

7. See, e.g., NARCOTICS ANONYMOUS, <https://www.na.org/> (last visited Dec. 2, 2018).

8. See generally U.S. Nat’l Library of Medicine, *Methadone*, MEDLINE PLUS, <https://medlineplus.gov/druginfo/meds/a682134.html> (last visited Dec. 2, 2018).

9. See generally Gavril W. Pasternak & Ying-Xian Pan, *Mu Opioids and Their Receptors: Evolution of a Concept*, 65 PHARMACOLOGY REV. 1257 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3799236/>.

buprenorphine.<sup>10</sup> Buprenorphine, people know as Suboxone.<sup>11</sup> There's the mono-product, Subutex.<sup>12</sup> There are other names, Zubsolv<sup>13</sup> and Bunavail.<sup>14</sup> And there's also naltrexone.<sup>15</sup> Naltrexone, it blocks that receptor completely. It has different—like, a Vivitrol injection<sup>16</sup> is probably what you hear the most about. I think the trick is, or the skill, like anything, is to find the right fit for that patient. And it changes. It's not always the same. Some people can be stable and in recovery for three years, and everything is fine. Then, something happens and they get triggered or whatever and they relapse. So it is something that's constantly changing.

But she is right. There's also this other aspect of drug treatment centers. What I've learned is they are therapist-driven. There's no real medication-plus-therapy. And usually that can be a problem. It's interesting, because they'll be in treatment for, say, 30 days. They'll get discharged, and then they relapse two weeks after being discharged.

**KS:** Do you all have any thoughts on what has actually gotten us to this point, that we're here talking about an epidemic? It's been declared a "national health emergency."<sup>17</sup> We've heard a lot about the impact of the epidemic on your practice and the barriers and the

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10. See generally U.S. Nat'l Library of Medicine, *Buprenorphine Sublingual and Buccal (Opioid Dependence)*, MEDLINE PLUS, <https://medlineplus.gov/druginfo/meds/a605002.html> (last visited Dec. 2, 2018).

11. Suboxone is a brand name of buprenorphine. *Suboxone Sublingual Film*, INDIVIOR, <https://www.suboxone.com/> (last visited Dec. 2, 2018).

12. Subutex is another brand name of buprenorphine. See *id.*

13. *Zubsolv Sublingual Tablets*, OREXO U.S., INC., <https://www.zubsolv.com/> (last visited Dec. 2, 2018).

14. *Bunavail*, BIODELIVERY SCIENCES INT'L, INC., <https://bdsi.com/bunavail/> (last visited Dec. 2, 2018).

15. See generally U.S. Nat'l Library of Medicine, *Naltrexone*, MEDLINE PLUS, <https://medlineplus.gov/druginfo/meds/a685041.html> (last visited Dec. 2, 2018).

16. Vivitrol is a brand name for naltrexone. *Vivitrol*, ALKERMES, INC., <https://www.vivitrol.com/> (last visited Dec. 2, 2018).

17. Press Release, The White House, Remarks by President Trump on Combatting Drug Demand and the Opioid Crisis (Oct. 26, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-combatting-drug-demand-opioid-crisis/>.

challenges that you're facing in your own practice, and in getting treatment for patients and getting us out of this. What has led us here?

**CH:** I think that we would all agree that it's definitely multi-factorial. There's not one entity or one point of failure. As a physician, I will tell you that, when I was in training as a medical student, and as a resident, there was a very big focus then on pain being the "fifth vital sign," as we used to say.

We can measure your blood pressure. We can measure your heart rate, your respiratory rate, your oxygen saturation. And, oh, by the way, you'd better ask about pain. And during that period of time, physicians, as well as hospitals, we were judged on how effectively we addressed and managed a patient's pain. And the ruler wasn't how many milligram equivalents of morphine you gave or which agent you used, A vs. B. It was the patient's attestation of how well you controlled his or her pain. And, I will tell you as an ER physician, looking backwards, I cannot dismiss the fact that that is probably at least part of the causal factor.

