THE OPIOID CRISIS
Losing a Younger Brother
Medication-First Approach
Use of Naloxone
View From the Front Line
KC-Area Death Statistics
Benefits of the PDMP

FEATURES
KCMS Physician Wellness Survey
Women Trailblazers Near Retirement
Physicians’ Freedom of Speech
Concern Over Drug Prices, Shortages
Special thanks to the following KCMS members and friends who have made contributions of $250 or more to the Kansas City Medical Society Foundation since November 2017. These contributions support needed medical care for low-income, uninsured individuals, delivered through MetroCare and WyJo Care.

MetroCare and WyJo Care connect patients with donated specialty care from a network of over 500 specialty physicians in the Kansas City area. Patients are referred to the program by primary care safety-net clinics and individual primary care providers. They must meet income requirements and not be eligible for other government medical assistance such as Medicare, Medicaid or VA benefits. These families often work in low-wage jobs without health benefits, earning too much to qualify for government assistance but not enough to afford health insurance while meeting other essential needs such as food, clothing and shelter.

*Thanks to you, many low-income families in greater Kansas City are receiving needed specialty care. You are helping to change their lives.*

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FROM THE Editor

03 What Happened?
HOW HAVE PHYSICIANS CONTRIBUTED TO THE OPIOID CRISIS?
By Michael L. O’Dell, MD, Editor, Kansas City Medicine

Editorially SPEAKING

04 Unemployed Physicians
3,700 MEDICAL GRADUATES LEFT WITHOUT RESIDENCY OPTIONS
By Charles W. Van Way, III, MD, Editor Emeritus, Kansas City Medicine

MEDICAL SOCIETY News

06 Initial Physician Wellness Survey Shows Higher Than Average Burnout-Related Scores
By Miranda M. Hoffman, MD, MEd; Carlie Nikel, PsyD; and Michael L. O’Dell, MD, Editor, Kansas City Medicine

08 The New Kansas City Medical Society
By Michael L. O’Dell, MD, Editor, Kansas City Medicine

14 Report on the 2018 AMA Meeting
OPIOID CRISIS, FIREARM VIOLENCE, MEDICAL EDUCATION, INSURANCE, PRESCRIPTION DRUGS, PHYSICIAN WELLNESS AMONG MAJOR TOPICS
By Charles W. Van Way, III, MD, and the Missouri AMA Delegation

16 Physicians Express Concern About Drug Shortages, Price Increases
By Jim Braibish, Kansas City Medicine

Women IN MEDICINE

10 Trailblazers: The Next Chapter
KU RESEARCH EXPLORES NEEDS OF WOMEN PHYSICIANS APPROACHING RETIREMENT AGE
By Kristi Birch

12 Members Respond to Resident Stress and Women Physicians

Commentary

18 Professional Speech: Do Doctors Have Free Speech?
RECENT COURT RULINGS ON PHYSICIANS’ DISCUSSIONS WITH PATIENTS
By Charles W. Van Way, III, MD, and Jeffrey S. Howell, JD

Community

18 An Alternative to the ER for Persons with Substance Use Disorder or Severe Mental Illness
KANSAS CITY ASSESSMENT AND TRIAGE CENTER
By Lauren Moyer, LSCSW, LCSW

Special Section

23 The Opioid Crisis: Searching for Solutions

24 Opioid Crisis Hits Home for KCMS Director
THE PERSONAL STORY OF LOSING A BELOVED YOUNGER BROTHER TO PRESCRIPTION OPIOID OVERDOSE
By Angela Bedell, MA, CAE

28 Medication-First Approach to Treating Opioid Use Disorder
MANY STUDIES SHOW EFFECTIVENESS OF MEDICATIONS OVER ABSTINENCE; PRIMARY CARE PRACTICES CAN PROVIDE TREATMENT
By Doug Burgess, MD

32 Life-Saving Naloxone to Treat Opioid Overdose
By Jennifer Santee, PharmD, and Melissa Palmer, PharmD, BCPS, BCPP

35 Opioid-Related Deaths in the Kansas City Area
By Robert Pietak, MD; Marius Tarau, MD; and Lindsey Haldiman, DO

37 View from the Front Line: A Paramedic’s Experience
By Michael L. O’Dell, MD, Editor, Kansas City Medicine

39 Care in Crisis: How the PDMP Can Assist Physicians
By Teesha C. Miller, MBA, MHA, CPB

ON THE COVER: Doug Burgess, MD, of Truman Medical Centers Behavioral Health points out the dopamine receptors in the brain that are involved with opioid addiction, in a discussion with a staff member. See special section on the opioid crisis starting on page 23. (Photo by Mike Curtis)
What Happened?

HOW HAVE PHYSICIANS CONTRIBUTED TO THE OPIOID CRISIS? WHAT CAN WE LEARN AND NOT REPEAT IN THE FUTURE?

By Michael L. O’Dell, MD, MSHA, FAAFP, Editor, Kansas City Medicine

This issue of Kansas City Medicine features articles on the opioid crisis and its impact on the Kansas City area. Included are reports from the paramedic community, the addiction treatment community, the Jackson County Medical Examiner’s Office, and more. I trust the readers will find this picture of our community broad and informative.

Physicians share some blame for the current opioid crisis. I think it is fair to ask, “What happened?” More importantly, we should ask, “What can we learn and not repeat in the future? How did we contribute to a public health problem of this magnitude?”

On a positive note, I am proud of the compassion that physicians have displayed for those in pain. As we tackle reducing opioid misuse, we must not lose our concern about pain and its devastating effect on patients. I was impressed by many things during the interview with a paramedic, Tara Hill, the text of which you will find in the following pages.

Most striking was her concern about the lack of treatment options for those in pain and how this often leads to opioid misuse. As physicians, we have found that opioids are not uniformly the best answer to patients in pain. We still have an obligation, rooted in compassion, to find effective ways of dealing with the suffering associated with pain.

We have learned that there are effective treatments for opioid addiction and misuse, as Dr. Burgess’ article points out. Tragically, these treatments are not always available or effective. Angela Bedell, our KCMS executive director and CEO, writes of her family loss. As the Medical Examiner’s Office report illustrates, we lose far too many to addiction each year in Kansas City. Much is left to be learned about how to develop and sustain active systems of treatment for those addicted to opioids and other drugs.

What remains incomprehensible to me is the failure of medicine to stay evidence-based as we sought to treat pain. I admit to myself that I did not question the use of narcotics in chronic pain as rigorously as I might have. Imagine my frustration to learn that much of the teaching about using narcotics for chronic non-cancer pain hinged not on a peer-reviewed study, but a brief letter in The New England Journal of Medicine regarding hospitalized patients, not patients with chronic pain! As a profession, we seemed too ready to have a simple answer to a complex problem. We did not examine the evidence as well as we should have. As a result, too many prescribed narcotics too often led to misuse.

We did not examine the evidence as well as we should have. As a result, too many prescribed narcotics too often led to misuse.

We have learned much from our opioid experience. We learned that our compassion must be coupled with good evidence if we are to safely and effectively practice. We have re-learned that suffering from pain is a complex issue which no single class of drug can adequately address. We are more aware of how controlled substances often find their way into more massive societal problems. And I can’t help but wonder, will our looming learning experience next be cannabis?

WOMEN IN MEDICINE

Our last issue of Kansas City Medicine contained a letter from Keith Ashcraft, MD, a member of the KCMS who has served the community for over four decades. The letter contained his opinion about special concerns for women in the practice of medicine. That opinion has generated a good deal of conversation, nearly entirely in opposition to Dr. Ashcraft’s thoughts on women in medicine. In this issue of the journal you will see some of the rebuttal the journal has received.

Your Editor,
Dr. Michael O’Dell

Michael O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at michael.odell@tmcmed.org.

REFERENCE

Our political and economic communities are greatly encouraged by the current unemployment rate, hovering just below 4%. And rightly so. It hasn't been that low for 10 years, and only occasionally before that. But... what about a physician unemployment rate of 4%? Would that be good? And what if that were the unemployment rate for fresh graduates? Suppose 4% couldn't get jobs? As the saying goes, a recession is when someone else can't get a job, but a depression is when YOU can't. Since pretty much all of us physicians have jobs, it's not a problem. Is it?

With that introduction, let's look at the results of March Madness. No, not the basketball games. The intern and resident match. NRMP National Intern and Resident Matching Program. March 15, 2018. Actually, it's a full week. On Monday, everyone finds out if they matched. On Tuesday, Wednesday and Thursday, those who were not matched scramble frantically to find a residency slot. The proper term is "participate in the Supplemental Offer and Assistance Program." SOAP. Great euphemism. It describes the process, without communicating the sense of devastation and the desperation of those who haven't successfully matched. Their whole lives are up for question. Someone whose dream was to be a neurosurgeon at Harvard has to settle for a family medicine residency in Omaha. You think failing to make the Beta fraternity was traumatic when you were in college? Ha!

Ahem. As I was about to say before the rant, the whole match process works pretty well, for most people. Well, a lot of people, anyway. OK, for the majority. The training programs get filled really well. Even before the "scramble," 96% filled. After the "scramble," 99.4%. It's good for the training programs. Really good. Training programs love the NRMP. But just how good is it for the applicants? You know, our students? Our successors?

The NRMP puts out a report each year. Preliminary results are published within a week or two. Then, the "final" results are published a couple of months later. The final results are more accurate, of course. So, let's look at them. Whatever else one can say about the NRMP, they are absolutely up front with their data. The final report runs to 116 pages, with 19 tables, 9 figures (Fig. 1), and a listing of every residency program in the country, with results. It doesn't list results by medical school, which would be important for future applicants.

So. In the 2018 match, there were 44,000 "registrants" worldwide who initially applied to the system. And there were just over 33,000 jobs to fill, of which 30,000 were PGY-1 positions. (Fig. 1) All of these numbers were a new high. Of those initial applicants, 19,000 were seniors at American allopathic medical schools. They did fairly well. Around 18,000 (94%) obtained positions, a few of which matched in the "scramble." Still. ... That's a 6% unemployment rate. It gets worse.

What about the other 25,000? First, many failed to complete applications and submit rank order lists. While there were 44,000 "registrants," there were only 37,000 "applicants" who put in a rank list. Why? Probably, because they didn't
have any expressions of interest. The average U.S. graduate fires out 40 to 60 applications and may get anything from 1 to 30 invitations to come interview. If an applicant, either in the U.S. or abroad, fails to hear back from anyone, he or she may reasonably conclude that it’s not worth putting in a rank order list.

INTERNATIONAL GRADUATES

That leaves 19,000. Just who were these other applicants? I mentioned “worldwide,” didn’t I? In fact, about 12,000 were international graduates, of whom 5,000 were U.S. citizens and 7,000 non-U.S. citizens. They did not all get jobs. In fact, assuming they put in a rank order list, they had about a 56% chance of getting a job. Well, then, no harm done. The rest can just stay home and work there, right? No. The U.S. citizens did slightly better than non-U.S. citizens, but U.S. citizens had only a 57% match rate. The biggest number of those were from Caribbean schools, but there are Americans in Europe, Mexico and elsewhere. And when they go home, they’re here, and they’re unemployed. That’s roughly 2,000 new and jobless MDs in our system. Each year.

What about osteopathic graduates? There were 4,600 in the match, a new high. They had an 82% match rate, the same as 2017, and the highest in history. There are still a number of osteopathic residencies around which match separately. Osteopathic graduates apply both to osteopathic programs and the NRMP. The true match rate is probably 85-90%, or even higher. Frankly, I’ve been unable to tell. With all osteopathic residency programs coming under the ACGME, all former osteopathic programs will soon be filled through the NRMP, and the match figures will become progressively more representative of osteopathic graduates.

So, let’s estimate that there are 1,000 U.S. allopathic graduates, 700 U.S. osteopathic graduates, and 2,000 U.S. international graduates out there after the match, looking for jobs. That’s 3,700 doctors who are NOT going to help with our physician shortage. To be fair, a lot of them will find their way to training positions next year. Some will find other ways to be employed. Maybe not as physicians, but somehow. I’m told pharmaceutical sales is a fine career path.

What’s the final score? The overall PGY-1 match rate was 78.3%. That’s the highest since 2003 and better than 2017. The number of applicants went up, and the number of non-U.S. graduates went down. Among U.S. seniors, 48% matched to their first-choice program, the second lowest on record. 73% matched to one of their top three choices. Of course, that means 27% did not. Still think that the match does a good job? In grade terms, 78% is what we used to call a “gentleman’s C.” Perhaps we shouldn’t call it March Madness, after all. We should call it the March Lottery. But it’s not the fault of the NRMP. They do a decent job, but they can’t match into positions which don’t exist. The harsh truth is, we are educating more MDs than we can train as residents, and not by just a few. Counting the international graduates who are U.S. citizens, we are educating about 15% more MDs and DOs than we can train. That’s shameful, and it is most definitely our fault as a medical profession. We need to expand our training programs, and we need to do it now.

There are 5,500 acute care hospitals in the U.S. The ACGME says that only around 800 institutions educate residents. That greatly overstates the situation, because some of those “institutions” cover several hospitals. But it’s still a big mismatch. What about YOUR hospital?

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at cvanway@kc.rr.com.

