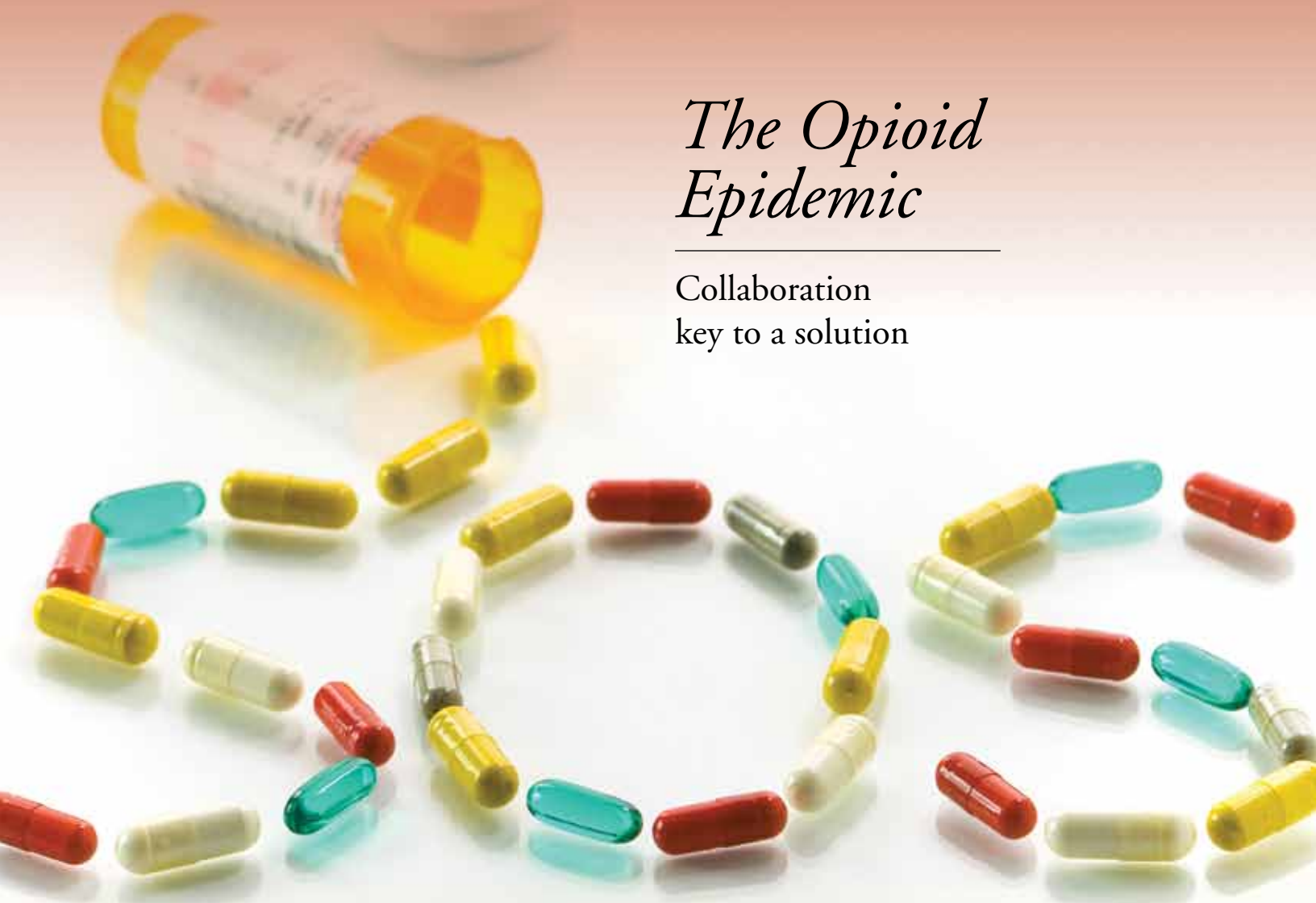


# Nebraska Medicine

Fall 2015 | Volume 14, Number 3

## *The Opioid Epidemic*

Collaboration  
key to a solution



Nebraska  
Medical  
Association

*Advocating for Physicians and the Health of all Nebraskans*

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# President's Message

by Harris Frankel, MD  
NMA President

I am greatly honored to be the newly elected president of the Nebraska Medical Association. I accept your confidence and willingness to lead this organization in what will surely be another year of opportunities for Nebraska physicians to advocate for not only our profession, but most importantly, our patients.

I would like to express my sincerest thanks to 2014-15 President Richard Blatny, Sr., of Fairbury for the outstanding job he did representing us this past year; a job truly well done.

Let me begin with a quote: "Medicine is in essence, a moral enterprise and its professional associations should therefore be built on ethically sound foundations." (Edmund Pellegrino and Arnold Relman)

Our reputation as an organization is and always has been in your hands as members...to advocate for our patients and the profession of medicine.

We demonstrate our relevance by leading those conversations that our patients, colleagues, the public and legislators are listening to. We need to embrace interprofessional education, clinical care and advocacy. The totality of cooperative and collective influence

can be much greater than the sum of the parts.

As members of our professional organization, as advocates for patients and public health alike, we have the responsibility to shape and influence health policy and not let it define us. We also have the responsibility to educate and advocate. Nothing is more critical to the future success of health care than for physicians to lead.

The big question is: do we have the will to do so?

Medicine has been, remains, and always will be a noble profession... a profession that has engendered trust which we must continue to earn. I have the utmost faith in the future of our profession. However, we are at a crossroads and face tremendous headwinds in the near term.

I would ask each of you to be a mentor. Show your younger partners and/or associates the importance of being involved; the importance of being heard. Ultimately, however, we must act together. Though we can make a difference as individuals, we need the strength of team...and there is no "I" in team.

In closing, I would like to partly quote one of the most famous speeches ever; that by Al Pacino in his role as

coach Tony D'Amato in the movie *Any Given Sunday*:

"On this team we fight for that inch. On this team we tear ourselves and everyone else for that one inch. We claw with our fingernails for that inch. Cause we know, when we add up all those inches that's going to make the difference between winning and losing; living and dying. I'll tell you this, in any fight, it is the guy who is willing to die who is going to win that inch. And I know, if I am going to have any life anymore, it is because I am willing to fight and die for that inch...because that's what living is... the six inches in front of your face. I can't make you do it. You gotta look at the guy next to you. Look into his eyes. Now I think you are going to see a guy who will go that inch with you. You will see a guy who will sacrifice himself for the team because when it comes down to it, he knows you'll do the same for him. That's a team gentleman. Either we heal as a team or die as individuals. That's football guys. That's all it is. Now what are you going to do?"

So I ask you, what are you going to do? □





# Executive Vice President's Message

## *Perspective*

by Dale Mahlman  
*NMA Executive Vice President*

**P**erspective is always interesting when it comes to politics and our everyday life. The past couple of years have provided me several opportunities to

keep my perspective in balance and as a result, I think I have a better understanding of what I think about different things.

Regarding the political world, having 15+ candidates for the Republican nomination for the Presidency meant watching multiple televised debates and hoping one of the candidates will jump out as the "best" option. However, my perspective on this is that the circus environment will continue until a few more drop out and one of the frontrunners begins to draw support from the whole party. For now, watching Mr. Trump proves to be entertaining and my hope is that all candidates, Republican and Democrat alike, have the end goal of making America great again. Nevertheless, as the caucuses and primary approach, let the posturing continue.

In viewing the local political environment, my perspective is term limits have motivated many good candidates

across the state to consider a run for the Nebraska Legislature. Our interest as an organization has been to get a physician elected to the Legislature. The last physician in office, Senator Joel Johnson, MD, of Kearney, left the Legislature in 2008. This year, we have TWO excellent candidates in District 25, Southeast Lincoln and rural Lancaster County, running against each other so while we like our chances better than in past years, we still have the difficult task of determining which of these excellent NMA members, Dr. Les Spry or Dr. Dale Michels, might advance to the November 2016 general election. The next four to five months until the primary will be critical for both candidates but knowing them both well, they will get their message to their constituents effectively.

With regards to health and wellness, two years ago the Nebraska Medical Association participated in a wellness conference in Nebraska City which focused on living a healthy lifestyle and the importance of healthy eating and exercise. Since that time I personally have had a new perspective on both, and the NMA has been active with Teach a Kid to Fish and Husker Sports Marketing promoting the ENERGY message created by Teach a Kid to Fish at Husker Sport-

ing activities, both in venue and on radio. Having heard Dr. Ali Khan, dean of the UNMC College of Public Health, recently describe his goal to make Nebraska the healthiest state in the nation, (we are currently ranked #10), makes a strong case that all Nebraskans, young and old alike, can do more individually and collectively in making Nebraska an example for all to follow.

What's next for organized medicine in 2016? Health care delivery and transformation will continue on many levels, and the NMA will be actively involved in the discussion. Medicaid will see the introduction of THREE managed care companies statewide and that will be a change. Practice transformation resulting from CMS grants will be occurring and for most of our practices it will be business as usual. The NMA will be engaged and active with all these efforts.

Lastly, dues statements for 2016 have been mailed. We hope from your perspective that the NMA continues to be a value to you and you continue to support the mission of the NMA, "To serve our physician members as advocates for our profession, for our patients and for the health of all Nebraskans." With all of you on our team, we can accomplish that goal. □



# What can Physicians do to Reduce the Epidemic of Prescription Drug Abuse?

by John R. Massey, MD  
State Representative American Academy  
of Pain Medicine  
Lincoln

Nebraska and Missouri are the last remaining states that have yet to implement a working prescription drug monitoring program. CDC data reports 23,000 prescription opioid / benzodiazepine deaths in 2013, (63/day). An additional 1 million ED visits were for prescription opioid/ benzodiazepine overdoses. Insurance industry analyses indicate the direct medical cost to be in excess of \$15,000 per patient with substance abuse, with far higher indirect costs. The Nebraska Medical Association has been working for years to advocate for legislation and funding to implement a working PDMP. When testifying to the legislative committee I'm always asked: "What are physicians doing to reduce the epidemic of prescription drug abuse?"

**Good question.** This is an iatrogenic epidemic. As physicians we tend to talk about "drug seekers" and "doctor shoppers." Problematically, the majority of patients who overdose are getting prescriptions from a single prescriber and are taking their medications not for recreational purposes, but in an attempt to treat or eliminate acute or chronic pain.

As medical providers, we are tasked with helping our patients understand the risks and benefits of any treatment we offer. We may differ individually on the nuances of this ongoing evaluation. Nonetheless, we are required by the state to evaluate and document the risk

/benefit ratio of controlled substances whenever we are utilizing them as a portion of care for patients in pain. We tell politicians that they are entitled to their own opinions, not their own facts. As providers, we can differ on the relative risk/ benefit ratio of any given treatment, but we must use data whenever possible to document an understanding of this ratio.

