

# Nebraska Medicine

Fall 2016 | Volume 15, Number 3

## *Nebraska's Prescription Drug Monitoring Program*

Physician participation a key to success



Nebraska  
Medical  
Association

*Advocating for Physicians and the Health of all Nebraskans*

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# President's Message

by Todd Pankratz, MD  
NMA President

It's a privilege to take on the role of leading Nebraska physicians for the next year. I want to thank Harris Frankel, MD, 2015-16 president, for his dedication and leadership this past year.

Partnerships are key to making the Nebraska Medical Association a great organization, and partnerships will be even more important in the near future with the changes on the horizon for physicians in Nebraska and nationally. These changes include physician payment models, employed vs. private practice employment models, Enhance Health Network and CHI, and lastly, the role of primary care and specialty care in these new payment models. As a result, it is imperative that we continue to create and nurture relationships that are built on trust and not divide into different groups. This will forge common goals, mutually beneficial to each individual and organization. We need to work together to make the transition into the new practice models successful not only for the practice, but most importantly for our patients.

The NMA has a long history of creating these partnerships. In 1976, we worked to create the Nebraska Hospital Medical Liability Act which today is one of the best malpractice caps in the country. Our Foundation has partnered with our medical schools to create scholarships for deserving medical

students. In the last two years we have increased our endowment for student scholarships by \$250,000. The total in endowed funds for student scholarships is \$1.5 million which may seem sufficient before you consider that our students have an average debt of nearly \$250,000 when they finish medical school. Please consider the Nebraska Medical Foundation when determining your annual charitable donations and in your estate planning.

Our Foundation also provided \$250,000 for additional grants to improve the health of Nebraskans. We have partnered with the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) to improve perinatal care in Nebraska. Along with the March of Dimes, NPQIC implemented a policy to ensure no elective inductions before 39 weeks. We have also given funds for simulation vans to help Nebraska physicians, hospitals, nurses and other care team members to prepare for emergencies. We have also been funders for several other projects including the Heroes Program through Children's Hospital and NMA member Karla Lester, MD, which focuses to reduce childhood obesity. In addition, NMA member Bob Rauner, MD, is leading an effort on a statewide Nebraska physician cancer screening program that aims to identify early breast and colon cancer with a goal of earlier diagnoses and better treatment.

We have a long history in the Nebraska Unicameral of supporting patient safety and physician issues. Last year we reviewed 250 bills, monitored 100 bills and were actively involved in the efforts of 12 of these bills, sending either letters or testifying in the best interest of our patients and physicians. It is critical that we continue building relationships with our legislators. I am asking for your help in this effort. We need physicians developing these relationships and partnerships with their senators because they trust their personal physicians to do what's right for the patients of Nebraska. We have some serious issues this year including medical marijuana, opioid drug use and reimbursement issues. When called upon we need you to write a letter, make a phone call or consider testifying.

Finally, the NMA leadership has been meeting with the leadership of specialty organizations twice each year. This has been helpful in understanding their issues and how we can assist them. This provides additional opportunities for dialogue, understanding and uniting together on issues.

In closing, I would ask each of you to make a commitment to being part of one of these partnership opportunities. We have a wealth of bright people who can affect positive change quickly when mobilized. I look forward to a great year. □



# Executive Vice President's Message

by Dale Mahlman  
*NMA Executive Vice President*

**A**nnual Session 2016 is in the books and was a great success.

Many thanks to those physicians and sponsors who took the time to attend this event and to our great team at the NMA for putting together another outstanding event. It was no small task I might add, and they are true professionals.

This year our programming focused on issues pertinent to physicians and patients alike including physician burnout, medical marijuana, physician leadership, opioid abuse and management, Maintenance of Certification and our concluding presentation, a fascinating look at current drug trends within the state. What an eye opening presentation to end the day!

As with years past, we recognized our Nebraska Medical Foundation scholarship winners rewarding Creighton and UNMC students who have demonstrated both excellent academic and community involvement. We also had five 50 year practitioners attend. It is

always a gift to be joined by these long-time NMA members. We also presented our 2016 NMA awards. This issue of Nebraska Medicine will highlight our outstanding award winners; find more information on page 6.

Our meeting also provided more insight into Nebraska's new Prescription Drug Monitoring Program (PDMP), the result of LB 471, introduced in 2015 by Senator Sara Howard of Omaha. This program, which will begin January 1, 2017, was years in the making and was a group effort between Senator Howard and her staff, along with the NMA, Nebraska Pharmacists Association and other interested parties. We want to thank Senator Howard for her leadership on this important public health legislation, an issue the NMA has been actively involved with for the past eight years. We have appreciated the support from NeHII, the Nebraska Health Information Initiative, through the legislative and development process as well. Their expertise and project management of this effort will go a long way in making the PDMP a success.

Like years past, fall in Nebraska means football, volleyball and support

of the Nebraska Medical Association. Dues statements are a necessary part in any professional association, and we hope to have your continued support in 2017. The NMA team is dedicated to educating, serving and advocating for our customers in the promotion of organized medicine.

Next year will provide us with a fresh start in the White House, at least 17 new state senators in the Legislature and hopefully your continued financial support. Our new president, Todd Pankratz, MD, of Hastings, highlighted our efforts and the importance of continuing to partner with other likeminded professional associations and health care advocates. We look forward to opportunities in 2017 to Advocate for Physicians and the Health of all Nebraskans and would love to call on you as one of our active members.

If you need more information on the NMA and our accomplishments in 2016, just give me a call. Or, visit our website and check us out on social media. The year 2016 has been a great year for the NMA, and we look forward to making 2017 even better. We're asking for your support! □





# 2016 Annual Membership Meeting Recap

## *Todd Pankratz, MD, installed as president of the Nebraska Medical Association*

**T**odd Pankratz, MD, of Hastings was installed as 2016-17 president of the association at its annual membership meeting and House of Delegates on September 16. The event was held at the Holiday Inn Downtown in Lincoln.

Dr. Pankratz began his obstetric and gynecologic practice in Hastings in 1998. He is certified by the American Board of Obstetrics and Gynecology and is a Fellow of the American College of Obstetricians and Gynecologists. Dr. Pankratz was born in Henderson, Nebraska, and completed his primary education there. He attended Hastings College and received his Bachelor of Arts degree in 1988. After receiving his doctor of medicine degree from the University of Nebraska College of Medicine in Omaha in 1992, he served his residency training at Truman Medical Center/St. Luke's Hospital in Kansas City, Missouri. Following completion of his residency training in 1996, Dr. Pankratz was in private practice in Iowa City, Iowa, prior to returning to Hastings.

Dr. Pankratz has been an active member of the NMA since 1998. From

2005-2011, he served as Greater Nebraska Medical Coalition president and served as treasurer from 2011 until his appointment to president-elect in 2015. Dr. Pankratz has served on numerous NMA committees and commissions including: the NMA Board of Directors, the Maternal and Child Health Committee, the Medical Home Committee, the Nebraska Medical Political Action Committee, the Nebraska Medical Insurance Services, the Health Care Reform Task Force, the Commission on Legislation and Governmental Affairs, and the Nebraska Medical (NMA) Foundation. He has served as a delegate from 2002 to present. Nationally, Dr. Pankratz is a diplomate of the American College of Obstetricians and Gynecologists currently serving as the District VI chair of Nebraska. He has been a member of the American Medical Association (AMA) since 1996 where he has served as an alternate delegate and delegate to the House of Delegates' Young



*Harris Frankel, MD, installs Todd Pankratz, MD, as 2016-17 president of the NMA.*

Physicians Section. He was also an AMA representative to the CAPIR Council for the American Dental Association from 2011 to 2014.

