

Controlled Substance Monitoring Database

2018 Report to the 110th Tennessee General Assembly



Health Licensure & Regulation
Controlled Substance Monitoring Database Committee
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Tennessee Department of Health Key Points Related To the Drug Epidemic

The 2018 Controlled Substance Monitoring Database (CSMD) report from Tennessee Department of Health (TDH) addresses activities and outcomes related to the substance abuse crisis as it relates to the CSMD. TDH is pleased to provide a comprehensive update on the prescription drug abuse crisis in the state at

<https://tn.gov/content/dam/tn/health/healthprofboards/csmd/2018%20Comprehensive%20CSMD%20Annual%20Report.pdf>. The CSMD Committee reports annually on the outcome of the program with respect to its effect on distribution and abuse of controlled substances; along with recommendations for improving control, prevention, and diversion of controlled substances.

Prescription drug monitoring programs, like Tennessee's CSMD, are the cornerstone to state-level interventions to improve opioid prescribing, inform clinical practice, and protect patients at risk.

Provision of accurate, timely dispensing information is essential to wise clinical decision making which can provide safe and effective treatment of pain.

Key findings for 2017:



- MME dispensed has decreased 32% (2012-2017)
- MME dispensed by top 50 prescribers has decreased 39% (2013-2017)
- Pain clinics have been reduced by 48% (2014-2017)
- Number of potential doctor shoppers have decreased 76% (2011-2017)
- Number of all opioid prescriptions have decreased by 14% (2015-2017)
- Patients receiving >120 MME/day decreased by 38% (2012-2015)



- Searches of CSMD have increased 363% and continue to increase (2012-2017)
- Strongest Board actions for prescribing or diversion increased 303% (2013-2017)
- Dispensers reporting within 24h went from 0% to 88% (2013-2017)
- The increase in Neonatal Abstinence Syndrome slowed to 2% (2016-2017)

Key Improvements in the CSMD in 2017:

- Clinical risk notifications were implemented to provide prescribers with proactive notification of their patients who had a significant change in key risk factors for increased opioid-related mortality.
- Improved time available: the CSMD system was up and functional 99.9% of the year.
- Improved response time in CSMD to less than two seconds if request does not include data from another state.
- The CSMD program in 2017 added Alabama, North Carolina (as of February, 2018), Ohio and Texas and is working with Georgia, Massachusetts, and Oklahoma to establish sharing of data.

- A new indicator has been added to the CSMD patient report which indicates TennCare has identified a patient in the CSMD who is locked into a single pharmacy.
- Tennessee was one of the first states to allow CRNA's without DEA numbers to have direct access to the CSMD
- Specific roles for State Medical Examiner, Deputy State Chief Medical Examiner and County Medical Examiners were created to allow direct access to the CSMD even if they do not have a DEA number.
- A question on patient report was added to allow CSMD users to indicate when patient lookup is due to suspected overdose.

Tennessee Department of Health Important Lessons and Concerns during 2017:

- There was one search of the CSMD for every two prescriptions in TN in 2017, up from one search for every 14 prescriptions in 2010. This is a remarkably high number of searches and, combined with the continuing decrease in MME dispensed, indicates the ongoing effectiveness of providing timely and accurate decision support for prescribing of controlled substances.
- For the first time, less than half of individuals (47%) who died of drug overdose had any controlled substance dispensed within 60 days of death. The increase in overdose deaths due to opioids in 2016 was largely due to illicit fentanyl (74% increase) and heroin (24% increase). This reinforces the need for a three pronged approach of prevention, treatment, and law enforcement in turning the tide of this epidemic.
- The number of patient reports requested increased 22% in 2017 to 8,623,521 compared with 2016.
- After four years of annual review of the top 50 prescribers, MMEs prescribed by this group have declined 39%, a rate of decline that is faster than the overall rate for the rest of the state.
- Benzodiazepines, such as Xanax and Valium, share the deadly side effect of respiratory depression with opioids, and concomitant use is known to be dangerous. The FDA has given their strongest warning to prescribers (a "Black Box Warning") about using opioids and benzodiazepines together. As compared with 2016, in 2017, dispensing of benzodiazepines decreased 8.0% overall. However, for people dying of opioid-related overdose death, benzodiazepines were present in 44%, highlighting the urgent need to avoid concomitant use of opioids and benzodiazepines.
- The number of prescriptions for stimulants continued to increase, growing by 50% from 2010 to 2017. This trend has been seen in previous epidemics of opioid abuse and highlights the urgent need for timely treatment of opioid use disorder.
- There has been a 236% increase in the number of prescriptions for buprenorphine between 2010 to 2017 for opioid use disorders dispensed to Tennessee patients. Since buprenorphine is helpful in stabilizing patients through medication assisted therapy, in conjunction with other support services, this trend is encouraging. However, buprenorphine has increasingly been present in patients dying of opioid overdose (4.1% in 2016) in Tennessee.