REFERENCE

Results of Initial Physician Wellness Survey Show Higher Than Average Burnout-Related Scores

**Survey is joint project between UMKC researchers and the Kansas City Medical Society; follow-up survey to be administered in the fall**

By Miranda M. Huffman, MD, MEd; Carlie Nikel, PsyD; and Michael O’Dell, MD, MHSA, FAAFP

Burnout is an overwhelming sense of emotional and spiritual exhaustion, a cynicism towards and detachment from individuals, and a rising sense of futility in one’s work.1 Studies have shown up to 50% of practicing physicians are experiencing some symptoms of professional burnout;2,3 and organizations are beginning to develop strategies to address this epidemic.4-6

Recently, the Kansas City Medical Society in cooperation with the University of Missouri-Kansas City sponsored a survey of all physicians in the greater Kansas City area to assess the current level of professional burnout. The survey assesses professional wellness using the Physician Wellness Inventory7 as well as factors that are protective against burnout.8,9 (using the Brief Resiliency Scale10 and the Short Grit Score11). In addition, the survey assesses the clinical environment of participants.12

This survey was sent via email and will be repeated every six months. After survey completion, participants have immediate access to their personal wellness scores and are able to connect with tools to increase their wellness. In addition, physicians can request to join a group of other physicians to focus on identifying meaning in the practice of medicine or to study mindfulness-based stress reduction. Finally, physicians can request that someone reaches out to them personally to connect with resources. Thirty-seven physicians expressed interest in at least one of these opportunities.

The initial survey was sent to 1,058 physicians in the Kansas City area. Of those, 105 physicians completed the survey (see Table 1 for results). The physicians participating in this study had a lower than average sense that the work they are doing has meaning and value (career purpose score), and higher than average distress related to their work. Low career purpose scores and high distress scores correlate with standard measures of physician burnout.

On the other hand, participants had above average cognitive flexibility (ability to adapt to difficult circumstances) and average to above average resiliency and grit. High cognitive flexibility, resiliency, and grit are protective against burnout. With the small sample size, it is difficult to say if Kansas City physicians are struggling more than the average physician.

Studies on physician burnout increasingly show that burnout is less due to an individual’s ability to cope with the demands of medical practice and more related to demanding environments that place excessive burdens on driven professionals.4 Therefore, standard interventions that are focused only on the creation of resilient physicians are un-
likely to provide meaningful, long-term improvements in physician well-being.

In our study, those physicians who completed this survey and report spending “moderately high” or “excessive” amounts of time on the electronic health record at home have an average distress score of 3.43 (overall study average distress score is 3.04). For those physicians who report that their team efficiency is “poor” or “marginal,” career purpose scores are lower at 3.87 (overall study average career purpose score is 4.03). Physicians reported their affiliations with various institutions throughout the metro area, but low response rates preclude feedback to organizations with this round of data collection.

Data collection and analysis will be ongoing. Physicians should expect to receive an email for the second survey in October. Additional findings from the study will be published in Kansas City Medicine.

Miranda M. Huffman, MD, MEd, is associate professor and vice chair of education in the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine and a clinical psychologist with Truman Medical Centers. She can be reached at huffmanmm@umkc.edu.

Carlie Nikel, PsyD, is an assistant professor in the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine and a clinical psychologist with Truman Medical Centers. She can be reached at carlie.nikel@tmcmed.org.

Michael L. O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at michael.odell@tmcmed.org.

REFERENCES


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Table 1: Range for all scores is 1 to 5. For distress score, lower scores show higher degrees of wellness; for all others, higher scores are associated with higher levels of wellness.
The New Kansas City Medical Society: A Community of Physicians Spanning the Entire Metro Region

By Michael L. O’Dell, MD, MSHA, FAAFP and Jim Braibish

Editor’s Note: The following article will appear in an upcoming issue of Missouri Medicine. It provides a summary of the new Kansas City Medical Society and Foundation.

On Jan. 1, 2018, we inaugurated a new Kansas City Medical Society, one that represents physicians from the entire Kansas City metropolitan area—in both Missouri and Kansas. It is a grand accomplishment for physicians and patients in our region and the start of an important new era.

The new KCMS is the result of a merger of the former Kansas City Medical Society in Missouri and the Wyandotte-Johnson County Medical Society in Kansas. The idea of one community medical society has been talked about and dreamed of for many years, and its time has arrived. Two organizations, each more than 130 years old, have worked hard to honor their heritage while organizing for today.

KCMS now welcomes members from the Missouri counties of Cass, Clay, Jackson and Platte, and the Kansas counties of Jackson and Wyandotte. About 60% of the Kansas City metro population resides in Missouri and the other 40% in Kansas.

Our medical societies recognize that the Kansas City metropolitan area is a regional presence not defined by state lines. We have a local motto you will see on t-shirts and coffee mugs around the region, “KC: Too Much City for One State.” As the city recognizes its regional oneness, the boundary of the state line diminishes in importance.

Our physicians practice in both states. Our patients live in both states. The Medical Society must speak for all patients and physicians, not just those on one side of State Line Road.

The activities of the new KCMS include:
- Advocating for physicians with legislators and insurance companies
- Providing educational programs on issues and trends in medicine
- Informing physicians through our journal Kansas City Medicine and electronic communications
- Coordinating volunteer health care for the uninsured and underinsured
- Promoting public health initiatives for the region
- Offering venues for networking among physicians

NEW FOUNDATION FOR CHARITY CARE

An important consideration throughout the merger discussion was the need to join the charitable care work of our respective foundations. The Kansas City Medical Society Foundation now manages the work of MetroCare and WyJo Care, our programs that match low-income, uninsured patients with specialty medical services donated by local physicians. Over 700 volunteer physicians from a variety of specialties are enrolled in MetroCare and WyJo Care, delivering over $7 million of charitable care per year.

The merger will help us expand these charitable care efforts. We also expect the unified foundation’s scope to grow to include other good work, such as assisting medical students in need.

ACCOMPLISHING THE MERGER

Over the last several years, the two societies began to collaborate on issues that are regional in nature. A bi-state Vaccination Task Force was formed to promote teenage vaccination against HPV and other diseases. We also collaborated to support Tobacco 21, an initiative to pass municipal and county ordinances prohibiting tobacco sales to persons under the age of 21.

In August 2016, both the WyJo and KCMS boards passed resolutions supporting the merger. A six-member transition team was formed to work out leadership, governance and other details of the new society. The team included Mark D. Brady, MD; Joshua M.V. Mammen, MD, PhD; Sheila M. McGreevy, MD; Michael L. O’Dell, MD, MSHA; Stephen Salanski, MD; and Gregory K. Unruh, MD. Throughout the process, they remained motivated by the common desire to ensure that area physicians are represented by a unified organization.

There were many complexities to be worked out in joining the two societies. Not only did we face the typical issues in a merger, we also dealt with creating a medical society that is a constituent of two state associations and responds to advocacy issues with two state legisla-
tures. It took 18 months of late-night meetings, writing new bylaws, developing a new governance structure and much heavy-lifting. Hard work was put into developing governance for today’s health care environment.

The new KCMS is governed by a 15-member Board of Directors. It is supported by a larger Leadership Council that includes the board along with representatives of area hospitals and other practices. The Leadership Council meets quarterly and discusses physician advocacy issues and patient advocacy and access concerns.

The new KCMS retains its strong relationship with MSMA and the Kansas City Medical Society (KMS). Both state societies played key roles in facilitating the creation of this new physician community. We encourage all of our members to join and be active in the appropriate state society.

**VISION OF THE FUTURE**

A unified medical society serving Kansas City now speaks with increased authority, advocating for patients and the physicians serving them. Through our new society, we will be better together. A better sense of community for physicians across the Kansas City area. Greater knowledge of the work, skill and professionalism among our Kansas City colleagues. And finally, striving together toward excellence in medical and surgical care for the people of Kansas City.

Michael L. O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He is past president of the Kansas City Medical Society and editor of Kansas City Medicine. He can be reached at michael.o'dell@tmcmed.org.

Jim Braibish, APR, is principal of Braibish Communications and managing editor of Kansas City Medicine. He can be reached at jbraibish@sbcglobal.net.

---

**New Medical Society Governance Structure**

- **PRESIDENT**
  - Joshua Mammen, MD, PhD

- **PRESIDENT-ELECT**
  - Mark Brady, MD

- **PAST PRESIDENT**
  - Gregory Unruh, MD

- **SECRETARY**
  - Carole Freiberger-O'Keefe, DO

- **TREASURER**
  - Christine White, MD

- **CHAIR, GOVERNANCE**
  - John Hagan, III, MD

- **CHAIR, LEADERSHIP**
  - Jim Wetzel, MD

- **CHAIR, STRATEGIC PLANNING**
  - Casey Rives, MD

- **CHAIR, PHYSICIAN ADVOCACY, MO**
  - Scott Roethle, MD

- **CHAIR, PHYSICIAN ADVOCACY, KS**
  - Scott Kujath, MD

- **CHAIR, PATIENT ADVOCACY**
  - Scott Kujath, MD

- **CHAIR, EDITORIAL COMMITTEE**

- **AT LARGE (2)**

- **CHAIR, FOUNDATION**
  - (ex officio if not physician)

- **CENTERPOINT**
  - Rishi Grewal, MD

- **CHILDREN’S MERCY KC**

- **LEE’S SUMMIT M.C.**

- **LIBERTY HOSP**

- **CHILDREN’S MERCY OP**

- **OVERLAND PARK REG**
  - Chris Dixon, MD

- **KU MED CENTER**

- **MENORAH M.C.**

- **OLATHE M.C.**

- **CHILDREN’S MERCY LAKewood**

- **ST. JOSEPH M.C.**
  - Kirk Sloan, MD

- **SAINT LUKES HOSP**

- **ST. LUKES EAST**
  - Tom Lovinger, MD

- **TRUMAN M.C.**
  - Stefanie Ellison, MD

- **TRUMAN M.C. LAKewood**

- **CENTERPOINT**
  - Michael O’Bell, MD

- **RESEARCH M.C.**

- **SAINT LUKES HOSP**

- **ST. JOSEPH M.C.**

- **TRUMAN M.C. LAKewood**

- **ST. LUKES EAST**

- **MISSOURI**

- **KANSAS**

- **ST. MARY’S M.C.**

- **RPO**
  - Keith Janta, MD

- **INDEPENDENT PRACTICE**
  - Aul Patel, MD

- **INDEPENDENT PRACTICE**
  - Jon Schultz, MD

- **INDEPENDENT PRACTICE**
  - Thomas Allen, MD

- **MSMA COUNCILORS (3)**
- **KMS TRUSTEES (1)**
“Medicine is so broad a field, so closely interwoven with general interests...that it must be regarded as one of those great departments of work in which the cooperation of men and women is needed to fulfill all its requirements.”

~ Elizabeth Blackwell, MD, 1821-1910, the first woman to receive a degree from an American medical school

Last year, for the first time ever, the number of women entering medical school in the United States surpassed the number of incoming men. Compare that to 1970, when barely 5 percent of American doctors were women. It’s easy to conclude from this headline-making news that women have reached full equality in the profession, but medical school matriculation is only the beginning of the story.

Just ask Kim Templeton, MD, professor of orthopedic surgery at the University of Kansas Medical Center, who was the first woman to enter the residency program in orthopedics at the Rush-Presbyterian St. Luke’s Medical Center in Chicago. Three decades later, Dr. Templeton is part of the still scant 5 percent of practicing orthopedic surgeons who are women. Not only do women doctors remain under-represented in high-paying specialties such as orthopedics and cardiology, they also tend not to progress to the top ranks of academic medicine. By Dr. Templeton’s count, she is just the sixteenth American woman ever to become a tenured professor of orthopedic surgery in the United States. Moreover, female physicians suffer from higher rates of burnout than men.

Dr. Templeton has spent much of her career outside the operating room addressing the issues of woman physicians as well as sex and gender differences in health and disease. Last year, she spoke at United Nations’ Empowering Women and Girls Summit about the impact of sex on chronic health conditions and thus on the ability of women around the world to lead productive lives. She also worked with the American Medical Association to expand their definition of women’s health to include all conditions for which there are differences between women and men. Spurred by her interest in sex- and gender-based differences in chronic pain, Dr. Templeton is now also looking at ways to address the country’s opioid crisis.

A former president of the American Medical Women’s Association and of the Ruth Jackson Orthopaedic Society, Dr. Templeton has addressed the United Nations Commission on the Status of Women about increasing the numbers of women in traditionally male medical fields and is currently leading a group within the National Academy of Medicine studying gender differences affecting physician burnout.

And now, she and Anne Walling, MD, professor emerita in University of Kansas School of Medicine-Wichita—with a grant by the Joan F. Giambalvo Fund for the Advancement of Women administered by the American Medical Association—are researching an under-studied group of American physicians who radically changed the face of medicine: women doctors now over 60
years of age. “There’s a lot of focus on younger women physicians and that’s important, but you don’t see any focus on older physicians,” said Dr. Templeton. “These women, by and large, don’t have a previous generation of women physicians to go to for advice on how to navigate the later phases of their careers. In addition, as we are looking at health care provider shortages—are women leaving medicine for reasons we could address?”

