



Nebraska Medical Association

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An Addictive Society

by Robert B. Rhodes, MD, FAAFP
President

Do we live in an addictive society? Do most of us have an addiction(s) by definition, or are we at risk? Is it in our genetic make up to have an addictive personality?

An addiction is the fact or condition of being addicted to a particular substance, thing, or activity. This can be harmful to one's physical, mental, social, or financial well-being. An addiction could be alcohol, drugs, food, sex, shopping, tanning, exercise, or screen time. Who would have thought that what started as a black and white TV screen or a computer with Lotus 123 would evolve into expanded screen time that would affect our jobs, marriages, parenting, kids, work, mental, and physical health? There are daily reminders of what has now turned into an addiction for some patients: 1000 channels of cable, video games, internet shopping, social media (i.e. Facebook, Snapchat or Twitter among many others), Netflix bingeing, and internet porn.

In this edition of the NMA Advocate, we will hear from local experts in the area of addictions. My thanks to our member physicians Todd Stull and Ken Zoucha and the additional authors for their efforts in their fields of expertise as addiction grows and challenges not just medicine, but our culture.

There are state laws in place that prohibit texting and driving and our state Legislature is debating if that should be a primary offense. "Lei down that phone" is the new mantra in Honolulu, Hawaii, as Honolulu has passed a city ordinance making it illegal to text while walking and crossing a city street. You can picture the origin of this due to an unfortunate pedestrian car accident due to *someone locked into their screen and not aware of their environment*. That last statement could also apply to many of us on any given day (even the screen time we spend on our laptop or computer due to EHR!)

Apple execs recently outlined their concerns regarding technology addictions and the downsides of technology products and services. In addition, the American Academy of Pediatrics has set recommendations for media use in kids. A recent Clinical Psychological Science study on the

potential negative effects of screen time on adolescents/teens revealed that increased screen time contributed to feelings of alienation and loneliness. That proved concerning especially where girls and social media platforms were concerned. Unfortunately, for many of them their feelings of self-worth correlate to the number of "likes" obtained. Boys, on the other hand, tend to gravitate towards video games where prowess is important. Both sexes showed that increased screen time increased feelings of depression.

In 2014 the American Psychiatry Association and the DSM-V didn't include porn addiction, sex addiction, or hyper-sexuality as a diagnosis, but they have already stated that it will be included in the next criteria. Like it or not, thanks to the internet, it is readily available to many eyes, including those that may be too young to understand how it affects immature and developing brains. Several studies have examined the impact porn has on the brain, and they point to negative effects. In a 2014 JAMA Psychiatry study, it found that porn may actually shrink your brain. A 2013 University of Cambridge study of brain imaging showed a "clear difference in the brain activity of compulsive sexual behaviors vs. healthy volunteers." The levels of dopamine surge were measured and were found to have the same levels for a heroin addict as it was for a porn addict - it physically changed in PET scans of the brains over time. Virtual reality devices are the latest equation in pornography addiction and something physicians should be aware of.

Finally, as we deal with any patient, friend, or family member that may be dealing with some kind of addiction, may we try to find it in our hearts and minds to try to help them get well.

The **Five A's** of counseling patients on nicotine can apply to our patients facing addiction: **Ask**, **Advise**, **Assess**, **Assist**, and **Arrange**.

Ask - Identify and document use or problem being discussed.

Advise - In a clear, strong, and personalized manner,



(continued on Page 4)

Executive Vice President's Message



by Dale Mahlman
NMA Executive Vice President

This edition of the NMA Advocate focuses on various forms of addiction, a timely topic given the national discussion on opioids. I want to thank Todd Stull, MD, for his leadership in this area and for his guidance in crafting this magazine and assisting us in finding topics and

authors. Addiction has been at the top of a list of items Rob Rhodes, MD, our current president, has made a priority during his presidency and it's something we will continue to focus on for many years to come.

Addiction, as defined by Merriam-Webster, includes the compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

As a society, I'd say most of us could easily come up with the name of either a musician, actor, or sports figure who has dealt with addiction issues. All too often those situations haven't ended well. Like many of you, I can think of family members, friends, and others who have dealt with these issues, either personally or within their circle of influence. Addiction can be destructive in so many ways, and yet it's often not really acknowledged and addressed the proper way.

Our intent with this issue is to highlight several types of addiction, the medicine associated with the addictions, and the treatments either available or in process to address

these complex medical diagnoses.

The variety of topics included in this issue will hopefully be helpful to you as you continue your efforts to help address the issue of addiction. As we worked through the process of identifying topics and the appropriate author for each, I was pleased to see the subject experts located right here in Nebraska. Some of the authors are current NMA members, some are researchers, and others are from the treatment provider community.

While alcohol, and more recently opioids, are in the news on a regular basis, we hope the additional information provided in this issue helps all of you better understand the concerns that face addiction treatment providers on a regular basis.

On a somewhat related note, I'd like to also extend a thank you to John Massey, MD, of Lincoln, who has also been a leader in this area. Dr. Massey, and many other members, provided a great deal of assistance in the formation of Nebraska's Pain Guidance document. We hope you've had the opportunity to review the document and to also sign up for Nebraska's Prescription Drug Monitoring Program. You may find information on both of these items on the Resources section of the NMA website, www.nebmed.org.

Tell us what you think about this issue and the articles that have been presented. Are these helpful to you either in your practice or personal life? We want to continue to identify topics of interest to our membership and always welcome your input. ☐

President's Message (continued)

urge the user to acknowledge the issue and urge the user to quit and seek help.

Assess - Is the user willing to make an attempt to quit at this time?

Assist - For the patient willing to make an attempt to quit.

Arrange - Schedule follow up contact, in person or via phone, preferably within the first week after the quit date.

As we take a holistic approach to our patients and their mind, body and spirit, may we not shy away from the conversations of how culture, sexuality, choices, and temptations affect our health. Ironically, I will leave you with this (playing off the ads from Dos Equis' Most Interesting Man in the World): I will share that we all must be vigilant in our own lives and...

Stay healthy my friends. ☐

Foreword

By Todd Stull, MD

As noted by the American Society of Addiction Medicine, “Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry.” Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Some do not believe addiction is a disease but more of a learning disorder with three critical elements. First, the behavior has a psychological purpose. Second, the specific learning pathways involved make it automatic and a compulsive behavior. Third, it does not stop when it is no longer adaptive. There are other explanations regarding the etiology.

Regardless of the etiology, most definitions share common behaviors including the inability to control use, compulsive patterns of use, inability to cut down use for sustained or prolonged periods, and cravings which likely start in the reward circuits of the brain and eventually reach a conscious level of awareness. Addiction can, in part, be thought of as “loss.” As one becomes more addicted they lose more...friends, job, finances, family, self-efficacy, self-regulation, and self-esteem. Much like many other health problems, people do not wake up and say “wouldn’t it be great if I was addicted to...” any more than a patient asking “wouldn’t it be great if I had cancer?”

Stigma continues to present a challenge for those with an addiction and often prevents people from getting help.

Research suggests that the majority of people hold negative attitudes and stereotypes towards people with addiction. Starting at a young age children develop the thoughts and language that continue throughout adulthood. Social distancing occurs and worsens the outcome both personally and in our society. Stigma can result in lower prioritization of public resources and support and thus poorer quality of care.

