

MINNESOTA MEDICINE

MARCH 2013



THE OPIOID CRISIS

COMBATTING
MISUSE THROUGH
BETTER PRESCRIBING

PAGE 20

ALSO INSIDE:

Moving **ADDICTION TREATMENT**
into this century PAGE 34

Minnesota's **DIVERSION DETECTIVE** PAGE 12

Stopping **DOCTOR-SHOPPERS** PAGE 16

PLUS:

NEONATAL DRUG withdrawal PAGE 48

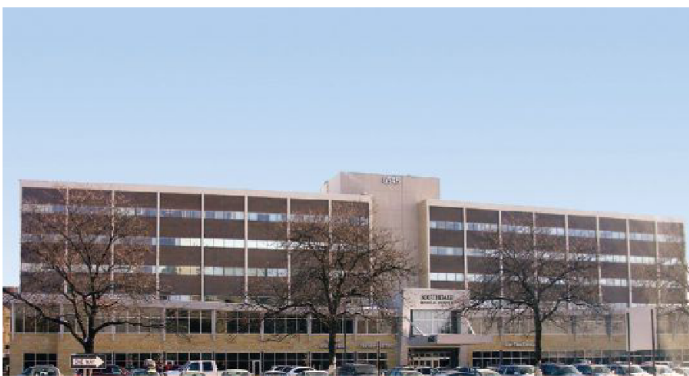


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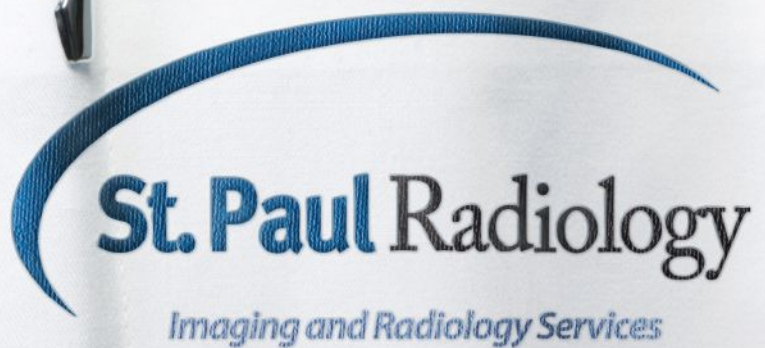


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CONTENTS

March 2013 | VOLUME 96 | ISSUE 3

FEATURES

ON THE COVER

20 **The opioid crisis**

Combatting misuse through better prescribing

BY JEANNE METTNER

FEATURE

10 **The medicine of addiction**

More physicians are needed to treat patients with alcohol and drug addiction.

BY SUZY FRISCH

FEATURE

12 **Diversion detective**

As he takes on the issue of drug diversion, Mayo Clinic's Keith Berge is questioning whether the consequences are tough enough.

BY KIM KISER

FEATURE

16 **Stopping doctor-shoppers**

Minnesota's Prescription Monitoring Program reduces abuse of controlled substances and improves care. Why aren't more physicians using it?

BY HOWARD BELL

Clinical AND Health Affairs

38 **The Rampant Abuse of Prescription Pain Medication**

BY CAROL FALKOWSKI

42 **Opioid Use and Abuse: A Pain Clinic Perspective**

BY DAVID SCHULTZ, M.D.

45 **A Comprehensive Response to the Opioid Epidemic: Hazelden's Approach**

BY MARVIN D. SEPPALA, M.D.

48 **Neonatal Drug Withdrawal**

BY JANE E. BARTHELL, M.D., AND JEANNE D. MROZEK, M.D.



20

10



12

16



DEPARTMENTS

4 EDITOR'S NOTE

6 LETTERS

8 PULSE

Training doctors to combat opioid abuse, prescribing resources, the FDA's new strategy

26 THE PHYSICIAN ADVOCATE

A few minutes with Rep. Jim Abeler, news briefs, Day at the Capitol recap.

56 EMPLOYMENT OPPORTUNITIES

63 AD INDEX

COMMENTARY

34 Moving addiction treatment into the 21st century

Our treatment system needs an overhaul.

BY ANNE PYLKAS, M.D.

36 Why doctors prescribe opioids to known opioid abusers

How cultural attitudes and financial disincentives affect the prescribing habits of physicians.

BY ANNA LEMBKE, M.D.