Opioids are often our best weapon for acute pain. They are much less effective at reducing chronic pain. Most studies show an expected 25-30 percent reduction in severity of chronic pain with the use of opioids. Studies differ on the prevalence of substance abuse issues in the population of patients with chronic opioid management. The number is somewhere around 13 percent. Furthermore, opioids tend to show the expected benefit for the first 4-12 weeks in the treatment of a pain state and then can steadily lose efficacy. Many chronic pain states become relatively opioid resistant. This further sets the stage for long-term complications as patients try to maintain the initial benefits they experienced over the course of time.

We can and must do better. When we employ a systematic and data driven approach to measuring the risks versus the benefits of controlled substances, we also increase patient satisfaction, pain relief and safety. While at the same time we reduce physician and staff frustration as well as time burden. With a small investment in education and organization we can leverage data collection to improve our care for these patients.

This process is called **Universal Precautions for Opioid Prescribing**. Just as in universal precautions are utilized to reduce the risk of blood borne pathogen transmission, this process utilizes validated metrics to assist in clinical decision making. It stratifies risk for prescribing before opioid therapy is initiated, as well as longitudinally during the management of these patients to monitor for subsequent development of problematic medication use. This process also utilizes the 4 As: Analgesia, Adverse effects, Activity, Aberrant behaviors. Documentation of these four factors correlates with best practice and not coincidentally is required by state statutes to be evaluated and documented for all patients who received these medications. As physicians we most commonly focus on patient reports of analgesic efficacy and adverse effects.

Activity maintenance and improvement has been shown to more closely correlate with long-term success or failure of treatment with opioids. Aberrant behaviors are commonly seen and are very commonly misidentified or overlooked by clinicians. The accumulation of aberrant drug taking behaviors becomes an indication of loss of control of the use of medications. These are often misunderstood or overlooked by prescribing clinicians. As such we miss the opportunity to intervene on behalf of our patients.

It is never possible to treat pain in the face of unrecognized substance abuse. A

(continued on Page 16)



# The Emergency Room perspective

by Jason Kruger, MD  
Lincoln

**P**rescription drug abuse is at epidemic levels across the United States. Death rates from prescription drug overdoses have increased dramatically since the late 1990s. As physicians we sometimes face a dilemma when prescribing controlled substances. First, we want to believe our patients. Most of our patients tell the truth and use their medications for the appropriately prescribed reasons. As physicians, we want and need the ability to treat acute pain in our patients. As physicians, we must balance this duty to treat with our duty to do no harm. Patients who struggle with addiction are often not entirely truthful. As an emergency medicine physician, I typically do not have a long-term established physician/patient relationship with the patients I see and treat in the emergency department. When I go through a history and physical exam with my patients, often the only information I have on their past and current medical history is the information they tell me. Again, most of



the time our patients participate in their health care in an honest and forthright manner. However, patients who struggle with addiction will give limited or false information in an attempt to further fuel their addiction. As an emergency physician, I need to be able to appropriately treat pain, but I do not want to further fuel a patient's addiction problem.

As an emergency physician in Nebraska, I practice in one of only two states that do not currently have a functioning prescription drug monitoring program (PDMP). In the spring of 2011, our state Legislature passed LB 237, a bill that was intended to establish a PDMP in the state of Nebraska. The bill passed unanimously and the Governor signed the bill into law that year. Unfortunately, there was no funding attached to the bill and Nebraska remains without a functioning PDMP.

Every day in the emergency department we see and treat patients with acutely painful conditions. Patient safety is a critical concern for all practitioners. It is impossible to tell if someone is abusing prescription controlled substances by simply looking at them. Providers need

information to make an informed decision on how best to safely treat a patient. With good information, we can appropriately intervene with patients who are using controlled substances in an unsafe manner. Frequently, friends and family members are unaware when their loved one is dealing with issues of addiction. Addiction is a treatable condition if it is identified and early treatment is preferable for success. Without the independent information available in a PDMP, providers are left guessing as to whether the patient in front of them is providing a full and accurate history.

It is challenging to prescribe potentially addictive pain medications to patients without the ability to independently verify their past controlled substance prescription drug history. Both prescribers and dispensers of controlled substances need the ability to independently verify prescription controlled substance histories to safely and effectively do their jobs. We do not want to harm our patients who struggle with addiction by giving them more addictive medications. When addiction goes unrecognized, the end result too frequently is death. □

# Chasing the Dragon...The Resurgence of Heroin

by Jane Theobald, MD  
Methodist Health Systems

There is nothing like the illness of a loved one to motivate a physician's quest for knowledge. Sadly, this is my story. I am a psychiatrist specializing in treatment of those with pain disorders and cancer. I see a fair amount of addiction. I believed for so long these stories belonged to my patients, but not to me. A year ago that belief came crashing down around me as I stumbled upon my own family's melee with heroin. My story is like thousands of others. But it is mine.

Until recently, heroin was viewed as a drug that's allure had peaked in the 1960s. It was the untouchable leper of recreational drugs only a very few individuals would ever dare try because consequences were viewed as so dangerous and unforgiving. Then OxyContin (oxycodone) and all her sisters came to town and deceptively changed the landscape.

Not long ago, there was an air of urgency in addressing and alleviating pain. In 1996 pain was dubbed "the 5th vital sign" by the American Pain Society and clinicians were urged to "optimize analgesic use." Patients and their loved ones viewed pain as unacceptable and often demanded aggressive treatment. Prescribing of opiates skyrocketed with the unintended consequence of addiction following in the wake.

While marijuana has often been viewed as the gateway drug for "harder" drugs, prescription opiates have proven to be the thoroughfare for heroin's resurgence. Patients prescribed opiates for legitimate pain concerns inadvertently get caught in the web of addiction as they find the medication numbs their emotional

pain. Kids as young as 12 or 13, oblivious of potential consequences, begin experimenting by sampling right from mom and dad's medicine cabinet. New heroin users are now more likely to be young, white and from affluent families. Average age of first use is often in the early 20s and typically follows dependency on prescription opiates. Users are frequently college educated and holding down full time jobs.

Where there is a market, there is a business opportunity, and opiate "pill mills" began cropping up across the landscape in the early 2000s. Eventually, the FDA intervened with a crackdown on such operations and there was a push to educate clinicians about safer prescribing. However, the horse was out of the barn. As opiates became increasingly expensive, a new business opportunity was ripe for the taking. OxyContin on the black-market can bring around \$80 per tablet. Heroin is cheap to produce and an equivalent dose costs only about \$10. Individuals facing a costly psychological dependency on OxyContin with brutal physical withdrawal symptoms, often find the switch to heroin an easy decision to make. Distribution networks are well established by worn pathways of the marijuana trade which has become less profitable as more and more states have legalized it in one form or another.

It was once believed heroin was the most addictive substance known. This has since been questioned. However, there is one key difference between this drug of abuse and others. One single miscalculation of dosage due to variability in potency can be fatal. Again, one single miscalculation of dosage can be **fatal**.... and often is. The number of heroin overdoses across

the U.S. has skyrocketed over the last five years. This does not exclude Nebraska. The trenches are deep here in the Midwest. According to Sgt. Dave Bianchi, spokesman for the Omaha police department, heroin users are now much younger and located in the city's wealthy neighborhoods. Deaths from overdose have occurred across the state, from metropolitan areas to tiny burghs. Visiting drug treatment centers in the state reveals history of heroin use is no longer an anomaly.

Education of physicians and vulnerable populations has been slow in coming. Affordable and effective treatment options for heroin use disorder remain elusive. There is little evidence supporting conventional chemical dependency treatment program or support group effectiveness. Structured individual cognitive behavioral therapy may be helpful, but it is often hard to find. Programs shown to reduce risk of morbidity and mortality include needle exchange, medically supervised injection centers, methadone and buprenorphine/naloxone (Suboxone) maintenance, and increasing naloxone (Narcan) availability. Naltrexone, not to be confused with naloxone, has shown promise in the medical management of opiate cravings. This includes an oral daily form (Revia) and a long acting injectable form (Vivactrol). Portugal's policy of decriminalization of heroin use in favor of aggressive treatment has shown surprising success.

As my colleagues, I encourage you to ask your patients about heroin use. Directly. They just might tell you. And if they do tell you, you might be able to

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# Nebraska Department of Health and Human Services HEALTH ALERT NETWORK Advisory

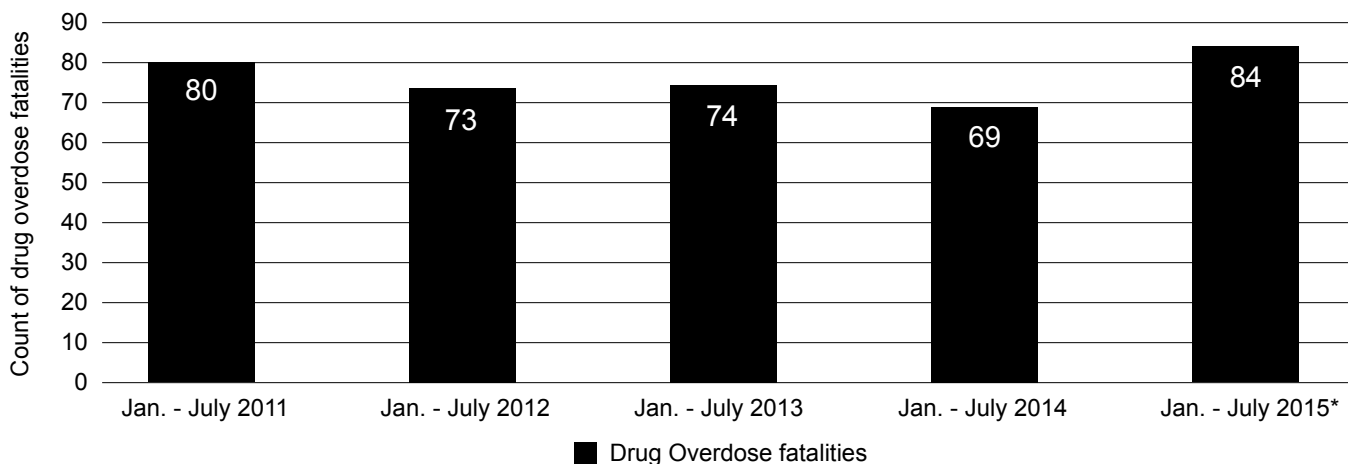


TO: Primary care providers, anesthesiologists, ERs, pharmacies, and public health  
 FROM: Thomas J. Safranek, M.D.  
 State Epidemiologist  
 PHONE: 402-471-2937  
 E-MAIL: tom.safranek@nebraska.gov  
 RE: **Notification - LB 390 Expanded use of Naloxone**  
 DATE: September 22, 2015

## Background

During January–July 2015, 84 drug overdose fatalities have been identified in Nebraska (12 deaths/month) representing the highest number of deaths for this time period in the past five years. (Figure).