Dr. Pankratz practices at Obstetricians and Gynecologists, P.C., in Hastings. He is a medical staff member of Mary Lanning Memorial Hospital where he has served on numerous committees. He also serves as medical director of Hastings Family Planning. His community involvement includes serving as a charter board member with 5 Points Bank of Hastings, Early Head Start, Rotary, Leadership Hastings, the Hastings Symphony, mentoring pre-med students at Hastings College, and First Presbyterian Church.

Dr. Pankratz and his wife, Jessica Meeske, a pediatric dental specialist, have two children, Robert, 21, and Sophia, 18. □

### **The NMA would like to welcome our new board members.**



**Rob Rhodes, MD**  
Lincoln  
President-Elect



**Kim Coleman, MD**  
Lincoln



**Kris McVea, MD**  
Omaha



**Chuck Reese, MD**  
Lincoln



**Richard Blatny, Sr., MD**  
Fairbury  
2014-15 President



**Jane Bailey, MD**  
Omaha



**Britt Thedinger, MD**  
Omaha

### **Thank you to our outgoing board members for their service to the Nebraska Medical Association and the patients of Nebraska.**

## 2016 Annual Membership Meeting Recap *(continued)*

### DISTINGUISHED SERVICE TO MEDICINE



Peter Whitted, JD, MD  
*Omaha*

### YOUNG PHYSICIAN OF THE YEAR



Travis Teetor, MD  
*Omaha*

### RESIDENT ADVOCATE OF THE YEAR



Jordan Warchol, MD  
*Omaha*

### FRIEND OF MEDICINE



Tom Obrist  
*Lincoln*

### PHYSICIAN OF THE YEAR



Chelsea Chesen, MD  
*Omaha*

### PHYSICIAN ADVOCATE OF THE YEAR



Bob Rauner, MD  
*Lincoln*

### STUDENT ADVOCATE OF THE YEAR



Michael Visenio  
*Omaha*

### 2016 50 YEAR PRACTITIONERS

Patrick Clare, MD  
Edward Cohn, MD  
Paul Collicott, MD  
Calvin Cutright, MD  
John Donaldson, MD  
David Dyke, MD  
Joseph Ellison, MD  
Albert Frank, MD  
Bert Frichot, III, MD  
Eva Garciano Brion, MD  
Martin Goldman, MD  
Philip Hofschire, MD  
Duane Koenig, MD  
Rajesh Kumar, MBBS  
Jiri Lukas, MD  
Joseph Lynch, MD  
James Manion, MD  
Pradip Mistry, MBBS  
Dennis O'Leary, MD  
Eugene Peck, Jr., MD  
Gayle Peterson, MD  
John Reilly, MD  
Sanat Roy, MBBS  
Mark Sorensen, MD  
Paul Steffes, MD  
Samuel Watson, MD  
Larry Wood, MD

### 2016 SCHOLARSHIP WINNERS

Daniel Agraz  
Andrea Bollom  
Bianca Christensen  
Emory Dye  
Shweta Goswami  
Brett Grieb  
Clara Hageman  
Nejmun Hussain  
R. Logan Jones  
Michaela Klesitz  
Michael Klinginsmith  
Joseph Lippert  
Brent Luedders  
Sydney Marsh  
Rebecca Osborn  
Michelle Polich  
Matthew Purbaugh  
John Riley  
Steven Shaw  
Diliana Stoimenova  
Leah Svingen  
Charles Viers  
Gabrielle Welch

**SAVE THE DATE**

**2017 Annual  
Membership Meeting**

**Friday, September 8, 2017  
Lincoln**

# 2016 House of Delegates Resolutions

The following resolutions were presented at the 2016 House of Delegates. Action taken is indicated.

## **RESOLUTION #1 – THE IMPACT OF TRAUMATIC POLICE EXPOSURES ON CHILD AND ADOLESCENT HEALTH**

WHEREAS, the recent events have raised awareness of significant racial issues surrounding the policing of our communities at all levels, and

WHEREAS, these interactions can and do have unintended adverse health effects of the people involved, either directly or indirectly and particularly on children and adolescents,

THEREFORE BE IT RESOLVED, That the Nebraska Medical Association work with community and school leaders, as well as police officials, to develop policies that limit the impact of traumatic police exposures on children and adolescents, especially racial and ethnic minorities.

*Following introduction by Kelly Caverzagie, MD, and discussion, a motion was made for an amendment to the resolution as follows:*

THEREFORE BE IT RESOLVED, That the Nebraska Medical Association work with community and school leaders, as well as police officials, to develop policies that limit the impact of traumatic police exposures on children and adolescents.

*Discussion followed. After discussion of the amendment, a motion was made, seconded and approved to accept by the House of Delegates.*

## **RESOLUTION #2 – ADDRESS THE EVER CHANGING HEALTH CARE AND PAYMENT DELIVERY SYSTEMS**

WHEREAS, the passage of the Affordable Care Act (ACA) in 2010 has changed the way health care is regulated and financed, and

WHEREAS, the resulting effects of the ACA since inception have included focus on Quality and Value-Based Care, the introduction of Patient-Centered Medical Homes (PCMH), adoption by Insurance Carriers of various quality based evaluation tools, and numerous CMS initiatives including ACOs, and

WHEREAS, the passage of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) further highlighted the Quality Payment Program (QPP) and Merit-Based Incentive Payment System (MIPS) as well as the Advance Alternative Payment Model (APM) creating opportunities and challenges for the medical practices across the state,

THEREFORE BE IT RESOLVED, the Nebraska Medical Association will create a committee of interested and informed members to review and respond to the rapidly changing Health Care and Payment Delivery environment, and

BE IT FURTHER RESOLVED, the Nebraska Medical Association will create access to information from various sources nationwide on these topics for members' education and assistance.

*Following introduction by Michelle Sell, MD, and discussion of the resolution, a motion was made, seconded and approved to accept by the HOD.*

## **RESOLUTION #3 – PRICE TRANSPARENCY IN MEDICINE**

WHEREAS, the health care system is entering the realm of value-based purchasing where information on both price and quality are needed for physicians to help their patients make informed decisions, and

WHEREAS, the increasing deductibles, co-payments and out of pocket expenses for patients are resulting in significant expense for patients, and

WHEREAS, one of the significant barriers to patients is the lack of transparency regarding the cost of their medical care, and

WHEREAS, many current contracts between third party payors and health care providers do not allow sharing of cost of care information, and

WHEREAS, many states are developing programs that promote the availability of pricing information,

THEREFORE BE IT RESOLVED, the Nebraska Medical Association in cooperation with business, industry and the Legislature will work to pass legislation that would make the pricing of shoppable health care services available to both physicians and patients. Such legislation would develop publically accessible sites that give the citizens of the state of Nebraska accurate, comparable and understandable information regarding the costs of their health care.

*Following introduction by Bob Rauner, MD, and discussion of the resolution, a motion was made, seconded and approved to accept by the HOD.*

*(continued on Page 8)*

# 2016 House of Delegates Resolutions *(continued)*

## **RESOLUTION #4 – NEBRASKA HEALTH CARE DECISION ACT**

WHEREAS, there is widespread support from stakeholders representing health care, the legal profession, social workers and medical ethicists in developing a set of Transportable Medical Orders for Nebraska, and

WHEREAS, a group representing the above stakeholders has developed proposed legislation tentatively titled the Nebraska Health Care Decision Act, and

WHEREAS, most states in the country have statewide and standardized forms for Transportable Medical Orders that address end-of-life decisions created after a discussion with their personal physician, and

WHEREAS, many Nebraskans would like a consistent and easily understandable form for communicating their end-of-life decisions to medical professionals and health care facilities,

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association in cooperation with stakeholders from health care, the legal profession, social workers and medical ethicists, support legislation based on the draft Nebraska Health Care Decisions Act.