Education and Survey Update:

- Educational programs by TDH staff reached approximately 3,000 attendees state wide. Education included information on regulatory changes, best practices for prescribing, dispensing, review of the Chronic Pain Guidelines and requirements related to pain clinics and pain specialists.
- The 2017 Prescriber Satisfaction Survey showed 87% of respondents report that the CSMD is useful for decreasing doctor shopping; and 48% report they are less likely to prescribe controlled substances after checking the CSMD.
- The 2017 Dispenser Satisfaction Survey showed 90% of respondents report that the CSMD is useful for decreasing doctor shopping; and 84% report that they are less likely to fill a prescription as written after checking the CSMD.

Trends in Drug Overdose Deaths in Tennessee and the Role of the CSMD

In the past year, there has been continuing progress in key CSMD-related indicators. The proportion of individuals receiving high MME prescriptions (above 120 MME daily) continues to decrease, and potential doctor shopping also continues to decrease. The TDH has built a tool to increase the efficiency and effectiveness of its review of clinician data to ensure focused investigations of clinicians and their charts.

The TDH uses methodology established by the CDC to understand and describe drug overdose deaths in our state (CDC, 2016)¹. Data from Vital Statistics indicates from 2015 to 2016, drug overdose deaths in Tennessee rose by 12%, increasing from 1451 to 1631, despite improvement in a number of measures of good medical practice, including reductions in the amount of opioids prescribed and dispensed, fewer doctor shoppers, and increased utilization of the CSMD. Although the proportion of drug deaths associated with opioids was approximately the same in 2016 (72%), this number includes illicit drugs. The proportion of deaths categorized by the CDC as associated with opioid pain relievers decreased from 48% to 45%. Deaths associated with benzodiazepines increased 16% from 492 to 573. Deaths that included a combination of benzodiazepine and opioid increased 17% from 447 to 522. Just under half (44%) of opioid associated deaths also included a benzodiazepine.

Under half (47%) of individuals who died of drug overdose had a controlled substance dispensed within 60 days of death, a decrease from 56% in 2015. This continues to suggest that other factors are playing a significant role in overdose deaths, including illicit fentanyl, heroin, and diverted prescription opioids.

¹ Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *MMWR Morb Mortal Wkly Rep* 2016;65:1445–1452. DOI: <http://dx.doi.org/10.15585/mmwr.mm655051e1>

Once again, the number of deaths in which fentanyl was involved increased 74%, from 169 to 294, and now account for 18% of drug overdose deaths. Heroin deaths increased 26 percent, from 205 to 260. Methadone deaths increased 22 percent, from 67 to 82 and buprenorphine associated deaths increased from 34 percent, from 50 to 67. Of the 67 deaths that included buprenorphine, 41 (61.2%) also had a benzodiazepine involved, and 10 (14.9%) had fentanyl involved.

The TDH continues to improve how the CSMD is used in stopping the epidemic and is combining data from the CSMD with other patient data to identify key markers for increased risk. Epidemiologists at the TDH continue to map the natural history of addiction from prescription phase to what appears to be the danger zone, when individuals may move into the illicit market and are at higher risk for overdose and death. Policy and programs can be targeted more specifically to intervene early, when recovery is easier and more likely to be successful. In addition, the Office of Informatics and Analytics is developing a data driven method of identifying prescribers who may be engaging in high risk prescribing or who have high risk patient populations.

The TDH is working closely with a number of other departments, including the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and the Tennessee Bureau of Investigation (TBI), to respond to the epidemic. This includes analyzing and providing county-level data to stakeholders on the ground, including drug coalitions, using data TDH epidemiologists are rapidly accumulating and analyzing and updating state-specific guidelines for use of controlled substances in pain management. In summary, the TDH is fighting an evolving epidemic that is invoking unprecedented collaboration among agencies and community partners. The CSMD is proving a key component to the TDH's response, by providing critical data when and where needed.

Moving Upstream to Use Weekly Hospital Data

In 2016, for every drug overdose death, more than 15 nonfatal overdoses were identified in state hospital discharge data having been treated in the emergency department or hospital. The proportion of these hospital visits due to opioids has steadily increased, with a particularly substantial increase in heroin related nonfatal overdoses continuing to be seen in 2016.

These overdoses are treated in emergency departments and hospitals, but information about those overdoses currently are not available to clinicians outside the hospital or to the CSMD. In 2016, Public Chapter 959 provided the Commissioner with the opportunity to require healthcare facilities to provide the TDH with near real-time data on nonfatal drug overdoses. Such a data collection system was implemented in 2017, with a pilot project involving 11 hospitals. The system is now in its active stage, with the expectation that all hospitals across the State will be on-boarded in the spring of 2018, ideally by the end of March. At this time, 13 hospitals are sending weekly data extracts, 31 are submitting test files and an additional 49 are registered and beginning the onboarding process. On average, a hospital moves from test to production in approximately three weeks. As this program expands statewide, these data will be used in developing risk indicators to provide clinicians with the important information that their patients may be headed for serious risk of negative outcomes, including fatal overdose.