Improving awareness is probably one of the most important things that can be done to counteract the negative stereotypes of those who suffer from an addiction. Teaching physicians to identify and manage their biases and language toward addiction is important. This can help with clinical care. Use of screening tools can also be helpful. Local, state, and national legislation can prove useful in the process.

As addiction medicine continues to advance, medication, psychotherapy, behavioral, and psychosocial programs along with social support, provide useful means to address and treat addiction. With these treatment modalities, outcomes continue to improve. The language and stigma used relating to addiction is perhaps the greatest barrier to care.

The most common addictions for Nebraskans are tobacco, alcohol, and cannabis. We are fortunate to not experience the severity of opioid addiction and deaths like many other states. We continue to have methamphetamine problems with the central and western part of the state experiencing a larger impact. In this edition of the NMA Advocate several topics are addressed including: adolescent substance use, Project ECHO, opioid treatment, tips on prescribing, reporting substance use in a colleague, and addiction in health care providers.

I am hopeful to live to see the day when we can talk about issues like addiction, suicide, and mental health without speaking in whispered tones. We all need to work together to reduce the shame and stigma that surround these common issues. □



Alcohol, Tobacco, and Cannabis: Where Addiction Starts and (Often) Ends



By Ryan Paul Carruthers, PhD
CenterPointe, Inc.

In 2015, the American Psychiatric Association (APA) made drastic changes to the diagnosis of what had been referred to as substance abuse and dependence disorders with the publication of the DSM-5. In moving from a two-disorder system to a one-disorder,

continuum-based system, not only did the APA modernize the diagnosis of addictive disorders to fit our current understanding of substance use problems, it also moved towards more recovery-oriented and person-first language. No longer are the terms substance abuse and substance dependence clinically relevant. Now, all those individuals who meet at least two of the slightly modified 11 criteria are diagnosed with a substance use disorder.

As the clinical diagnosis of these disorders has changed, other realities have not changed. The first is that by far the most common three substance use disorder diagnoses in America, and in Nebraska, are static. They are, of course, tobacco, alcohol, and cannabis, in that order. The results of the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2016 National Survey on Drug Use and Health (NSDUH)¹ were recently published and show what most physicians and substance use treatment programs throughout the country already know: that these three drugs are where the drug problem in the United States is the most problematic.

Cigarette smoking, according to the Center for Disease Control, is the primary factor in more than 480,000 deaths in the United States every year. Although cigarette smoking has declined on a consistent basis for decades, in 2016 there was an estimated 51.3 million cigarette smokers in America. Cigarette smoke byproducts include hundreds of chemicals including: hydrogen cyanide, acetic acid, sodium hydroxide, formaldehyde, geraniol, hydrazine, toluene, cadmium, methanol, urea, and naphthalene. By far the most problematic byproduct of smoking cigarettes is the amount of tar that is produced and builds up in the lungs.

One current factor that is causing concern in the medical field is the growing prevalence of alternative mechanisms for delivering nicotine, including e-cigarettes and vaping. Although these products do not produce the exact same chemical byproducts of smoking cigarettes, initial research shows some e-cigarette products contain benzene, isoprene, diethylene glycol, formaldehyde, and N-Nitrosornicotine, all of which are consistent with cigarette smoke. Even with regulation increasing on these products, the scientific research has yet to conclusively determine just how problematic these delivery mechanisms are. One thing is conclusive, tobacco-use disorders continue to be the primary mortality-producing addictive behavior, and it continues to be the most preventable cause of death every year.

Alcohol use, according to the NSDUH, is tracked by three metrics: current use, defined as any use in the last 30 days; binge use, defined as drinking 5 or more drinks for men and 4 or more drinks for women on a single occasion and within 2 hours; and heavy usage, defined as binge drinking 5 or more days in the last 30 days. Overall, underage alcohol use across these three domains has been in consistent decline for over a decade, but rates appear to be leveling off. Despite this reduction, 136.7 million Americans aged 12 and over report current alcohol usage, including 65.3 million binge drinkers and 16.3 heavy drinkers.

Most Americans do not realize the potentially harmful effects of ethyl alcohol and certainly do not realize that this intoxicant is the same ethanol that is added into our gasoline. The dangerous effects of alcohol, unlike tobacco, are both acute and long term. Binge drinking leads to blood alcohol contents that can be dangerous, as in controlled studies most people will show signs of intoxication at a .05 blood alcohol content, well within the legal limits to drive. Also, because only a limited amount of alcohol can be processed by the liver in an hour, blood alcohol contents that reach dangerous levels higher than .15 mean the person will have alcohol consistently pacing

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Development and Progression of Adolescent Substance Use Disorder

By Kenneth Zoucha, MD, FAAP, DABAM

Description: In this article, I intend to inform the reader about the good news of declining incidence of substance use among adolescents yet convey a sense of urgency that more work is to be done in the face of the nation's crisis of overdose deaths, especially those involving opioid medications and illicit drugs. The statistics show that Nebraska ranks lower than the national average on many indices involving adolescent substance use. Although this is good news, the impact this has on youth and families is significant. Prevention and treatment are vital and physicians, especially primary care physicians, can play a fundamental role in this effort.

According to the 2017 Monitoring the Future Survey (MTF), an annual survey of 45,500 8th, 10th, and 12th graders across the country that gathers statistics about the use of alcohol and other drugs (AOD), it is striking to note that the use of most drugs decreased in all three grades from previous years. Two of the three most common substances used by teens, alcohol and cigarettes, continued to show significant declines. For example, alcohol use had declined to record lows at 61 percent of 12th graders reporting any use of alcohol and 45.3 percent reporting having been drunk before completing high school. The other major substance used by teens, marijuana, shows an increase in use over all three grades. The increase is statistically significant when all three grades are combined. Of greater concern is the fact that attitudes among all students demonstrated a move toward greater acceptance of marijuana. Historically, when there is less harm seen in the use of a particular drug the use of that drug eventually rises.

The Behavioral Health Barometer is a publication released by SAMHSA (NSDUH). Data from that document showed that in 2014-15, 7.5 percent Nebraska youth age 12-17 (11,000) used alcohol for the first time and 4.1 percent (6,000 youth) used cigarettes and marijuana each for the first time. About 13,000 youth aged 12-17 used alcohol in the last month in Nebraska. As our country is in a national

emergency involving deaths associated with opioid use, it is important to note that the 2013-2014 survey demonstrated that approximately 6,000 Nebraska teens aged 12-17 reported nonmedical use of pain relievers within the year prior to the survey. Nationally, 20 percent of adolescents have misused pain medications.

All statistics about the use of AOD for youth in Nebraska are equal to or lower than national averages. The exceptions include cigarette use and binge alcohol use for youth in Nebraska that were higher than the national averages, albeit not to a statistically significant degree. Although Nebraska can take pride in the lower than national averages for the use of many substances, there is work to be done to improve prevention and treatment efforts.