*Following introduction by Bob Rauner, MD, and discussion of the resolution, a motion was made, seconded and approved to accept by the HOD.*

## **RESOLUTION #5 – NEBRASKA DIABETES PREVENTION PROGRAM**

WHEREAS, an estimated 86 million adults have prediabetes, but only 10% know of their diagnosis, and

WHEREAS, 15-30% of prediabetics

will develop prediabetes within 5 years, and

WHEREAS, Congress authorized the CDC to establish and lead a National Diabetes Prevention Program (NDPP) based on low-cost interventions that could be implemented across the U.S.<sup>1</sup>, and

WHEREAS, the NDPP has been shown to effectively delay or prevent progression of prediabetes to Type 2 diabetes in a significant number of patients, and

WHEREAS, Nebraska is one of eight states identified as having a population at higher risk for prediabetes and diabetes and public health grants have already been applied to establish Diabetes Prevention Program (DPP) lifestyle change programs across Nebraska modeled after the NDPP, and

WHEREAS, the CDC, AMA, the Nebraska Department of Health and Human Services and other organizations are:

- in the process of developing plans to raise public awareness of prediabetes and its complications/prevention programs
- accrediting DPP based on standards developed by the CDC to assure quality and consistency
- working with payers to cover the cost of the DPP lifestyle change programs as a successful, cost-effective intervention that will delay or decrease progression to diabetes in a significant number of prediabetics and decrease expenditures related to diabetes and its complications,<sup>2,3</sup> and

WHEREAS, many health care providers are unaware of the existence of current and future DPP locations across the state,

THEREFORE BE IT RESOLVED, the NMA be actively involved with the

Department of Health and Human Services in the DPP planning process for the State of Nebraska, and

BE IT FURTHER RESOLVED, the NMA participate in the implementation of the DPP across Nebraska through education of physicians and health care teams in regard to prediabetes, associated risk factors, appropriate interventions, and the identification of DPP locations across the state available for referral of qualified patients, and

BE IT FURTHER RESOLVED, the NMA collaborate with interested specialty societies to raise awareness of diabetes prevention, develop an adequate number of CDC certified DPP programs, and coordinate efforts to obtain adequate funding from Medicare/Medicaid and commercial insurance programs to ensure sustainability of the DPP programs.

*Following introduction by Kevin Nohner, MD, and discussion of the resolution, a motion was made, seconded and approved to accept by the HOD.*

1) Participation in a structured lifestyle change program with goals of education (both individually and in group settings within the local communities), loss of 5-7% of body weight, and 150 minutes of moderate activity/week

2) United Health Group currently covering these services, Medicare will begin coverage in 2018 for CDC certified DPP

3) 58% success rate if < 60 years old, 71% if over 60; 10 year success of 34%. Financial ROI estimated at 3:1 within the first 3 years and even greater savings are obtained if diabetes is prevented over a lifetime

Resolutions may be submitted to the NMA Board of Directors at any time throughout the year. Resolutions or inquiries about resolutions should be directed to NMA Executive Vice President Dale Mahlman at dalem@nebmed.org or (402) 474-4472. □



# LB 471, Battling the Opioid Epidemic

by Senator Sara Howard  
Nebraska Legislature, District 9

Opioid addiction and abuse is one of the fastest rising epidemics facing the nation. So many Nebraskans are impacted by opioid addiction, and the Nebraska Legislature recognizes this as a major issue in our state.

In February of 2016, we passed legislation to improve Nebraska's prescription drug monitoring program, operated by the Nebraska Health Information Initiative (NeHII). NeHII is the secure, online, web-based Health Information Exchange (HIE) for the state of Nebraska. Under LB 471, beginning January 1, 2017, all controlled substances dispensed in our state will be required to be reported to the Prescription Drug Monitoring Program (PDMP). The Nebraska Department of Health and Human Services, along with NeHII, has been awarded federal grants that will allow the PDMP information to be

accessed at no cost to the state, prescribers and dispensers. All parties have been working diligently to get the program up and running so that providers may begin accessing it as early as possible and populating the system with patient data.

Going one step further, beginning on January 1, 2018, Nebraska will require the reporting of all prescriptions dispensed in the state. This will allow providers and dispensers to provide medication therapy management to patients in Nebraska. Medication management is a key to combatting chronic disease and improving the overall health outcomes for Nebraskans. Medication management is a multi-faceted process of reconciling, monitoring and assessing the medications an individual takes to assure compliance with a specific medication regimen, while also ensuring the individual avoids potentially dangerous drug interactions. Nebraska's PDMP is an integral part of the doctor-patient relationship and the medication management process.

Our work with the PDMP and the fight against opioid abuse is not over. I have been working closely with the Nebraska Department of Health and Human Services, NeHII and providers all over the state to look at elements that will continually improve the functionality of the system. I will be introducing legislation in the 2017 legislative session to implement some of these improvements. We continue to consider prevention, provider best practices for opioid treatment and dispensing and future funding for the system upon the conclusion of federal support.

My goal is to make Nebraska one of the leading states in the nation in the fight against opioid addiction and abuse. I feel from personal experience that no family or individual should have to endure the effects of addiction and abuse. □



# Nebraska Opioid Prevention Efforts

by Amy Reynoldson, DHHS Prescription Drug Overdose Prevention Coordinator  
Kevin C. Borchert, NeHII PDMP Program Director  
Rachel Houseman, NeHII Project Manager

The Nebraska Department of Health and Human Services (DHHS) has been awarded a Center for Disease Control (CDC) Prescription Drug Overdose Prevention for States (PDO PFS) grant to focus efforts on reducing opioid abuse and addiction by working with external stakeholders to implement three major components.

Those components include enhancing and maximizing the prescription drug monitoring program (PDMP), establishing statewide pain management guidelines and creating awareness about increased access to Naloxone.

## Prescription Drug Monitoring Program

Efforts to enhance and maximize the PDMP are underway. These include the implementation of legislation that requires reporting of all dispensed prescriptions by dispensers, development of training and educational materials for the PDMP and guidance from the PDMP Work Group. The PDMP Work Group consists of stakeholders from several Nebraska professional associations and various health/medical boards. Prescribers

and dispensers will be educated about the enhanced PDMP system in the fall of 2016. The system will become available on January 1, 2017.

Prescribers will have the option of utilizing the enhanced PDMP system for patient care and treatment purposes January 1, 2017. Prescribers and dispensers can register for the PDMP through the NeHII website ([www.NeHII.org](http://www.NeHII.org)).

## Why is it important to have a PDMP in Nebraska?

Similar to the national trend, in the past several years Nebraska has seen an increase in emergency department visits and deaths due to drug overdoses, in particular due to opioid pain relievers. According to Nebraska Vital Records, this trend has led to a rise from 36 deaths (age-adjusted rate (AAR) of 2.2 per 100,000) in 1999 to a peak of 149 deaths (AAR of 8.2 per 100,000) in 2015 (preliminary data). Of these drug overdose deaths in 2015 at least 54 (36%) were opioid related. Prescription drug abuse has risen to epidemic proportions across the country. Although the problem is not as significant in Nebraska as in many other states, the state is not immune from this problem. According to the Drug Enforcement Administration (DEA), Nebraska ranks at or near the bottom for the cumulative distribution of hydromorphone and oxycodone but ranks 30th in the nation for hydrocodone in 2013 and 2014. For these reasons and others, Nebraska is focusing resources on the prevention of prescription drug overdoses.