**Figure 1. Number of Drug Overdose Fatalities January - July  
Nebraska 2011-2015\***



Data Source: Nebraska Vital Records, 2011-2015 \*preliminary results for July 2015

Case definition – if underlying cause of death included one of the following ICD-10 codes X40-X44, X60-X64, X85, Y10-Y14 or if any contributing cause field contained one of the following ICD-10 codes; T36-T39, T40.1-T40.4, T41-T43.5, T43.7, T50.8, T50.9

The majority of all 2015 overdose deaths have been reported as unintentional (81%) and occurred among males (58%) and persons aged 45-64 years (55%); most involved either a prescription or illicit opioid.

## New Legislation:

On May 27, 2015 Governor Ricketts signed LB390 (Statute 28-470 <http://nebraskalegislature.gov/laws/statutes.php?statute=28-470&print=true> ). This law allows health professionals to prescribe, administer, or dispense naloxone to persons experiencing an opioid-related overdose **or to a family member or friend in a position to assist such individuals**. This law also authorizes emergency responders and peace officers to administer naloxone to persons experiencing this type of overdose.

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## Health Alert Network Advisory *(continued)*

### **Persons at high risk of opioid overdose include:**

- a. People who mix prescription opioids with alcohol or benzodiazepines such as Klonopin, Valium, and Xanax.
- b. Persons who are opioid naïve or have a low drug tolerance (limited ability to process a certain amount of a drug) from either never using the drug before or after taking a break from use either intentionally (e.g., while in drug treatment or on methadone detoxification) or unintentionally (e.g., while in jail or the hospital<sup>1</sup>).

### **Therapeutic Intervention: Consider prescribing naloxone along with the patient's initial opioid prescription**

With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from having a naloxone kit in the event of overdose. Patients who are candidates for such kits include those who are:

- Taking high opioid doses for long-term management of chronic malignant or nonmalignant pain.
- Receiving rotating opioid medication regimens and are at risk for incomplete cross-tolerance.
- Discharged from emergency medical care following opioid intoxication or poisoning.
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinence programs.
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

Consider having at-risk patients create an “overdose plan” to share with friends, partners, and/or caregivers. Such a plan should contain information on the signs of overdose and how to administer naloxone or otherwise provide emergency care (as by calling 911).

Follow best practices for responsible analgesic prescribing, including:

- o **Prescribe** the lowest effective dose and only the quantity needed for the expected duration of pain.
- o **Plan** with your patients on how to stop opioids when their treatment is done.
- o **Provide** your patients with information on how to use, store, and dispose of opioids.
- o **Avoid** combinations of prescription opioids and sedatives unless there is a specific medical indication.

For more information on safe prescribing tools please go to:

<http://www.cdc.gov/drugoverdose/prescribing/tools.html>

### ADDITIONAL RESOURCES

- Naloxone guidelines for pharmacists: [https://cpnp.org/\\_docs/guideline/naloxone/naloxone-access.pdf](https://cpnp.org/_docs/guideline/naloxone/naloxone-access.pdf)
- SAMHSA Opioid overdose toolkit: [http://store.samhsa.gov/shin/content/SMA13-4742/Overdose\\_Toolkit\\_2014\\_Jan.pdf](http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf)
- Harm Reduction Coalition: <http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/opioid-od-risks-prevention/>
- CDC Prescription Drug Overdose What Health Care Providers Need to Know: <http://www.cdc.gov/drugoverdose/epidemic/providers.html>
- SAMHSA Opioid Overdose Prevention toolkit, pg. 11: [http://store.samhsa.gov/shin/content/SMA13-4742/Overdose\\_Toolkit\\_2014\\_Jan.pdf](http://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf)

# Which of Your Patients is Likely to Overdose on Opioids?

by Marcia Muetting, Pharm.D., R.P.  
Nebraska DUR Director  
Nebraska Pharmacists Association

Newspapers and professional journals have been flooded with articles highlighting the issues of substance abuse and overdose in the United States.



We have all read about pill mills, doctor shopping and the epidemic of drug abuse. While Nebraska ranks lowest among the states for prescription drug overdose, each year the number increases. In 2008, the rate of death due to drug overdose was

5.5 per 100,000. That number increased to 6.7 per 100,000 in 2010.<sup>1,2</sup> Data from the Nebraska Regional Poison Center shows that the number of reported exposures to analgesics has increased from 3,156 in 2010 to 4,141 in 2012.<sup>3</sup> These statistics parallel the increase in prescribing of opioid pain relievers across the United States with a fourfold increase in sales from 1999 to 2010.<sup>1</sup>

While the above statistics do not distinguish the use of opiates for terminal cancer or end of life, the focus of this article is on the use of opioids in the treatment of chronic, non-cancer pain.

## Factors that Increase Risks of Death Due to Overdose in Patients with Chronic, Non-Cancer Pain

Certain opioids are associated with a higher risk of death from overdose. Methadone tops the list of drugs with the highest risk, followed by oxymorphone and fentanyl.<sup>4</sup> Approximately 33 percent

of deaths due to opioid overdose involved no other medications.<sup>5</sup>

Specific drugs, when added to opioids, also increased the risk of overdose death. Approximately 50 percent of all deaths in the United States due to opioid overdose involved another drug and 16 percent involved drugs that were not specified. Benzodiazepines, in combination with opioids, were involved in 17 percent of the overdose deaths. Cocaine or heroin, in combination with opioids, was involved in 15 percent of deaths, and benzodiazepines with cocaine or heroin were involved in 3 percent of deaths.<sup>5</sup>

The opioid dose is a risk factor. In the CONSORT study, patients who received more than 100 mg per day morphine equivalent dose (MED) of opioids were nine times more likely to experience an overdose (fatal and non-fatal). In this study, it was observed that the patients who received the highest doses were most often male, smokers, had a history of treatment for depression or had a history of substance abuse. More total overdoses occurred, however,

in patients taking lower doses, because the total number of patients taking lower doses was higher.<sup>6</sup> While higher doses are considered a risk factor, even patients taking lower doses are at risk for overdose.

The information in Table 1 can be used to calculate the MED for the listed opioids. A patient's total daily dose of each opioid taken per day is multiplied by the factor listed and added together to calculate the approximate MED.

Patients were at an increased risk of overdose if they had recently received a sedative-hypnotic medication. In comparison to the patients not taking a sedative-hypnotic in the study, patients taking a sedative-hypnotic were 30 times more likely to experience an opioid overdose. The risk did not increase with the frequency of receiving sedative-hypnotics.<sup>6</sup>

## Strategies to Monitor Patients

Patients who must be treated long-term with opioids should be supervised closely and be instructed in the appropriate use of opioids.<sup>6</sup>

Prescribers should ask patients about their use of alcohol and other drugs. When possible, patients with a history of mental health issues or substance abuse should be referred to a specialist. Successful pain management will address treatment of any existing mental health issues.<sup>7</sup>

Prescribers should consider "pain contracts" or opioid treatment agreements. These agreements should address at a minimum: how often a patient can obtain

(continued on Page 17)

TABLE ONE

Drug Name	Factor to Calculate MED
Codeine	0.1499
Dihydrocodeine	0.1499
Fentanyl Patch	6.02
Fentora	0.07
Hydrocodone	1
Hydromorphone	4
Levorphanol	7.5
Meperidine	0.1
Methadone	7.6923
Oral fentanyl (except Fentora)	0.06
Oxycodone	1.4925
Oxymorphone	3.03
Tapentadol	0.2

# Too Many Lives Destroyed

by Doug Peterson  
Attorney General

I have never had to shout at my friend. In fact, I can't remember a time where I've ever had to shout in anger at any friend. But on this day it was necessary to make it clear to Jack<sup>1</sup>, he could no longer continue to indirectly enable his son to feed his prescription drug addiction. For two years I watched Jack do everything he could to try to help his son in spite of the fact that Devon<sup>2</sup> was stealing jewelry from his mother, clothing from his two sisters, and actually breaking into the homes of family friends. His son's prescription drug addiction had turned their family life into an absolute nightmare. Jack had to let Devon crash. It was through this traumatic experience that I witnessed, firsthand, the reach of destruction caused by prescription drug abuse in Nebraska.

Prescription drug abuse is an extensive problem addressed by local law-enforcement officers, our school systems, and our medical care providers. The problem ranges from junior high and high school students raiding the family drug cabinet to see what they can bring to a pharmacoparty<sup>3</sup>, to a full-fledged addict manipulating the prescription of opiate drugs such as oxycodone, hydrocodone, hydromorphone, and methadone<sup>4</sup> in order to feed an addiction or sell to the addicted.

Unfortunately, Nebraska is one of only two states that does not have a mandatory prescription drug monitoring program (PDMP)<sup>5</sup>. This lack of a program creates an environment that makes it easier to "doctor shop" for pain med prescriptions or falsify a prescription. It

creates a situation where pharmacists are unable to see if the person is abusing. As a result, the problem of pharmaceutical drug abuse in Nebraska continues to get worse, and outside buyers now perceive Nebraska as a safer place to obtain their supply.<sup>6</sup>

The U.S. Center for Disease Control and Prevention (CDC) has classified prescription drug abuse as an "epidemic."<sup>7</sup> The Office of National Drug Control Policy called prescription drug abuse "the nation's fastest growing drug problem."<sup>8</sup> This misuse and abuse is particularly true among young people. According to studies, young people tend to believe that prescription drugs are not as dangerous as street drugs because of the fact that they are prescribed by a physician.<sup>9</sup> Furthermore, dependency can easily occur when patients are properly prescribed opiate drugs for pain management, but develop a dependency on the pain management and soon find themselves addicted. As a result, each year we are seeing a concerning increase in the number of Emergency Department visits involving nonmedical use of opiates and opioids.<sup>10</sup> In 2010, enough opioid pain relievers were sold to medicate every adult in the United States with the equivalent of a typical dose of 5 mg of hydrocodone every four hours for one month, a 300% increase in the sales rate over 11 years<sup>11</sup>. Clearly, such a usage rate does not correlate with an actual medical need. The challenge is to reduce the likelihood of opiate misuse, while not creating barriers to legitimate use of pain management between the patient and treating physician.

In order to address this problem in Nebraska, the Nebraska Medical Associa-

tion, the Nebraska Pharmacists Association, Nebraska Hospital Association, representatives from Health and Human Service agencies, and the Nebraska Attorney General's Office have been meeting to move forward with a mandatory PDMP. The National Drug Control Strategy and CDC have identified PDMPs as a key strategy for reducing prescription drug misuse.<sup>12</sup>

State Senators Sara Howard, Brett Lindstrom, John Kuehn, and Kathy Campbell, are to be applauded for working to change our laws to make a PDMP possible. My hope is that this collaborative effort will allow physicians, dentists, clinics, and pharmacists to work together in real time to better identify the individuals who are abusing the drugs.