The adolescent and early adult years are a particularly vulnerable time for use of AOD due to rapid changes in brain development. Both animal and human data show that synaptogenesis predominates in childhood and eventually gives way to synaptic pruning in response to learning, experience, and exposure. Over time, synapses that receive specific stimuli become stronger and those that do not receive input become weaker and, as noted above, may eventually be pruned. Psychopharmacological and neuroimaging studies have shown both structural and functional changes in three areas of the brain in particular due to exposure to substance use, misuse, and addiction.

The Nucleus Accumbens, which is a part of the Ventral Striatum (part of the basal ganglia), contains mesolimbic dopaminergic projections that play a major role in the process of addiction. Trigger-induced activation of these circuits results in overvaluation and increased pursuit of pleasurable experiences. Second, the prefrontal cortex, the area that regulates hedonic drive and evaluates risk versus reward, is the slowest developing part of the brain, not fully maturing until the mid-twenties. Lastly, the amygdala, a brain region that is paramount to the experience of anxiety (fear and panic) is at the least active stage in adolescence

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Development and Progression of Adolescent Substance Use Disorder (continued)

than at any other stage of life. All of these areas are known to be altered in the face of the use of alcohol and other drugs that cause surges of dopamine and other important neurotransmitters 5 to 10 times higher than that experienced by normal human activity. This leads to a state of brain functioning in adolescents that ever-increasingly places emphasis on dopamine-related overvaluation of reward coupled with poor assessment of risk and developmental inability to regulate these concerns.

Continued use of substances eventually leads to diminished baseline dopamine activity and diminished dopamine response to normal, pleasurable life events. In addition, the “anti-reward” stress system in the brain shows a marked increase in activity. Subsequently, when a patient is trying to quit their use of substances that diminished dopamine activity and increase in the “anti-stress” system in the brain (which includes the neurotransmitters corticotropin releasing factor and dynorphin) leads to withdrawal symptoms with physical and emotional distress. This discomfort then leads to a compulsive pattern of substance use despite negative consequences and is one of the main reasons it can be so difficult to abstain.

Genetics is thought to play as much as 40-60 percent of the risk associated with experimental substance use leading eventually to Substance Use Disorders. Epigenetics, the ability of environmental and/or social factors that can lead to potentially long-lasting changes to gene expression, is being extensively studied as a means to identify contributions to the onset of AOD disorders. Examples such as academic failure, parental tolerance of adolescent substance use and use by close contacts, and child abuse or family disruption that are known precursors to the onset of substance use point to these possible epigenetic changes.

The impact of substance use on teens involves medical, psychosocial, and emotional/mental health. The most common consequences include decreased school performance and truancy, delinquency, multiple sexual partners with increasing risk of sexually transmitted infections (STIs), family conflict, elopement from home, depression, or suicide attempts. Psychiatric symptoms are

common among adolescents with Substance Use Disorders and screening for alcohol or other drug use is warranted with any teen presenting with these symptoms. Medical complications of substance use can include recurrent headaches or abdominal pain, insomnia, fatigue, frequent falls or accidents, dental disease, and infectious diseases, including STIs as noted above.

Changes seen in adolescents can be found with earlier onset cannabis use and poorer performance in multiple areas of life that include life satisfaction, academic and professional achievement, and quality of life and well-being. Heavier, chronic marijuana use is also associated with earlier onset, exacerbation, and worse clinical course in mental health conditions, including anxiety and psychotic disorders. Finally, when compared with the initiation of chronic cannabis use in young adulthood, teens who start using cannabis at a younger age can have greater cognitive impairment in attention and executive functioning and a possible decrease in IQ.

The American Academy of Pediatrics recommends screening for use of AOD at adolescent health supervision visits and appropriate acute-care visits. Data shows that primary care clinicians (PCC) can have a vital part to play in the identification and treatment of adolescents with Substance Use Disorders. A formal validated screening tool is an excellent way to do this in a short amount of time in a busy PCC office. The Screening to Brief Intervention tool (S2BI) uses a comprehensive initial question with responses to determine four levels of intervention for tobacco, alcohol, and marijuana: no use, use only once or twice, monthly use, or weekly use. With positive responses to one of these three substances, the tool then goes on to ask the same question of four more classes of drugs. The comprehensive initial question is: “In the past year, how many times have you used Tobacco? Alcohol? Marijuana?” Suggested responses utilizing motivational interviewing techniques then guide the clinician to brief advice to the patient that focuses on encouraging abstinence or referral to treatment after further screening utilizing the CRAFFT tool. This free toolkit is available at www.mass.gov/maclearinghouse.

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Development and Progression of Adolescent Substance Use Disorder (continued)

Numerous treatment modalities exist when further intervention is warranted. These include individual outpatient and group outpatient treatment, Intensive Outpatient Treatment (IOP), day hospitalization, acute inpatient care, and short-term and long-term residential treatment. Intoxication and withdrawal management with both social and medical levels of care are also available in some areas. Evidence for treatment of adolescent SUD treatment shows that the lowest level of care that allows the youth to remain in the home is best. Length of time receiving treatment also is important with 90 days or longer, not necessarily all of the treatment at the same level of care, being ideal. Use of motivational interviewing, cognitive behavioral therapy, contingency management, family therapy, solution focused therapy, and/or 12-step facilitation therapy can all have a place in an individualized plan of care for each youth. It is important to discover and understand the treatment providers and levels of care that exist in a clinician's practice area as all of the above treatment levels of care and modalities do not exist in all areas of Nebraska. It helps to develop relationships with these providers when referral for assessment or treatment becomes necessary.

Medication treatment for adolescents with SUD is also an option for clinicians who choose to offer more in-depth management. For youth that are interested in nicotine cessation three options are available. Bupropion is a dopamine and norepinephrine reuptake inhibitor that has shown some success in youth 16 years of age and older. Varenicline, a nicotine receptor agonist, is approved for patients 18 years of age and older. However, studies exist showing efficacy in patients down to 16 years of age. Finally, nicotine replacement therapy is an option, although there are no studies showing efficacy in adolescents. Dosing is the same as would be prescribed for adults.

Alcohol Use Disorder (AUD) also has options for medication treatment as well. Naltrexone, a mu opioid receptor antagonist, can be prescribed as an oral pill form as well as a long-acting depot-IM injection. This medication, especially in the long-acting IM injection form, has shown reduction in alcohol use in adolescents 16 years of age and older.

Finally, the American Academy of Pediatrics released a policy statement in September 2016 recommending that clinicians consider offering medication-assisted treatment to their adolescent and young adult patients with Opioid Use Disorders (OUD) or refer them to clinicians who can. Medication intervention has significant evidence for the efficacy in treating patients with OUD. Buprenorphine is a partial mu opioid receptor agonist/antagonist, which means that it has a ceiling effect. Buprenorphine is usually combined with naloxone to reduce aberrant use of buprenorphine via intravenous route. Buprenorphine/naloxone exists as a sublingual film or tablet given each day to help reduce the significant withdrawal symptoms experienced when a patient stops using opioid medications and to normalize brain function. Studies show that patients 16 years of age and older remain in treatment for longer periods of time, are less likely to be involved in criminal activity, and show a reduction in risky behaviors that can lead to the morbidity and mortality seen in patients with OUD. Under the DATA 2000 waiver this medication can only be prescribed for the treatment of OUD by a clinician that has received specialized training and has then obtained a specialized DEA license. Naltrexone, as mentioned above for the treatment of AUD, is also effective for the treatment of OUD as a mu opioid receptor antagonist and can be prescribed by any clinician. It is vitally important to note that none of the medication interventions listed above are effective without concomitant use of the psychotherapeutic treatment.