## PDMP Legislation

Nebraska Legislative Bill 237 was passed in 2011 and established a PDMP through a collaborative effort of the Department of Health and Human Services (DHHS) and the Nebraska Health Information Initiative (NeHII). Through this partnership the PDMP was created utilizing the NeHII Health Information Exchange infrastructure without state or federal funding. Although much of the prescription reporting was done in near-real time, the data was incomplete. In 2014, LB 1072 repealed the prohibition of using federal funds, which allowed DHHS to seek federal grants.

In 2016, Governor Ricketts signed Nebraska Legislative Bill 471 into law which reiterated that, "the primary purpose of the PDMP is to prevent the misuse of controlled substances that are prescribed, allow prescribers and dispensers to monitor the care and treatment of patients for whom such prescription drug is prescribed to ensure that such prescription drugs are used for medically appropriate purpose."

Per LB 471, beginning January 1, 2017, dispensers will report all dispensed controlled substances to the PDMP, and beginning January 1, 2018, dispensers will report all dispensed prescriptions to the PDMP. DHHS will promote the use of the PDMP system as a best practice to both prescribers and dispensers.

The PDMP system in Nebraska is unique compared to others across the nation. The state's PDMP system is 1) incorporated with the Health Information Exchange, 2) a public health

(continued on Page 17)



Amy Reynoldson



Kevin C. Borchert



Rachel Houseman

# PDMP – A Piece of the Prescribing Puzzle

by Liane Donovan, MD  
Pain Medicine, Lincoln

The prescription drug monitoring program is a tool that the physicians in the state of Nebraska have been requesting for a number of years. The initial drug monitoring program was set up through Nebraska Health Information Initiative (NeHII) which only captured a portion of the patients in the state. Additionally, patients could elect to opt out of the reporting measure. When this occurred, clinical information would be lost. These concerns have been addressed by a new prescription drug monitoring program set for release in the state on January 1, 2017.

The PDMP is intended to assure that physicians have the most accurate data possible regarding which medications have been dispensed to a given patient with a given name. By analyzing a data set prior to prescribing, it will be possible for clinicians to be aware of which medications have been prescribed, by whom, in what quantities and over what time frame. The PDMP is not a substitute for good clinical decision making by the physician or a substitute for advanced and open dialogue between physician and patient. This dialogue should focus on the difference between appropriate and inappropriate medication usage. We must always remember that the hallmark of substance abuse disorder development is the loss of control of medication usage.

Patients who take certain combinations of medications have been shown to be at increased risk for abuse. The use of opioids in combination with benzodiazepines or sedative hypnotics is especially

problematic; as in the hydrocodone, Xanax, soma triad. With utilization of the PDMP, there may be a realization that one physician is prescribing the opioid while another is prescribing the “sleep aid” or “muscle relaxant.”

One very important advantage of the PDMP is the ability to provide important information regarding a high-risk patient by identifying those patients obtaining multiple prescriptions through multiple providers and pharmacies. The risk of an adverse or catastrophic event increases exponentially when this occurs. Clinicians must be aware that this can indicate a patient with multiple medical procedures or comorbid illnesses, but may also potentially indicate a patient with an intent to deceive and hide overall medication usage. Often, patients are one step ahead of the clinician who is focused on trust and compassion. It will be up to the prescribing physician to make thoughtful, and often difficult, decisions regarding high-risk patients identified as receiving medication through numerous prescribers and pharmacies.

It will remain the joint responsibility of the prescribing clinician and the patient to assure that medication is utilized in the fashion it is prescribed. This is part of the function of the opioid agreement (not a pain contract). Within this agreement, the physician and patient will set appropriate boundaries for medication use, for reporting compliant use and for defining the path forward should adverse usage patterns begin to develop.

As with any tool, the PDMP will only be valuable if it is used correctly and consistently. It will be critical for physicians to understand how to appropriately use

the PDMP, to understand what the data indicates and - more importantly - the limitations of the data. It is vital that clinicians realize that the program itself will not protect patients from harmful use of medications. Additionally, by itself, the PDMP will not prevent physicians from prescribing for patients at risk for harm to themselves.



It is important to note that, unless you are the original prescriber, it may not be possible to know if the patient is taking the medication as prescribed or is taking it outside the prescribing parameters. There is no provision within the existing software to know with precision what the directions on a prescription medication bottle say. For example, a prescriber in the habit of writing “hydrocodone 5/325 1-2 po q 4-6 hours” creates a situation that allows the patient to take anywhere between 0 and 360 pills in a month and still be compliant. An outside provider will not be able to easily discern whether a patient is taking the medication within the expected range or overusing the medication. It will be important for physicians to make better decisions and to clearly communicate expectations in advance of prescribing.

In summary, the PDMP is a step forward which can become a valuable tool for Nebraska physicians. We, as clinicians, have finally been granted our wish for an improved system and now it is up to us to evaluate and utilize the information that the PDMP provides as a component in our drive to decrease prescription drug misuse and abuse. □



# An Emergency Room Perspective on the PDMP

by Jason Langenfeld, MD, FACEP  
Immediate Past-President, Nebraska  
Chapter American College of Emergency  
Physicians

For years physicians have been chided for under treating pain. Pain scores have become the “fifth vital sign.” Our performance is measured by the polled satisfaction of our patients, with a focus placed on pain management. Those scores can affect our employment or compensation. In caring for our patients and attempting to provide them with the highest satisfaction, we have worked diligently to control pain. With the reliance on opiates for pain control, more and more prescriptions have been written. More potent, longer-acting opiate pain medications have been developed and marketed.

According to the Centers for Disease Control and Prevention, the amount of prescription painkillers dispensed in the U.S. and related deaths quadrupled from 1999 to 2013, even though the number of Americans suffering from pain remained essentially unchanged. The National Institute on Drug Abuse estimated in 2012 that between 26.4 million and 36 million people abuse opiates worldwide, with an estimated 2.1 million people in the United States suffering from substance use disorders related to prescription opioid pain relievers. In addition to opiates, benzodiazepine and sedative prescriptions are on the rise as well and may pose a threat to our patients and the

community. Since 2009, deaths as a result of drug poisoning have surpassed deaths from motor vehicle crashes. In 2010, there were 13,652 unintentional deaths from opioid pain medications (82.8 percent of the 16,490 unintentional deaths from all prescription drugs), and there was a five-fold increase in treatment admissions for prescription pain relievers between 2001 and 2011 (from 35,648 to 180,708.) In addition to mortality and toll on human lives, estimates have placed the cost of nonmedical use of opioid pain relievers at up to \$72.5 billion annually.

With those numbers in mind, and with recent high profile cases and accidental deaths, there are increasing questions concerning pain management practices and the prescribing of opiate medications. CNN and other news outlets have done countless specials regarding prescription medications and the opioid epidemic in the U.S. Steven Stack, MD, FACEP, the immediate past-president of the AMA, wrote an open letter to physicians calling on the medical profession to “play a lead role in the opioid epidemic that, far too often, has started from a prescription pad.” We even received a mass mailing from the Surgeon General “asking you to pledge your commitment to turn the tide on the opioid crisis.”

Some emergency departments, health systems, and even state organizations are developing policies and recommendations to curb the prescription of these medications. Some are even calling for “opioid-free” emergency departments, or withholding all opiates in the case of chronic non-cancer pain, headache, lost prescriptions and nearly anyone with

previous opiate prescriptions. Some providers have chosen individually to abandon opiate prescribing completely amidst concerns for complications and liability.