When I walk into a room, and in the back of my mind, now as a vice president and chief medical officer, we're being judged on how effective our patients report—when they're getting some type of patient satisfaction or patient loyalty survey—how well we managed and treated their pain. So, if I'm the opioid addicted addict, whether it's heroin or fentanyl or Lortab<sup>18</sup> or Percocet,<sup>19</sup> and I come to the ER, and I complain to Dr. Hamm that I'm in pain, and Dr. Hamm knows that this is my tenth visit of the day. And he says . . . he addresses me very frankly, and he offers me help and I refuse. And I get a survey, and I'm asked how well he listened to me. Was he compassionate?

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18. Lortab is a prescription pain reliever that combines acetaminophen and the opioid hydrocodone. *See generally* U.S. Nat'l Library of Med., *Label: Lortab—Hydrocodone Bitartrate and Acetaminophen Tablet*, DAILYMED, <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1fb18a80-8ef0-4bce-bb0d-9a86851c5206> (last updated Oct. 20, 2006).

19. Percocet is a prescription pain reliever that combines acetaminophen and the opioid oxycodone. *See generally* U.S. Nat'l Library of Med., *Label: Percocet—Oxycodone Hydrochloride and Acetaminophen Tablet*, DAILYMED, <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e> (last updated July 21, 2010).

Did he care about me? Did he address my pain? Did he effectively manage my pain? What am I going to say?

So, as a physician, on the front end, you know that you're being judged on that and there were lectures I sat in on. Sit down because the patient will perceive the duration of time you were at the bedside was twice as long. We had lectures on which pain scale to use. Do you use one to ten? Do you use the faces model, where you go from being happy to sad?

**SH:** That is so stupid.

[LAUGHTER]

**CH:** It really is, but, you know, we had to do it. So, pain was the fifth vital sign. When you got to the point where compensation and referrals and all of that were based on you being graded as a physician, whether it was five out of five stars, or the A through F grading system, it definitely affects your behavior at the point of encounter with your patient. In the ER, as a medical director, I had to counsel some of my partners, because it was really easy to have a quick encounter and get to that next patient if you just gave a three-day supply of pain medicine, and then sent them off to their primary care physician or Dr. Hamm to deal with long-term. The patient was happy. The doctor was happy. It was a quick, timely visit. You move on to the next one, and so I think that was part of it.

**SH:** It's interesting. I don't know how true this is, I heard this though: when the debate was going on, whether pain was the fifth vital sign, they actually were trying to consider oxygen saturation. Why would we pick that? It's quantifiable. It is exactly what it is, but we are not going to pick that. We're going to pick something that's very subjective. I think there's more overprescribing. Like she said, that plays a big part. You know, "for every ill, there's a pill."

[LAUGHTER]

**SH:** I think that we, as a society, believe that, and, in primary care, it's true. I've seen people come in, and they're complaining of cold symptoms. It's three days. I know, I'm just gambling. 80% of the

time, it's a virus, and antibiotics aren't going to help a virus, but they want something. I don't give it to them, but they're not pleased with it. We think that there's a fix—a quick fix. I really think the more I—you know, you are always smarter looking back—that the behavioral stuff we need to really evaluate medicine overall. You know, diabetes. No one prescribes this medicine and says, “Here's this insulin. Now go eat whatever you want.” It's the same way. How many people—I have family members with high cholesterol, and they still live in Memphis.

[LAUGHTER]

**SH:** Just kidding. No, they have high cholesterol, and they're prescribed a statin,<sup>20</sup> but they're still eating biscuits, and they can't give up the biscuits.

**CH:** And barbecue.

[LAUGHTER]

**SH:** Right. So, I think that it's the behavioral step that we need to kind of—it plays into it. And I think that's probably also a reason why we got into this.