Other issues surrounding adolescent substance use include concerns about confidentiality and drug testing. Although the use of some substances is on the decline, use of alcohol and other drugs remains a substantial public health problem. Screening, identification, management, and referral to treatment remain challenging for clinicians. However, they can rely on recommendations based on research evidence and expert consensus to guide their practice efforts. Exciting ongoing research in the neurodevelopmental aspects of the use of alcohol and other drugs should lead to better prevention efforts and

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Addiction in Health Care Providers



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INTRODUCTION

Substance use disorder (SUD) and alcohol use disorder (AUD) are the DSM-5 terms now used, respectively, for addiction and alcoholism. SUDs have been recognized by medicine as diseases for 60 years. These are defined as “bio-psycho-social” diseases based on genetically-identifiable risks accounting for about 60 percent of causality, while set and setting (e.g., peer, family, and others’ beliefs and behaviors; environment; stress, and distress) encompass psychological and social risk factors. The seat of SUDs is in the subconscious brain, refuting commonly-held beliefs that they represent “willful misconduct” which would require a cortical locus of control.

HEALTH CARE PROVIDER SUD RISKS

Although ill-defined, estimates place the lifetime prevalence of AUD and other SUDs in health care providers (HCPs) at about 10-15 percent for alcohol and about 3 percent for other drugs, which is essentially the same as for the general population. If these figures reflect the lifetime risk for HCPs in Nebraska, more than 600 of the physicians and 6,500 of other HCPs presently licensed in the state could experience an SUD at some point. Some of these individuals may be in recovery, but population treatment statistics suggest that less than 15 percent of these individuals have accessed recovery resources. While the risks of developing an SUD appear to be consistent without

regard to occupation, HCPs are less likely than the general population to become dependent on illicit “street” drugs while being equally likely to develop an AUD and more likely to develop a prescription drug SUD. Drugs commonly used in specific practice environments are often associated with SUDs in HCPs in those areas (e.g., parenteral fentanyl in anesthesiologists/nurse anesthetists, inhaled nitrous oxide in dentists, or oral hydrocodone or oxycodone in pharmacists); AUD in combination with prescription drug SUDs is not uncommon in HCPs.

SUD PATTERNS OF DEVELOPMENT AND RECOGNITION

The pattern of development of an AUD and/or other SUDs in HCPs is individually variable. Most typically, SUDs other than AUD involve initial exposure through prescribed treatment of pain or anxiety with opioids or benzodiazepines or self-medication of physical or mental health concerns. Job, health, or other stressors often cause escalation of use to a point at which the HCP continues use despite clear evidence of significant adverse consequences. The cycle of SUD development is often initially liking the substance, progressing to wanting the substance, and, finally, needing the substance.

HCP DRUG-SEEKING BEHAVIORS

HCPs who are diverting prescription medications from the workplace will often seek to manage or have ready access to workplace controlled substances, work alone or at odd hours, or even come into the workplace when they are not scheduled to work. Conversely, HCPs with SUDs where the workplace is not the source of the drug may more often arrive late for work, leave early from work or have excessive absenteeism, especially following several days off.

WHY DON'T THEY JUST STOP?

The person with an SUD is driven to the false conviction that their use of the substance is just as important to their survival as are other life-sustaining subconscious processes such as breathing, nutrition, and hydration. Typically, a substance user initially experiences pleasurable (euphoric, sedative, or stimulant) effects from their drug. With ongoing

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Addiction in Health Care Providers (continued)

and escalating dosing of the substance to the point that a diagnosable SUD has developed, the pleasurable effects have usually diminished to the point that the person with the SUD, at best, at their maximum dose, experiences what had been their baseline mental state at the time that they started using the substance. At times between doses, or if dosing is interrupted, the person with an SUD often becomes dysphoric, experiencing the withdrawal effects characteristic of their drug of choice. Thus, the person with an SUD is driven to maintain substance use based on the real risk of withdrawal and their conviction that the substance is foundational to their existence. The result is that the person with an SUD displays characteristics contrary to their fundamental character, such as lying, theft, or social isolation. Denial is a common finding in those with SUDs.

GETTING THEM HELP

Helping a person with an SUD attain recovery usually involves a number of people. A brief intervention may be conducted with the patient, usually by a PCP, to express concern about possible substance use risks. To break through the denial accompanying an SUD, a concerned group intervention may be arranged, typically coordinated by an SUD treatment counselor or program and individuals who are acquainted with the patient and are concerned about his or her behaviors. Where there is a precipitating event such as a car crash while intoxicated, being found to be intoxicated at work, or caught diverting controlled substances, a more urgent, less formal crisis intervention may be conducted. Crisis-based interventions are commonly used for HCPs, especially when the SUD is recognized in the workplace or due to legal charges. The typical goal is to persuade the individual with a probable SUD to obtain an SUD evaluation and then follow through with any recommendations made by the evaluator. If the HCP is diagnosed with an SUD, the goal becomes assisting them with developing a plan to follow through with the recommendations. This may include helping them to locate a formal treatment program appropriate to their needs, recovery support group meetings, or other available recovery resources.

HCP SUD RECOVERY

HCP Boards' responsibility is to protect the public. HCPs can endanger the public if they are impaired by alcohol or any other substance causing SUDs. Loss of an HCP's credentialing used to be the typical action taken by HCP Boards for HCPs with SUDs. The Nebraska Licensee Assistance Program (NE LAP) provides HCPs who are credentialed by the Nebraska DHHS Licensure Unit with SUD evaluations, treatment referral assistance, case management/monitoring, and education. The NE LAP assists HCPs who have been referred to the NE LAP by the Nebraska DHHS Licensure Unit or Investigations Unit, as well as those HCPs who are self-referrals, or are referred by their employer, attorney, or educational institution. Absenting legal or practice issues that must be statutorily reported to DHHS, those who self-refer will not be reported to the Nebraska DHHS unless they fail to comply with any term or condition of the NE LAP treatment plan. HCPs who are reported to the DHHS for potential SUDs will typically be interviewed by a DHHS investigator. A hearing may be held to gather and process information for consideration by the HCP's credentialing Board. Boards will then review presented evidence and, in consultation with representatives from the Nebraska Attorney General's office, provide recommendations to the Nebraska Chief Medical Officer. Recovery contracts with a licensing board or the NE LAP are often used and contain elements for monitoring and to enhance the chance of success.

ASSISTANCE AND SUPPORT RESOURCES FOR HCP RECOVERY

The NE LAP (<http://www.lapne.org/>) is available to all credentialed HCPs in the state of Nebraska. While many states use this model, others have separate programs for each profession, some Board-administered, others functioning as a volunteer group not affiliated with Boards. Pharmacist recovery programs are listed by state (under State PRN Information) at www.usaprn.org; International Doctors in Alcoholics Anonymous (IDAA) is a worldwide fellowship of over 9,900 HCPs that is dedicated to achieving and maintaining SUD recovery. Membership in IDAA (www.idaa.org) is open to addicted or recovering

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The Opioid Epidemic: We Know the Problem, Where Are the Answers?