In the emergency department, or acute care settings, we are tasked with treating a variety of conditions with limited background. Whether an urban, suburban, or rural setting, academic or community, we struggle with the balance between providing the relief that our patients need and avoiding harm with medication diversion or misuse. We also have the distinct burden of witnessing the effects of abuse, addiction and overdose firsthand. While electronic health records and health information exchanges can be cause for frustration, they have also allowed increased access to patient medical information. Unfortunately, that access is often limited and is inconsistent at best. Many of us have made changes to our practice and prescribing patterns to try and avoid misuse of medication, but we are left relying on incomplete information. We are left to wonder how our practices affect the patient, family, community and the epidemic as a whole.

The Nebraska Chapter of American College of Emergency Physicians (ACEP) has long advocated for a prescription drug monitoring program in our state. Dr. James Quinn, former president of Nebraska ACEP, came to our organization with a charge nearly a decade ago. He expressed frustration that Nebraska was one of the few states without a functioning Prescription Drug Monitoring Program (PDMP.) We have continued to advocate tirelessly for a system that would work to protect our

(continued on Page 18)



# Prescription Drug Monitoring – An Important Tool in the Opioid Epidemic

*by Cynthia Paul MD, JD  
Board Certified Psychiatrist  
The Coeur Group, founding member  
President-Elect Nebraska Psychiatric Society*

**T**he psychiatric field is facing one of the largest medical epidemics of the 21st century: prescribed opioid drug abuse. According to the most recent statistics, in 2014 the lives of more than 14,000 people were claimed by prescription opioids. The good news is that Prescription Drug Monitoring Programs, or PDMPs, are a new, helpful weapon in the war against opioid abuse. Currently there are 49 states with active PDMPs; the District of Columbia and U.S. territory Guam join these states. Several studies have shown that states with PDMPs have lower rates of patients admitted into opioid treatment programs than states without.

Nebraska has a rate of 79 painkiller prescriptions per 100 people. This statistic isn't necessarily indicative of an addiction epidemic, but it is significant because it shows the large amount of opioids circulating through our state. LB 471 enhanced the state's prescription monitoring system to better prevent misuse of prescription drugs by requiring dispensers of prescriptions to report prescriptions and also made the system free and accessible to all prescribers and dispensers.

The benefits of PDMPs extend far beyond Nebraska. In a statement from the National Alliance for Model State Drug Laws, a PDMP is a tool that can be used to: "support access to legitimate

medical use of controlled substances, identify and deter or prevent drug abuse and diversion, or inform public health initiatives through outlining of use and abuse trends." The largest benefit of PDMPs is that they can act as a way to gather information about the constantly changing drug climate in America. It is a resource that may not immediately affect the day-to-day life of the drug user, but can affect the problems of addiction on a much larger scale.

Frequently, primary care providers are the first place patients get a prescription for opioid pain medication. It is easy to see how dealing with repeated calls for opioid prescriptions, requests for increasing amounts of medications and repeated excuses about why scripts are needed can take its toll on our already overworked primary care colleagues. I encourage providers to view these requests through a different lens. No one intends to develop an opiate use disorder. Most patients are embarrassed and ashamed of their use disorders.

Requiring frank difficult conversations in the office prior to refilling pain meds can facilitate change. Providers facilitate change when they are empathetic and accept that patients are ambivalent. Change, to most, is uncomfortable, even if it is for the better. Lecturing, giving advice, and directly trying to persuade patients to change are counterproductive. It does not resolve ambivalence and encourages resistance. Though conversations about substance use disorders are difficult and at times frustrating, arguing with a patient

leads to a breakdown in conversation. Once the relationship is broken, trust in a provider is diminished, and the conversation has stopped, there can be no opportunities to help heal. Ultimately, patients are responsible for personal change but providers can offer a safe place to keep change conversations going. Referrals to opiate replacement therapy like Suboxone and Methadone are important. Suboxone can be safely prescribed in a primary care setting, with a reasonably small amount of training and planning.

Accessing a PDMP could start the conversation about helping patients address a use disorder. After developing a treatment plan **with** a patient, not **for** a patient, the PDMP can help with accountability, and analysis of whether a treatment plan is working or needs to be changed. The PDMP can also help collaborative care hopefully resulting in a reduction in amount of opioids prescribed if warranted, and possibly lowering the risk to a patient of developing an opioid use disorder. Substance use disorders are complicated and hard to treat, like many illnesses. As medical professionals, we need to be vigilant to treat people with substance use disorders with same respect, patience and compassion we strive to provide to all patients. Empathy and compassion, frank discussions, rolling with resistance and open lines of communication are our tools in combating opiate use disorder. Hopefully, the PDMP can be one more tool in this fight. □

# Pain on the Prairie

by Mike McGahan, MD  
Emergency Medicine  
Grand Island

**P**atients have pain. In the Emergency Department we manage all kinds of pain: chronic, acute,



subacute, holding severed fingers, headaches, toothaches, back pains, fractures, sprains and on and on and on. I give patients the benefit of the doubt the first time I see them that their pain is real. This is how I have practiced especially since the Joint Commission (JCAHO) in 1996 told us that pain is the 5th vital sign, and we should address pain as such. We should have the patients rate their pain on a 10 point scale and address the pain. But something happened over the years since that time. As we implemented the pain scale and treated the 5th vital sign, the number of opiate overdose deaths have increased yearly. Not only opiate overdose deaths increased, but the number of opiate addicts has also increased. And if you have ever tried to get an opiate addict into a treatment program, good luck because they are few and far between. The problem falls back on law enforcement and emergency departments; ask any cop or emergency medicine doc. This story has been all over the news for the last several months, even

in my little hometown newspaper, (see Grand Island Independent, August 21, 2016, page 3A, 'Opioid overdose deaths on the rise, many due to prescription drugs')

What we have now is the law of unintended consequences coming into play. We have treated pain aggressively to comply with JCAHO requirements, patients' rating of their pain and hospitals' concern with patient survey results ("Did we treat your pain to your satisfaction?") The unintended consequences are overdoses, addicts and stimulating illegal drug business.

Illegal drug business; how is that possible? We have the increasing number of addicts which is the demand side of the graph. The supply side is one Percocet goes for \$20 - \$30; at least that was the going price the last time I spoke with one of our street cops. Looking back, how am I going to sort out the legitimate patient from the entrepreneur? Do the math, 30 pills times \$30 = \$900 times 3-4 prescriptions is \$2,700 - \$3,600. Not bad for a few days of traveling from this emergency department to another emergency department or even to a provider's office. The State Patrol used to give us warnings about professional patients in the area or being reported at different emergency departments. That went away with HIPPA. Sometimes pharmacies will let us now that someone

just filled 90 Percocet last week; do I want them to fill the 20 Percocet that I just prescribed? One night I filled Lortabs for someone I thought was a legitimate patient. The next night I was working at another emergency department 90 miles down the road, and the same patient shows up with the same complaint and asking for the same prescription thinking I did not recognize him.

The problem here is that we had no way of tracking controlled medications, i.e. opiates, until now. Starting 2017 the Nebraska Prescription Drug Monitoring Program will come into effect. Nebraska is one of the few states that did not have such a program. I am licensed in Kansas which has such a program. The program, KTRA Cs, is easy to use and only requires signing up online and changing your password every three months. It also integrates with the surrounding states that also have such programs. This is a tool to help us monitor patients that are either episodic or we see in offices frequently. The problem of identifying legitimate patients and making correct pain treatments will be helped by such a program. Nebraska's program will have most of these features and will be quite useful to all medical professionals, just ask any cop or emergency medicine doc. I encourage you to sign up for and use the PDMP! □



# The Pharmacy Perspective

by Joni Cover, JD  
Chief Executive Officer  
Nebraska Pharmacists Association

As Nebraska health care providers ready for the implementation and operation of a prescription drug monitoring program (PDMP), Nebraska becomes the 49th state to support a functioning PDMP. We are, however, the first state to utilize our health information exchange, or NeHII, to serve as the PDMP. While there have been many challenges in the adoption of a PDMP for the state, Nebraska pharmacists have supported the implementation of a functioning PDMP for the monitoring of controlled substance prescribing and dispensing for years.