These physicians are the women who were the first to enter medical school after the 1972 passage of Title IX, which outlawed gender discrimination in education, and found that even though the doors were finally open, the environment could still be hostile. These are the doctors who remember people saying they should stay home and raise their children instead of apply to medical school. These are the doctors who remember having to wear multiple layers of clothing and duck into a closet to strip down to their surgical scrubs because there was no changing room for women like there was for men. These are the women who still are often addressed professionally by their first names, instead of “Dr. [last name].”

Today, these women find themselves with another part of the trail to blaze. As the first generation of female physicians to reach retirement age, they have no role models for navigating the latter part of their professional lives. Moreover, they stand in a blind spot: In addition to most studies on gender bias focusing on younger female physicians, the information about retirement and financial issues for doctors is designed by and for men, points out Dr. Templeton, and focuses almost exclusively on financial issues.

Dr. Templeton and Dr. Walling are looking to change that. Their study will examine the career issues that senior women physicians face. “This is something that impacts not only physicians and their satisfaction with their career and their risk of burnout, but it also helps medicine in general. If we can keep these women happy in their work, then that’s another way we can address the health care provider shortage;” Dr. Templeton said.

**IDENTIFYING THE ISSUES**

Dr. Templeton noted that while some issues may not vary between men and women doctors, others do. For example, burnout is more common for women physicians; the question is why. Last year, Dr. Templeton and Dr. Walling decided to hold focus groups with KU doctors in Kansas City and Wichita to begin exploring these issues.

Many of the women in the focus sessions talked about being the caretakers of elderly parents or other relatives, a job that seems to fall to women more than men. When they were young women, HR policies were in place if they had children. But what about now, when they find themselves caring for older relatives and sometimes grandchildren? “They were really struggling with being part of the sandwich generation,” said Kari Nilsen, PhD, an assistant professor in Family and Community Medicine at the KU School of Medicine—Wichita who designed and ran the focus group sessions.

Dr. Walling remembers being one of those caretakers. “I used FMLA to care for my parents,” she said. “Then I got sick, but I’d already used up all my sick leave.”

Of course, caretaking issues affect older women regardless of profession, but Dr. Templeton, who gets to work usually by 6:30 a.m. so that she can be ready for patients, noted that it can be even more complicated for women in medicine: “If you’re in the business world, the further you go up the food chain, the more control you have over your time,” she said. “As a physician, your time is dictated by needing to see your patients; you might need to be the doctor who is there for 24 hours straight. And then there’s being on call—you can get called in no matter where you are.”

Finances were also cited as a significant concern. As physicians, the women were generally well paid, but they did not necessarily know how much they needed to retire, how to invest for retirement, or how to sign up for Medicare. Some had left these issues up to their significant others. “We were surprised by that, but these were doctors in an academic setting,” said Dr. Templeton. “We will be looking next at physicians in private practice and see if the response is any different.”

Remaining relevant and respected in their field and keeping up with technology were other common concerns. “You have to stay up to date clinically, and then there’s the technology—electronic medical records, apps, and so forth,” said Dr. Walling. “People are always wondering if you’re up to date and if you can cut it, and that’s harder if you are also taking care of your aging mother.”

**TAKING IT STATEWIDE AND NATIONAL**

The researchers plan to use what they learn from focus groups to devise questions to send electronically to female physicians ages 60 and over in the Kansas Medical Society database. The questions will cover caretaking issues, financial matters, the impact of personal health on their practice, how their career affects their health, their confidence in navigating (continued on page 13)
GOVERNMENT, INSURANCE, MOC FUEL STRESS TODAY

The letter to the editor by Dr. Keith Ashcraft in the spring issue of Kansas City Medicine fails to reflect the reality of and stressors in medicine these days. These stressors—EMR, insurance prior authorizations, MACRA, MIPS, PCMH, MOC, patient satisfaction measures affecting our choices and our pay, and the details of our work lives being dictated to us by administration if we are employed physicians—all lead to a very different experience for physicians these days vs. even 10 years, let alone 40 years ago.

The workplace in general, whether medical or nonmedical, has been slow to accommodate the needs of women. Or really I should say to accommodate families with children. Sadly, the brunt of the work and responsibility and expectations for raising children still falls to women ... even when that woman is a physician with crazy hours and responsibilities at work. Or when a woman is a top executive for a Fortune 500 company. Or when a woman works two jobs at minimum wage to make ends meet.

Physician mothers don’t get burned out by the pull they feel for both work and home. The demands placed on us by the government and insurers and our own medical boards to keep up with MOC is what is wearing us down and burning us out.

~ Christine White, MD

IMPLICIT BIASES REMAIN

In 2018, there are hardly any social or professional circles in which it is acceptable to voice the idea that women should not be in medicine because of their "maternal instincts." The recent exception is Dr. Ashcraft’s letter to this journal suggesting physician burnout could be prevented by weeding out those female medical school candidates who might be distracted by family obligations down the road.

Dr. Ashcraft’s letter was disheartening to me, and apparently also, to a large group of physician moms communicating on Facebook. Understandably so. To suggest that the problem is us, rather than the culture in which we work, is discouraging.

Unfortunately, Dr. Ashcraft’s suggestion doesn’t seem that far removed from the implicit biases built into the fabric of our practices and daily lives. We see the ramifications of this unspoken culture when a colleague decides to take a four-week maternity leave or struggles to find a time or place to use a breast pump or takes a disproportionate pay cut to in order to pick up kids from day care on time. Implicit bias, as noted in a recent Harvard Business Review article on the lack of women in leadership positions in medicine, is pervasive in our medical communities and a driving force on the trajectory of our careers.

In 2018, when a thoughtful and respected local journal prints the suggestion that we weed out physicians with “maternal instincts” rather than change the culture in our medical centers, we know we still have a long, long way to go.

~ Sheila McGreevy, MD

MORE UNDERSTANDING BETWEEN GENERATIONS

It was interesting to read Dr. Keith Ashcraft’s letter to the editor about resident burnout. I am brought back to memories of my own mentors during training and the harrowing stories of their residencies—the time commitment, the sacrifices to their spouses and families, the malignant way in which they were treated. I, too, started my training before the residency work hours were capped. Those first few months were the hardest I’ve endured, with many tears from frustration, exhaustion, feelings of inadequacies that only a new trainee to a field can appreciate.

But then as I settled into my new role and responsibilities, I fell in love with medicine again and began to thrive. I was young and single, but the hopes of
a spouse and children were always in my mind. I completed my Med/Peds residency and went on to do a fellowship in critical care. After 10 years in practice, I still consider this to be the best career one could have. I love my challenging and rewarding job. I have a terrific husband—also a physician—and two kids of whom I couldn’t be prouder. We make our hectic life work through planning and division of labor for the kids and household. I feel the same pulls that any working mother has when away from her family. I don’t think that is limited to medicine in any way.

As for preventing resident burnout, I don’t know the right answer. Nobody can tell you what you’re getting into by getting married or becoming a parent, and by the same token no one can prepare you for what it will be like to be a physician. Residency is hard, and there is no way around it. Clinical practice is hard as well, with the sacrifice of one’s own needs, leisure time and time spent with one’s family. The stress and demands do not change with the change in ranks.

I’m reminded of an article published in The PEO Record about the values and psyche of different generations, intending to assist multigenerational women of the same chapter to better relate to one another. In the workplace, it’s important to realize that different generations are motivated by different things. Our entering residents are less Millennials and more Gen Z, looking for structure, clear direction, feedback and transparency. They want a work-life balance as does my generation, the Xers, and want to be valued. Perhaps as mentors to this group we can seek to understand their motivations and what makes them tick, rather than expect that they will thrive in the same way as the Traditionalists and Baby Boomers did. They need guidance in how to maneuver this health care system, which is unrecognizable from 40 years ago. I think the answer is with understanding values rather than gender biases. I do think that there is a common thread with physicians of all generations when speaking to the topic of burnout. Volume demands, nebulous quality indicators, EHR and copious amounts of documentation to name a few. I don’t have the answers, but tolerance and seeking to understand our fellow colleagues is a great place to start.

~ Carole Freiberger-O’Keefe, DO

KCUMB Breaks Ground on Expansion

Kansas City University of Medicine and Biosciences broke ground on a new state-of-the-art Center for Medical Education Innovation (CMEI). The $33-million, 56,000-square-foot facility will feature standardized patient rooms (where trained actors play the role of patients), high-fidelity simulation rooms (where medical robots display a variety of disease processes), a skills simulation deck that utilizes the latest in virtual reality and haptic technologies, and a simulation command center. It will also include nearly 13,000 square feet of classroom space and an advanced physical diagnosis and Osteopathic Manipulation Medicine.

TRAILBLAZERS (continued from page 11)

ing retirement, how they interact with younger colleagues, disrespect from younger colleagues, the impact of changes in health care bureaucracy and technology, and feelings of isolation, stress and other indicators of burnout.

They then hope to take their survey national, using perhaps the AMA or the AMWA database and presenting their findings at meetings and through publications.

Ultimately, the researchers want to build a framework to develop educational materials—seminars, webinars, publications—designed for women to help them navigate the latter part of their careers.

“One of those poignant moments of the focus sessions was when someone said, “This is the first time in my life I have ever felt vulnerable,”” said Dr. Templeton. “She was trying to decide whether to retire, and she didn’t know what she was supposed to do next. There wasn’t a path to follow or a preceding generation to show her what retirement looked like. There wasn’t ready access to resources. We are hoping to help change all that.”

Kristi Birch is a science writer for the University of Kansas Medical Center.
Report on the 2018 AMA Meeting

OPIOID CRISIS, FIREARM VIOLENCE, MEDICAL EDUCATION, INSURANCE, PRESCRIPTION DRUGS, PHYSICIAN WELLNESS AMONG MAJOR TOPICS

By Charles W. Van Way, III, MD, and the Missouri AMA Delegation

Co-published with Missouri Medicine

The American Medical Association considers all matters of health as its charge. But every year, certain things are emphasized over others. At this year’s meeting June 9-13 in Chicago, these were the opioid crisis, public health, firearm violence, medical education, insurance and finance, prescription drugs and physician well-being.

OPIOID CRISIS

The opioid crisis concerns all physicians. With considerable pressure from both state legislatures and medical organizations, physicians have collectively reduced opioid prescriptions by 20% over the last 2-3 years. But the death rate continues to rise. Several resolutions addressed this by condemning the companies making opioids, by educating physicians, by better training medical students and residents, and by encouraging drug companies to produce alternative non-addicting classes of pain killers. The problem is growing, and there was little consensus on how to deal with it.

A resolution addressed the problem of drug-assisted sexual assault by calling for mandatory drug testing of all victims. Rebecca Hierholzer, MD, of Kansas City and Mark Miller, MD, from the AMA Council on Science and Public Health educated the HOD about drug-facilitated assault, especially about the inability of hospitals and clinics to offer immediate testing due to lack of quick reliable assays and chain-of-custody issues. Occasionally, the HOD can become collectively enthusiastic about an appealing policy, without considering whether that policy is feasible. The well-intentioned resolution was not adopted.

FIREARM VIOLENCE

Perhaps the most vocal issue at the meeting was firearm violence. Existing AMA policies were strengthened by resolutions supporting prohibition of “assault-type” weapons, “bump” stocks, large capacity magazines and armor-piercing bullets; mandatory registration of all firearm owners; and requiring that persons be licensed before they can purchase a semi-automatic firearm. This highly confrontive approach had a great deal of appeal to the delegates, who were focused on mass shootings, especially at schools.

Both a report from the AMA and a presentation on prevention of firearm violence took a public health-oriented approach. The 0.3% of deaths from mass shootings are highly publicized and distressing to all of us. But 59% of firearm deaths are suicides and 39% are from interpersonal violence. To lower firearm deaths, these must be addressed. The panel presentation advocated collaboration among physicians, public health, hunting organizations, gun safety groups and the general public. The AMA appears to be adopting a carrot and stick approach, calling for restrictive regulations while still advocating a collaborative approach.

Continuing with current political issues, the HOD adopted a resolution calling for a change in the current administration’s policy of separating families of illegal immigrants, jailing the adults and placing the children elsewhere. This resolution was featured in newspaper articles across the country. As we all know, the policy has since been rescinded. But the issue remains, and implementation of new policies is “evolving.”

A resolution from Oklahoma called for physician education on human trafficking. A large percentage of victims come to the health care system, but very few are identified by physicians or hospital staff personnel. Human trafficking is a much larger legal and public health problem than most of us appreciate, and such education will have significant impact.

MEDICAL EDUCATION

The AMA remains active in improving medical education. A report discussed the growing mismatch between places available for graduate medical education and the number of physicians (MD and DO) being graduated. There are more first-year jobs than there are graduates of US MD/DO schools, but much fewer than the total number of applicants. An increasing number of U.S. MD/DO graduates from U.S. and international schools are without positions following graduation. The report strongly advocated expanding graduate medical education to keep pace with expand-
ing undergraduate medical education. Placement of graduates in GME should become one of the criteria by which medical schools are judged. The problem of graduates without residencies is severe, with perhaps 3,000 to 4,000 new MDs and DOs each year being unable to find a training position. (Editor’s note: See Dr. Van Way’s comments and data on this problem in his “Editorially Speaking” column on page 4.)