By Stephen Tetrault, DO

On October 26, 2017, President Donald Trump declared the opioid epidemic a public health emergency under the Public Health Services Act. This would help direct federal agencies to provide more grant money to combat the epidemic. While he did not go so far as to declare this a National Emergency under the Stafford Disaster Relief and Emergency Assistance Act (which would have allowed an increase in spending by tapping into the Disaster Relief Fund, although this is generally meant more for natural disasters rather than health emergencies), this declaration helped thrust the opioid epidemic into the national spotlight.

Since 1999, the number of American overdose deaths has quadrupled. From 2000-2015, more than 500,000 people have died of drug overdoses (with the majority of those deaths from opioid use), including 64,000 deaths in 2016. Every day, over 1,000 people are treated in emergency departments for misusing prescription opioids. Drug overdoses rose 21 percent among middle aged Americans this past year, and life expectancy in the U.S. as a whole has decreased for two consecutive years, the first time this has happened since the 1960s. Some of the overdoses are related to the illegal purchase and production of opioids. However, 40 percent of all U.S. opioid overdose deaths are attributed to prescription opioids. This is clearly a problem worth attention.

Approximately 15 percent of patients who have Opioid Use Disorder receive treatment. 20.6 million people were classified as needing but not receiving substance abuse treatment in 2012; 1.1 million people agreed they needed treatment, and even 31.3 percent of those people reportedly made an effort to find treatment but were unable to find appropriate treatment options. This number is likely higher in the last six years.

There has been an increase in exposure to this epidemic since the declaration of a public health emergency. News coverage, blog articles, podcasts, and other forms of media

have described the problem. Solutions are challenging. How do we solve this epidemic? There has been a substantial improvement in the availability of naloxone. Naloxone is an opioid antagonist that can reverse the effects of the opioid and save the life of a person who has overdosed. EMTs have greater access to this medication out in the field, pharmacies have started carrying this on the shelves, and emergency departments have this medication readily available during acute evaluations. This may be a bandage that saves lives, but does not address other aspects of addiction. Solutions likely rest with prevention, early intervention, and treatment.

Buprenorphine is a medication used for opioid treatment. It comes in two forms, one called Suboxone (Buprenorphine-Naloxone) and Subutex (Buprenorphine). Buprenorphine is a partial mu receptor agonist, Kappa receptor antagonist, and Nociceptin receptor agonist. This medication comes as a film, buccal film, or tablet. Buprenorphine and methadone are used to treat addiction and suppress cravings for opioids and prevent withdrawal. Unlike methadone (that needs to be administered in a specific treatment center), buprenorphine can be prescribed by any qualifying physician who has obtained the eight-hour training and DEA waiver. Buprenorphine is a potent analgesic and mildly reinforcing to improve compliance.

As the dose of buprenorphine increases, the response plateaus, thus creating a “ceiling effect.” The sedative and respiratory effects of the medication flatten out as the dose is increased making it much safer than methadone in overdose. The naloxone component of Suboxone remains inactive as long as the medication is taken in an appropriate form. If the patient was to crush the Suboxone and inject it, the naloxone component would be activated and create a withdrawal state. The Suboxone form serves as a deterrent to modify the medication.

For many patients addiction is a chronic condition like hypertension or diabetes. For many patients that have chronic conditions, long-term treatment is important. Use of medication such as methadone or buprenorphine occasionally may be short term, but often they are used for

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Pain and Substance Use Disorders: Project EHCO

*By Dr. Christine Chasek LIMHP, LADC, MAC, LPC
Associate Professor, University of Nebraska at Kearney
Director BHECN-Kearney*

According to the Substance Abuse and Mental Health Services Administration (SAMSHA) approximately 20.1 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in 2016. This includes 15.1 million people who had an alcohol use disorder and 7.4 million people who had an illicit drug use disorder. An estimated 2.1 million people had an opioid use disorder, which includes 1.8 million people with a prescription pain reliever use disorder and 0.6 million people with a heroin use disorder.¹

Closer to home, Nebraska hospital discharge data from 2007 to 2014 indicates that the rate of inpatient hospitalization for SUD has increased from 1150 to 1474 per 100,000 person and annual opioid-related overdose death rates rose from 2.4 to 3.0 per 1000,000.² In a single-day count in 2015, 671 individuals in Nebraska were receiving buprenorphine or methadone as part of their substance use treatment, however an average of about 3,000 individuals aged 12 or older (0.21 percent of all individuals in this age group) had used heroin in the past year indicating a greater need for treatment.³

While Nebraska has not seen the sharp increase in opioid related problems as other parts of the country, the high binge drinking rate in Nebraska is a concern. Approximately 20.3 percent of the population engages in binge drinking ranking Nebraska 47th overall in the country. Put into perspective, only three states have higher binge drinking rates than Nebraska. In addition, 106,000 individuals aged 12 or older (6.8 percent of all individuals in this age group) in 2014–2015 had an alcohol use disorder in the past year. While these numbers are high, even more concerning is the lack of treatment to address these issues; 90 percent of those who need treatment for an SUD do not receive it largely due to lack of identification of an SUD, access to services, and the stigma associated with SUDs and abusing medication for chronic pain conditions.⁴

Over the past 20 years the definition of addiction has been refined through research to more accurately define

this disease and in the process addressing the stigma attached to it. The American Society of Addiction Medicine (ASAM) now defines addiction as a chronic, relapsing disease of the brain with social and behavioral manifestations marked by continued alcohol or drug use despite negative consequences.⁵ This definition emphasizes substance use disorders as treatable illnesses based on multi-determined and multi-causal perspectives.⁶ Consequently, treatment has come to encompass a wide range of therapeutic processes, including medication assisted treatment aimed at meeting the specific needs of the client taking into account biological, psychological, and social aspects of addiction. The ASAM criteria for treatment is based on a continuum encompassing four of service including early intervention, outpatient treatment, residential treatment, and medically managed intensive treatment.⁷ These guidelines are a great tool for addressing SUD treatment needs, however the addiction problem must first be identified which is not always easy especially in the case of patients who present with chronic pain issues and are searching for pain relieving medications.