Reaction has varied in the mandate to report all dispensed prescription data in 2018. While some view the reporting of all data as a great way to have access to information to assist with medication reconciliation and medication therapy management, others fear that their patients may not want all of their prescription data being shared. Pharmacists would also like to see Nebraska's PDMP connect to the PDMPs in the surrounding states to help health care providers treat and monitor patients that may be receiving more than

the safe limits of controlled substance across state lines.

Nebraska pharmacists and pharmacies are preparing their software systems for the interconnection to NeHII and the PDMP to report dispensed controlled substances data. Because of the uniqueness of pharmacy information being reported into an electronic health record system, concerns about the ease of transmission and accuracy of the data once it is in the system must be tested in advance. Controlled substance data reporting is standard throughout the industry because of the reporting to PDMPs in other states. When all dispensed prescriptions are reported beginning in 2018, the ease of data transmission into the PDMP will be a challenge as these requirements are different and unique to Nebraska. For pharmacies operating in many states, reporting all prescription data requires changes to existing reporting processes.

Pharmacists are hopeful that the NeHII system will allow pharmacists and prescribers to sort the data in a meaningful way as to avoid information overload. Questions from patients about why all of their medications are going to be included and how to get access to the information are just a few issues that pharmacists and physicians may face in the adoption of the PDMP. In

addition, some have concerns that the system will not be utilized by pharmacists when dispensing and physicians when prescribing controlled substances as has been the experience in many other states.

A challenge for all health care providers with the implementation of the PDMP will be identifying available resources to assist patients with addiction and substance use disorder. Nebraska's health care system may not be equipped or have enough capacity to provide treatment and other necessary services to those individuals who are in need of help. Pharmacists and physicians must continue to communicate effectively and in a timely manner about patients who may have addiction issues. The PDMP will assist in identifying patients, allowing us to provide assistance that ultimately prevents the overuse and misuse of controlled substances.

The take away lesson from the implementation of this system is communication, collaboration and interaction are all essential among all members of the health care team. After all, the goal is to establish a PDMP that provides meaningful information to deliver great care for patients which leads to a healthier Nebraska. □



# Our Duty to Meet the Future

by Doug Peterson  
Attorney General of Nebraska

The conversation in Nebraska regarding prescription drug abuse reaches back into the Legislative Chamber and the work done over several years preparing for the passage of LB471, leading to Nebraska's Prescription Drug Monitoring Program. Senator Sara Howard introduced the legislative bill and subsequently negotiated the various interests through to final passage, which Governor Ricketts signed into law in February of this year.

My exposure to the destruction of abuse from prescription drugs came through family and friends' stories of suffering and anguish, some of which I shared on the pages of this magazine last year. My recognition of the scope of abuse deepened when the Nebraska State Patrol, DEA, and parents of stricken or deceased children spent time in our office, giving accounts of their own deeply moving and tragic family histories.

As I serve alongside other Attorneys General across the United States, they too tell of the ravages of harm being wrought in their states, where opioid abuse has been dramatically increasing. They caution me of the watchfulness

necessary on the heels of implementation of a PDMP. They have learned that once needed and necessary accountability for distribution of prescription drugs occurs, abusers may seek out alternatives. And many Attorneys General see heroin use is dramatically rising under their watch.

West Virginia, New Hampshire, Wisconsin and Ohio are all seeing significant statistical increases of abuse. This abuse is not happening in the alleys of cities but in suburban homes, curbside in family cars, in aisles of convenience stores and in rural communities. The prevalence of cheaper, stronger heroin available in pill form is an imported concentration of this illicit drug.

Such a devastating landscape is not easily overlooked. In fact, it led me to reach out to Jeffrey Gold, MD, chancellor at UNMC, asking him to join me in partnership for the work needing to be done in protecting our state. He agreed without hesitation and immediately offered to partner, as well as for UNMC to serve as host to Nebraska's Opioid Summit held on October 14.

Also hosted by U.S. Attorney Deb Gilg and the Department of Health and Human Services, the Opioid Summit was attended by 300 people from multiple disciplines. It serves as the first conversation in bringing and building collaborative forces in our state to do all

in our power to hold additional harm from coming across our borders.

The Summit was spent defining the problem and exploring best practices for effective prevention, concerted law enforcement, and improved treatment.

You are able to access the entire archived Summit here: <http://www.unmc.edu/cce/opioid/video>.

The charge given at the close of the Summit was for open dialogue and ongoing feedback to continue to be given. A Summit summary is being prepared which will provide tangible vision for our next meeting scheduled in mid-November at UNMC.

The formulation of a task force is being examined. The three-pronged approach of prevention, law enforcement, and treatment will continue to formulate future defenses and responses to the opioid crisis that threatens our nation.

John Armstrong, MD, former surgeon general of Florida, conducted our closing session and began with a most fitting quote from George Will which is appropriate for my use in closing, "The future has a way of arriving unannounced."

Let us work together to do all in our power in service to Nebraska families, as they seek the good life. And may our united determination foster futures of hope, protection and healing. □



## Nebraska Opioid Prevention Efforts *(continued)*

model, 3) a tool for improving patient safety.

### **Comprehensive Approach - Opioid Prescribing Guidelines**

DHHS is committed to establishing statewide evidence-based opioid prescribing guidelines. An internal DHHS team with representatives from multiple divisions is working closely with external stakeholders to develop prescribing guidelines. The CDC Guideline for Prescribing Opioids for Chronic Pain, released March 2016, will be used as a model in the development of these prescribing guidelines. DHHS will provide voluntary pain management continuing education, focusing on the statewide prescribing guidelines for all prescribers.

DHHS supports increased uptake of best practices in pain management and increased training on access to medication assisted treatment (MAT). A key piece of this process is collaboration with local, state and

national partners, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), to provide ongoing education and up-to-date best practices. Access to health care, support for treatment and alternative methods to treat pain are important concepts to address in the pain management education.

DHHS expects these two efforts, prescribing guidelines and the enhanced PDMP, to work hand in hand to improve patient safety and reduce adverse drug interactions. As implementation moves forward, availability for ongoing technical education for prescribers and dispensers will continue. This education will include how to use the PDMP system (supported primarily by NeHII) and education related to opioid use, abuse, and treatment.

### **Improving Awareness**

Given the complexity of the efforts to reduce opioid use and addiction, DHHS has enhanced communication

efforts by working across divisions to coordinate one message with partners and stakeholders. Communication has been disseminated to regional behavioral health partners monitoring network capacity for access to and availability of medication assisted treatment. DHHS has also developed a website to support the PDMP efforts and provide information for prescribers, dispensers, and consumers in one location. The website includes 1) information on the PDMP, 2) FAQs for three audiences (prescribers, dispensers, and consumers), 3) information for/about project partners, 4) resources, and 5) current news related to opioid efforts. In the current era of health care delivery where consumers want to be involved in their well-being, the PDMP is one way that DHHS is helping people to live better lives by providing adequate information and treatment strategies related to pain and addiction. The website can be found at: <http://dhhs.ne.gov/publichealth/PDMP/> ☐



## An Emergency Room Perspective on the PDMP *(continued)*

patients and allow all Nebraska providers to provide the best and most informed care. We have met with and worked with members of our state Legislature and the Nebraska Department of Health and Human Services, relaying our experiences and often sharing heartbreaking stories we have seen in our emergency departments to make our case.