Health insurance and health care financing continues to be a major concern. The cost of health insurance is unreasonably high. The financial strain of illness has become the most common trigger for individual bankruptcies. A report from the AMA Council on Medical Services put part of the blame for recent increases on the repeal of the individual mandate. It recommended making premiums deductible up to 500% of the present limit, educating the public on health insurance and establishing a federal reinsurance program. A resolution from Missouri called for evaluation of medical student education in health finance; this was referred for study, presumably by the Council on Medical Education.

Prescription drug shortages continue to plague the health care system. The AMA has already declared this a public health crisis. A resolution called for steps to be taken to minimize the impact of natural disasters on the drug supply. The possible role of pharmacy benefit managers in restricting the supply of drugs and increasing their cost was also discussed. Resolutions called for more control of pharmacy benefit managers, which are now given an anti-kickback “safe harbor” from oversight and regulation.

Continuing concerns about the electronic health record (EHR) resulted in a number of resolutions. One proposed requiring integration of prescription drug monitoring program with EHRs; this was referred for study, as it turns out to be a very complex technical issue. Other resolutions dealt with requirements for interoperability and sharing of information, meaningful use requirements, integration of drug cost data and education of students and residents in the use of EHRs. There was a Board of Trustees report on “augmented intelligence” (AI), the new term for artificial intelligence. Several resolutions either dealt with AI or referred to it.

As always, there were a number of proposals concerning public health. Resolutions dealt with vaccination against papilloma virus. Resolutions on e-cigarettes called for effective regulation by the FDA, including listing of ingredients and national-level rules on things like access by minors.

STATE ISSUES

The meeting of the Organization of State Medical Association Presidents (OSMAP) the day prior to the House of Delegates meeting was, as always, devoted to state issues. AMA 2017-18 President David Barbe, MD, from Mountain Grove, Mo., spoke on the current initiatives of the AMA. He included work-life balance, insurance issues, scope-of-practice issues, opioid use and the always-critical issue of membership in the AMA. He included work-life balance, insurance issues, scope-of-practice issues, opioid use and the always-critical issue of membership in the AMA. Other state-level issues included a movement for tort reform in Arkansas, a critical Wisconsin Supreme Court decision affecting caps on malpractice settlements, an attempt to impose medical price controls in California and an opioid education program from Ohio. In Delaware, the medical society is beginning the use of blockchain technology to speed up prior authorization requests.

Several people from Missouri were in leadership roles. Dr. Barbe, completing his term as AMA president, addressed the House of Delegates by emphasizing the importance of physician leadership. Edmund Cabbabe, MD, from St. Louis serves on the Council for Long Range Planning and Development. Jerry Kennett, MD, from Columbia concluded eight years’ service on the Council on Legislation. The author continues to serve on the Steering Committee of OSMAP.

Barbara McAneny, MD, was inaugurated as the 173rd president of the AMA. An oncologist from Albuquerque, N.M., Dr. McAneny has promoted innovative practice models and has been a strong voice for care of the Hispanic and Native American populations in New Mexico.

Patrice Harris, MD, was elected to be president-elect. A psychiatrist from Atlanta, Ga., she has been chair of the Board of Trustees and has been a strong advocate for the care of underserved minorities.

Besides Dr. Van Way, other KCMS members serving in the Missouri delegation were James DiRenna, DO; Rebecca Hierholzer, MD, and Joanne Loethen, MD, MA.

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at evanway@kc.rr.com.
Shortages of needed drugs and spikes in the cost of certain drugs have physicians concerned. National physician organizations are speaking out on the subject, and it has been a topic of discussion at Kansas City Medical Society board meetings. At its annual meeting in June, the American Medical Association adopted a policy declaring drug shortages “an urgent public health crisis,” adding that it will urge the Dept. of Health and Human Services and the Dept. of Homeland Security to examine drug shortages as a national security initiative. The Food & Drug Administration formed a task force in July to address drug shortages.

**SCOPE OF THE PROBLEM**

Currently, the U.S. is short on 182 drugs and medical supplies, according to the American Society of Health-System Pharmacists. The list includes IV bags, injectable morphine and other powerful painkillers, anesthetics, antibiotics, electrolytes, cancer drugs and much more. All of these are of critical importance to patients with serious illnesses.

A May 2018 survey by the American College of Emergency Physicians found that 91% of emergency medicine physicians say they have recently experienced a drug shortage and 44% say their facilities are inadequately prepared for a surge of patients during a disaster.

Cost is a concern as well. Reports cite instances where the prices of certain generic drugs rose by more than 1,000% in a year. For example, the price that hospitals and pharmacies pay for a bottle of 500 tablets of doxycycline rose to $1,849 in April 2014 from $20 in October 2013. The price of a bottle of pravastatin rose to $196 from $27 in the same time period.

Overall, prescription drug spending rose 73% from 2010 to 2017, according to a report by the Blue Cross and Blue Shield Association on its members. The increase was driven largely by a 25% annual jump in the cost of brand drugs with patent protection and no generic alternative—285% over the seven years.

**CAUSES**

Many factors contribute to shortages and the rise in drug prices. One issue that physician advocacy groups currently are highlighting is the financial arrangements that pharmaceutical companies have with hospital group purchasing organizations (GPOs) and pharmacy benefit managers (PBMs). The source of the problem is the “safe harbor” provision in a 1987 Medicare law that exempts GPOs from the Medicare anti-kickback statute. PBMs were subsequently given “safe harbor” in 2003 by Dept. of Health and Human Services regulatory action.

According to Physicians Against Drug Shortages (PADS), the GPOs award exclusive contracts to favored suppliers in return for various fees and rebates. The group says these arrangements have inflated annual supplies costs by at least 30%, or upwards of $100 billion. The same practices have driven up the cost of drugs sold by PBMs to individual consumers by at least $100 billion annually as well, says PADS’ analysis. These arrangements also create barriers for smaller or newer companies to enter the market.

Consolidation in the pharmaceutical industry is another factor; fewer suppliers means less competition. Three companies now control over 40% of the generic market: Teva, Mylan and Novartis. In a November 2017 report, the Government Accountability Office stated, “Research GAO reviewed indicates that fewer competitors in the drug industry are associated with higher prices, particularly for generic drugs.”

A 2017 study published in the Annals of Internal Medicine found that less market competition led to increases in generic drug prices.

Another contributor to less competition is the closing of generic drug production facilities due to quality issues. In 2015, there were 267 recalls of generic drug products. Also, drug companies pay manufacturers to delay the production of generics through “pay for delay” agreements; the Federal Trade Commission in 2010 estimated this practice costs consumers $3.5 billion per year.

Physicians are encouraged to write to their senators and representatives in Congress and speak to their patients about these issues.

**REFERENCES**


Top Drugmakers by 2016 Generics Revenue in USD Billions

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<th>Company</th>
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Source: Fierce Pharma, May, 2017

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Over 30 news items posted in July!
As doctors, do we have free speech? More explicitly, can government regulate what we may or may not tell patients? Most of us are highly offended by the suggestion that the State of Wherever could regulate our communication with patients. But … it’s been tried, several times.

In 2011, the legislature of the great state of Florida passed a law called Privacy of Firearm Owners Act (PFOA). It caused—pardon the expression—a firestorm. It was denounced by medical organizations, from the AMA down to local medical societies. Now, the intent of the law was to protect gun owners from pediatricians (it is really hard to say that with a straight face). It seems that the American Academy of Pediatrics had advised its members to ask parents about guns in the house, whether they were secured from eager little hands, and what sort of safety precautions were wise. Some parents complained to their elected officials, and, in an attempt to protect Second Amendment rights, Florida managed to trample all over the First Amendment. The PFOA prohibited doctors from asking patients about firearms, with $10,000 fines, and possible medical license sanctions.¹

Doctors and medical organizations in Florida immediately challenged the law. The suit was known, perhaps inevitably, as “Docs versus Glocks.” Its subsequent course was back and forth. First, a federal judge barred enforcement. Then, in 2014, a three-judge panel from the 11th Circuit Court of Appeals upheld the law three separate times. Finally, in 2017, the entire 11th Circuit struck down the PFOA by a vote of 10-1, ruling it clearly violated physicians’ First Amendment rights.¹ That settled the issue and set a precedent. At least in the jurisdiction of the 11th Circuit. In a way, it is a pity that it wasn’t taken up by the U.S. Supreme Court, because a SCOTUS precedent is binding across the country.

Other states considered the issue and similar laws were introduced in a number of them, including Montana, Michigan and Missouri. Aha! That got your attention, didn’t it? The Missouri Legislature actually passed a similar law in 2013. It was vetoed, and the state Senate couldn’t muster enough votes for a veto override. In 2014, they passed it again, and this time they overrode the governor’s veto. Rest assured, thanks to the Missouri State Medical Association (MSMA) lobbyists, Missouri’s law is different from Florida’s. It does not prohibit physicians from discussing firearms with their patients. Instead, it prevents the government from forcing physicians to talk to patients about guns or forcing them to turn over medical records that contain firearm information to the government.

**What is the Basis of These Types of Laws?**

Well, there is a legal concept called “professional speech.” The theory goes that because the state licenses physicians (and nurses, lawyers, accountants, etc.), the state has the right and obligation to regulate speech by professionals. It’s related to “commercial speech,” which is in fact subject to regulation. Clearly, if professional speech can be regulated, there are all kinds of things that we could be required to say or avoid saying. Firearms are just the tip of a potentially large iceberg.

What we need, to repeat myself, is a decision by the Supreme Court. And, in a very surprising way, we now have one. The Supreme Court recently issued a decision about limits on free speech from California. In the Becerra case, California had required pregnancy counseling centers run by pro-life groups to tell their clients about state-run abortion services.² Advocates of the law argued that professional speech is unprotected, and because of that, it can be compelled. The Supreme Court disagreed, stating that argument leads to an unjustified limit on free speech.

Let me interject a couple of disclaimers. First, the whole case had other elements not described above. Second, I’m not advocating either side in the debate between pro-choice and pro-life. The important thing about this decision is
The theory goes that because the state licenses physicians (and nurses, lawyers, accountants, etc.), the state has the right and obligation to regulate speech by professionals.

that it supports our ability to talk to our patients without interference. Becerra actually addresses very specifically the whole issue of professional speech. Three quotations from the text of the decision illustrate this:2

But this Court has not recognized “professional speech” as a separate category of speech. Speech is not unprotected merely because it is uttered by “professionals.” This Court has “been reluctant to mark off new categories of speech for diminished constitutional protection.”

This Court’s precedents do not recognize such a tradition for a category called “professional speech.”

The dangers associated with content-based regulations of speech are also present in the context of professional speech. As with other kinds of speech, regulating the content of professionals’ speech “pose[s] the inherent risk that the Government seeks not to advance a legitimate regulatory goal, but to suppress unpopular ideas or information.”

There is a certain irony, here. The 11th Circuit struck down an attempt from the political right to regulate professional speech about firearms. The Supreme Court struck down an attempt from the political left to do the same thing, about abortions.

I believe it would be hard to find people who agree with the political effect of both of these decisions. However, the text of the decisions themselves is very good news for physicians. These two decisions give us a great deal of protection in what we may discuss with our patients. Despite a 5-4 decision, the Becerra case, in particular, establishes a strong precedent by directly addressing the concept of professional speech. More importantly, it virtually discredits the concept that professional speech can be regulated simply because the professional is licensed by the state.

Considering all of this, then, will future legislators refrain from trying to regulate what we say to patients? Not a chance. From state to national levels, the urge to regulate will always be with us. There will be more attempts in the future. But the rejection by the Supreme Court of the entire concept of professional speech puts a major obstacle in the path of any legislator who wants to tell us what we should or should not say. The lesson to take home is that our profession now has new grounds to support our freedom of speech. If we work together with our local, state and national organizations, we can keep that freedom in the years to come. ☺

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City. He can be reached at cvanway@kc.rr.com.

Jeffrey S. Howell, JD, is general counsel & director of government relations for the Missouri State Medical Association. He can be reached at jhowell@msma.org.

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Northland Health Alliance Seeks Input

Do you live or practice in the Northland? The Northland Health Alliance is seeking public input for its 2018 Community Health Needs Assessment. Input from the 2015 assessment led to implementation of the Signs of Suicide prevention program in local schools and creating a website directing the community to local health resources. For more information and to complete the online survey, visit https://northlandkchealthalliance.org/.
An Alternative to the Hospital Emergency Room for Persons With Substance Use Disorder or Severe Mental Illness

KANSAS CITY ASSESSMENT AND TRIAGE CENTER PROVIDES SHORT-TERM STABILIZATION FOR UP TO 23 HOURS

By Lauren Moyer, LSCSW, LCSW

In cities across the country, individuals with behavioral health issues routinely present at emergency departments or even worse are jailed. Such interventions rarely, if ever, change behavior or resolve a crisis.

Three-year trend data (2012-2014) generated by the Missouri Hospital Association indicates that Kansas City-area hospital emergency departments experienced over 8,000 visits per year from patients with substance use disorders (having no other life-threatening emergent medical conditions), along with over 9,000 visits per year from clients with severe mental illness. What’s more, a high percentage of these individuals had histories of repeated ED visits, some as high as 100 visits annually. The same individual may present for substance abuse disorder on one occasion and severe mental illness on another. Such repeated visits tie up hospital ED resources that could otherwise be used for individuals in acute medical crises.