Neonatal Abstinence Syndrome Surveillance Update

Since surveillance of Neonatal Abstinence Syndrome (NAS) began in 2013, there has been a slight non-statistically significant increase in the case rate from 11.7 cases per 1,000 live births in 2013 to 13.3 in 2017 (provisional data). In 2017, 1,081 cases were reported, of which 70.0% were exposed to medication assisted treatment (MAT) and 75.2% were exposed to at least one legally prescribed medication, either alone or in conjunction with diverted or illicit substances. The highest rates of NAS were observed in East, Northeast health regions and Sullivan County.

The Role of and Presence of Pain Clinics across Tennessee

The number of pain clinics declined to 172 in 2017 which represents a 48% decrease from the peak number of 333 in 2014. One of the goals of the TDH has been to increase access to quality pain management. As of July 1, 2016, TCA § 63-1-306 requires that pain management specialists be the medical directors of pain clinics. Medical directors who are pain specialists based on training as defined by statute should provide consistency in the quality of care for the citizens of Tennessee.

The certification system changed to a licensure system on July 1, 2017, TCA § 63-1-316 requiring more intensive reporting and inspection. Prior to licensure the clinics are inspected and patient charts are reviewed and must meet minimum standards of care to pass inspection.

After a public hearing on July 24, 2017, the pain management clinic rules were adopted and posted on November 26, 2017 <http://publications.tnsosfiles.com/rules/1200/1200-34/1200-34-01.20171126.pdf>.

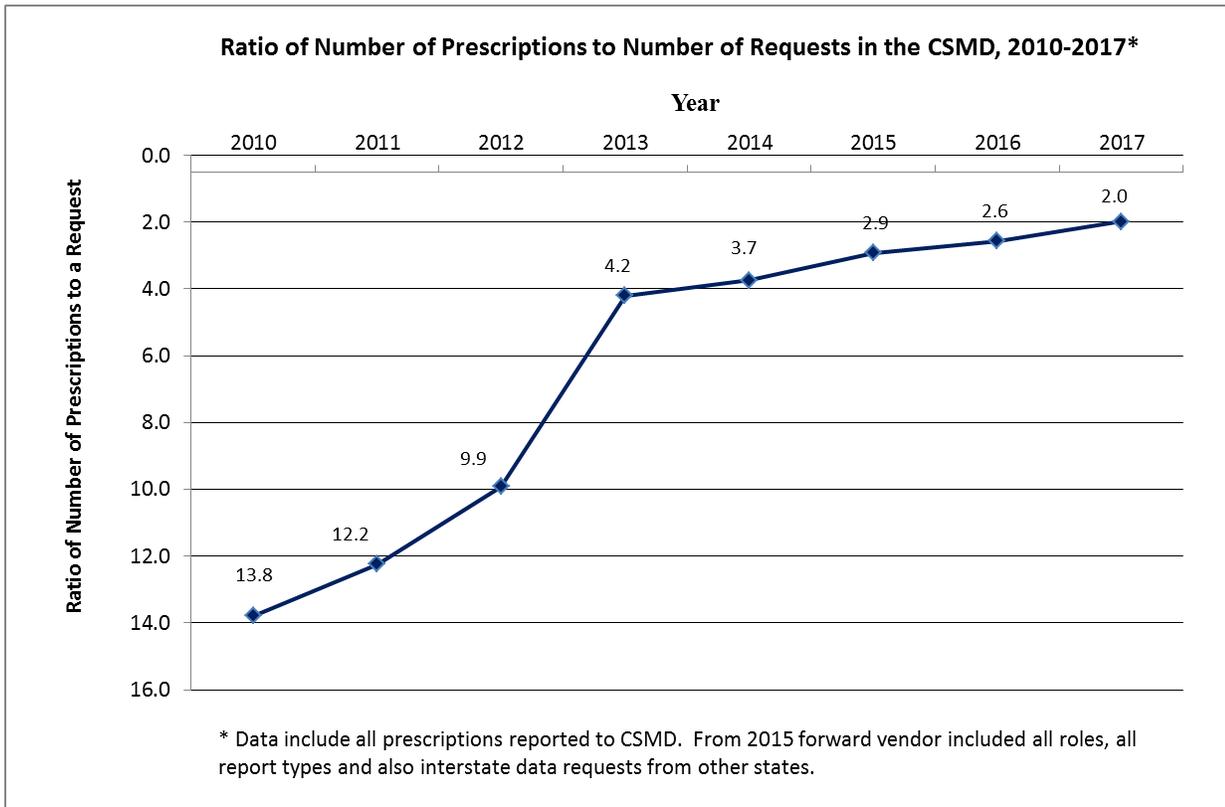
Pain Clinic Practice Guidelines have been developed and were published in January of 2017 with help from pain medicine specialists and other groups. The guidelines are available at: https://www.tn.gov/content/dam/tn/health/documents/Pain_Clinic_Guidelines.pdf.