Over the last few years, I have had the privilege of representing the emergency physicians in our state within our national organization. I have been often asked to explain why our state was one of the last without a functional PDMP. Finally, the 2016 Nebraska Legislature passed LB471, introduced by Senator Howard, providing for a comprehensive prescription drug monitoring program. Thanks to the determined efforts by many Nebraskans, including

lawmakers, law enforcement, health care professionals, victim advocates, and families, we can look forward to a PDMP that is useful, inclusive, and accessible. I am excited at the prospect of a comprehensive program that is available to all prescribers, with complete information; where inquiry is facilitated, though not mandated. I will now be proud to describe the progress we have made and the efficacy of our new PDMP. It will help each of us to provide safer, informed care for our patients, and to help decrease inappropriate opiate prescriptions.

Mixed messages persist and every day we face conflicting public opinions and policies that can create unreasonable expectations for pain control. There is not one solution that fits all settings, patients or providers. Patients will

continue to come to us in pain and in need of help, and there will continue to be a role for opiate and sedative medications as we strive to provide the best care for our patients. We need to educate prescribers on alternative treatments and have frank discussions with our patients on expectations of pain control. We will benefit from cooperation and national access to health and prescribing information.

The pendulum of medical care and public opinion will continue to swing. I know not if or where it may come to rest. Our charge, as it has always been, is to provide the best care for our patients and our communities without doing harm. With Nebraska's new Prescription Drug Monitoring Program, we will have an important tool to help meet that challenge. ☐

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## Over 290 pharmacies across Nebraska will take back leftover medications for proper disposal

The Nebraska Medication Education on Disposal Strategies (MEDS) coalition educates Nebraskans about drug disposal and provides safe disposal options to better safeguard the environment and protect public health. Over 290 pharmacies across Nebraska are accepting leftover, expired and unused medications for proper disposal. Physicians can direct patients to the Nebraska MEDS website, [www.nebraskameds.org](http://www.nebraskameds.org). Or, they can call

the Nebraska Regional Poison Center at 1-800-222-1222 to find a participating pharmacy near them.

Since August 2012, 33,176 pounds of medication have been collected by Nebraska pharmacies for proper disposal.

This project is being offered to the state of Nebraska by a statewide coalition of partners and with funding from the Nebraska Environmental Trust.

The Nebraska MEDS coalition

consists of the Nebraska Pharmacists Association, the Lincoln/Lancaster County Health Department, the Nebraska Department of Environmental Quality, The Nebraska Regional Poison Center, the Nebraska Department of Health and Human Services, WasteCap Nebraska, The Groundwater Foundation, and the NMA. ☐

## New Members

### Bellevue

Donny Suh, MD, FAAP

### Crete

Troy Miller, DO

### Elkhorn

Ramya Chilukuri, MD

Dali Huang, MBBS

### Fremont

Nagendra Natarajan, MBBS

### Kearney

Kyle Rupp, DO

### Lincoln

Jesse Dunn, MD

### Missouri Valley, IA

Austin Saavedra, MD

### Omaha

Arie Albulushi, MD

Marcus Arthur, MD

Stephan Barrientos, MD

David Berkheim, MD

Katherine Brown, DO

Vamsi Krishna Chilluru, MBBS

Dele Davies, MD

Amaninderjeet Dhaliwal, MD

Morgan Dreesen, DO

Jill Faraci, MD

Ali Fiamengo, DO

Mary Fortini, DO

Rebecca Glasgow, DO

Christopher Graves, MD

Elizabeth Hultgren, MD, PhD

Grant Hutchins, MD

Vikram Jala, MBBS

Aravdeep Jhand, MBBS

Grant Jirka

### Omaha (continued)

Andrea Jones, MD

Siva Sundeepp Koppolu, MBBS

Zachary Kwapnoski

Daniel Kwon, MD

MacKenzie Laurila, DO

Megan Lawless, MD

Huy Le, MD, PhD

Kylie Liermann, DO

John Loftus, MD

Ly Luu, MD

Ahmed Munir, MBBS

Rina Musa, MD

Heather Obregon, MD

Spyridon Pagkratis, MD

Jai Parekh, MBBS

Thomas Perry, DO

Oak Prachuaphunyachart, MD

Ahmad Qurie, MD

Ahmed Rahma, MD

Erin Ranum, MD

Jarin Redman, MD

Casey Sautter, MD

Sophia Schneider

Mohammad Selim, MBBS

Tiffany Tanner, MD

Meg Thacker

Suraj Timilsina, MD

Laura Vance, DO

Keith Vrbicky, Jr.

Luke Wenzel, DO

Brian Westerhuis, MD

Kimberly White, MD

Jennifer Wright, MD

Niraj Yadav, MBBS

### Papillion

Adrienne Dekarske, MD

## Necrology

Daniel George Bitner, MD

Bellingham, WA

3/22/2016

Maurice F. Quinlan, MD

Omaha

5/27/2016

Coley Patrick O'Doherty, DO

LaVista

5/29/2016

Daryl Rahy Stephenson, MD

Yankton, SD

6/16/2016

Jack Keith Lewis, MD

Omaha

6/20/2016

James Joseph Regan, MD

Omaha

6/27/2016

Charles Morton Root, MD

Baltimore, MD

7/2/2016

Hester T. Lewis, MD

Lincoln

7/11/2016

John F. Fitzgibbons, MD

Panora, IA

7/16/2016

Kenneth C. Stout, MD

Benkelman

7/21/2016

Carl Laeton Boschult, MD

Omaha

7/22/2016

Robert Bass, MD

Perkins, OK

8/4/2016

Robert Proulx Heaney, MD

Omaha

8/6/2016

Stephen Edward Budd, MD

Omaha

8/15/2016

Milton Roger Johnson, MD

Scottsbluff

8/29/2016

Robert G. Townley, MD

Omaha

9/9/2016

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# Ask a Lawyer

## *Can a Physician be liable in a Medical Malpractice Action because of a Patient's Suicide?*

*“Can a Physician be liable in a Medical Malpractice Action because of a Patient's Suicide?” was the question posed in a recent Florida Supreme Court decision. Chirillo v. Granicz, \_\_ So.3d \_\_, 2016 WL 4493546 (Fla. 2016).*



In October 2008, a patient called her physician's office and told the physician's medical assistant that she had stopped taking the antidepressant Effexor. The physician, Dr. Chirillo, had prescribed the medication for the patient in 2005. The patient explained to the physician's medical assistant that she had stopped taking the medication because the patient thought she was having side effects from it, such as not sleeping well, being under mental strain, crying easily and having gastrointestinal problems. The patient said that she had not “felt right” since June or July. The medical assistant provided the information to the physician, and the physician subsequently changed the patient's prescription to Lexapro and referred the patient to a gastroenterologist. The patient was called back that day and instructed to pick-up samples of Lexapro and a prescription for that medication. However, the office did not ask the patient to make an appointment with the physician. The patient picked-up the Lexapro samples and prescription the day she called the physician's office. The next day, the patient was found dead -- a suicide.

The patient's family was shocked at her suicide because she had not

given them any indication of being suicidal. Although the patient had told the patient's adult daughter that she was crying easily, not feeling well, and that her stomach hurt, the daughter encouraged the patient to call her physician. The patient's husband thought his wife's discomfort was primarily physical rather than emotional.

The patient's husband, Mr. Granicz, subsequently filed a medical malpractice action against the physician, his practice, and his practice group alleging that the physician had breached a duty of care in treating the man's wife and that the patient's suicide was a result of the breach. In his defense, the physician argued that he owed no duty to the patient to prevent an unforeseeable suicide while the patient was outside of the physician's control. Two Florida lower courts examined the facts and came to different conclusions based upon how each court identified the issue to be decided: In one case, whether a duty to prevent a patient's suicide existed under the circumstances; in the other, whether the physician had a duty to exercise reasonable care in the physician's treatment of the patient.