In 2013, a group of committed area stakeholders gathered to create a different option for these individuals. Throughout the next two years, this group established the Kansas City Assessment and Triage Center (KC-ATC), a public and private partnership between Kansas City stakeholders that include courts, law enforcement, hospitals, city officials and the Missouri Department of Mental Health. The objective of the KC-ATC is to divert persons with mental health and substance use disorders away from jails and area emergency rooms to a safe place where they can be assessed and stabilized, then treated at a behavioral health outpatient or residential service if necessary. Funding was secured from Ascension Health, local hospitals, and other community partners.

In 2016, ReDiscover was chosen as the lead agency by the City of Kansas City to operate the KC-ATC. The KC-ATC, located at 2600 E. 12th St. downtown, has two units with a total of 18 slots. There are nine slots in the Sobering Unit for those currently under the influence of a substance and nine slots available in the Stabilization Unit for those with a primary mental health issue. The maximum length of stay for an individual is 23 hours. The center is open 24 hours/7 days a week.

Individuals receive a case manager who assists them in getting connected to long-term support services.

Discharge functions include:
- Linking the patient back home to family or friends
- Arranging follow-up with a behavioral health provider and/or support services
- Providing bridge case management and medications
- Securing emergency housing until permanent housing is available
- Collaboratively developing a crisis plan in the event of future distress

The KC-ATC has been open almost 18 months and has received well over 4,000 referrals. Of those referrals, 70% are male, over 70% are homeless, and the majority are currently under the influence and are suffering from co-occurring issues. Some 64% of the referrals come from area hospitals and the rest from the...
KCPD and EMS. Among referrals, 77% were between the ages of 25 and 54 years and the average length of stay for a client is 16 hours.

While an individual is only able to stay at the KC-ATC for 23 hours or less, the larger goal at the KC-ATC is ongoing case management. ReDiscover recognizes and has thrived at providing intensive case management services to individuals who aren’t quite ready to change. At KC-ATC, individuals receive a case manager who assists them in getting connected to long-term support services. The client may work with the case manager for as little as a week or as much as three to six months, depending on the individual’s level of care needed and motivation. This ongoing case management is what distinguishes KC-ATC from becoming another revolving door—the crucial ingredient of the success of the KC-ATC model.

An equally important resource is the funding we receive from the Missouri Department of Mental Health for aftercare services. If someone is uninsured and can’t get their medication filled, the aftercare service funds are allowed to be used flexibly to cover medication costs, pay for rent or immediate supportive housing and/or assist in paying for on-going outpatient treatment services. This has also allowed us to increase engagement rates in on-going treatment as we can assist in meeting the basic needs to those referred.

The KC-ATC was also created to assist in further identifying gaps in our system of care and help to find solutions. One of those areas is quick access to case management and medication services. KC-ATC sometimes keeps individuals longer for both case management and medication services due to the wait time at local outpatient centers. This is an area in which we are continually working to improve.

The KC-ATC has seen many success stories throughout the 18 months of being open. John is one of those such individuals. John spent 10 years in and out of jail. Once he arrived at KC-ATC, he had lost connections to family and loved ones—and more importantly he had lost all hope. John wanted to end his life. He had struggled with bipolar disorder and used drugs such as heroin to stabilize his mood swings. KC-ATC provided him medication and found a transitional housing program which he agreed to enter. His KC-ATC case manager continued to follow him and through conversations, learned that he had been a cook at one point in his life. With this information, the case manager helped the man enroll in a culinary educational program, which led him to a job as a sous chef in a Kansas City hotel making $60,000 annually—all within just seven months of his first visit to the KC-ATC. John was also connected back to his girlfriend and finally reported having hope again.

Lauren Moyer, LSCSW, LCSW, is vice president of clinical services at ReDiscover. She can be reached at lmoyer@rediscovermh.org, or (816) 581-5816.

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**Research Explores Stem Cells, Neuroblastoma**

Researchers from the Stowers Institute for Medical Research recently published the following research projects:

- A method has been identified to expand blood-forming, adult stem cells from human umbilical cord blood. This development could make these cells available to more people, and be more readily accepted in those who undergo adult stem cell treatments for conditions such as leukemia, blood disorders, immune system diseases, and other types of cancers, but who do not have an appropriate available bone marrow match. In the study, published online July 31, 2018, in *Cell Research*, researchers zeroed in on a protein that affects multiple targets and pathways involved in hematopoietic stem cell self-renewal, a broader approach than other studies that focus on a single target or pathway in the process.

- A new model has been developed to identify neuroblastoma, a rare childhood cancer of the sympathetic nervous system. Using a 6-gene input logic model, the team simulated a molecular network of developmental genes and downstream signals that predicted a favorable or unfavorable disease outcome based on the outcome of four cell states related to tumor development — cell differentiation, proliferation, apoptosis, and angiogenesis. The study, a collaboration between researchers at Stowers, the University of Michigan and Oxford University, was published in the July 2018 issue of *Biophysical Chemistry*. 
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*Source: internal company data 2015-2017
The opioid epidemic in the United States and Kansas City has reached crisis proportions, with no clear resolution in sight. In just four years, from 2013 to 2016, the number of opioid overdose deaths jumped over 68% nationally.

Much of the recent jump is due to the powerful synthetic drug fentanyl; deaths from fentanyl and other synthetics rose 525% from 2013 to 2016 in the U.S. Heroin overdose deaths spiked upward beginning around 2010, showing an increase of 410%.

The widespread use of prescription opioids for pain relief is associated with abuse. In 2015, an estimated two million people in the U.S. suffered from substance use disorders related to prescription opioid pain relievers. Additional data from the NIH National Institute on Drug Abuse shows:

- Roughly 21% to 29% of patients prescribed opioids for chronic pain misuse them.
- Between 8% and 12% develop an opioid use disorder.
- An estimated 4% to 6% who misuse prescription opioids transition to heroin.
- About 80% of people who use heroin first misused prescription opioids.1

In this issue of Kansas City Medicine, local experts give us their perspectives on the problem:

- KCMS Executive Director and CEO Angela Bedell shares the heartbreaking personal story of losing her brother to prescription opioids.1
- Doug Burgess, MD, explains how medication-first is now the clear evidence-based preferred treatment for opioid use disorder.
- UMKC Pharmacists Jennifer Santee, PharmD, and Melissa Palmer, PharmD, describe the use of naloxone to treat opioid overdoses.
- Three physicians from the Jackson County Medical Examiner’s Office provide data for the Missouri counties of the metropolitan area.
- Kansas City Medicine Editor Michael L. O’Dell, MD, MSHA, interviews a Kansas City Fire Department paramedic on what she experiences on the front lines of overdose cases.
- Teesha Miller, who oversees the Prescription Drug Monitoring Program for Jackson County, reminds us of the importance of this program.

REFERENCE
Opioid Crisis Hits Home for KCMS Executive Director

THE PERSONAL STORY OF LOSING A BELOVED YOUNGER BROTHER TO PRESCRIPTION OPIOID OVERDOSE

By Angela Bedell, MA, CAE

I once had a boss who loved to say “it’s not personal, it’s business,” which drove me nuts. He always said it when someone was getting laid off or a program being discontinued, or (in my mind) when making a decision that he didn’t really have the spine to own. I also could not imagine how you could spend 40+ hours per week with anyone or working on anything then proclaim that decisions were not personal.

I am all business in my role as executive director for the Kansas City Medical Society. But it is also very, very personal. It’s personal every time I take a night away from my family to attend a meeting or represent the Society in the community. It’s been personal as the Society has done advocacy projects that affect the health of me, my loved ones and my community.

Nothing, though, as been as personal as the opioid crisis and the work the Society has done on the subject.

Just a week into the presidency of Dr. Michael O’Dell, I had to call him and, over huge lumps in my throat, tell him, “Kevin passed away.” I couldn’t breathe. I’ll never forget that moment.

That had been my mom on the phone. She was living in New Mexico and my brother was staying with her. She found him, her youngest child, dead that morning. I knew I had to get to her, and somehow managed to get my whole family on an 11:00 flight to Albuquerque where she was.

MY BROTHER AND OUR FAMILY

Mom became pregnant with me at only 16 years old, and while she accomplished amazing things for her young age, she was still a teenager and she wasn’t prepared for the world. We were often without things like a phone and I saw Mom in tears many times, worried about paying bills.

Mom completed a high school degree and then went to college, first at night and finally full-time, with a goal to graduate college before I did high school. She worked at a bank and took classes at night, and I was often “in charge” at home.

Whether you believe the birth order theories or not, they played out with precision in my family. As the oldest child, I brought home good grades, never got into any trouble, and was always responsible for all the other kids. When I went to the pool in the summer, I remember keeping one eye on each of my younger brothers. In middle school and junior high, I often could only go to football games and summer carnivals if I had two little boys with me.

Kevin was the youngest, and without a doubt the baby. In high school, I had very high ACT scores. But a few years later he came home with super-high ACT scores (almost perfect) which annoyed me because the kid never studied. Mom and I both loved to talk about how smart he was. He was super intelligent, as well as a gifted athlete. He was a quiet and intense kid, always in deep thought. He would get interested or involved in something and immerse himself in it day and night. He led a life of “no grey areas.”

Having been a teenage mother and enduring gross chauvinism in her early jobs, Mom wasn’t a fan of the Midwest or of small town life. The day I graduated high school, she, my stepdad and my two brothers moved to California. They landed in Roseville, outside Sacramento. Both of my brothers transitioned from class sizes of 200 to class sizes of 2,000. I worried they wouldn’t get to participate in sports in such a large school, but I was wrong. Both made the varsity football team; Kevin was an exceptional athlete and became a starter as a sophomore. This ended up being a problem, as he took some hits from really big kids, and a shoulder injury ended up causing lifelong pain.

A QUICK DESCENT

The phone call that came on that January morning is undoubtedly the
most shocking thing that has happened in my life. Though I never imagined he might die, I suspected something was wrong in Kevin's life before the holidays. A few days before Christmas, Mom, Kevin and his two sons, and my own family were gathered at my house. Kevin wasn't himself. (He had been dealing with intense arthritic shoulder pain for over a year. It had been so bad he could no longer do landscaping and had to give up most of his favorite activities.). This day was different; he was staring blankly as though he was half asleep. He did make enough conversation that day to tell me his holiday plans, which included spending a couple weeks in New Mexico before starting a new job in mid-January.

After seeing Kevin in this state, I called Mom. She told me that he was severely depressed and she was worried. I don’t know if I literally rolled my eyes, but that was certainly part of my reaction. It seemed she was making excuses for her baby. I misinterpreted his struggles and I still have serious regrets about that.

I met Kevin briefly on Christmas Eve afternoon and he handed me a gift for my daughter, a Shopkins Bakery. For a single guy with two children, this was very thoughtful to find gifts for my daughter, down to the girly gift bag. He was celebrating Christmas with his children and then heading to New Mexico to enjoy the mountains and stay at Mom’s. That was the last time I saw him.

After he had been in New Mexico a few days, Mom told me on the phone that he was really enjoying the outdoors and the mountains, that he was going hiking everyday and he’d lost weight. Mom moved to New Mexico just two years before to teach Navajo kids in an under-served rural community; she lived alone and was enjoying his company.

Right after the New Year, out of the blue, Kevin made an unusual, one-day trip from New Mexico to Kansas City to see his children. Strangely quick, I thought, for such a long drive.

THE MORNING THAT KILLED HIM

That morning began with my family in our usual routine. My daughter was eating breakfast and I was quizzing her on her spelling words. My husband Larry was cleaning up breakfast dishes and he got a phone call.

(continued)
opioids. And Kevin managed to get four prescriptions for them within four hours, in the Kansas City area. I know because the day after I arrived in New Mexico and made it to Mom's house, I went through his briefcase and found the checkout paperwork from every single physician he saw. I saw the dates and times he was at the offices. The notes include things like “he hopes to soon be off OxyContin” and “he has lost 10 pounds in two weeks and is making progress toward health goals.”

I’ll never forget sitting on the floor of the guest bedroom of Mom’s small house in New Mexico, reading the papers and holding the pill bottles, and feeling like I was holding the weapon that killed my brother.

My brother had experienced real pain over months, and because of it, became under-employed and stressed. He may have been scared to be in New Mexico without access to pain medicine, and thought he was “stocking up.” He may have been in a state of addiction that I will never completely understand. I don’t know his thoughts that day, so I don’t know how “wrong” he was or how much of a “victim” he was. To me it doesn’t matter now, but when I hear discussions on the opioid epidemic, I am surprised how much it matters to policymakers to categorize the people involved and their behaviors.

To really understand the social complexities of addictions and mental health issues, it’s necessary to know the true stories of what’s making people sick and even killing them. In the case of my brother’s death, it’s not complexities, just a couple simple principles that I hope to share.

Whether simple or complex, the factors twisting data and reported outcomes are influenced by one thing: family pride. The problem is that families do not want to share the ugliness of the true story they just experienced. I really don’t want to tell the part of this story that is my brother’s “fault.” He was a generous, brilliant, creative soul who coached his son’s ball teams and built a landscaping business and his legacy should not be his cause of death.

The unusual 14-hours-each-way drive back to Missouri was made to obtain opioids. And Kevin managed to get four prescriptions for them within four hours.