Additionally, version 2 of the Chronic Pain Guidelines was completed by the Chronic Pain Guidelines Expert Panel in 2016 and posted in January 2017. The guidelines and those who gave of their time and expertise to make the guidelines a reality are available at: <https://www.tn.gov/content/dam/tn/health/documents/ChronicPainGuidelines.pdf>.

Fewer Prescriptions without CSMD Evaluation

The Prescription Safety Act (PSA) of 2012 facilitated a substantial increase in utilization of the CSMD and the PSA of 2016 again expanded the requirement for when healthcare practitioners are to check the CSMD. Year after year the CSMD continues to have significant increases in the number of registrants. By the end of 2017 the number of registrants had grown to 47,294. This slight increase was not as much as seen in previous years due to the CSMD efforts to inactivate unused accounts to minimize security risk and better prepare the program for a planned upgrade. Prior to the PSA of 2012 and 2016, Tennessee had 14 prescriptions reported for every CSMD patient request and now there are approximately 2 prescriptions reported for each request. The number of patient reports requested increased 22% in 2017 to 8,623,521 compared with 2016.

Ratio of Number of Prescriptions to a Request in the CSMD, 2010-2017

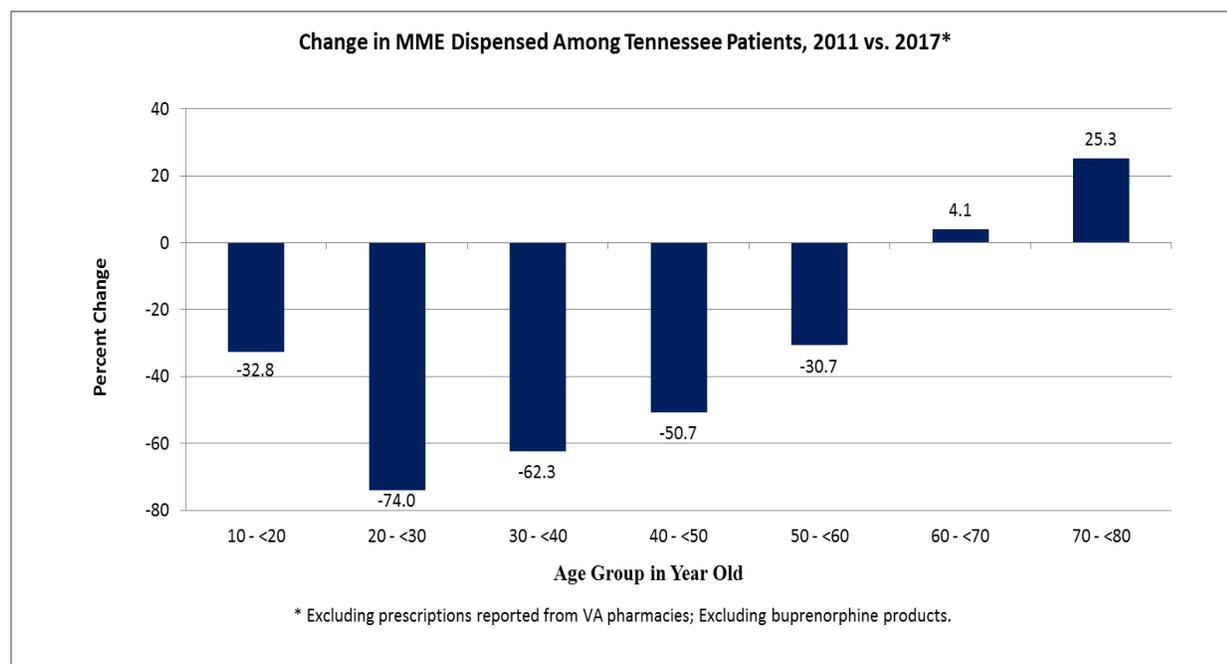


Law enforcement requests to the CSMD continue to be a critical use of the CSMD as TDH works together to address questionable controlled substance use in Tennessee. Of the 8,623,521 requests 1,390 were from law enforcement officers. Effective July 1, 2011, law enforcement officers were granted access to the CSMD. That access was further expanded through the PSA of 2016. During 2016, the TDH received a federal grant that will allow enhancement of the CSMD to provide law enforcement and drug courts improved access to the CSMD that will occur once the CSMD migrates to a new application.