The rise in SUDs across the country has been associated with the dramatic increase in prescription drug abuse and subsequent abuse of opioid related illicit drugs. Much of the work in Nebraska on this front has been focused on prevention efforts including the development of the prescription drug monitoring program and pain management prescribing resources. In October 2017, DHHS released the Nebraska Pain Management Guidance Document, a prescribing resource for providers that was developed in conjunction with the Nebraska Medical Association, professional boards, and physicians. This document aligns with the Centers for Disease Control and Prevention's Guidelines for Prescribing Opioids for Chronic Pain and is intended to make clinical decisions easier, provide effective options to treat pain, and ensure safety.⁸

To further help providers who are treating patients who present with chronic pain or substance use disorders, the Nebraska DHHS Division of Behavioral Health, UNMC



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Pain and Substance Use Disorders: Project EHCO (continued)

Department of Psychiatry, and the Behavioral Health Education Center of Nebraska has launched a Project ECHO supported by the State Targeted Response to the Opioid Crisis Grant from SAMHSA/ CSAT. The ECHO model (Extension for Community Healthcare Outcomes) implemented in Nebraska provides an opportunity to promote, identify, and expand the access for treatment of chronic pain and SUDs particularly in underserved areas. The Pain and Substance Use Disorder EHCOs are videoconference case-based learning sessions focused on developing knowledge and engaging in de-identified patient consultations to help providers assess and treat patients presenting with chronic pain or SUDs.⁹ The goal of Project ECHO is to create local content experts helping to bridge the gap between specialty and primary care improving access and health outcomes for patients. Providers who attend ECHOs have access to content experts in pain management, psychiatry, behavioral health specialists, and recovery advocates as well as formal assessment tools and didactic knowledge used to improve practice. Research has consistently found that when compared to controls, providers who attend EHCOs have significantly increased their knowledge and self-efficacy in pain related and SUD related care.¹⁰ All ECHOs are free of charge and can be accessed by registering at <https://www.unmc.edu/bhecn/education/project-echo.html>. To learn more about the Pain and Substance Use Disorder ECHO in Nebraska please visit the website or contact Dr. Christine Chasek at chasekc1@unk.edu. □

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Alcohol, Tobacco, and Cannabis: Where Addiction Starts and (Often) Ends (continued)

throughout their body for several hours or even longer. It is through this prolonged exposure to alcohol's presence that heavy drinkers can experience problems in nearly every organ in the body. The World Health Organization has taken the step of labeling alcohol a carcinogen as a result. Education on these basic facts about alcohol is important for physicians and patients alike.

With the changes in 2015 to the diagnosis of substance use disorders, the American Psychiatric Association also recognized for the first time the reality of cannabis withdrawal as a diagnosable acute condition. Its symptoms include irritability, nervousness or anxiety, sleep difficulty, decreased appetite, restlessness, depressed mood, and somatic symptoms causing significant discomfort. This finally dispels the myth that cannabis is only psychologically and not physically addictive. As with other substances, cannabis withdrawal is a dose- and frequency-related phenomenon. Unlike tobacco and alcohol use rates, however, marijuana usage in the United States is rising. Approximately 24.0 million Americans used marijuana in the last month according to the NSDUH.

Like tobacco, over the last decade, there has been an increase in new delivery methods for cannabis-based products, including vaporizing, oils, and edible products. The higher amount of tetrahydrocannabinol in these products, though typically stated on the labels, makes them more dangerous and has led to a drastic increase in marijuana-related emergency room visits in Colorado, where they recently legalized recreational marijuana.

Potency of cannabis continues to rise as well. Attitudes about marijuana in our culture continue to indicate the increase in marijuana usage will not change in the near future. However, because of the legal status of marijuana and the specific ramifications this has on scientific research, much less is known about the long-term harmful effects of prolonged exposure to marijuana.

Physicians in the state of Nebraska are likely to encounter users of these substances on a regular basis. The best practice is to screen all individuals aged 12 and over for both alcohol and substance use disorders, using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. Recommended screenings include the Alcohol Use Disorders Identification Test (AUDIT), and the Drug Abuse Screening Tool (DAST). Both 10-question screeners can be administered in nearly any setting and provide quick results to whether or not an intervention is warranted. In addition, physicians are encouraged to familiarize themselves with referral sources in the community that specialize in substance use disorder treatment. SAMHSA has a specialized treatment locator on their website. ☐

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Development and Progression of Adolescent Substance Use Disorder (continued)

better management strategies through evidence-based practice. These efforts will reduce stigma surrounding substance use disorders that will improve the ability of patients to receive the medical care they deserve. Prevention works, treatment is effective, and people can and do recover. □

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The Opioid Epidemic: We Know the Problem, Where Are the Answers? (continued)

long-term maintenance treatment. This is very similar for some patients who have hypertension. For those patients who have a significant addiction, it is difficult to taper off of an opioid replacement treatment as relapse is very high. At this point it does not appear there are any long-term adverse events with the use of buprenorphine.

A physician, physician assistant, or nurse practitioner who completes the coursework can submit a form to the DEA for the waiver. Once approved the DEA provides an additional number to be used to prescribe buprenorphine. In the first year of prescribing, they can have 30 patients under their

care. After the first year, if they submit a request to the DEA, additional patient limits can be obtained. Information can be found at www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator.

This article serves as an introduction to opioid addiction and treatment. Buprenorphine can be used in this capacity along with psychosocial forms of treatment. As we continue to search for answers to address addiction treatment and the opioid epidemic, buprenorphine offers a readily available relatively safe option that can save lives. □

Addiction in Health Care Providers (continued)

doctorate level HCPs, PAs, NPs, CRNAs and those in training for these degrees; Bachelor's degree pharmacists are also eligible.

In Nebraska, there are two Licensee Support Group (LSG) meetings per week in Omaha for HCPs and HCP students who have or are recovering from an SUD. There is interest in establishing similar groups in the Lincoln and Grand Island/Hastings/Kearney areas. To obtain information about Omaha LSG meetings or about starting LSGs elsewhere in Nebraska, please contact Jeff Baldwin at jbaldwin@unmc.edu or at 402-493-2384 (h). HCP support groups are a supplement to regular attendance at community-based support groups such as A.A. or N.A. The primary reason HCP-specific support groups such as

the LSGs exist is there are often issues of professional shame and professional licensing and compliance with probationary contracts that are not usually issues that HCPs feel comfortable discussing in other settings. HCPs facing reporting to DHHS or Boards for potential SUD problems may benefit by enrolling as soon as possible in the NE LAP rather than waiting several months until the Board initiates formal action. By doing this, the HCP can complete an SUD evaluation and will often be able to complete any treatment recommendations and begin to develop a healthy recovery prior to any action from DHHS. Approximately 85 percent of HCP participants remain in recovery at five years for those who remain committed and engaged in recovery. □



Medical Student Update

How medical students are taking action to fight the opioid epidemic



By Alicia Smith, M3
UNMC

According to the CDC, opioids were involved in more than 42,000 drug overdose deaths in 2016. This is not new information for any of us. We have all heard of the opioid epidemic and more than likely know at least one person who has been affected in some way. Many of us see patients every day that are dependent on opioids for chronic pain. The problem is multi-faceted, with blame being placed on all sides. At the same time, experts are seeking solutions from every angle. There is federal legislation in the CARA Act, state legislation mandating PDMP use, changes in curriculum from high school to medical school, and much more. I see individual physicians changing their prescribing habits and residents learning best practices, but what about medical students? We are, after all, the future of the industry that holds the prescription pad.

How has the opioid epidemic impacted medical students? There have been vast movements to increase medical school education about addiction, substance use, and opioids. In 2016 the CDC published a list of guidelines that medical schools could pledge to incorporate into their curricula. States like Massachusetts have worked with their medical schools to create core competencies. Additionally, most medical schools appear to have taken an introspective look at their own curriculum to create accountability therein. Furthermore, the best education some of us receive is every day on the wards or in clinic. There, we are perfectly placed to learn from our attendings' trials and errors. We

are fortunate to be able to formulate our own approach to difficult situations with minimal risk. We appreciate the physicians who are open about their own experiences and challenge our thinking.