My brother’s death certificate reads “atherosclerotic … cardiovascular disease.” I don’t really want to share this secret, but the fact is my mother and I were both relieved that the coroner did not make any proclamation of addictions. Mom in particular was really concerned that may happen, and would forever be “the story.” I have a good friend who also lost her brother from an opioid addiction, and while she is certain this is what killed him, it certainly is not on the death certificate.

My first point is this: The data on deaths from opioids may be grossly understated, as no one dies from only the addiction. Several recent studies in fact support that actual death totals may be much higher.12

When the KCMS board discussed opioid abuse, the question was asked about the data. I wanted to speak up and point out how understated I think the numbers are. I didn’t, as the story I had to share isn’t short.

THE REAL PROBLEM

I’ve sat in civic and county committee meetings on behalf of the Medical Society when a local PDMP was being discussed. I had a letter from then-President, Dr. Stephen Salanski, proclaiming the Society’s support of allowing physicians access to information about patients prescriptions. The Jackson County meeting went well, I read the letter and listened to a short discussion before a unanimous vote.

The next meeting, at City Hall, was different. I read the same letter then sat down and listened to the committee’s discussion, which included comments about “needing to stop criminalizing addicts.” While I appreciate the service, the leadership and the intentions of the group, I was astounded how uninformed they were.

I knew that my brother seriously misrepresented his situation to physicians, (and yes, I know, he is responsible for his actions) but I also knew he hadn’t technically broken the law. The conversation I was hearing—like many in health care—was focused on finding fault instead of a solution. It was superficial, lacking in important facts and frustrating to listen to. I sat up tall and took deep breaths, and resisted the temptation to go to the microphone and say, “You don’t get it, the doctors want to help these patients and they need information to do it.”

I made it through that meeting by watching Drs. Rex Archer and Sarah
Martin-Anderson, and saying silent prayers that they would have the patience and perseverance to complete their work. (They did.)

More frustrating to me personally was what came later: the PDMP issued by executive order from the office of former Gov. Eric Greitens, which basically just monitored physicians’ prescribing habits. As if the doctor who sees the most patients in pain is over-prescribing. Have lawmakers never had a family member in pain?

I am completely certain that if any of the four doctors my brother saw that morning in Missouri had been able to know what prescriptions he already had, they wouldn't have written him another one. I am certain that at least one of those physicians would have tried to get him help for his addiction. My other simple point: the doctors needed information, not regulations.

Now that a little time has passed since my brother’s death, I remember the months of pain being harder on him than the addiction. None of us could really draw the line on where one ended and the other began. The pain eliminated the outdoor life he loved. He gained weight, his blood pressure rose and the lack of sleep kept him in a constant dazed, fatigued state. There certainly is a place for appropriately managed pain medicine.

After my brother’s death, I had to hold it together and organize a memorial and take care of the usual business. Our mom and his dad, for various reasons including emotional distress and their own health issues, were overwhelmed. Like many women, I took care of my family, I got my job done, and no one saw any dropped balls. Looking back, I see that I was walking through quicksand every day, and that for a couple years, life was blurry and tough.

At annual meetings, I sometimes have told the membership “thank you for this professional opportunity, it is an honor to work to advance your mission.” It truly is an honor. And it’s very personal. ©

Angela Bedell, MA, CAE, is executive director and CEO of the Kansas City Medical Society and Foundation. She can be reached at abedell@metromedkc.org.

REFERENCES
In the United States, drug overdoses, the majority of which are related to opiates, kill around 64,000 people every year. If current trends continue for the next five to six years, the number of drug overdose deaths in the 21st century will approach one million people. Present-day drug overdose deaths exceed those numbers seen during the peak of the HIV/AIDS epidemic. However, unlike the HIV/AIDS epidemic, deaths related to drug overdose have not fallen, even though highly effective treatments exist (Fig. 1). In fact, recent data indicates that from 2016-2017, deaths related to drug overdose have increased by 22% over the previous year.

MEDICATION FIRST MODEL

While the reasons for the continued increase in overdose deaths are varied, one of the major contributing factors is a lack of access to evidence-based treatment. With close to two million people identified as having an opioid use disorder, specialty clinics lack the capacity to meet this volume on their own. Additionally, the treatment provided at specialty care clinics varies greatly from site to site. Patients are frequently required to participate in intensive psychosocial interventions as a condition of being prescribed medications.

If patients do receive medications, their treatment often consists of detoxification followed by abstinence-based treatment that is associated with relapse rates over 90%. A 2003 study by Kakko et al. compared treatment with buprenorphine to detoxification followed by intensive psychosocial interventions without buprenorphine treatment. While the numbers in the study were small, 75% of participants treated with buprenorphine were still in treatment at one year, but no participant remained in the psychosocial-intervention-only group. Within two weeks, 75% of participants in this group had dropped out of treatment and, even more alarmingly, 20% of them were dead by the conclusion of the study.

Treating opioid use disorders within primary care settings offers many advantages. In addition to increased capacity and ease of access, patients may feel less stigmatized if their care is delivered in a traditional medical setting. Additionally, opioid use disorders are often first diagnosed in primary care clinics so access to readily available treatment can reduce barriers and cut down on delays in starting treatment.

There is ample evidence supporting the effectiveness of treating opioid use disorders within a traditional medical setting. In 1997, France responded to a marked rise in opioid overdoses by approving buprenorphine treatment without requiring specialized training or certification. Among primary care providers, 20% began to offer this treatment in their standard practice locations. This increase in buprenorphine prescriptions was correlated to a decrease in opioid related mortality. Similar results have been demonstrated in the United States. In Baltimore, increased treatment with buprenorphine, and to a lesser extent methadone, resulted in over a 50% reduction in overdose deaths.

Some clinicians may be reluctant to treat opioid use disorders in a primary care setting due to a lack of immediate access to psychosocial interventions such as group therapy and individual counseling. However, a recent Cochrane review found that there was no impact on retention in treatment or illicit opioid use when intensive psychosocial interventions were added to methadone or buprenorphine alone. Another study found a 75% reduction in illicit opioid use as measured by urine toxicology screens when wait-listed patients were provided with bridge buprenorphine. They received minimal interventions outside of treatment with buprenorphine.

Psychosocial interventions will continue to play an important role in the treatment of opioid use disorders and should be offered to patients. However, the research demonstrates that the most effective treatment for opioid use disorders is medication. This evidence supports a new approach to the treatment of opioid use disorders where there is rapid access to medications with minimal barriers to starting and continuing treatment. This model has been referred to as the “Medication First” model because it emphasizes the use of medication as an essential first step in engaging patients in treatment. Provid-
ing medication up front allows patients to participate in other interventions without suffering through opioid withdrawal. It also decreases the likelihood that they will die while awaiting intake at a specialty clinic.

**INITIATING TREATMENT OF OPIOID USE DISORDER**

Screening instruments such as the Drug Abuse Screening Test (DAST)\(^1\) can be useful in identifying individuals who warrant further assessment. Further evaluation needs to establish a diagnosis of Opioid Use Disorder according to the DSM-5\(^2\) or Opioid Dependence Syndrome according to The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).\(^3\)

It is important to distinguish between patients who may be exhibiting symptoms of physical dependence and those with an opioid use disorder. Patients with physical dependence may be successful with a gradual taper of opioids and alternative pain management strategies. The American Society of Addiction Medicine (ASAM) National Practice Guidelines\(^4\) provides a comprehensive overview of considerations when evaluating patients for opioid use disorder. Special consideration should be given in screening for infectious diseases (hepatitis, HIV and tuberculosis), acute trauma, pregnancy and cellulitis or abscesses.

Laboratory testing should include a complete blood count, liver function tests, urine toxicology and tests for hepatitis C and HIV. Testing for other sexually transmitted infections and pregnancy is considered on a case-by-case basis. Patients should undergo screening for other substance use and any co-occurring mental health conditions. A thorough review of active medications should be completed. Concomitant prescription of benzodiazepines should be used with extreme caution in patients with an opioid use disorder. The FDA recently reviewed risk data on combined use of benzodiazepines and methadone or buprenorphine. In August of 2017, they issued a drug safety warning that identified an increased risk of serious side effects, but concluded that “the opioid addiction medications buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS).”\(^5\)

**MEDICATIONS USED IN THE TREATMENT OF OPIOID USE DISORDERS**

There are three classes of medication with FDA approval for the treatment of opioid use disorders: full opioid agonists, partial opioid agonists and full opioid antagonists. All three have proven efficacy but vary significantly in their mechanism of action and initiation procedures. The choice of which agent to use is based on a number of factors including access to treatment, previous patient experiences and clinician assessment. The goal of treatment is to reduce mortality, decrease use of illicit substances, prevent withdrawal and cravings, and reduce the symptoms associated with illicit opioid use. Treatment should be continued for as long as the patient is benefiting, remains at risk for relapse, has no serious side effects and wants to remain in treatment.

All patients with an opioid use disorder should be counseled on the use of naloxone. This is covered by most insurance companies and is available in Missouri without a prescription. The CDC recommends naloxone be made available to all patients prescribed more than 50 morphine milligram equivalents per day.

**METHADONE**

While methadone can be prescribed in the management of pain, methadone for the treatment of opioid use disorder can only be provided by opioid treatment programs (OTPs). A recent search of the U.S. Substance Abuse and Mental Health Administration’s opioid treatment program directory identified 16 OTPs in (continued)

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**Fig. 1: Total U.S. Drug Overdose Deaths 1999-2016. Source: Centers for Disease Control, National Center for Health Statistics**

![Total U.S. Drug Overdose Deaths](image)
the state of Missouri, all of which were located in metropolitan areas. In cases where hospitalization is required and a patient would be unable to present to their OTP, their methadone can be provided after verification of dosage with the treating OTP.

Methadone is a full agonist at the mu opioid receptor and has a long half-life which limits the euphoria as well as peaks and valleys which can contribute to misuse. When starting treatment at an OTP, individuals are required to present on a daily basis to have methadone dispensed. The dosage is titrated until withdrawal symptoms and cravings resolve. After they are stabilized, patients are able to earn take-home doses based on their progress in the program. After one year, they are eligible for up to two weeks of take-home treatment and after two years, they can take home up to four weeks.

Important considerations in treating individuals who are receiving methadone include the potential for QT prolongation and interactions with other medications which can significantly increase or decrease methadone metabolism. Periodic EKGs may be useful in monitoring patients with conditions that predispose them to cardiac arrhythmias. A review for potentially harmful medication interactions should be completed prior to starting or stopping any medications.

**BUPRENORPHINE**

The Drug Abuse Treatment Act of 2000 (DATA) allows practitioners to prescribe buprenorphine in any clinic location including offices, community hospitals, health departments and correctional facilities. Providers must first receive a waiver from the Drug Enforcement Administration which requires them to complete eight hours of training, offer referral for psychosocial interventions and keep a log of the patients they are treating at any given time. They are limited to 30 patients in the first year, 100 patients in their second year and 275 patients after that.

Buprenorphine is available in several formulations which are dissolved under the tongue. Many of these options contain naloxone which has poor oral bio-availability but acts as an abuse deterrent. A new extended-release formulation was also approved by the Food and Drug Administration in December 2017. This is a long-active injectable which is administered every four weeks.

Buprenorphine acts as a partial agonist at the mu opioid receptor site and an antagonist at the kappa opioid receptor site. Given that it acts as a partial agonist, there is a lower risk of overdose and respiratory suppression. Most individuals experience a ceiling effect at 24-32 mg; higher dosages do not produce a greater effect. Buprenorphine binds with high affinity to mu opioid sites so consideration must be given to management of acute pain. Buprenorphine’s high affinity for mu opioid receptors also means that prescription opioids may have significantly reduced efficacy in treating acute pain. Non-opioid pain medications and nerve blocks will continue to be effective alternatives.

Care must also be taken when starting people on buprenorphine. Individuals must be in mild to moderate opioid withdrawal before the buprenorphine is initiated or they could experience precipitated withdrawal due to buprenorphine displacing other opioids in the body. In order to avoid this, the medication should be started at 2-4 mg and titrated gradually, with additional dosages taken every 1-2 hours until symptoms of withdrawal and opioid cravings resolve. For a more detailed explanation of the induction process, refer to the ASAM’s National Practice Guideline.14

The induction process can be completed in-office, but recent trends have moved towards providing appropriate patients with a small supply of buprenorphine along with instructions on how to complete the induction at home. There have been over 1,100 cases of home induction reported in the medical literature16 and there are several studies which support the safety of this approach.17-19 The consensus opinion of ASAM’s National Practice Guideline Committee supports the use of home induction.14

**NALTREXONE**

Naltrexone works as a full antagonist...
at the mu opioid receptor site. It requires that patients be abstinent from opioids for 7-10 days which can make it difficult to initiate in individuals who are likely to experience significant withdrawal symptoms. However, unlike treatment with methadone or buprenorphine, naltrexone does not produce withdrawal symptoms if it is suddenly discontinued. Adherence with oral formulations tends to be poor, but it is also available in a long-acting formulation that is administered every four weeks. This has been shown to be effective in helping people maintain abstinence and possibly reduce cravings for opioids.20,21 There have been some rare cases of liver toxicity associated with naltrexone, so liver function tests should be performed periodically and in cases where there are signs and symptoms of toxicity. In situations where acute pain management is required, opioids will be ineffective, but non-opioid pain medications and nerve blocks will continue to be effective alternatives.