MME Improvements and Concerns by Age Group

For 2017, the CSMD program provided a more detailed analysis of the MME for trends by age group for Tennessee patients. Encouragingly, there was a decline in MMEs dispensed for the 10 to 59 age ranges compared to 2011 data. These improvements for the younger age groups are an indicator that the TDH’s efforts are preventing a new generation from being overexposed to opioids by the healthcare system. In the age groups over 60 the upward trending MME is slowing. In 2017, MME increased 4.1% compared to 2011 in the 60–69 age group. This is an improvement over 2016 when MME increased 12.8% compared to 2011 for the same age group. Another observation was in the 70-79 age group in 2017 the MME increased 25.3% compared to 2011. An improvement was also observed over 2016 when MME increased 28.3%.

Change in MME Dispensed Among Tennessee Patients, 2011 vs. 2017



Trends Related to Utilization of Benzodiazepines and Stimulants

Benzodiazepines, such as Xanax and Valium, showed an 8.0% decrease in prescriptions from 2016 to 2017. This class has seen a notable decline in prescribing and dispensing for people between the ages of 20 and 59.

The number of prescriptions for stimulants has continued to increase, growing by 50% for patients in Tennessee from 2010 to 2017.

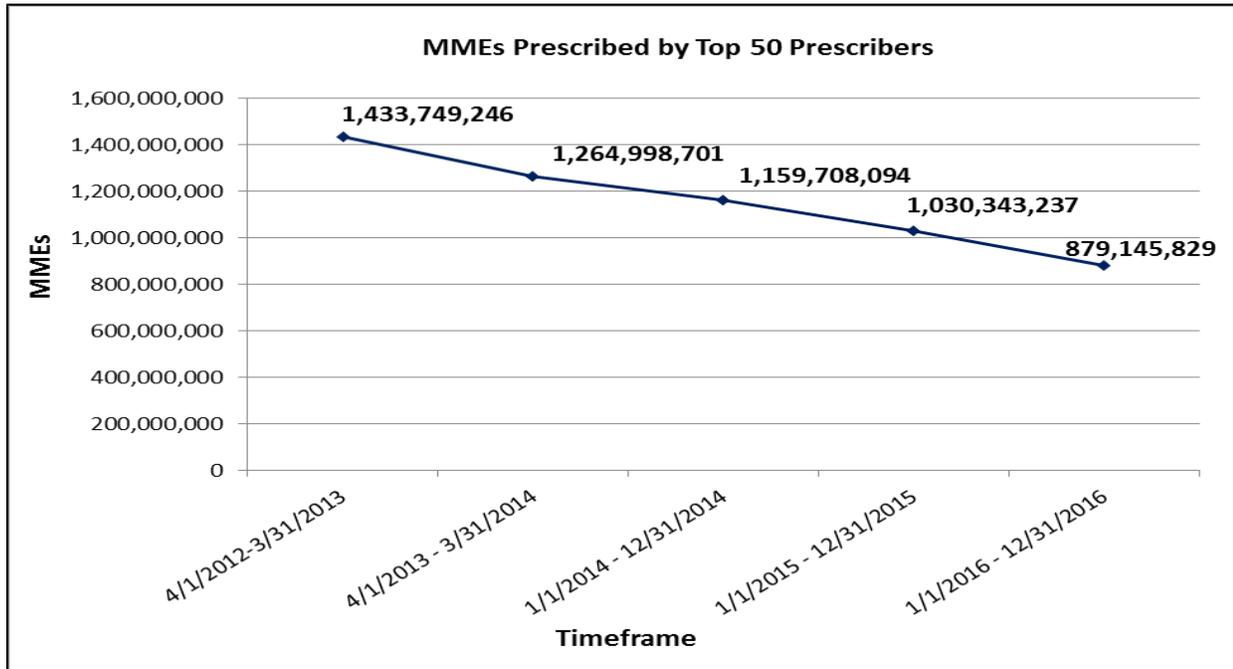
Increased Buprenorphine for Opioid Use Disorders

There has been a 236% increase in the number of prescriptions comparing 2010 to 2017 of buprenorphine for opioid use disorders dispensed among Tennessee patients. This may indicate that many patients have been successful in getting treatment for opioid use disorder but it should be noted that these drugs can be associated with overdoses and NAS.

Interventions Related to Top 50 Prescribers and Top 10 Prescribers for Small Counties

TCA 68-1-128 (passed during 2015) required the TDH to continue to identify the top 50 prescribers in Tennessee and added a new requirement for the TDH to identify the top 10 prescribers from all of the combined counties having populations of fewer than 50,000 residents to the top prescriber annual identification process. After four years of experience with the top 50 prescriber analysis, the MMEs prescribed by this group have declined 39% since the first analysis performed on data from 04/01/2012 – 03/31/2013 as noted in the line graph below.