Most medical students aren't bystanders; we want to be active. We want to be involved. Over the past few years, the solutions to the opioid epidemic have been targeted at current physicians. All the while, students have been seeking their own, and Nebraska medical students are no exception. Our UNMC and Creighton AMA/NMA Chapters held a naloxone training workshop on January 30. We invited an Emergency Medicine physician, a pharmacist, and a flight nurse to talk about their experiences with overdoses and how to treat them. Students were able to practice naloxone administration in each of its forms. Student efforts across the country also include organizing opioid take back days and volunteering in clinics that care for patients with opioid use disorders. Students have also been actively involved in advocacy efforts. We have sent letters, participated in social media campaigns, lobbied congressional members, and more. For the past two years our AMA/NMA Chapters have advocated for the CARA Act during national advocacy campaigns and at Capitol Hill visits. This year was no different. More than 10 students from Creighton and UNMC traveled to Washington, D.C., to participate in advocacy on these very issues.

As a medical student, I believe that my role in fighting the opioid epidemic is essential. The education of future physicians makes a major difference, and students are ready to be a part of the solution. ☐

Medical Student Update

Undergraduate Medical Education: Perspective of a Third Year Medical Student

By Nicole Minalt, M3
Creighton University School of Medicine

July 1 of the third year in medical school marks the start of the clinical years around the country. It is a day that students dream of even before receiving their white coats and arguably even more so during the pre-clinical years. It is a time when students finally leave the lecture halls in exchange for the hospital wards to interact with patients. The patients would now be our primary teachers. So we hoped. However, with the increased pressures to achieve honors in clerkships and above average scores on board examinations that were originally designed to be pass/fail, students are turning away from learning from patients to learning what is “high-yield” from question banks and review books. Have students lost sight of what it means to be a physician? Or rather have the chronic assessments boiled down undergraduate medical education into a high-yield review book?

According to the results from the 2016 National Resident Matching Program (NRMP) Program Directory Survey, three of the top five factors for selecting applicants to interview include USMLE Step 1, 2 and grades in required clerkships.¹ It is understandable for medical students to feel their time is wasted rounding on patients or scrubbing into an eight hour total colectomy surgical case. They know that precious time could be utilized doing question sets to score higher on exams and that residencies will reward these efforts. The disheartening

reality is a patient in need of care is not going to present to the emergency department or clinic in the form of a multiple choice question filled with buzz words.

Creighton University School of Medicine (CUSOM), and many medical schools around the country are undergoing or have undergone curriculum revision to enhance undergraduate medical education. Unfortunately, there is not a tried and true formula to implement to train the next generation of physicians. Like other schools, CUSOM is moving away from pre-clinical lecture based learning to small group case-based learning. The goal of case-based learning is to prepare students earlier on in their training for clinical practice through the application of knowledge.² As a current medical student, I have hopes that this model of learning will return medical education to students as thinkers and not robots who are trained to answer multiple choice questions. My fear is that although our schools are trying to provide its students a quality education that will prepare us for the clinical setting. The problem is at a national level where the emphasis to a great candidate is mostly based on high board scores. □



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New Members

Grand Island

Lindsey Mettenbrink, DO

Kearney

Brittani Moeller, DO

Lincoln

Justin Adkins, MD

Lisa Adkins, MD

Rebecca Bowen, MD

Rachel Brock, DO

Namita Dhiman, MBBS

Laura Ellson, MD

Daniel Finn, MD

Daniel Hadland, MD

Sara Hargreaves, MD

Mark Henderson, DO

Ahsan Iftikhar, MD

Sion Kim, MD

Amanda Knapp, MD

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Beth Sanley, MD

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Dane Todd, MD

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Necrology

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Grant

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12/16/2017

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Lincoln

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11/1/2017

Harold W. Keenan, MD

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Internal Medicine

8/28/2017

John J. Matoole, Jr., MD

Omaha

Internal Medicine

12/9/2017

Monte M. Scott, MD

Omaha

Endocrinology

10/26/2017

Milton Simons, MD

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Ask a Lawyer

Updated January 2018

Originally prepared for publication in December 2016

Does the mandatory duty to report under Nebraska's Uniform Credentialing Act apply if a chemically impaired practitioner enters the Nebraska Licensee Assistance Program?

What should you do when a physician colleague or other licensed colleague is found to be practicing while impaired by alcohol, controlled substances, mind-altering substances, or a physical, mental, or emotional disability? Urge that person to contact the Nebraska Licensee Assistance Program to get help. Doing so may eliminate both your mandatory reporting obligation and that of the impaired individual under Nebraska law. It may also help your colleague get his or her life back on track and keep them out of the disciplinary process.

The mandatory duty to report concerning an impaired professional applies if you have first-hand knowledge about an impaired professional in your own profession or another profession. As a general rule, a credential holder, such as a physician or physician assistant, is obligated to submit a report to the Nebraska Department of Health and Human Services (the "Department") if he or she has first-hand knowledge that someone in his or her profession has been practicing while that individual's "ability to practice is impaired by alcohol, controlled substances, mind altering substances, or physical, mental, or emotional disability" Neb.Rev.Stat. § 38-1,125(1)(a). The mandatory duty to report also applies if you have first-hand knowledge about a credentialed person in another credentialed profession practicing when impaired by "alcohol, controlled substances, mind altering substances, or physical, mental, or emotional disability." Neb.Rev.Stat. § 38-1,125(1)(b).

A mandatory report is required to be submitted within thirty (30) days of the occurrence that "triggers" the mandatory duty to report. In the legal world, "first-hand" information generally means a person actually witnessed, observed, or perceived through one's senses the conduct at issue.

These two duties within the mandatory reporting law, to report an impaired professional in one's own profession and an impaired professional in another profession, can be eliminated when the "credential holder who is chemically impaired enters the Licensee Assistance Program," Neb.Rev.Stat. § 38-1,125(2)(c). This is the case except as otherwise provided in the Licensee Assistance Program's authorizing statute, Section 38-175. A separate duty to report statute, Section 38-2897 applies to pharmacy interns or pharmacy technicians.

The Department contracts with Best Care Employee Assistance Program to provide the Nebraska Licensee Assistance Program (NE LAP) services. By statute, the NE LAP services are limited to "providing education, referral assistance, and monitoring of compliance with treatment for abuse of, dependence on, or active addiction to alcohol, any controlled substance, or any mind-altering substance." Neb.Rev.Stat. § 38-175(1). Participation in NE LAP is voluntary.

Participation in the NE LAP is generally confidential; however, if the program's evaluation of the licensee determines that the licensee's abuse, dependence, or active addiction may pose a danger to the public health and safety by the licensee's continued practice or if the licensee fails to comply with any term or condition of his or her treatment plan, NE LAP is required to report that information to the Department. Neb.Rev.Stat. § 38-175(2)(a).