It will take more than just a PDMP to solve the prescription drug abuse problem. It will also include ongoing education in our high school systems and in our communities about the dangers of pharmaceutical drug abuse. Our office is committed to do whatever we can to further this initiative. It will be critical that all health care providers across Nebraska join in the effort. Too many lives have already been destroyed. It is imperative that we all work together for solutions. □



1. Not actual name.

2. Not actual name.

3. <http://www.lockthecabinet.com/why/why-lock-the-cabinet/>, <http://www.chicagotribune.com/sns-health-kids-raiding-medicine-cabinet-story.html>

4. <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/Downloads/prescription-opioids-booklet0814.pdf> (pages 4-5)

5. <http://www.namsdl.org/library/6D4C4D9F-65BE-F4BB-A428B392538E0663/> (slide 2, footnote 1)

(continued on Page 16)

# Preventing Prescription Drug Overdoses in Nebraska

by Senator Sara Howard  
Legislative District 9

The CDC tells us that in 2013, of the 43,982 drug overdose deaths in the United States, 22,767 over 50 percent were related to pharmaceuticals. And of those 22,000 plus deaths, over 70 percent involved opioid analgesics known to most of us as prescription pain killers.

There are many factors in which providers agree might be driving up the use of prescription pain killers. Some of them include that health care providers in different parts of the country don't agree on when to use prescription painkillers and how much to prescribe. Some increased demand for prescription painkillers is from people who use them non-medically (using them without a prescription or just for the high they cause), sell them, or get them from multiple prescribers at the same time. Due to the lack of a PDMP in our state, Nebraska has become a hub of sorts where people from out of state come to fill prescriptions in order to sell them on the street. Too many families have fallen victim to losing a loved one because of prescription drug abuse. This problem continues to grow and it is time that we as a Legislature produce a real solution to this problem.

This is not the first time that we have talked about this issue. In 2011, my mother, Senator Gwen Howard, first began the conversation with her bill, LB 237. LB 237 established a system of prescription drug monitoring that the Department

of Health and Human Services would create in collaboration with the Nebraska Health Information Initiative, also known as NeHII. Implemented in 2009, NeHII is a statewide information exchange that allows users of its system to look at a complete health history of a patient, including prescription drug history. LB 237 passed in 2011 and was signed in to law.

Because of language in the original bill restricting use of state funds to establish the program and the continual rise in prescription drug abuse, the issue was again brought to the table by Senator Steve Lathrop of Omaha in 2013 and 2014. LB 535 (in 2013) was used as the conversation starter. He then introduced LB 1072 in 2014 which originally had language for a task force component, but due to the potential fiscal impact the language was stricken. As amended, LB 1072 allowed Nebraska to accept outside sources of funding, including grant dollars to assist with their efforts in creating a PDMP.

Because of the importance of this issue I have again brought this subject to the Legislature through LB 471. I believe that the time is now to get this program implemented and working to prevent further tragedies from occurring in our state. My legislation will still use NeHII as the vehicle for the prescription drug monitoring program. There are many other states who are moving toward health information exchanges to house their PDMPs as they see the benefits that it provides as a hub for patient health information.

Currently, LB 471 is being held in the Health and Human Services Committee where we will again take up the issue this

January once the legislative session starts. I believe that for our system to be the most effective it must have the following components:

- Prohibit patients from opting out of the system;
- Require all prescribed and dispensed prescriptions of controlled substances to be entered into the system, including those of cash pay patients not using a third-party payor such as an insurance company - many patients who are accessing multiple physicians and pharmacies will pay cash to avoid questions of why they are doing so;
- Allow all prescribers and dispensers of prescription drugs to access the system at no cost to them;
- And ensure that the system includes information from all payers including the Medical Assistance Program

The Department of Health and Human Services has recently been awarded two grants, one from the Centers for Disease Control and the other from the U.S. Department of Justice. Combined, these two grants will fund our PDMP for the next five years so that we can provide this service to providers and dispensers at no cost. One of the best ways to ensure usage of this system is by providing it at no cost so that our health care professionals can all access the program.

There are states that have seen the positive effects of an active Prescription Drug Monitoring System. New York saw a 75 percent drop in patients who were seeing multiple prescribers to obtain the same drugs, which would put them at higher

*(continued on Page 17)*





# Physicians Leading Fight against Opioid Crisis

by *Patrice A. Harris, MD, MA, chair, American Medical Association Task Force to Reduce Opioid Abuse*

Deaths from prescription opioid and heroin related overdose have become a public health crisis in America — currently outpacing the number of deaths from car accidents, federal statistics show. While over the last few years there has been some headway on the national front to begin turning the tide on this crisis, with 44 people still dying each day, from overdose of prescription opioids, and many more becoming addicted, this epidemic demands increased attention from the entire medical community as well as intensified efforts and new funding from all levels of government.

This includes a focused national push to increase the availability and access to comprehensive pain treatment options as well as a comprehensive approach to ensure more consistency in the governance of individual states' physician drug monitoring programs, (PDMPs) — such as ensuring privacy protections when sharing data between states. Additionally, strong steps must be taken to eliminate illegitimate pill mills.

We recognize that there is no one-size-fits-all approach that will turn the tide, but strong leadership and swift action from our nation's physicians inspires hope that we will heal this public health crisis. This is the driving force behind the work being done by the AMA Task Force to Reduce Opioid Abuse to identify the best practices to combat this public health crisis and move quickly to imple-

ment these practices across the country.

As physicians, we recognize that it is our responsibility to work together to provide a clear road map that will help bring an end to this public health epidemic.

**By taking five critical actions, physicians can make a significant difference and save lives:**

1. Register for and use state-based prescription drug monitoring programs (PDMP). Physicians should register for and consult these databases to identify patients at risk for opioid misuse and help patients with substance use disorders get appropriate treatment.
2. Discuss with patients available treatment options. When caring for patients with pain, physicians should understand the best possible options available for treatment. Physicians should ensure patients in pain are not stigmatized by having open and honest conversations on whether opioids should be considered as the preferred course of treatment or if other pain management is appropriate.
3. Take advantage of educational opportunities. Robust education is key to ensuring patients receive appropriate care to meet their individual needs. Physicians must be kept abreast of the tools and resources that meet the needs of their specialties, practices and patient populations to deliver the most comprehensive and appropriate pain treatment, while safeguarding against opioid overdose.
4. Reduce the stigma of pain and of having a substance use disorder. America's patients who live with acute and chronic pain deserve compassionate, high-quality and personalized care. As physicians, we must do everything we can to also reduce the stigma associated with substance use disorders that discourages patients from seeking addiction treatment and strive to create health care responses that ensure patients live longer, fuller and productive lives.
5. Increase access to naloxone and support Good Samaritan protections. Access to these have been shown to save tens of thousands lives across the country. Nebraska physicians can now prescribe, dispense or distribute naloxone not only to patients at risk for opioid overdose, but also to their family members friends who are concerned about their loved ones' risk of overdose.

There is still much work to be done and we recognize that it will take time to turn the tide, but we know that physicians in Nebraska and across the nation are committed to showing the leadership our patients need and deserve to once-and-for-all bring an end to this deadly epidemic.

Learn more about the AMA Task Force to Reduce Opioid Abuse: [www.ama-assn.org/go/endopioidabuse](http://www.ama-assn.org/go/endopioidabuse) □



# Preparing Prescribers to Confront the Opioid Crisis

## *U.S. Capitol Visitor Center, SVC 212-10*

### *October 6, 2015*

*Remarks by ONDCP Director  
Michael Botticelli*

#### **The Administration's Progress to Date**

Since the start of the Obama Administration, the Office of National Drug Control Policy (ONDCP) has worked to address the drug problem beyond the scope of public safety. In word and action, we have made it clear that a public health – and public safety approach are essential if we want to be successful in reducing drug use and its consequences.

In 2011, the Administration released its plan to address prescription drug abuse. The Plan laid out a strategy to address the epidemic – which was ravaging our Nation. And since the introduction of the plan we have also worked to expand access to medication assisted treatment and naloxone.

The Plan's four pillars include education of parents, patients and prescribers, effective monitoring of prescription drugs, secure and responsible drug disposal, and law enforcement. Prescribers play a role in the first three areas.

#### *Education*

Education is the first pillar.

Educating parents – patients – and prescribers.

Parents should understand the importance of keeping track of any medications they have in the house. And understand how dangerous it can be if any members

of their family misuse opioids.

Educating patients is important so that they know to ask questions if they are prescribed opioids, particularly if a patient has a substance use disorder or is already on another medication.

And it is vitally important to our efforts that we train health care providers in proper opioid prescribing. In four years of medical school, medical students receive on average only 11 hours of pain medication training.<sup>i</sup> And virtually none on the treatment of substance use disorders.

Various Federal agencies are leading the way by making certain that their workforce is properly trained. Prescribers at the NIH Clinical Center take continuing education on safer prescribing when they are hired.

Over 1,000 providers have been trained by the Indian Health Service on pain, diversion, screening for substance use disorder, and alternatives to opioids for pain.

In the Department of Justice's Bureau of Prisons, virtually all of the supervisory medical staff and dentists have completed an online training program.

The Department of Defense is developing policy that will require prescribers in all branches to take the Military's "Do No Harm Training".

The Food and Drug Administration (FDA), through its voluntary Risk Evaluation and Mitigation Strategy (or REMS), provides a training program on extended-release/long-acting opioids.

Thousands have taken this program.

But does prescriber education work?

Researchers in Massachusetts recently published an evaluation of a REMS program produced at Boston University called "Scope of Pain."<sup>ii</sup> The evaluation showed provider knowledge gains after the program. More important, 86 percent of providers reported implementing changes in their clinical practice when asked about it two months later.

And states are leading the way in this important effort. Today, 10 states (Connecticut,<sup>iiiiv</sup> Delaware,<sup>v</sup> Iowa,<sup>vi</sup> Kentucky,<sup>vii</sup> Massachusetts,<sup>viii</sup> New Mexico,<sup>ix</sup> Nevada,<sup>x</sup> Tennessee,<sup>xi</sup> Utah,<sup>xii</sup> and West Virginia<sup>xiii</sup>) have passed legislation mandating training for prescribers.

#### *Monitoring*

The Plan's second pillar concerns expanding and improving prescription drug monitoring programs (PDMPs). Today all but one state – Missouri – has a PDMP. PDMPs are databases that allow prescribers to check on drug-interactions and alert them to early signs of opioid use problems or diversion.