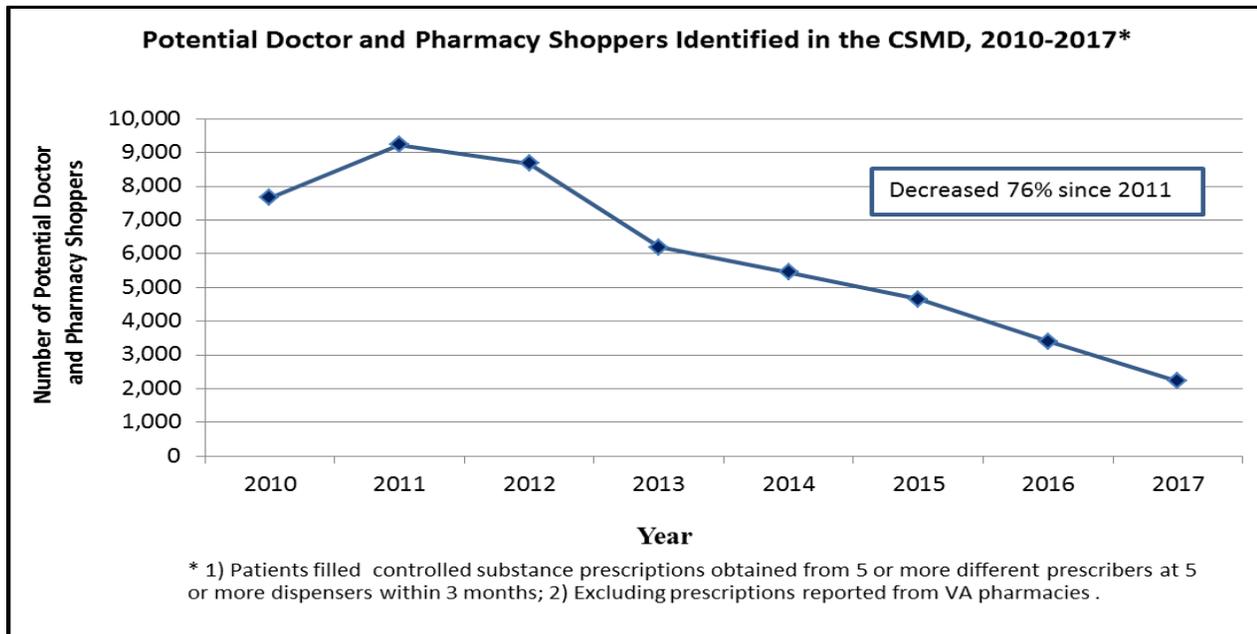
MMEs Prescribed by Top 50 Prescribers



Decline in Potential Doctor-Pharmacy Shopping

The past few years, TDH has defined a potential doctor and pharmacy shopper as an individual visiting five or more prescribers and five or more dispensers in a 3 month period, referred to as 5-5-3 criteria. Within Tennessee, there has been a 76% decrease of potential doctor and pharmacy shopping patients from 2011 to 2017.

Potential Doctor and Pharmacy Shoppers Identified in the CSMD, 2010-2017



User Satisfaction & Perception of the CSMD

The 2017 CSMD survey was the third for prescribers and the second for dispensers. Highlights of the 2017 survey are listed below.

2017 Prescriber User Survey

As a measure of satisfaction with improvements to the CSMD, a survey of prescribers was conducted in 2017 with greater than 2,800 prescribers responding:

- 63% use the CSMD at least monthly;
- 65% of responders have changed a treatment plan after viewing a CSMD report;
- 66% report discussing the CSMD report with their patients;
- 20% of responders are more likely to refer a patient for substance use disorder treatment;
- 87% of respondents report that the CSMD is useful for decreasing doctor shopping;
- 48% report that they are less likely to prescribe controlled substances after checking the CSMD;
- 60% of respondents received a Clinical Notification and of those 71% felt information useful;
 - Increase awareness (respondents could choose more than one):
 - 89% more aware of patients going to multiple prescriber;
 - 57% more aware of patients going to multiple dispensers;
 - 66% more aware of patients receiving highest dose of opioids.

2017 Dispensers User Survey

A survey of dispensers was conducted in 2017 with approximately 1,000 responding:

- 84% use the CSMD at least monthly;
- 69% of responders communicate with the prescriber after viewing a CSMD report;
- 69% report discussing the CSMD report with their patients;
- 59% of responders are more likely to communicate with the prescriber regarding a patient with potential for referral to substance abuse treatment;
- 90% of respondents report that the CSMD is useful for decreasing doctor shopping;
- 79% report that they are less likely to fill a prescription as written after checking the CSMD.

Database Performance

In 2017, the CSMD system was up and functional 99.9% of the year. Due to the CSMD team working with its vendor the system stabilized in 2017. The CSMD responds in less than two seconds when a patient request is initiated that does not include data from another state.