**DW:** And, of course, I think when you have an entity as large as an insurance company paying for the drugs without really any type of limitation—so, no matter what the doctor prescribed, however much, we were paying for it. And it wasn't until maybe seven or eight years ago—there's a small town in east Tennessee named Jellico. I don't know if any of you have heard of it, but, in Jellico, they were probably getting prescriptions in the numbers of the hundreds of thousands. And there's not even ten thousand people that live in Jellico. So we started looking into it and started saying “oh my gosh, we have a huge problem.” Before we knew it, for the prescribers, we were like, “we are going to kick you out of our network.” Well, unbeknownst to us,

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20. Statins are in a class of drugs used to treat high levels of cholesterol. *See generally* U.S. Nat'l Library of Med., *Statins*, MEDLINE PLUS, <https://medlineplus.gov/statins.html> (last visited Dec. 2, 2018).

the TBI was sitting in that office because they're trying to figure out what's going on. And we send the doctor a letter saying, "we're going to kick you out of the network." And the TBI contacts us and says, "no, you will not. You will rescind your letter." But it's what is required. So what we had to learn from that process is collaboration. Throughout all of this, we have to collaborate because otherwise we find ourselves in situations that we're not technically supposed to be in. But Jellico was the real reason why, as an insurer, we learned in Tennessee how bad the opioid crisis was because we honestly did not have a clue.

**KS:** So, one often-alleged, true or not, cause of the epidemic that we haven't touched on yet is whether overprescribing is at fault. Ms. Winton mentioned that in this one town, but that sounds like an extreme case. But there's a question as to whether overprescribing, say post-surgically, has contributed to the epidemic, and I'm interested in your thoughts on that. But what I would really like to use our remaining time for is to say, assuming that were true—and we heard from Gov. Haslam on the recording this morning with Tennessee Together,<sup>21</sup> the big plan to address overprescribing. That is one example of restrictions on opioid prescribing, requirements for checking the controlled substance monitoring database. We also have the Tennessee pain management guidelines.<sup>22</sup> We have prescribing guidelines from the Center for Disease Control<sup>23</sup> and multiple other organizations that are involved in trying to tell physicians how to prescribe and how to practice medicine. And I would be interested in whether you think that is the right path.

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21. See generally Hon. William E. Haslam, *Tennessee Together: Governor's Welcome*, 48 U. MEM. L. REV. 1025 (2018).

22. See generally TENN. DEP'T OF HEALTH, TENNESSEE CHRONIC PAIN GUIDELINES: CLINICAL PRACTICE GUIDELINES FOR OUTPATIENT MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN (2017), <https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf>.

23. See generally *CDC Guideline for Prescribing Opioids for Chronic Pain*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/prescribing/guideline.html> (last updated Aug. 29, 2017).

So, it's a little bit of a compound question, in terms of, does that contribute, in your experience, and, either way, are we on the right path in these legislative and guideline initiatives? And then also, from the payer perspective, with what BlueCross is doing?

**CH:** So, from the provider's perspective, and I probably speak for ER physicians, staffing six Methodist ERs in our city, we're very supportive of it and appreciative of it. I will admit that we moaned and groaned when Tennessee law mandated that we do a two-hour prescribing course if we were going to prescribe controlled substances in the state. We moaned and groaned about it. But we all walked away like, "man." We talked about things we learned, perspectives that we weren't aware of. Also, as a military officer, I have a DEA license and, as a privileged provider in the United States Air Force, I, too, have to do two modules of education as a provider of controlled substances. At any military location around the world you can treat obviously someone with a need for pain medication.

Again, the problem is multi-factorial. I don't think legislation alone fixes the problem. When you look across the spectrum of who abusers are, they're not just heroin users or fentanyl users. There are some patients whom we introduce to opiates. Does every ill require a pill? And does that pill need to be a controlled substance? So, as a provider, the legislation and the restrictions have actually given us a new scope. Pain *was* the fifth vital sign. Now, it's not, but it's still important to address. And we are so varied on our willingness to prescribe, what we prescribe, how much we prescribe, how often, and who we prescribe to. I think that those restrictions help narrow the scope to make it a little more safe.