Kentucky,<sup>xiv</sup> New Jersey,<sup>xv</sup> New Mexico,<sup>xvi</sup> New York,<sup>xvii</sup> Oklahoma,<sup>xviii</sup> and Tennessee<sup>xix</sup> all require their prescribers to use their state's PDMP prior to prescribing in certain circumstances. In Tennessee, where the requirement to check the PDMP went into effect in 2013, there was a drop in the number of high utilizers of opioid pain relievers from the fourth quarter of 2012 to the fourth quarter of 2013.<sup>xx</sup>

*(continued on Page 15)*



# Preparing Prescribers to Confront the Opioid Crisis *(continued)*

And while PDMPs are important, we need to make sure they receive adequate resources to ensure that they are easy to use. In addition, we need to make sure PDMPs can operate across state lines. We are pleased that today that at least 30 states have some ability to share data with other states. And the Departments of Health and Human Services and Justice are working to expand data sharing capability.

In 2014, the Department of Veterans Affairs finalized a rule authorizing VA physicians to access state PDMPs in accordance with state laws and to develop mechanisms to begin sharing VA prescribing data with state PDMPs.<sup>xxi</sup> As of last April [2015], 67 VA facilities were sharing information with PDMPs in their respective states. VA providers have also begun registering and checking the state databases.

Although PDMP reporting is not required by Indian Health Service (IHS) facilities, many tribal nations have declared public health emergencies and elected to participate with the PDMP reporting initiative. As of March 2014, IHS is sharing its pharmacy data with PDMPs in at least 19 states<sup>xxii</sup> and negotiating data-sharing with more states.<sup>xxiii</sup>

## *Disposal*

The third element of our plan is disposal. The majority of individuals who begin misusing prescription drugs get them from family and friends. For this reason, we must make it easier to dispose of unused medications.

The Drug Enforcement Administration (DEA) has partnered with hundreds of state and local law enforcement

agencies and community coalitions, as well as other Federal agencies, to hold 10 National Take-Back Days since 2010. With the most recent Take Back taking place just last month, DEA collected and safely disposed of millions of pounds of unneeded or expired medications.

In September 2014, DEA published the final regulations on controlled substance disposal. Now ONDCP and our Federal partners and stakeholders are beginning to inform the public about the regulations and looking at ways to stimulate local disposal programs in partnership with pharmacies and law enforcement. The DEA regulations allow for many options, including mail-back programs, which may help with unique state situations that would otherwise require a legislative solution.

## **Medication Assisted Treatment**

The fact is, we cannot afford to wait to address the opioid crisis. We need early identification and evidence based treatments and it must happen now. Recent data show the high proportion of fatal overdoses involving prescription opioids leveling off in this country but, at the same time, a dramatic 39 percent increase in overdose deaths involving heroin from 2012 to 2013.<sup>xxiv,xxv</sup>

We know that medication assisted treatments, when combined with other behavioral supports, are effective at treating opioid use disorders. Medication Assisted Treatment saves lives while increasing the chances a person will remain in treatment and learn the skills and build the networks necessary for long-term recovery.

The President's 2016 Budget Request

includes millions of dollars in additional funding for treatment efforts. The Health Resources and Services Administration has offered \$300 million in supplementary grants to support medication assisted treatment expansion in Health Centers. And the Substance Abuse and Mental Health Services Administration gave an additional \$11 million in FY 2015 to support medication assisted programming.

We cannot expect attitudes to improve if we fail to intervene in the medical system where the problem can be addressed at the highest levels of care by those who can provide the most effective treatments.

## **Conclusion**

You all play critically important roles in finding solutions to our nation's drug problem, and it starts with leveraging the prevention and the medical system for:

- Preventing substance use from ever beginning;
- Identifying those with a potential substance use disorder earlier;
- Ensuring linkage to treatment;
- Engaging people in treatment; and
- Providing access to naloxone and overdose education.

Let's tackle these issues together so we can help all Americans live safer and healthier lives. □

i) Mezei L, Murinson BB; Johns Hopkins Pain Curriculum Development Team. Pain education in North American medical schools. *J Pain*. 2011 Dec;12(12):1199-208. doi: 10.1016/j.jpain.2011.06.006. Epub 2011 Sep 25. PMID: 21945594

ii) Alford DP, Zisblatt L, Ng P, Hayes SM, Peloquin S, Hardesty I, White JL. SCOPE of Pain: An Evaluation of an Opioid Risk Evaluation and Mitigation Strategy Continuing Education Program. *Pain Med*. 2015 Aug 25. doi: 10.1111/pme.12878. [Epub ahead of print]

*(continued on Page 24)*

## What can Physicians do to Reduce the Epidemic of Prescription Drug Abuse? *(continued)*

patient who calls and reports increasing pain and has been taking medications more frequently than prescribed, or running out of medications early, or who has had multiple emergency room visits, or who has gradually lost activity tolerance or who complains of pain despite the lack of objective evidence may well be developing a comorbid substance abuse issue. These are all aberrant medication taking behaviors. All patients may have one or two such behaviors, but the ACCUMULATION of these behaviors signifies a loss of control over the use of medications of abuse and therefore indicates the potential development of a substance abuse disorder. These patients physically experience pain that continuously worsens despite unrelenting dose increases with the use of more and more potent opioids. In these situations the “pain medications” interact with neurotransmitters and paradoxically cause the physical expression of pain in order to maintain CSF dopamine levels. This is no different than self-medicating with alcohol for depression or cocaine except

as physicians we are not prescribing these to our suffering patients. When this occurs, it is inappropriate to blame the patient if we fail to assist them in understanding what is occurring.

Patients do not choose to deceive us or wish to abuse medications. They most often miss the signs themselves because they trust that we would not prescribe for them if it wasn't in their best interest. It is also suboptimal to fire a patient or give them just enough medication to get to another provider who does not have the benefit of longstanding relationship with a patient with longitudinal observation. When this occurs, we owe our patients the honest and respectful communication that **the medication has become part of the problem rather than just an incomplete solution.** When we fail to identify or communicate this to our patients we set the stage for doctor shopping or worse.

Pain agreements (not pain “contracts”) merely serve as an advance means to document that patients and clinicians mutually understand the difference

between appropriate and inappropriate use of medications which could signify the loss of control over the use of medications. They provide no safety role if they do not spell out specific expectations on the part of the patient. They are not true contracts and it is important for clinicians to be willing to change course if patients are not responding to treatment with opioid medications or are losing control of the use of these medications.

As physicians we recognize that undertreatment of pain is a larger problem than substance abuse. But if we remember that it is not possible to successfully treat chronic pain in the background of medication abuse, and that abuse physiology increases the subjective experience of pain in order to maintain CSF dopamine levels, we can more easily understand the need to avoid inappropriate treatment with these medications.

In short, pain treatment and avoidance of prescription opioid abuse are NOT mutually competing goals, no matter what Big Pharma wants us to believe. □

## Too Many Lives Destroyed *(continued)*

6. <http://www.ketv.com/news/nebraska-known-for-blackmarket-prescription-drugs/24671974>

7. [http://www.cdc.gov/media/releases/2011/p1101\\_flu\\_pain\\_killer\\_overdose.html](http://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html)

8. <https://www.whitehouse.gov/ondcp>

9. <http://medicineabuseproject.org/news-events/news/national-study-teen-misuse-and-abuse-of-prescription-drugs-up-33-percent-si> “More than a quarter of teens (27 percent) mistakenly believe that “misusing and abusing prescription drugs to get high is safer than using street drugs,”” [https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-](https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/Documents/Prescription%20Drug%20Abuse%20Prevention%20Program_Grades%205-8%20Lesson%20Plans.pdf)

[Instruction/Documents/Prescription%20Drug%20Abuse%20Prevention%20Program\\_Grades%205-8%20Lesson%20Plans.pdf](https://www.gadoe.org/Curriculum-Instruction/Documents/Prescription%20Drug%20Abuse%20Prevention%20Program_Grades%205-8%20Lesson%20Plans.pdf) (page 1)

10. <http://www.samhsa.gov/data/sites/default/files/DAWN2k11ED/DAWN2k11ED/DAWN2k11ED.pdf> (page 55) <https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse> “For example, the estimated number of emergency department visits involving nonmedical use of opioid analgesics increased from 144,600 in 2004 to 305,900 in 2008”

11. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6226a3.htm>

12. [http://www.cdc.gov/HomeandRecreationalSafety/pdf/HHS\\_Prescription\\_Drug\\_Abuse\\_Report\\_09.2013.pdf](http://www.cdc.gov/HomeandRecreationalSafety/pdf/HHS_Prescription_Drug_Abuse_Report_09.2013.pdf) “Equipping clinicians with clinical tools, such as ready access to prescription drug monitoring program (PDMP) data, prescribing guidelines, and electronic health records with integrated clinical decision support can address several drivers of prescription drug abuse.” (Page 25: Clinical Practice Tools)



## Chasing the Dragon...The Resurgence of Heroin *(continued)*

help them. For families struggling with addiction, I recommend the following two books to help them make informed decisions: *Beyond Addiction: How Science and Kindness Help People Change* by Jeffrey Foote, et.al. and *Inside Rehab: The Surprising Truth About Addiction Treatment and How to Get Help That Works* by Anne M. Fletcher.

As a closing thought, I'd like each of you to consider offering a prescription

for naloxone to every appropriate patient. This includes all individuals prescribed opiates as well as those with a history of misuse and/or heroin use. It will save lives. Teach opiate user's families/friends how to administer naloxone. You may not know how to write the prescription. A few short months ago, I didn't either. Naloxone HCL 0.4 mg/ml, 2 x 1 ml single dose vials; Intramuscular syringe, 23 G, 3cc, 1 inch; Sig: for suspected opiate/heroin over-

dose, inject 1 ml IM in shoulder or thigh. Call 911. Repeat in 3 minutes if necessary.

Please do not hesitate to contact me with comments or questions at [jtheob1@nmhs.org](mailto:jtheob1@nmhs.org).

*Editor's note:* Additional information on naloxone can be found on the Project Dawn website: <http://www.odh.ohio.gov/sitecore/content/HealthyOhio/default/vipp/drug/ProjectDAWN.aspx>. Or, you may Google Project DAWN. □

## Which of Your Patients is Likely to Overdose on Opioids? *(continued)*

refills, conditions of early replacements for lost prescriptions, storage safety, using one prescriber, the patient will not "share" medication, and monitoring of adherence through urine screens. Patients need to be educated that the agreement is intended to protect them from adverse events and to foster a relationship of collaboration with the prescriber.<sup>7</sup>

In Washington, the Agency Medical Directors' Group partnered with prescribers to establish dosing guidelines for the use of opioids. These guidelines include specific recommendations for initiation, transition, and maintenance of opioids in patients with chronic non-cancer pain.

Specifically, a MED threshold of 120 mg per day was recommended. The guidelines recommend that a patient receiving more than 120 mg MED should be referred to a pain specialist for treatment.<sup>8</sup> Workers' compensation data was evaluated after the implementation of the guidelines and modest decreases were observed in the volume of Schedule II and III prescriptions and deaths due to prescription opioids.<sup>9</sup> □

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## Preventing Prescription Drug Overdoses in Nebraska *(continued)*

risk of overdose, while Florida saw more than a 50 percent decrease in overdose deaths from oxycodone.