The supported browsers that provide the best performance of the CSMD include Internet Explorer 8 or above, Safari, Chrome, and Firefox. At this time Edge is incompatible with CSMD. Language has been

added to the login page of the CSMD to make users aware of which browsers are compatible with the CSMD.

Increased Interstate Data Sharing

The PSAs of 2012 and 2016 permit data sharing with other states. One of the areas of focus for 2017 was to enhance the sharing of prescription data with other authorized states. The CSMD program shared data with Kentucky, Virginia, South Carolina, Mississippi, Arkansas, North Dakota, Louisiana, West Virginia, Minnesota, and Michigan practitioners to give them a more complete picture of patients' controlled substance prescription history. The CSMD program in 2017 added Alabama, Ohio and Texas and has been in communication with Georgia, Massachusetts, North Carolina, and Oklahoma to share data. Each state has unique regulations and requirements that need to be addressed to share data.

Security Measures

The CSMD program improved its operations and security by moving its data storage to an Amazon Web Services (AWS) center. CSMD data, now housed at the AWS center, is encrypted both at rest and in transmission. Additional security, previously unavailable due to on-site storage, has been gained by restricting encryption key access in such a way that the data cannot be unencrypted at the AWS data center where it resides.

TDH Provides Significant Educational Outreach

Over 50 presentations were made live across the state to approximately 3,000 attendees to educate on regulatory changes related to the best practices of controlled substance prescribing, dispensing, and monitoring as well as the Chronic Pain Guidelines and requirements related to pain clinics and pain specialists. The audiences consisted of consumers, health care providers, law enforcement officers, drug enforcement officials, and attorneys.

Ten of these events were accredited courses complying with the education requirement in TCA § 63-1-402 and provided in partnership with East Tennessee State University (ETSU) and Vanderbilt University. Programming included live audiences, live streaming, and archived efforts to reach all health care providers. The streaming and archived programs reached additional health care providers. Each of these educational opportunities allowed health care providers to earn Continuing Medical Education (CME) or other Continuing Education (CE) credits. We had 2,136 healthcare providers to successfully complete the online course through Vanderbilt in 2017.

TDH Grants Update

CDC Grant – In September 2015, TDH was awarded a grant of \$3.4 million from the Centers for Disease Control and Prevention (CDC) to assist with funding epidemiologic studies pertaining to the nation's prescription drug overdose (PDO) epidemic. Funding for this initiative, "PDO: Prevention for States" (PFS), was awarded to sixteen states. The grant expanded upon the work already under way

through the “PDO: Boost” grant. In 2016, the TDH was awarded additional, supplemental funding to expand use of data and allow for better, complex linkages across data sources. In 2017, TDH was awarded an additional supplement to coordinate regional planning summits for opioid response, and to support public education about the risks associated with opioids. The purpose of the PFS grant is to provide state health departments with additional resources and support needed to advance interventions for preventing prescription drug overdoses within their own jurisdictions.

- Overall, the funding supports part of the Director of Informatics and Analytics salary, a statistical research specialist, seven epidemiologists and costs for building, maintaining and conducting analysis in the TDH Health Enterprise Warehouse. It is this work that is allowing the team to generate learning using combined data about prescriptions, hospital based care for overdoses, births and deaths and other important data subsets, such as Worker’s Compensation data.
- Included in the grant work are a number of key areas of activity:
 - **Enhancing and Maximizing CSMD**
Using data to better understand the behavior of the prescription drug overdose epidemic.
 - **Expanding and Improving Proactive CSMD Reporting**
To identify and address inappropriate prescribing patterns.
 - **Implementing Community or Insurer/Health Systems Interventions**
Improving opioid prescribing interventions for insurers and health systems, as well as enhancing the use of evidenced based opioid prescribing guidelines.
 - **Conducting Policy Evaluations**
Evaluation of policies and legislation currently in place to further understand what is working well and areas for improvement to prevent prescription drug overdoses.
 - **Developing and Implementing Rapid Response Projects**
Implementing a project to advance an innovative prevention approach and respond to new and emerging crises and opportunities.

In addition, in 2016, the TDH was awarded a grant from the Department of Justice (DOJ) under the Harold Rogers program; to create rapid data based collaboration between TDH, TBI and TDMHSAS. The grant will fund improved access for law enforcement and drug courts to the CSMD, and the collection and integration of law enforcement and mental health data to better identify and react to emerging and existing hotspots, as well as changes in the drug epidemic. The grant supports a full time junior epidemiologist to develop visualizations and data analytics on which the team can act.

Finally, in 2017, TDH received another CDC grant, this one to enhance surveillance of opioid overdoses. For this grant, we are working to expand the nonfatal overdose reporting from hospitals and to validate those data, and we are working on establishing methods of early identification of fatal overdoses, in collaboration with the Office of the State Medical Examiner.