Note that participating in the program does not preclude an investigation into alleged statutory violations that could result in disciplinary action. However, inquiries requesting information or assistance of the Department for a referral or treatment personally or for any other credentialed person for an alcohol or substance abuse problem must be

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8 Tips for Prescribing Pain Medication

By COPIC's Patient Safety and Risk Management Department

Prescribing opioids requires careful considerations. The following are not guidelines; they are merely suggestions or tips for clinicians to consider when they are prescribing these medications:

1) Make sure the clinical diagnosis is correct

Is the opioid you're giving indicated for the diagnosis that you are treating? When pain is out of proportion to the disease, you need to consider if there is another process or even a malignancy causing the severe pain. A thorough history and physical is helpful in sorting through what is going on. Make sure the opioids are necessary and if they are not working ask "what else is going on?"

2) Register for the Nebraska Prescription Drug Monitoring Program (PDMP)

The PDMP is a statewide tool that collects dispensed prescription information. Become comfortable with it and use it. All dispensed controlled substances are required to be reported daily to the PDMP, and as of 1/1/18, dispensed prescriptions are required to be submitted daily too. Even when you think everything is legitimate, check the PDMP to verify that everything is correct. Bookmark it on your computer, then checks can be done in one or two minutes—they can be reassuring, or they can be eye-opening.

3) Consider alternative treatments

If the pain is from neuropathy or shingles, consider some of the many other neurologic medicines that work for these illnesses. If treating fibromyalgia, remember that there are no controlled studies that suggest opioids help with this condition. Again, consider alternative (often neurologic) drugs.

4) Be aware of the risk of accidental death from overdose

Pain management experts point to four common issues in reviewing accidental overdose deaths:

- A lack of appreciation of the highly variable metabolism of methadone, particularly when first starting the medication.

- Trusting conversion tables and switching 100 percent "equivalency" when changing to a new agent. The conversion tables have been called into question especially in the initial period. Close follow-up and potential reduction of the initial doses when converting among different opioids is likely indicated.
- A lack of appreciation of the complexity of the metabolism of concomitant long and short acting opioids, leading to unpredictable toxic levels.
- Concomitant prescription of benzodiazepines in combination with high-dose short and long acting opioids.

5) Perform an addiction screen

The CAGE screen is simple and well known. Some of the others, such as the Screener and Opioid Assessment for Patients in Pain (SOAPP), are made especially for chronic narcotic use and are subtler. It is important to know if the patient has a high-risk for addiction and/or if there is an underlying psychological disorder or prior abuse that makes opioids have a higher addiction potential.

6) Do a urine toxicology screen

In conjunction with the above, a urine toxicology screen should be considered before embarking on treatment. It can help answer several questions:

- Is the patient using other street drugs?
- Is the patient claiming that he or she is not taking opioids, yet testing positive on the toxicology?
- Is the patient supposedly on drugs, yet the toxicology screen is negative? Consider diversion in this situation.

You can make random urine toxicology screens a condition of your continued prescribing via the opioid contract/ agreement, but must still inform the patient that you are doing the test (it cannot be done surreptitiously).

7) Have the patient sign a pain consent form

The informed consent form is a tool to help you review the risks and benefits for using opioids as well as the



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Ask a Lawyer (continued)

referred to the NE LAP by the Department. This is the case unless a complaint is made to the Department about the credentialed person, if a complaint has already been made about that person, or if an investigation or disciplinary action is in process against the individual. Neb.Rev.Stat. § 38-175(5).

There are, of course, other mandatory reporting duty requirements. These reporting duties arise whenever a credentialed professional is personally subject to the loss of employment, the loss or denial of privileges or the loss of a credential related to a “physical, mental, or chemical impairment.” Neb.Rev.Stat. § 38-1,125(1)(c)(i), (ii), (iv), and (vi). In those situations, the mandatory duty to report is not excused by a chemically impaired credential holder’s participation in the NE LAP.

Consequently, if the disciplinary process has not begun, if a complaint about a credential holder’s impairment has not been submitted to the Department, or if the credential holder has not yet suffered an adverse action or consequence because of a chemical impairment, contacting the NE LAP may help a credential holder address his or her chemical impairment problem without the necessity of involving the Department and its disciplinary process.

NE LAP may be contacted at (402) 354-8055 or (800) 851-2336, or via email at lapne@bestcareeap.org. Confidential information should not be sent by email. NE LAP has 24-hour assistance line available any day of the year by its professional counselors. If contact to the program is needed urgently, a call to (800) 851-2336 or (402) 354-8055 will put that person in touch with a professional counselor at NE LAP. The program may also be contacted during its regular business hours, from 8 a.m. to 8:30 p.m. Monday through Thursday, from 8 a.m. to 4:30 p.m. on Friday, or from 8 a.m. to 12:30 p.m. on Saturday.

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

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8 Tips for Prescribing Pain Medication (continued)

potential side effects (constipation, sexual dysfunction, and drowsiness are among the many potential side effects). Remember to warn patients about using opioids while driving or using heavy machinery. And make sure you talk about the interaction with other drugs, especially alcohol and marijuana.

8) Listen

Some of our most difficult patient conversations occur around these drugs. The patient wants pain relief, and

we have an obligation to relieve suffering. On the other hand, there are times when it is clear that opioids are not what are best for the patient. “Primum Non Nocere” is the first precept of medical ethics. Instead of starting the boundaries discussion with a resounding NO, listen to what the patient is concerned about, understand his or her fears, and see if there is compromise that will meet the patient’s needs and still be considered safe medicine.





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How Much Will I Save on Taxes Next Year?

SHEA MEARS, CPA, CFP®, MBA, Lead Advisor

Great question. There is a number of changes to the tax code that will affect everyone in 2018. Hopefully, everyone will see a tax decrease. However, there are so many moving parts, that it's hard to know for sure. A few of the major changes:

- 1 First, the tax rates are lower. If you are married and have \$250,000 in taxable income, your top bracket would have been 33 percent. Under the new law, it will be 24 percent.
- 2 Next, the standard deductions have doubled. However, personal and dependency exemptions have gone away.
- 3 Charitable contributions are still deductible. But now, cash contributions are limited to 60 percent of adjusted gross income (AGI), instead of 50 percent.
- 4 Medical expenses are deductible to the extent that they exceed 7.5 percent for all taxpayers.
- 5 Mortgage interest is limited to the interest on the first \$750,000 in acquisition indebtedness. There is no more home equity indebtedness.
- 6 State income and property taxes are limited to a combined \$10,000.
- 7 The casualty and theft deduction is gone, unless the loss is due to a presidentially declared disaster area.
- 8 Miscellaneous deductions subject to 2% of your AGI are now gone.
- 9 Moving expenses are no longer deductible.
- 10 Qualified 529 distributions have been expanded to include higher education and up to \$10,000 per student per year for qualifying K-12 expenses.
- 11 The alternative minimum tax (AMT) phase-out has increased.
- 12 The child tax credit has been expanded to \$2,000 and doesn't phase out until \$400,000 in AGI.
- 13 Income from Pass-Through entities could receive a 20 percent deduction at the taxpayer level, depending on the type of business and income levels.

There are enough changes that it is extremely difficult to say how much your taxes will decrease if at all, and it likely will take a few months to fully understand all the details. However, if you have questions or would like to discuss this topic more, please give us a call.



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