While Nebraska is very different demographically from both New York and

Florida, I find it hard to believe that we would not see a positive result from being more stringent with our Prescription Drug Monitoring Program. Nebraska currently has a rate of 79 painkiller prescriptions per

100 people. It is my hope that as a state and through the passage of LB 471, we can work toward ending this devastating type of drug abuse and support a state full of happy, healthy Nebraskans. □

# 2015 Annual Membership Meeting Recap

On Friday, September 18, the NMA held its annual membership meeting and House of Delegates. We were pleased to have so many physicians across all areas of the state and representing many different specialties attend the meeting.

The day was full of activity beginning with the NMA's quarterly board meeting, the Greater Nebraska Medical Caucus and programming that discussed the transformation of health care including a panel discussion by representatives from various entities. In the afternoon the House hosted many guest speakers including former NMA president and Undersecretary for Food Safety at the U.S. Department of Agriculture Richard Raymond, MD; DHHS CEO Courtney Phillips and Calder Lynch, Medicaid Director; Attorney General Doug Peterson; Les Spry, MD and Dale Michels, MD, candidates for Legislature; and Karla Lester, MD, on the Energy campaign project from Teach a Kid to Fish and the NMA among others. Our regular business meeting included a PAC and legislative update and resolutions. Resolution action taken can be viewed on page 20 of this issue.

Our evening festivities included our scholarship presentation and the honoring of our 50 year practitioners and 2015 award winners. After Dr. Frankel's installation, those in attendance were entertained by The Chief Complaints. You can see photos from this year's meeting on the NMA Facebook page, [www.facebook.com/nebmed](http://www.facebook.com/nebmed).

Harris Frankel, MD, of Omaha was installed as your 2015-16 president of the Nebraska Medical Association, at the NMA's annual membership meeting.



*2014-15 President Richard Blatny, Sr., MD, installs Harris Frankel, MD, as the NMA's 2015-16 president.*

Dr. Frankel is a native of Omaha, Nebraska. He obtained his Bachelor of Arts in animal physiology from the University of California, San Diego, in 1982. He then attended the University of Nebraska, College of Medicine and received his MD degree in 1986. Thereafter, he completed a one-year internship in general internal medicine at Creighton University Affiliated Hospitals in Omaha. He then completed a neurology residency at the University of Texas Southwestern Medical Center at Dallas in 1990. During the last year of training Dr. Frankel served as chief resident for the Department of Neurology at Parkland Memorial Hospital and the Dallas VA Medical Center.

Upon completion of his residency training, Dr. Frankel returned to Omaha and joined the private practice of Neurology. After nearly 21 years of private practice, he then joined the Department of Neurological Sciences at the University of Nebraska Medical Center. He is a member of the active staff of the

Nebraska Medical Center and serves as medical director for the UNMC Physicians Clinical Neurosciences Center. In January 2014, Dr. Frankel joined the executive leadership team of Nebraska Medicine and currently serves as senior vice president and chief medical officer.

Dr. Frankel is board certified in the specialty of neurology by the American Board of Psychiatry and Neurology. He is a member of Alpha Omega Alpha and a member of a number of professional organizations including: the American Academy of Neurology, the Nebraska Medical Association and the American Medical Association. He is a past president of the Metropolitan Omaha Medical Society and past president of the Nebraska Health Information Initiative, Inc. (NeHII).

Thank you again to all the NMA members who took time to attend this year's annual meeting! Please save the date for next year's meeting, September 16 in Lincoln. □

# 2015 Annual Membership Meeting Recap *(continued)*



**YOUNG  
PHYSICIAN  
OF THE YEAR**  
Michelle Sell, MD  
*Central City*



**PHYSICIAN  
OF THE YEAR**  
Gerald Luckey, MD  
*David City*

## DISTINGUISHED SERVICE TO MEDICINE



David Filipi, MD  
*Omaha*



Linda Ford, MD  
*Bellevue*



Chuck Gregorius, MD  
*Lincoln*



**PHYSICIAN  
ADVOCATE  
OF THE YEAR**  
Britt Thedinger, MD  
*Omaha*

## STUDENT ADVOCATE OF THE YEAR



R. Logan Jones



Alicia Smith

## 2015 50 YEAR PRACTITIONERS

John Allworth Albers, MD  
Kenneth Paul Barjenbruch, MD  
Charles Lawrence Barton, MD  
George Basque, MD  
Dennis Beavers, MD  
Richard Francis Brouillette, MD  
William Carl Bruns, MD  
Colleen Willert Dilley, MD  
Donald Dynek, MD  
Carl Thomas Frank, MD  
Vernon Ford Garwood, MD  
Thomas John Imray, MD  
Joseph Anthony Jarzobski, MD  
David F Johnson, Jr., MD  
Harold Wallace Keenan, MD  
James Robert Newland, MD  
Loren Paul Petersen, MD  
James Joseph Phalen, MD  
Samar Kumar Ray, MBBS  
James Joseph Regan, MD  
Wendell Fred Ropp, MD  
James Scharphorn, MD  
Robert F. Shapiro, MD  
Duane Oliver Sherwin, MD  
Fordyce Edward Stivers, MD  
Rudolf Strnot, Jr., MD  
Donald Angus Swanson, MD  
Noble Leroy Swanson, MD  
Balachandran Wariyar, MBBS  
Ronald Leroy Wax, MD  
Wayne Kirk Weston, MD  
James Jefferson Woodbury, MD

## 2015 SCHOLARSHIP WINNERS

Colby Argo  
Clayton Damme  
Karen Dionesotes  
Jason Eckmann  
Alexis Erbstr  
Brett Grieb  
Chantal Heathers  
Meredith Humphreys  
Sydney Johnson  
Aparna Kailasam  
Michaela Klesitz  
Michael Klinginsmith  
Lindsay Leikam  
Katherine Lester  
Joseph Lippert  
Taylor Losey  
Brent Luedders  
Priya Maillacheruvu  
Alicia McCabe  
Ian Parsley  
Elizabeth Rodriquez  
Gregory Rufener  
Lance Schell  
Irsa Shoiab  
Brody Slostad  
Jessica Sonderup  
Nickolas Stasic  
Jenna Stecker  
Diliana Stoimenova  
Leah Svingen  
Stephanie Weed

# 2015 House of Delegates Resolutions

The following resolutions were submitted for consideration at the NMA's annual membership meeting.

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## RESOLUTION #1 – INFORMED CONSENT FOR HIV TESTING

Resolved that the Nebraska Medical Association seek to introduce legislation that would repeal Nebraska Revised Statute 71-531. (Nebraska Revised Statute 71-531 was enacted in 1994 requiring specific written informed consent for the performance of Human Immunodeficiency Virus [HIV] testing except in the case of organ and tissue donation, certain insurance underwriting, and certain instances in the Department of Correctional Services.)

*Approved by House of Delegates*

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## RESOLUTION #2 – STATEWIDE IMMUNIZATION PROGRAM

Resolved that the Nebraska Medical Association work with the Nebraska Legislature to introduce legislation that would create a system in Nebraska that would provide adequate reimbursement, cost savings and immunization tracking using the Vermont system as a template or requiring that the present system be used more adequately.

*Referred to Board of Directors for review and action*

## RESOLUTION #3 – PRICE TRANSPARENCY IN MEDICINE

Resolved that the Nebraska Medical Association in cooperation with business, industry and the Legislature develop legislation that would not allow future contracts that prohibit price transparency. Such legislation would also 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 for tests, procedures and planned hospitalizations.

*Approved by House of Delegates*

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## RESOLUTION #4 – MODEL HEALTH CARE ENVIRONMENT FOR REDUCING HEALTH CARE COSTS

Resolved that the Nebraska Medical Association collaborate with appropriate stakeholders including but not limited to Nebraska Department of Health and Human Services, insurance companies, health systems to:

- Enhance transparency with regards to the costs/charges of care at the level of provider order-entry into an electronic health record.
- Track costs/charges of entered orders on a per physician/per practice basis and report that data to those physicians/practices in order to enhance the cost effectiveness of provider prescribing patterns.

- Pilot novel reimbursement systems and structures that incentivizes reduced costs and adherence to cost-effective, evidence-based guidelines.

### **Motion was made for an addendum to be added to the resolution as follows:**

- Pilot novel reimbursement systems and structures that incentivizes reduced costs and adherence to cost-effective, evidence-based guidelines as supported by specialty definition according to the subspecialty or specialty guidance.

*Referred to Board of Directors for review and action*

---

## RESOLUTION #5 – NMA COMMITTEE OF NEBRASKA PHYSICIAN SPECIALTY/ SUBSPECIALTY SOCIETIES

Resolved that the Nebraska Medical Association will establish and lead a committee of physician leaders of Specialty and Subspecialty Societies in Nebraska; and

Further resolved that the Nebraska Association will share information on health policy issues with the committee; and

Further resolved that the committee will be encouraged to engage their Society members in working with the Nebraska Medical Association on health policy issues that affect Nebraska patients and physicians.

*Approved by the House of Delegates*

*(continued on Page 21)*



# 2015 House of Delegates Resolutions (continued)

## **RESOLUTION #6 – CREATION OF A NEBRASKA MEDICAL ASSOCIATION PHYSICIAN SHORTAGE TASK FORCE**

Resolved that the Nebraska Medical Association establish a task force to investigate and provide recommendations to improve the problem of physician shortages in Nebraska by exploring mechanisms to expand residency training opportunities within Nebraska.

*Approved by the House of Delegates*

## **RESOLUTION #7 – ELECTRONIC RESIDENCY APPLICATION SERVICE (ERAS)**

Resolved that the Nebraska Medical Association ask the AMA HOD to study and make recommendations for revisions to the Electronic Residency Application Service (ERAS) to revise access limitations to include medical school staff supporting students.