The Florida Supreme Court observed that a duty can arise because of a statute, judicial interpretations of statutes, case law, and the facts of a given case. Where a statutory duty applied, determining whether a duty arose from the facts of a case was inapplicable. As a result, the lower court that based its decision on the statutory duty was determined to have taken the correct approach. Although

no duty existed in Florida law to prevent a non-inpatient's suicide, the Florida Supreme Court noted that other types of duties could apply such as the duty owed to the patient under the applicable statute, namely, to treat the patient according to the standard of care. The Florida Supreme Court did not decide the issue of liability. Instead, the case was remanded with instructions to proceed to trial.

Under Nebraska law, Neb.Rev.Stat. § 44-2810. Malpractice or professional negligence is defined to mean

in rendering professional services, a health care provider has failed to use the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by members of his profession engaged in a similar practice in his or in similar localities. In determining what constitutes reasonable and ordinary care, skill, and diligence on the part of a health care provider in a particular community, the test shall be that which health care providers, in the same community or in similar communities and engaged in the same or similar lines of work, would ordinarily exercise and devote to the benefit of their patients under like circumstances.

A medical malpractice case in Nebraska requires a plaintiff to prove the (1) applicable standard of care, (2) that the defendant's conduct deviated from the standard of care, and (3) that the deviation from the standard was

*(continued on Page 24)*



# CDC Guidance on Opioid Prescribing

By COPIC's Patient Safety and Risk Management Department

**D**rug overdoses are the No. 1 cause of accidental deaths in the U.S., surpassing deaths by motor vehicle accidents. Many drug overdose deaths involve prescription medications, predominantly opioids. Even greater by orders of magnitude are those patients and their families affected by opioid dependence and addiction.

Guidance strategies to combat this epidemic are now being endorsed by many large public agencies, including the Centers for Disease Control and Prevention (CDC).

## CDC GUIDANCE

Published in March 2016, the "CDC Guideline for Prescribing Opioids for Chronic Pain" report is directed at primary care physicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. However, the report has recommendations relevant to all prescribers of opioids with extensive analysis of the evidence related to:

- When to initiate or continue opioids for chronic pain
- Opioids selection, dosage, duration follow-up and/or discontinuation
- Assessing risk and addressing harms of opioids use

COPIC suggests that all opioid prescribers review the entirety of the report, but we emphasize the following 12 recommendations (note that items 6 and 11 apply to all prescribers of opioids, even short-term):

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain, and clinicians should consider opioid therapy only if benefits for pain and function outweigh risks.
2. Before starting opioids therapy for chronic pain, clinicians should establish treatment goals, including realistic goals for pain and function, and consider how opioids therapy will be discontinued.
3. Before starting and periodically during opioids therapy, clinicians should discuss with patients known risks and realistic benefits of opioids therapy, and patient and clinician responsibilities for managing therapy.
4. When starting opioids therapy, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
5. Clinicians should prescribe the lowest effective dosage, and should carefully reassess evidence of benefits and risks when increasing to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day.
6. Long-term opioids use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms within one to four weeks of starting opioids therapy or escalating dose, and should evaluate benefits and harms of continued therapy with patients every three months or more frequently.
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms, such as sleep apnea, pregnancy, renal or hepatic insufficiency, patients over the age of 65, mental health conditions, substance use disorder and/or prior overdose. Risk mitigation includes offering naloxone especially when there is a history of overdose, history of substance use disorder, opioid dosages  $\geq 50$  MME/day, or concurrent benzodiazepine use.
9. Clinicians should review the prescription drug monitoring program (PDMP) when starting opioid therapy and periodically, ranging from every prescription to every three months.
10. Clinicians should use urine drug testing (UDT) before starting opioid therapy and consider UDT at least annually.
11. Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for opioid use disorder.

Link for the full CDC report:

<http://goo.gl/I629u9>.

 **COPIC**  
Better Medicine • Better Lives

# What to Do With Your Extra Dollars

by Marcus Iwig, CPA, CFP  
Provided by the Foster Group

Interest rates have been at historic lows for a number of years now and it often leads physicians to ask what they should do with their surplus cash-flow to create the most wealth. Should you accelerate the payoff of student loans and mortgage debt or should you invest the surplus because borrowed dollars are so cheap that, in some cases, the return on the invested dollars could be higher than the interest costs?

Looking at recent history, you could certainly make the case for investing free cash flow over paying off debt. For instance, the S&P 500 has annualized returns of 9.33% over the three years ending May 31, according to Morningstar. According to the Federal Home Loan Mortgage Corporation (Freddie Mac), the highest national average 30-year mortgage rate in that three-year time has been 4.43% back in January of 2014. That was easy, keep the mortgage and invest the difference, right? Not so fast, there's a lot more to it than that. We have a required disclaimer in our industry, "Past Performance Does Not Guarantee Future Results," so while the S&P 500 may have returned 9.33% annualized over the past three years, it returned -0.73% in 2015. Also, don't forget reducing or eliminating your mortgage or other debt offers guaranteed return equal to the interest rate you pay. While mortgage rates may be historically

low, many of them are still higher than high-quality corporate and government bonds available to investors, and many investors have bonds in their investment portfolio.

More importantly, decisions like these should be run through each person's comprehensive financial plan and, like fingerprints, every person's financial plan is unique. When you base the decision on an individual's personal financial plan, which includes their long-term goals, you often find this is not an either/or decision.

Goals and a comprehensive plan can work somewhat like an algorithm for deciding where to put extra cash-flow. Your goals will likely create a schedule for eliminating debt that may not utilize all of your free cash-flow. If you want the freedom to work part-time in ten years, that may require a payment schedule for your mortgage to be eliminated by then. Any free cash-flow after you've made the monthly payment could then be invested. Likewise, if you have kids that will be heading to college, one consideration is to determine a payment schedule that eliminates the mortgage by the time your first child goes to college, freeing up cash flow to help cover education costs, if necessary.

If you are an early-career physician expecting to have the opportunity to invest or buy into a practice in the next few years, it may be better to direct extra cash to a conservative investment so you have the capital, when needed, to buy in. Once that's happened, you might start paying off your mortgage

more aggressively or consider investing additional dollars, depending on what goals exist at that point.

What you do with surplus cash-flow is the right question to ask, and the best way to answer the question is to sit down and create a long-term comprehensive financial plan with a financial advisor that accounts for all of your goals. If that's done, then you will have a clearer answer for where surplus cash-flow should go each month to best achieve your goals.

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2016 NMA Edition

VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE

**Mark Stadtlander**

CFP®, Chief Executive Officer

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## Ask a Lawyer *(continued)*

the proximate cause of the harm to the plaintiff. *Olson v. Wrenshall*, 284 Neb. 445, 450 (2012).

Essentially, the Florida Supreme Court in *Chirillo* concluded that the wrong question was being asked by one of the lower courts. The question was not whether the physician had a duty to prevent the patient's suicide. It was instead whether the physician owed the patient a duty of care under the circumstances. In all likelihood, a similar case in Nebraska would be analyzed with reference to the "ordinary and reasonable care" standard. If faced with the same facts as Dr. Chirillo, what would you do? ☐

*Ask a Lawyer is a feature of the Nebraska Medicine. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to submitted questions are provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank Building, 233 S. 13th St., Suite 1900, Lincoln, NE 68508-2095. The answer in this issue was provided by Jill Jensen of the Cline Williams Law Firm. Questions relating to specific, detailed, and factual situations should continue to be referred to your own counsel.*

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