TDH Recommends the Following Approaches to the Opioid Epidemic

- **We recommend decreasing the supply of and reliance on opioids for pain**
Specifically, we suggest working with prescribers and dispensers to reduce the duration and intensity of opioid use in opioid naïve patients, providing overdose information from patients seen in Emergency Departments, developing timely ways to track naloxone administration, improving our high risk patient model including proactively reaching out to clinicians with information about high risk patients via clinical notifications, improving medication take back programs, and promoting safer, effective non-opioid treatments for pain.
- **We recommend increasing focus on prevention**
Specifically, we suggest developing education for patients, healthcare practitioners, and healthcare trainees, to clearly communicate the risks of even short duration opioid exposure. Additionally, we recommend focus on adolescents to foster resistance to substance abuse, increasing screening for opioid abuse (SBIRT), increasing the availability of SUD treatment and increasing oversight of clinics offering MAT (through MHSAS), expanding support for community drug coalitions including their important work to reduce the stigma of substance use disorders, adopting effective safe syringe programs, and increased use of naloxone (estimated to decrease overdose deaths by 10%).
- **We recommend focus on reducing NAS**
Specifically, increasing support for prevention of unintended pregnancy and strategies for prevention of substance abuse, and focusing on medical management of pregnant women at risk of substance use disorder, especially in the third trimester.
- **In summary**
By focusing on minimizing opioid exposure for people who are opioid naïve, we “turn off the faucet” and avoid the difficult and expensive physical, legal and mental health implications of progression to dependence and substance use disorder. By better integrating actions thorough rapid analysis and coordinated responses we can work with communities to address developing problems before they become more entrenched in our communities. By working to eliminate the stigma of SUD we can help people who have substance use disorders to get help early, when treatment is easier and more successful.

Conclusion

While much progress has been made, much work remains to be done. This is an urgent situation that is unparalleled in recent state history. Much more should and, thankfully, can be done. TDH is pleased to see improvements in opioid prescribing and dispensing across the state and is maximizing partnerships with other agencies and grant funding to best design a process to more quickly share information and empower CSMD users, law enforcement, drug courts and coalitions to have the best information available to fight the substance abuse crisis. While these are important steps in fighting the prescription drug epidemic, several important new initiatives have begun across the state involving many partners both inside and outside of government. We must continue to take action in three areas: prevention,

treatment, and law enforcement in order to reverse the overdose death trend in Tennessee and to shrink the number of NAS cases in our state.

The TDH would like to provide a special thanks to the current and past members of the legislature, the CSMD Committee, the Tennessee Chronic Pain Guideline Expert Panel and the leadership of other federal and state agencies as we continue to work together to form a team of teams that will be successful in preventing harm to the public health from the prescription drug abuse crisis.

2018 Members of the CSMD Committee

<i>Member Name</i>	<i>Board</i>
<i>Melanie Blake, M.D.</i>	Board of Medical Examiners
<i>Katherine N. Halls, DDS</i>	Board of Dentistry
<i>Brent Earwood, APN, CRNA</i>	Board of Nursing
<i>Brad Lindsay</i>	Board of Optometry
<i>Shant Garabedian, DO</i>	Board of Osteopathy
<i>Michael Dickerson, D.Ph.</i>	Board of Pharmacy
<i>Sheila Schuler, DPM</i>	Board of Podiatry
<i>Stephen Ladd, DVM</i>	Board of Veterinary Medical Examiners
<i>Omar Nava, PA-C</i>	Committee on Physician Assistants
<i>Robert Ellis</i>	Public Member Board of Medical Examiners
<i>Lisa Tittle</i>	Public Member Board of Pharmacy

Acronyms

Advanced Practice Registered Nurse	APRN
Amazon Web Services	AWS
Centers for Disease Control and Prevention	CDC
Certified Registered Nurse Anesthetist	CRNA
Continuing Education	CE
Continuing Medical Education	CME
Controlled Substance Monitoring Database	CSMD
Controlled Substance Monitoring Database Committee	CSMD Committee
Department of Justice	DOJ
Drug Enforcement Administration	DEA
East Tennessee State University	ETSU
Emergency Department	ED
Food and Drug Administration	FDA
Medicated Assisted Treatment	MAT
Mental Health and Substance Abuse Services	MHSAS
Morphine Milligram Equivalents	MME
Neonatal Abstinence Syndrome	NAS
Physician Assistant	PA
Prescription Drug Monitoring Program	PDMP
Prescription Drug Overdose	PDO
Prevention for States	PFS

Acronyms	
Prescription Safety Act	PSA
Screening, Brief Intervention and Referral to Treatment	SBIRT
Substance Use Disorder	SUD
Tennessee	TN
Tennessee Bureau of Investigations	TBI
Tennessee Code Annotated	TCA
Tennessee Department of Health	TDH
Tennessee Department of Mental Health and Substance Abuse Services	TDMHSAS
Veterans Affairs	VA