*Approved by the House of Delegates*

If you would like full copies of any of the above resolutions, please contact Ranae Bremer at (402) 474-4472 or ranaeb@nebmed.org. Questions may be directed to NMA Executive Vice President Dale Mahlman at (402) 474-4472 or dalem@nebmed.org. □

## SAVE THE DATE

### **Interdisciplinary Continuing Education Opioid Education**

*Saturday, July 16, 2016  
Cornhusker Marriott Hotel  
Lincoln*

Continuing Medical Education  
Credits will be offered

*Hosted by the Nebraska  
Pharmacists Association*

#### **TOPICS INCLUDE:**

- Appropriate use of opioids for non-cancer, acute and chronic pain
- Non-pharmacological treatments for pain
- Identifying overdose – administration of Naloxone
- Treatment of addiction – Naloxone/Buprenorphine
- Pain psychology
- Methadone treatment clinic
- Law enforcement – what's happening in Nebraska

## *New Members*

### **Hastings**

William David Terrell, MD

### **Kearney**

Amanda Lueshen Davis, MD

Shannon Nichole Hoos-Thompson, MD

### **North Platte**

Amy Christine Short, MD

### **Omaha**

Andrew Irwin Gelbman, DO

Erin Maura Talaska, MD

HelenMari L. Merritt-Genore, DO

Mathagondapally S. Arun, MD

Richard Hamilton Legge, MD

Umasankari Sundaram, MBBS

Yon Jung Chong, MD

### **Student Members**

Joshua Michael Allwardt

Bianca Bendix Christensen

Blake Alan Cover

Anthony Easterday

Nathan Alan Foje

Jonathan A. Greenberg

Haley Danielle Heibel

Shauna Mae Lindstedt

Hannah Elizabeth Malcolm

Alicia Marie McCabe

John Blaine Riley, III

Roman Shrestha

Courtney Smith

Alexandra Lyn Springman

Nicholas John Gray Swingle

Sean Charles Tomes

Alexandria Marie Valdrighi

Austin Michael Wheeler

## *Necrology*

David Rosenberg, MD

Omaha

10/05/15

Thomas Tonniges, MD

Omaha

10/06/15

# Ask a Lawyer

## *What do Physicians need to know about 2015 LB 107?*

*October 9, 2015*



Although there are many similarities between the requirements of LB 107 and prior law, the ability of a qualified nurse practitioner to practice independently of a collaborating physician is a significant change for health care in Nebraska. With the passage of LB 107, a nurse practitioner with sufficient experience can now be licensed and establish his or her own independent practice without having an integrated practice agreement with a collaborating physician.

The new statute is identical to 2014 LB 916, which passed in the previous Legislative session but was pocket vetoed by Governor Heineman. This time, the law was signed by Governor Ricketts on March 5, 2015 and became effective on August 30, 2015.

- As of August 30, 2015, to be licensed as a Nebraska nurse practitioner, an individual must:
- Have a master's degree or doctorate degree in nursing;
- Have completed an approved nurse practitioner program;
- Demonstrate completion of separate course work in pharmacotherapeutics, advanced health assessment, pathophysiology or psychopathology; and
- Submit to the Nebraska Department of Health and Human Services (the "Department") proof of professional liability insurance required under Neb.Rev.Stat. § 38-2320.

Neb.Rev.Stat. § 38-2322 (as amended by 2015 LB 107). Only those individuals, who have not completed the minimum

2,000 hours of supervised or otherwise qualifying practice as a nurse practitioner, will be required to enter into a transition-to-practice agreement with a "supervising provider." If a nurse practitioner meets the minimum experience requirements of the law, he or she may practice without physician supervision or without supervision by another provider.

LB 107 also allows other nurse practitioners to serve as a supervising provider to another nurse practitioner under a transition-to-practice agreement. A "transition-to-practice agreement" must be in writing and provide that a supervising provider and the supervised nurse practitioner will practice collaboratively within their respective scopes of practice.<sup>1</sup> The supervising provider is responsible for oversight of the nurse practitioner to ensure the quality of health care provided to patients.

Formerly, nurse practitioners were limited to having only physicians serve as a collaborating provider under an integrated practice agreement. The difficulty that some nurse practitioners had in identifying willing physicians to serve as collaborators was one of the reasons used in support of LB 107's passage. Now, in addition to physicians, under LB 107, a supervising provider can be another nurse practitioner in the same or a related specialty or the same field of practice as the individual supervised. Such supervision is permitted if the supervising nurse practitioner submits to the Department evidence of having completed 10,000 hours of practice as a nurse practitioner under a transition-to-practice agreement, under a similar type of agreement, through independent practice,

or a combination of these.

"Supervision" is defined in the statute in a similar manner as it was in prior law and Nebraska regulations. See Neb.Rev.Stat. § 38-2310(3)(b) (Reissue 2008); 172 NAC § 100-005.02.2.e. "Supervision" requires "ready availability of the supervising provider" to consult with and direct the activities of the nurse practitioner. Like prior law for nurse practitioners and collaborating physicians, a supervised nurse practitioner and the supervising provider are each responsible for their individual decisions in managing a patient's health care. The nurse practitioner and his or her supervising provider are jointly responsible for the health care provided to a patient based upon the scope of practice of the nurse practitioner and the supervising provider.

LB 107 is now the law. The debate about its potential effects on health care in the state has ended. Time will tell whether proponents' promises or physician concerns about LB 107's significant changes will be seen. □

*Ask a Lawyer is a feature of the Nebraska Medical Association newsletter. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank, 233 South 13th Street, Lincoln, Nebraska 68508-2095. The answer in this issue was provided by Jill Jensen. Questions relating to specific situations should continue to be referred to your own counsel. 4837-9804-4969, v. 1*

1) A transition-to-practice agreement form developed by the Department is available at <http://dhhs.ne.gov/publichealth/Licensure/Documents/TransitionToPracticeAgreement.pdf>.

# Telemedicine and Liability Issues in Nebraska

By COPIC's Patient Safety and Risk Management Department

Although the definitions of telemedicine and telehealth vary at the state and federal level, "telehealth" in Nebraska has been defined as the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. It includes services originating from a patient's home or other location, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring.

## PHYSICIAN-PATIENT RELATIONSHIP

Formation of a physician-patient relationship is usually clear in the traditional practice setting, but it may not be as clear where a physician has no in-person contact with a patient or where the physician is advising another practitioner who is at the patient's location. Even if the physician is just advising another practitioner, the consultant may also be considered a "treating" physician if:

- The consultant interprets patient data such as labs, EKGs, or imaging studies.
- The consultant participates in diagnosing the patient and prescribing a course of treatment.
- The treating practitioner must rely on the consultant's expertise rather than exercising his or her judgment in treating the patient.

If a physician is being paid to provide consulting services, that may be a factor

in determining whether the physician has a "contractual" obligation to the patient.

Proper documentation of a telemedicine encounter is important for showing the existence of a physician-patient relationship. A physician providing consultation via telemedicine will want to carefully review any contractual agreements as well as documents used to memorialize a patient's agreement to be treated through telemedicine.

## STANDARD OF CARE-MEDICAL LIABILITY

In a medical liability case, a physician is held to the standard of reasonable and ordinary care, defined as "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."

Although this hasn't been specifically addressed in Nebraska law, a practitioner will likely be held to the same standard of care as in a traditional encounter and not a "telemedicine" standard. The Federation of State Medical Boards, in its model telemedicine policy, takes this approach: "[A] physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not."

Whether approaching a patient differently under the "circumstances" of a telemedicine encounter meets the standard of care will depend on expert testimony and the facts of a case. Some specialty societies have developed telemedicine guidelines.



Although treatment guidelines don't define the standard of care, they may be considered as some evidence of the standard of care if an expert in the same field would reasonably rely upon them when treating a patient.

## INFORMED CONSENT

When a patient is being treated remotely, the informed consent process should include any pertinent benefits, risks, and alternatives that are unique to the telemedicine setting.

The patient should understand the limitations of telemedicine and that the physician may decide that it is inappropriate to evaluate and treat, or continue to treat, the patient through telemedicine. While there is no one informed consent process that would be applicable to all telemedicine encounters, the American Telemedicine Association guidelines<sup>1</sup> include some recommendations that are relevant in many cases.

- The provider should set appropriate expectations in regard to the telemedicine encounter. This may include prescribing policies, scope of services (including the structure and timing of services), communication and follow-up.
- Topics to be reviewed with patients include confidentiality and the limits of confidentiality in electronic com-

(continued on Page 24)

## Telemedicine and Liability Issues in Nebraska *(continued)*

munication; an agreed upon emergency plan particularly for patients in settings without clinical staff immediately available; the process by which patient information will be documented and stored; the potential for technical failure; procedures for coordination of care with other professionals; a protocol for contact between visits; and conditions under which telemedicine services may be terminated and a referral made to in-person care.

The Nebraska Medicaid program requires a health care practitioner who

delivers a health care service to a patient through telehealth to ensure that certain written information is provided to the patient prior to the initial telehealth consultation. The patient must sign a written statement that the patient understands the written information and that the information has been discussed with the practitioner or his or her designee. A sample form is available via the following link: <http://dhhs.ne.gov/Documents/471-000-10.pdf>

### ABANDONMENT

When a physician acts as a primary

treating physician through telemedicine, rather than as a consultant, it is essential that the patient understands how to receive follow-up care and with whom. In the absence of any special agreement limiting the physician's service, a physician may face an abandonment claim if the physician unilaterally ends the physician-patient relationship when a patient requires ongoing care and the patient has not been given proper notice. □

1. <http://www.americantelemed.org/docs/default-source/standards/core-operational-guidelines-for-telehealth-services.pdf?sfvrsn=4>

## THE OPIOID EPIDEMIC

## Preparing Prescribers to Confront the Opioid Crisis *(continued)*

PMID: 26304703

iii) CONN. GEN. STAT. § 20-10b (2015), available at <http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm>

iv) CONN. GEN. STAT. § 20-10b (2015), available at <http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm>

v) CONN. GEN. STAT. § 20-10b (2015), available at <http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm>

vi) IOWA ADMIN. CODE r. 253-11.4 (2011), available at <https://www.legis.iowa.gov/docs/ACO/chapter/07-22-2015.653.11.pdf>.

vii) 201 Ky. Admin. Reg. 9:250 (2013), available at <http://www.lrc.ky.gov/kar/201/009/250.htm>.

viii) MASS. GEN. LAWS ch. 94C, § 18(e) (2011), available at <https://malegislature.gov/Laws/General-Laws/PartI/TitleXV/Chapter94C/Section18>.

ix) N.M. ADMIN. CODE § 16-10-14 (2012), available at <http://164.64.110.239/nmac/parts/title16/16.010.0014.htm>.

x) NV. SB 459 (2015), available at <https://www.leg.state.nv.us/Session/78th2015/Reports/history.cfm?BillName=SB459>

xi) TENN. CODE ANN. § 63-1-402 (2013), available at <http://www.tn.gov/sos/acts/108/pub/pc0430.pdf>.

xii) UTAH ADMIN. CODE r. 58-37-6.5

(2012), available at [http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5\\_1800010118000101](http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5_1800010118000101).

xiii) W. VA. CODE § 30-1-7A (2011), available at <http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=1&section=7A>.

xiv) Kentucky 201 KAR 9:260. 2012. Available at <http://www.lrc.ky.gov/kar/201/009/260.htm>

xv) P.L. 2015, c.74 (N.J. 2015), available at [http://www.njleg.state.nj.us/2014/Bills/AL15/74\\_.PDF](http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF)

xvi) New Mexico Register. 16.12.9.9. November 15, 2012. Available at [http://www.nmcp.state.nm.us/new-mexico-register/prev\\_issues/prev\\_issuesxxiii/xxiii21/16.12.9amend](http://www.nmcp.state.nm.us/new-mexico-register/prev_issues/prev_issuesxxiii/xxiii21/16.12.9amend)

xvii) New York 3343-A. 2012. Available at <http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a>

xviii) Oklahoma 3251. 2010. Available at [http://www.oklegislature.gov/cf\\_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf](http://www.oklegislature.gov/cf_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf)

xix) Tennessee 2253. 53-10-310. 2012. Available at <http://www.tn.gov/sos/acts/107/pub/pc0880.pdf>

xx) Tennessee Department of Health Controlled Substance Monitoring Database Committee. Controlled Substance Monitoring Database 2014 Report to the 108th Tennessee General Assembly, February 1, 2014.