It also makes it very easy for me to look at my revolving-door, returning patient and to say, "Hey, I recognize you're in pain. It's not a crime to be in pain. However, there are better safer ways in which you can have your pain treated. And Tennessee state law mandates that I instruct you of that. They mandate that I check the prescription monitoring database to make sure that I'm compliant with those rules. And, by the way, your report is twelve pages with fifteen providers, ten different pharmacies, and multiple agents. And I know most of these providers by name are ER physicians. So, hey, recognize this isn't safe, and let me introduce you to my buddy, Dr. Hamm, and let's see if we can better control your pain in a safer manner." So, I think



it's helpful. And I think the physicians, once we got over the initial grumbling of being forced—or “volun-told,” as we say in the Air Force—to do all this training, because we went to school for umpteen years and you need to teach me how to write a prescription, once we got that education, we realized that we were part of the solution and we welcome it.

**KS:** Thanks.

**DW:** We had a lot of physicians get really upset with us. We implemented a prior-authorization process for any long-acting opioid. The provider would have to submit information to us—several things—one, if there was a plan to taper the individual off of these long-acting opioids; two, what type of pain did the individual have that warranted that prescription. So, the doctors had to provide some additional information. When we implemented that back in January 2017, they were upset. We got some nasty, nasty letters. However, as we proceeded in the process, we've gotten some phone calls from some people saying, “You know what? I'm really grateful that you guys implemented this plan, because it allowed me to do a better job with my practice.”

We also give providers a scorecard, and it compares them to other providers in their area to say, “here's where your prescribing practice is, and here's where everyone else is around you,” just to inform providers to let them know, “here's where you are, here's where you stand, and here's maybe what you can do to improve upon that.” But it's really trying to be more collaborative than just hammering down, because, at the end of the day, as an insurance company, we can deny your claim. All we're saying is, “we're not going to pay for it.” Like, if you still want to go out and get something, you absolutely can go do it. But that doesn't mean that we have to pay for it.

**SH:** So, um, hmm. I—

**DK:** See? See? See?!

**CH:** Notice that I'm sitting between them, right?

[LAUGHTER]

**SH:** No, it's not like that at all. I think she's right. I think we do need to work to be collaborative. When I do hear "guidelines" and "restrictions," it's a double-edged sword. I think that there are times when I really do welcome it, I like it, because it allows me to keep rapport with the patient. So, in other words, when I know this patient doesn't need something, it's like, "Hey, man, it's not me! It's—"

[LAUGHTER]

**SH:** "This is law." I mean, I literally say over and over again, "Listen, no one makes me prescribe these medications to you. But if I do prescribe, I do have to prescribe in an appropriate manner. It's not appropriate for me to prescribe this for you. So no one makes me do it, but if I do it, I need to do it like this." So, I do think they can be helpful.

They can be harmful, too, because not everybody fits into this perfect little matrix. This has nothing to do with you personally, but it's interesting, "prior approvals," I hear that, and I'm like, "huh."

[LAUGHTER]

**DW:** We don't like them either, by the way.

**SH:** It's interesting, a barrier, for example, in my group. It's not just me. There are other prescribers. If I have a patient, a TennCare patient on a medicine, and I get a prior approval and it takes—by the way, it takes three days, which, again, is weird when I've got a window of time—I've got somebody who hasn't used or is in active withdrawal because the guidelines say that they have to be in active withdrawal in order for me to prescribe. You get a COW score, which is a clinical opioid withdrawal score. I've got to wrap it up. So, if I prescribe this, there's a window. There are three days I have to wait. Say I'm not there, and another doctor is there in my group with the name on top of it, and they write the prescription and sign it that prior approval needs to be changed again to that person. I mean that's kind of a barrier.

**KS:** Any final thoughts, recommendations, and we'll wrap up? I'm not sure how much time is left. We're done? Alright, well, thank you.