THE BIG PICTURE

The opioid epidemic is the most severe substance-use-related epidemic in the history of the United States. Traditional approaches to treatment have been ineffective, and deaths continue to accumulate. Communities that have expanded access to effective treatments by extending services to standard medical settings have demonstrated a remarkable reduction in mortality rates. It is imperative that our medical community reduce unnecessary barriers and obstacles to accessing lifesaving medication. While the medications may be new or unfamiliar to some, with time and practice, they can become as easy to use as many of the medications currently prescribed during routine office visits.22

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Missouri is facing an opioid overdose crisis. In 2016, 908 people died from opioid overdose and one out of 66 deaths was due to opioid overdose. The incidence of mortality due to opioid overdose increased 35% from 2015 to 2016.

MAKING THE CASE FOR INCREASED ACCESS TO NALOXONE

As a recognized public health crisis, opioid overdose has triggered three priority areas determined by the U.S. Department of Health and Human Services: prescriber education, improved access to medication-assisted therapy for opioid use disorder (OUD), and expanded naloxone access. Prescribing of naloxone is supported by the American Medical Association, the American Society of Addiction Medicine, the American Pharmacists Association, and other stakeholders including the World Health Organization. In addition, the U.S. Surgeon General released a statement this year that patients who are currently taking high doses of opioids for pain, those misusing opioids both prescription and illicit, and those who come in contact with people at risk of opioid overdose should have naloxone within reach and be taught how to administer.

However, the idea of the Peltzman Effect is holding sway over some, or the idea that those partaking in a risky behavior, i.e. risky opioid use, will increase this behavior if they believe they have a safety net, i.e. naloxone. This remains to be appropriately validated. In a study of 1,985 adults on long-term opioids for pain, 38.2% were prescribed naloxone after provider and staff training with a decrease of emergency room visits by 63% compared to those not prescribed naloxone.

Prescribing of naloxone is supported by the American Medical Association, the American Society of Addiction Medicine, the American Pharmacists Association, and other stakeholders including the World Health Organization.

Naloxone has a markedly benign safety profile and produces no clinical effects when administered to patients with no opioids in their system. Although given its mechanism of action, it is by definition inducing opioid withdrawal; this is very rarely life-threatening and should not be a reason to avoid the use of naloxone. The risk of seizures during opioid withdrawal could occur following intoxication with tramadol.

LIABILITY QUESTIONS

Some providers have expressed concern that prescribing naloxone will increase liability. Lawyers examining co-prescribing of naloxone and opioids commented that the legal risk with prescribing naloxone is equal to or even lower than prescribing other medications. These same authors note the plaintiff must provide evidence that the defendant did not meet the current standard of care in order for a lawsuit to be successful. The current standard of care is to prescribe naloxone if indicated, as supported by multiple national organizations and the U.S. Surgeon General.

An increase in naloxone access should be seen as beneficent rather than a liability. Historically, naloxone has been available at needle-exchange and harm reduction programs. In 2010, a survey revealed 188 naloxone distribu-
tion programs that reported a reversal of 10,171 opioid overdoses. On a smaller scale, out of 47 intranasal naloxone kits prescribed by pharmacists at a San Francisco Department of Public Health pharmacy, there were a reported three opioid overdose reversals. Mortality benefit of naloxone distribution has also been shown in Massachusetts communities through a decreased opioid overdose death rate in comparison to communities without naloxone distribution.

LEGAL ASPECTS OF NALOXONE USE IN MISSOURI

Organizations acting under a standing order by a physician may have on hand and dispense naloxone without a license or permit as long as the organization does not collect reimbursement for dispensing the naloxone. A standing order is available for pharmacists licensed and practicing in the state of Missouri to dispense naloxone for persons at risk for opioid overdose.

Anyone seeking emergency treatment for an opioid overdose (whether the patient or someone else helping the patient) is protected from charges for possession, violation of restraining order, and/or violation of probation or parole. The Good Samaritan Laws, however, do not provide immunity against other crimes such as distribution of a controlled substance.

WHO SHOULD RECEIVE A NALOXONE PRESCRIPTION

As overdose can occur with both therapeutic and recreational use of opiates, take-home naloxone has been identified as a means of reducing opiate overdose in patients deemed high-risk. Risk factors for opioid overdose include concomitant use of benzodiazepines, history of opioid use or other substance disorder(s), comorbid mental health conditions, polypharmacy, and daily opioid over 100mg morphine equivalents. The burgeoning county-based Missouri Prescription Drug Monitoring Program (PDMP) is a tool that should also be utilized to report and analyze substance use patterns.

<table>
<thead>
<tr>
<th>Name</th>
<th>Route</th>
<th>SIG</th>
<th>How Supplied</th>
<th>Extra Supplies Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcan®</td>
<td>Liquid; intranasal</td>
<td>4 mg (contents of 1 nasal spray) as a single dose in one nostril; may repeat every 2 to 3 minutes in alternating nostrils until medical assistance becomes available.</td>
<td>4mg/0.1mL</td>
<td>None</td>
</tr>
<tr>
<td>Evzio®</td>
<td>Solution; auto-injectable (IM or SQ)</td>
<td>0.4 mg or 2 mg (contents of 1 auto-injector) as a single dose; may repeat every 2 to 3 minutes until emergency medical assistance becomes available.</td>
<td>0.4 mg/0.4 mL (0.4 mL); 2 mg/0.4 mL (0.4 mL)</td>
<td>None</td>
</tr>
<tr>
<td>Generic naloxone</td>
<td>Solution; injectable</td>
<td>0.4 to 2 mg; may need to repeat doses every 2 to 3 minutes.</td>
<td>0.4 mg/mL (1 mL); 4 mg/10 mL (10 mL)</td>
<td>Two 3 mL syringes, and two 25 G, one inch needles</td>
</tr>
<tr>
<td>Generic naloxone</td>
<td>Solution pre-filled syringe; injectable, may be used intra-nasally</td>
<td>0.4 to 2 mg; may need to repeat doses every 2 to 3 minutes. Off label dosing: 2 mg (1 mg per nostril) using generic injectable solution (with a mucosal atomization device); may repeat in 3 to 5 minutes.</td>
<td>2 mg/2 mL (2 mL)</td>
<td>Two 25 G, one inch syringes; two intranasal mucosal atomizing devices (MAD 300) if using nasally</td>
</tr>
</tbody>
</table>

The Centers for Disease Control and Prevention opioid prescribing guidelines recommend consideration of naloxone for patients prescribed more than 50mg morphine equivalents per day in addition to those who have a history of overdose or substance use or are also co-prescribed a benzodiazepine.

PRESCRIBING NALOXONE

Naloxone is available in various formulations. Details regarding each formulation are provided in Table 1. Two brand name formulations of naloxone, Narcan® and Evzio®, are commercially supplied as a kit containing all of the supplies the caregiver will need to administer two doses. The caregiver will need additional supplies if administering the generic injection solution either intramuscularly or intranasally:

- For intranasal administration—two 2 mg/2 ml pre-filled syringes and two intranasal mucosal atomizing devices (MAD 300)
- For administering the 0.4 mg/ml inject-
tion intramuscularly—two vials, two 3 ml syringes, and two 25 g, one inch needles.

- For administering the 2 mg/2 ml injection intramuscularly—two prefilled syringes and two 25 g, one inch syringes.14

  The relative efficacy/safety of intranasal naloxone compared to intramuscular naloxone is not certain from an evidence-based medicine perspective. Two randomized controlled trials have compared intranasal to intramuscular administration of naloxone and produced conflicting results regarding efficacy. Subjects in these trials received higher volumes of naloxone intranasal than what a patient would receive with the current commercially available formulations. Authors have questioned whether the efficacy of intranasal naloxone may differ depending on the volume administered.19,20

  Training should be provided to those who will be administering naloxone. Caregivers should be made aware of the signs and symptoms of opioid overdose (e.g., the patient is unarousable, the patient's breathing is slow and/or shallow, the patient's fingernails and/or lips are blue or purple, and/or the patient has "pinpoint" pupils) and that they should seek emergency services for the patient, even if the patient responds to naloxone administration.21 Onset of action is 2 to 5 minutes, dependent on the selected formulation. Due to the short duration of action (approximately 30 to 90 minutes), a second dose may be required, particularly if a long-acting opioid was ingested. Pregnancy should not preclude naloxone administration.17

  It is important to note that naloxone is not administered by the patient who is suffering an opioid overdose. Naloxone is administered by bystanders, thus, training of not only the patient but those close to them is of vital importance. Naloxone may be requested by caregivers or friends/family of opioid users.

**COST CAN BE AN IMPEDIMENT FOR SURE**

Many insurance companies including Missouri Medicaid do cover naloxone, although differences in co-pay and/or coverage based on the formulation can be expected. The MO-HOPE Project offers free naloxone to certain agencies and the request form may be found on their website, https://mohopeproject.org. The Missouri State Targeted Response Grant has provided the addiction recovery center Healing House with naloxone and OUD recovery support services.22 Community health centers, charitable clinics, federally qualified health centers and other nonprofit providers may contact Direct Relief (Direct Relief, 1-800-676-1638) to ascertain eligibility for intramuscular naloxone.

Kaleo, the manufacturer of Evzio®, provides two programs for commercially insured and non-insured patients. The EVZIO2YOU program allows commercially insured patients to have select pharmacies mail Evzio® to their home or physician's office at no cost to the patient or physician. Patients can find more information about this program through the Evzio® website at https://evzio.com/patient. Patients without and not eligible for commercial or government-funded insurance who are legal United States residents and have an annual household income less than $100,000 can receive Evzio® at no cost through the Kaleo CARES Patient Assistance Program. More information is available at https://evzio.com/patient/kaleo-cares. Patients with government-funded insurance (e.g., Medicaid, Medicare Part D, Tricare, or Veterans Affairs) do not qualify for the ENVIO2YOU or Kaleo CARES programs.

Naloxone is a potentially life-preserving medication, and should be prescribed to patients at risk of an opioid overdose. There is a variety of formulations that can be prescribed and the patient and/or caregiver/friend/family member should also be included in the patient education. &

Jennifer Santee, PharmD, is a clinical associate professor at the University of Missouri-Kansas City School of Pharmacy and currently practices as a clinical pharmacist in various ambulatory care clinics at Truman Medical Center-Lakewood. She can be reached at santeej@umkc.edu.

Melissa Palmer, PharmD, BCPS, BCPP, is a clinical assistant professor at the University of Missouri-Kansas City School of Pharmacy and currently practices as a psychiatric consult liaison clinical pharmacist at North Kansas City Hospital. She can be reached at palmerme@umkc.edu

**REFERENCES**


Opioids are a class of drugs that include the illicit drug heroin as well as the prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and other synthetic analogues just to name a few. Opioid drugs, typified by morphine, produce their pharmacological actions, including analgesia, by acting on receptors located on neuronal cell membranes. The presynaptic action of opioids to inhibit neurotransmitter release is considered to be their major effect in the nervous system. Deaths are usually attributed to respiratory depression.

In the U.S. the highest drug death rates are among individuals ages 25 to 54. The Centers for Disease Control and Prevention reports the age-adjusted death rate from overdoses more than tripled from 1999 to 2016.1 This has been a major issue for medical examiner offices in larger metropolitan cities throughout the United States. The crisis results in an increased workload for the forensic pathologist and puts a strain on the annual operating office budgets to cope with the increased laboratory analysis costs.

With the constant occurrence of newly formed synthetic-related opioid compounds, it becomes a challenge to identify the presence of these drugs in the body. Many drug-related deaths may go undiagnosed until adequate toxicological analysis can be developed to identify these new analogues.

The Jackson County Medical Examiner’s Office (JCMEO) takes jurisdiction of cases from Jackson, Cass, Clay and Platte counties, covering an overall population of approximately 1.2 million. We examined the opioid related deaths in our office for the years 2013 to 2017.

On average our office investigates around 104 deaths per year due to opioids and 29 deaths per year due to non-opioid prescription drugs deaths. Consequently, the fatality rate due to opioids is approximately 11 per 100,000 population compared to 4 per 100,000 population for non-opioid prescription drugs.

**OXYCODONE LEADING CAUSE 2013-2015**

From 2013–2015, the JCMEO handled 332 opioid-related deaths, the majority of which were classified as accidents in terms of the manner of death with a minority (7 to 13 per year) classified as suicides. Less common additional opioid related fatalities included one natural, one as an undetermined, one an accident/traffic and one as homicide during the same years. The death ruled as homicide involved an individual who was using opioids for chronic pain syndrome secondary to a remote gunshot wound to the neck.

During this period, the most frequent fatal opioid drug in our population (in Jackson County and overall in our jurisdiction) was oxycodone, followed by, in order, hydrocodone, methadone and morphine. The most affected age group was 51 to 60 years followed by 41 to 50 years and 31 to 40 years, with males more affected than females. For this same period, opioid-related deaths accounted for 13% of non-natural deaths (or 28% if you exclude traffic fatalities). For comparison, in the same time interval of 2013–2015, homicides and traffic accidents accounted for 16% and 13% of all non-natural deaths, respectively. Overall, opiates were responsible for almost 60% of drug-related deaths in our population, representing more than 7% of total cases of in which we assumed jurisdiction.