Page 5. Available at [http://health.tn.gov/statistics/Legislative\\_Reports\\_CSMD\\_AnnualReport\\_2014.pdf](http://health.tn.gov/statistics/Legislative_Reports_CSMD_AnnualReport_2014.pdf) Linked to 9-04-2014

xxi) Disclosures to Participate in State Prescription Drug Monitoring Programs, 78 Fed. Reg. 9589 (Feb. 11, 2013); 79 Fed. Reg. 14400 (Mar. 14, 2014).

xxii) Indian Health Service. (2014). Prescription Drug Monitoring Programs: Indian Health Service Update. Harold Rogers PDMP Annual Meeting, September 23, 2014. Retrieved from [http://www.pdmpassist.org/pdf/PPTs/National2014/2-13\\_Thundercloud.pdf](http://www.pdmpassist.org/pdf/PPTs/National2014/2-13_Thundercloud.pdf)

xxiii) Cynthia Gunderson, Prescription Drug Monitoring Programs & Indian Health Service, Barriers, Participation, and Future Initiatives, Presentation at Third Party Payer Meeting, December 2012. <http://www.pdmpexcellence.org/sites/all/pdfs/Gunderson.pdf>.

xxiv) Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from <http://wonder.cdc.gov/mcd-icd10.html> on January 30, 2015.

xxv) Source: CDC/Wonder; data extracted May, 2013





# Physician Advocacy Breakfast at the Capitol

On January 12, 2016, the Nebraska Medical Association will host its annual Advocacy Breakfast at the State Capitol.

**Wear your white coat and plan to attend.**

Let's send a strong message that the leaders of the health care team, Nebraska physicians, are engaged as advocates for physicians and the health of all Nebraskans!

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**When: January 12, 2016, 7:30-9:00 a.m.**

---

**Where: Room 1023, State Capitol**

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**Who: Nebraska physicians across all specialties,  
residents and medical students**

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RSVP to Meghan by January 5  
at [meghanj@nebmed.org](mailto:meghanj@nebmed.org) or (402) 474-4472.  
Register online: [www.nmaevents.org](http://www.nmaevents.org)

Be assured that health care providers across the entire spectrum are out advocating for their profession.  
Physicians need a seat at the table to be heard!

**We look forward to seeing you on January 12  
and don't forget to wear your white coat!**

Cosponsored by



# Giving More & Paying Less

## *Donor-Advised Funds—What's not to like?*

by Ross Polking

Provided by the Foster Group

**A**s 2015 starts to wind down, many physicians are thinking about how to positively impact causes and organizations about which they are passionate. A further benefit of this endeavor is the opportunity to lessen one's annual tax burden. A donor advised fund (DAF) is a fantastic tool for gifting and tax mitigation that is worth considering. DAFs are philanthropic vehicles operated by public charities which are relatively uncomplicated, widely available, and cost-effective for charitable pursuits. They are simpler to set up and less capital-intensive than a private foundation. They also allow for greater control and personal input than direct donations.

The premise and process is simple:

- 1) Choose an organization that offers a DAF, and open an account.
- 2) Deposit cash or transfer securities into the account, surrendering your ownership of the assets.
- 3) Provide direction to the DAF on how the account is invested, when and to whom dollars are distributed.

Here are a few of the benefits and inner workings of DAFs:

- **Avoid capital gains taxes on highly appreciated securities.** Making donations using appreciated securities

is one of the most tax-efficient ways of giving. Donors not only get an immediate tax deduction for the fair market value, they also avoid paying any capital gains tax when those shares are liquidated inside the DAF. Many investors have large unrealized gains built up in after-tax portfolios with the market rise over the past few years.

- **Reduce future tax burden on heirs.**

Listing a DAF as a beneficiary of an investment account removes those assets from one's estate at the time of death without subjecting them to gift tax consideration. Consider this so long as heirs are taken care of with other assets.

- **Mitigate large expected tax bills.**

A deduction for a donation to a DAF is taken in the same year as contribution to the fund, rather than the year of the distribution from the fund to a charitable organization. This allows for the flexibility to minimize taxes in years when you expect a large tax bill while still preserving the ability to make a gift at the right time. Additionally, gift amounts that exceed Adjusted Gross Income limits (50% for cash, 30% for property) can carry forward for up to five years.

- **Deductions and capital gains mitigation are more valuable.**

Because of the increase in marginal income and capital gains taxes, limiting their effect is now of even greater benefit. The highest marginal tax rate is near 40%,

while the top capital gains tax rate is 20%. Both have increased in the past year and offer even more incentive to the giver to mitigate taxes with their charitable gifts.

Physicians are sacrificial not only with their time, but with their financial resources as well when it comes to making a greater impact. Giving to charity can be done in many ways. Just be sure you are maximizing every dollar with efficient giving techniques, benefitting the causes you are passionate about as well as your own pocketbook. Stay diversified. □

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FOSTER GROUP® PRESENTS

# VECTORS & VIEWPOINTS®

2015 NMA Edition

VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE



**Ross Polking**  
CFP®, AIF®, Lead Advisor

## Today's question:

### *How does Charitable Giving fit into a person's financial plan?*

As a part of our relationship with the Nebraska Medical Association, we would like to offer you a complimentary Second Opinion. This \$1,500 service is yours at no charge. We invite you to participate in this unique opportunity to acquaint yourself with Foster Group and bring clarity, reduce complexity and increase your probability of financial success.

I think one of the most important parts of a person's financial plan is charitable giving, because of the perspective it gives a family.

Some of my favorite experiences as an advisor involve seeing the freedom that comes when a client begins to see the impact that a small gift can make on the recipient. This can be done through automatic gifts to one's church, random acts of generosity like buying a stranger lunch, or strategic, large-scale gifts to help build the Children's hospital in Iowa City! A favorite book of mine is, "I Like Giving", which is filled with stories of people impacting others through small and large acts of generosity.

You can read some of these stories at [www.ilikegiving.com/stories](http://www.ilikegiving.com/stories) and see how you get inspired!



Contact us today at **844-437-1102** or visit **[fostergrp.com/NMA](http://fostergrp.com/NMA)**.



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## Seeking Family Practice/ OB Physician

Kearney Clinic located in Kearney Nebraska is seeking a full time Family Practice/OB physician. Kearney Clinic is a multi-specialty physician owned group consisting of 25 physicians.

Specialties include:

Family Practice with OB, Pediatrics,  
General Surgery and Vascular Surgery.

Interested applicants should submit resume to:  
Family Practice Physician Position  
Attn: Administrator  
Kearney Clinic  
211 West 33 St.  
Kearney, NE 68845



**Kearney  
Clinic, P.C.**



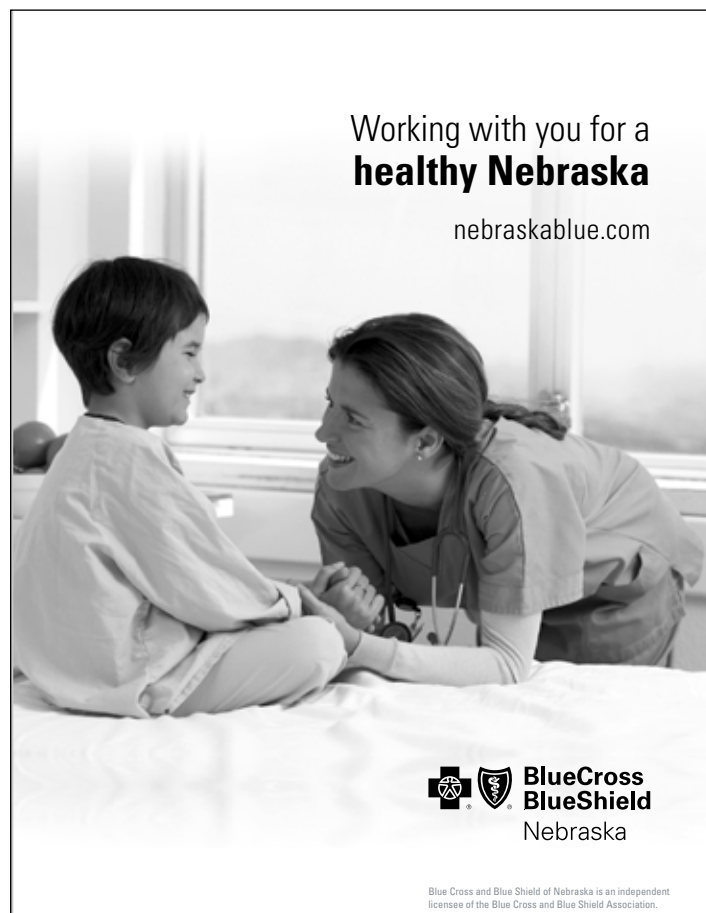
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# Concussion

## Recognition & Management

*Because research frequently sheds new light on concussion care...*

this course is provided to Nebraska physicians as a comprehensive overview and guide for best practices in concussion recognition and management –

*to help ensure that*

**every child sustaining a concussion in Nebraska is managed according to current best practices.**

*Topics include:*

➤ **Nebraska Concussion Awareness Act**

The four principal components: Education, Removal from Play, Clearance to Return to Play, and Return to Learn. What is the health care provider's role?

➤ **Concussion Characteristics & Epidemiology**

Facts and myths, special problems with youth concussions, multiple injuries, and after effects.

➤ **Concussion Symptoms & Signs**



**<http://dhhs.ne.gov/ConcussionManage>**



**CMEs available**

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through joint sponsorship of Children's Hospital & Medical Center and Nebraska Concussion Coalition, Brain Injury Association of Nebraska, and NET. Children's Hospital & Medical Center is accredited by the Nebraska Medical Association Commission on Medical Education to provide continuing medical education for physicians. Children's Hospital & Medical Center designates this enduring activity for a maximum of one half (0.5) *AMA PRA Category I Credits™* per module. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Hospital Review

# 100 Great Hospitals in America

In Nebraska, there is only one.

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Cadaver-Sinai Medical Center

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Duke University Hospital

Emory University Hospital

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