**OPIOID-RELATED DEATHS IN 2016**

In 2016, opioids deaths represented 6% of JCMEO cases. There was a total of 98 opioid-related fatalities, 18 of which involved heroin. Of those 98 cases, the manner of death was ruled accident in 91 cases and suicide in 7 cases (one case involved a traffic accident in which opioid use was a contributing factor). Oxy-
Opioid crisis

Opioid-related deaths in Metropolitan Kansas City Counties

The above data represents deaths where opioids (prescription, heroin, fentanyl and others) are listed as a single cause or one of multiple causes. Data from Johnson County is not available for 2015-2016. Sources: Medical examiner offices of Jackson, Johnson and Wyandotte counties.

codone again was the most frequent fatal opioid drug. In contrast to 2013–2015 opioid-related deaths, fentanyl was found to be the second most frequent opioid drug involved, followed by heroin, hydrocodone, morphine and methadone. Most of opioid-related deaths in 2016 involved multiple drugs. Thirty-two of the 98 opioid-related deaths involved single drug use, the most frequent of which was heroin followed by oxycodone and fentanyl in that order. A total of 13 individuals died from exclusive heroin use, the majority of which were white males with an average age of 38 years.

Preliminary examination of opioid-related deaths in 2017 revealed the investigation of a total of 92 opioid-related deaths within the jurisdiction of the JCMEO. The majority of individuals were white males with an average age of 42 years. Interestingly, the most frequent fatal opioid drug involved was now heroin, accounting for 31 deaths followed by oxycodone accounting for 20 deaths. Both fentanyl and hydrocodone were each implicated in 10 deaths. Multiple drugs contributing accounted for the remaining 31 deaths.

Deaths from Heroin and Fentanyl Increasing

Opioid abuse is a major problem in the United States and has resulted in numerous deaths throughout the nation. At the JCMEO, the overall percentage of deaths related to opioids for the past five years has not significantly changed. However, we have seen a definite rise in deaths in which heroin and fentanyl are implicated. Oxycodone continues to be a major player in opioid-related deaths. Our data is in keeping with that seen nationwide in which white males from their 30s and 50s seem to be at the highest risk of death related to opioid use.

At the JCMEO, our medico-legal death investigators are trained to collect a detailed history from family and friends as well as examine the death scene for drug paraphernalia. Consequently, the majority of opioid-related deaths are suspected prior to autopsy.

However, this is not always the case. Our office performs toxicology testing on every decedent brought into our office to ensure that drug-related deaths are not missed. Unfortunately, toxicology testing for newly developed synthetic opioid compounds, particularly fentanyl analogues, continue to be a challenge for our office as well as offices nationwide requiring expensive send-out testing. At the same time, the Centers for Disease Control and Prevention estimates that the total “economic burden” of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of health care, lost productivity, addiction treatment and criminal justice involvement.\footnote{1} \footnote{2}

Robert Pietak, MD; Marius Tarau, MD; and Lindsey Haldiman, DO, are deputy medical examiners at Jackson County Medical Examiner’s Office. They can be reached at (816) 881-6600, mtarau@jacksongov.org.

References


First responders are critical to the survival of those with medical emergencies, including those who have overdosed on opioids. As physicians, most of us rarely get the opportunity to experience emergencies in the community. Paramedics, on the other hand, develop a deep understanding of the city, not only dealing with crises, but with the hundreds of other instances in which they enter the living spaces of citizens.

On May 18, I had the pleasure of interviewing Tara Hill, a paramedic employed by the Kansas City Fire Department. Tara has several years of experience in her role. Her assignments have included both suburban and inner city duties. We focused on her perceptions of the opioid epidemic and its impact on Kansas City.

Paramedics with the Kansas City Fire Department are called out of the station 12 to 15 times per day in a 24-hour shift. In Ms. Hill’s estimation, 10 percent of these calls are genuinely emergency calls. Ninety percent of calls result in transport of a patient to a hospital emergency room.

Opioid-related calls are a modest percentage of all ambulance requests. Overdoses and intoxication-related calls are frequently related to heroin, methamphetamine, and even phencyclidine use. These calls are more frequent than calls on prescription diversion. Excluding alcohol, it remains somewhat rare that a call involves a drug-intoxicated person who has suffered from an acute injury, such as a fall or motor vehicle accident. While there are more calls regarding drug abuse in the urban core, the same drugs are seen in suburban area calls. The majority of emergency calls involve injected drugs. When a patient is confused, the paramedics are often encountering someone who is not only intoxicated but also in septic shock.

In Kansas City, the police respond to a scene involving a new ambulance dispatch. The police provide scene control and security for the patient and paramedics. It is reasonably common for others at the place of an overdose also to be currently abusing drugs and for the bystanders to be intoxicated. While Ms. Hill has not encountered inebriated bystanders’ fear of police presence at a scene, she is grateful for the police presence. She did not feel this police presence lessened the likelihood that overdose callers would contact EMS.

Many times, an opioid overdose is related to underlying medical conditions and failures of the medical system to provide needed care. Patients in pain will commonly keep taking more drug acutely in a desperate attempt to relieve their pain, with a resulting overdose. When a patient runs out of their pain medication, 911 is often called and the patient is then taken to a hospital emergency room. Pain and withdrawal lead the patient to attempt to obtain their narcotics. Not infrequently, Ms. Hill has received a second and even third call from a patient who did not receive the desired narcotic following the first transport: the patient calls again and wants a ride to a different hospital. Ms. Hill noted that many patients have a known need for surgery, such as joint replacement, but whose insurance and financial status does not permit such an operation to occur. Living with acknowledged pain, these surgically untreated patients seek pain relief that often leads to opioid addiction.

Naloxone use by KCFD paramedics is not as frequent as might be expected. There are many reasons for this relatively infrequent use. By protocol, naloxone use is for the significantly obtunded patient or those in respiratory arrest. There are pragmatic reasons as well. Often, with a reversal agent given, the patient becomes belligerent, even threatening, towards the paramedics. A patient whose (continued)
overdose is reversed with naloxone may refuse transport to an area emergency room. The paramedics worry whether the reversal will last as long as it takes to clear the abused drug metabolically. Finally, reversal with naloxone is often accompanied by emesis and explosive diarrhea, an unpleasant event at best, especially if you have to clean the inside of the ambulance before the next run.

Finally, a word about our paramedics. I found Tara Hill to be an informed, well-trained and exceptionally compassionate professional. I also believe she is representative of this segment of our medical community. We are indeed fortunate to have our area served by our paramedics.

Michael O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at michael.o'dell@tmcmed.org.

**Left:** Kansas City Fire Department paramedics Tara Hill, left, and Burt Appleby perform a naloxone administration training exercise on a mannequin. **Right:** Tara Hill, interviewed for this article. (photos by Mike Curtis)

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**MEDICATION FIRST**
(continued from page 31)


16. Gunderson EW. Models of Buprenorphine Induction. PCSS MAT Training. Online Module


There has been a massive response to the declaration of an opioid crisis in Missouri and across the United States. Professionals, health care and otherwise, scramble to take action. Yet drug use has been around for many years; in fact, opiates date back to the late 1800s. Missouri is among the 23 states and Washington, D.C., that have statistically higher rates of drug-related overdose deaths than the rest of the nation. Additionally, at 35 percent, the state’s increase in opioid overdose deaths between 2015 and 2016 was significantly higher than the national increase of 29 percent.¹

We see around us how communities are riddled with violence and families destroyed by illicit and prescription drug use. Many lay people as well as professionals wonder what can be done. Communities of care scramble to create and implement policies, and work feverishly to develop and deploy useful interventions and education programs. Initial responses include an emphasis on providing better education, changing policy, revamping prevention campaigns, looking at our treatment options, and changing the way law enforcement responds to substance and opioid use disorders (SUD/OUD).

In Missouri, a major response to the crisis was the launch of a Prescription Drug Monitoring Program (PDMP) based in St. Louis County in April 2017. The initial group of 14 participating jurisdictions included Jackson County, Kansas City and Independence; Clay County more recently has joined. Providers in these jurisdictions can register for access to the PDMP. People continue to debate the efficacy and merits of PDMPs along with other emerging harm reduction measures aimed at combating opioid addiction.

In Missouri, physicians and pharmacists can supervise and delegate access to the PDMP to certain staff who assist in the course of patient care.

In other states, PDMPs have been shown to reduce opioid prescriptions. In 2011 and 2012, Ohio and Kentucky mandated clinicians to review PDMP data and implemented pain clinic regulation. It is reported the morphine milligram equivalents per capita decreased in 85% and 62% of counties from 2010 to 2015.²

In New York state, lawmakers mandated prescribers to check the state PDMP before prescribing opioids in 2012. The next year that state saw a 75% drop in patients’ seeing multiple prescribers for the same drugs. Tennessee realized a similar gain as their state lawmakers passed a similar law in the same year. As a result, in 2013 there was a 36% decline in patients’ seeing multiple prescribers for the same drugs.²

We now know that overdoses from prescription opioids are a driving factor in the 15-year increase in opioid overdose deaths. We don’t yet know how to solve this problem. One of the ways to combat the problem is for providers to check the PDMP when clinically indicated. This can be time consuming for a provider and admittedly is an additional step in patient care. It is critical to strike a balance between addressing legitimate practitioner concerns and implementing support systems with the ability to fundamentally impact patient safety.³

Good care does not happen in a silo. It is a concerted effort of practitioners working together for the best possible outcome. Using the PDMP can assist in the provision of good care when the team members have access and use it.

In Missouri, physicians and pharmacists can supervise and delegate access to the PDMP to certain staff who assist in the course of patient care.
pharmacy technician, pharmacy intern, medical intern, dental hygienist and others. Delegate users are able to make patient requests on behalf of their supervisory physician or pharmacist who authorizes access. Delegate accounts are tied to the supervisory provider’s account, and the supervisory provider maintains all liability.

By registering all delegates providing patient care, this helps their surveillance for the PDMP. Nurses are reporting cases in which they’ve discovered patients with multiple prescriptions for stimulants, benzodiazepines, and controlled substances prescribed by doctors in offices and emergency rooms all written within days of each other. A quick check in the PDMP can pave the way for a conversation concerning opiate use disorder, or altered the course of treatment, but most importantly can save a life.

To date, 60 Missouri jurisdictions have enacted authorizing legislation to join the PDMP (Fig. 1). There are just over 6,880 approved users. The PDMP covers 79% of state population and 92% of health care providers averaging 3,300 patient searches per day.

PDMPs are not perfect. There are system design imperfections. There is usually about a 24-hour delay in the uploading of data. And PDMPaware is not fully integrated into the clinical workflow. While these system imperfections are important drawbacks that should be addressed, they are not impermeable barriers to the provision of care.

Providers opting not to use the system due to the barriers effectively render PDMPs useless in their clinics. The delegate users will not have access to the system until and unless their provider/supervisor grants them access. In order to grant access to a delegate, supervisory providers must first register for their own access with the PDMP.

Some clinicians who opt not to use the PDMP have made decisions to simply decline to prescribe opioids, raise prescribing thresholds, refer patients elsewhere, or substitute nonmonitored drugs—all of which could compromise appropriate symptom management.3

The metropolitan Kansas City area is engaged in a robust collaborative effort aimed at supporting patients, families, providers and law enforcement in their response to the opioid crisis. Groups such as the Health Care Foundation of Greater Kansas City, First Call, KC Area Regional Opioid Crisis Task Force, Kansas City Health Department, Greater Kansas City Opioid Treatment Workgroup, KC Perinatal Collaborative, and more are working with community stakeholders to combat the epidemic and provide valuable resources and services. Intense community and provider education efforts, medication assisted-treatment programs, syringe exchange programs, and safe injection sites are part
of collaborative efforts occurring around Kansas City.

Research supports the use of medication-assisted treatment (MAT) as effective in facilitating recovery from opioid addiction for many patients. It treats opioid addiction as a medical disorder. MAT is most effective in a “whole-patient” approach which also includes necessary supportive services such as psychosocial counseling, treatment for co-occurring disorders, medical services, and vocational rehabilitation.4

“As you look at France, they were able to drive down their opioid rates and their heroin usage by making it easier for folks to get access to MAT,” U.S. Surgeon General Jerome Adams, MD, said at an American College of Emergency Physicians forum in Washington, D.C. “So, we know that this can work.”

POLICY CHANGES

Beginning March 1, 2018, the Missouri departments of Social Services, Mental Health, and Health and Senior Services will begin enforcing national standards for prescribing opioids to chronic pain patients. The departments are working to bring MO HealthNet providers who aren’t following Centers for Disease Control and prevention guidelines into compliance when it comes to opioid prescriptions. Providers will need to respond to the Missouri Medicaid Audit and Compliance Unit with clinical data justifying the prescription history or a plan for modification to comply with the MO HealthNet standard.5

Opioid use disorder is complex and requires a multi-pronged approach to developing solutions with two goals: identify and help individuals who are currently facing opioid use disorder; and implement prevention strategies to reverse the alarming trends. There is no single action, software package, system, or policy change that will suddenly halt and reverse this crisis. Research and changes to both practice and policy are important strategies currently being implemented by Missouri hospitals, providers and other key partners. One place you can start is by registering and using the Prescription Drug Monitoring Program.6

Teesha C. Miller is director of the prescription drug monitoring program for Jackson County. She can be reached at tcmiller@jacksongov.org.

REFERENCES


NALOXONE (continued from page 34)

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