MEDLAW

52 Prescription opioid abuse: finding a feasible solution

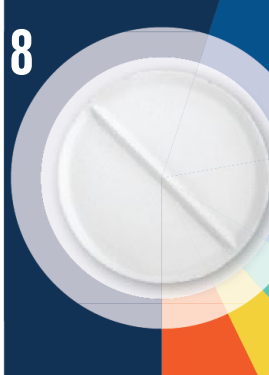
States employ different legislative strategies to curb misuse.

BY JULIANA MILHOFFER, J.D.

END NOTE

64 Hypnos

A POEM BY GREGORY A. POLAND, M.D.



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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

As physicians, we are charged with healing and providing comfort, and frequently comfort means treating pain.

Rational prescribing

Her head rested on the desk as I walked into the exam room. “How are things?” I asked. As she raised and started to shake it she said, “The same.” She continued to shake her head like a 2-year-old refusing to eat her peas as she ran through the litany: “The pain in my hands ... I just can hardly stand it. And my feet ... I can hardly walk. Nothing seems to take the pain away.” Her diagnoses included chronic pain, fibromyalgia and osteoarthritis.

I asked a few more questions to see if any new symptoms had surfaced since her last visit, then reviewed what medications other than Percocet she had tried in the past, including during the years with her previous doctor. I had prescribed gabapentin, antidepressants and nonsteroidals in an attempt to cut down on her narcotic use. But our conversation followed the usual script.

My exam, as usual, found nothing new. And, as usual, I wrote her a prescription for the same number of Percocet as I did last time. She promised to return in a month, which she always did. The visit was all litany, a predictable repetition of all her previous visits. Though short, it was exhausting.

Caring for patients with chronic pain who use narcotics can be challenging for physicians. The predictability of their symptoms nags like a child begging for a toy. We know what the answers to our questions will be. The unprovability of their symptoms offends our doctor-need for explanations and raises a twinge of distrust. Pain is by definition subjective and invisible, and most chronic pain patients have neither a definable explanation for their symptoms nor X-ray findings that differentiate them from other patients with their diagnosis who have only minimal pain. The intractability of their symptoms

goads our frustration as we dish out a Band-Aid in a bottle—oxycodone, hydrocodone, morphine—knowing that addressing the etiology of their pain lies beyond our abilities.

Our frustration becomes mixed with fear as every few months we read in the newspaper of some fellow physician sanctioned by the Board of Medical Practice for prescribing too many narcotics to patients. We usually don't know the details of the story—how much the doctor prescribed or what monitoring they did—but we can't help wondering every time we write that Percocet prescription, “Am I doing this right?”

As physicians, we are charged with healing and providing comfort, and frequently comfort means treating pain. That task is easy when the cause of the pain is obvious such as a broken bone or surgery. But isn't our job the same even when the invisible, unprovable pain lingers?

Physicians need help navigating the pain treatment maze and this month's issue provides some. It offers guidance from multiple organizations about safe prescribing, tells how pain specialists can help with rational treatment of pain, discusses the role of addiction specialists when pain medication use crosses over into abuse, and describes a state-run database that can help us know if our patients are getting prescriptions from multiple doctors. We're not alone in dealing with this difficult problem.

I expect to see my patient again in a month, and I suspect the visit will have no surprises and I will emerge from the exam room tired. But this time, I will be wielding tools designed to help make narcotic prescribing rational and safe. ■■

Charles Meyer can be reached at meyer073@umn.edu.



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Medicine and business

The article “Restrictive covenants—unnecessary harm” by Gordon Apple, J.D., and Kimberly Wernsing, M.D., (February, p. 37) raises an important issue. As a pediatrician who experienced a six-month noncompete last year, I can relate to having to move away from my family for weeks at a time in order to comply with my contract. But the sadness and disappointment I felt during that time was not because I was away from my family as much as it was because I was unable to care for patients in their time of need.

Prior to leaving my group, I spoke with a family about their son who had metastasis from an adrenocarcinoma. It was decided at that point they would enjoy the time they had together and only palliative measures would be taken. We discussed the local hospice program and its ability to care for children, if necessary. I expressed my willingness to help out in any way when the time came. Unfortunately, it was only a month later (two weeks after leaving my group) that I received a call from the family saying that their son was having problems and would likely need to be

admitted to the hospital. Although it was my intention to care for this child during this period, it was evident from discussions with my previous group and their lawyer that I was to have no contact with previous patients or face legal ramifications. I had my wife contact the family to let them know that I would not be able to care for their dying son. As his parents and I hugged at his funeral three months later, I cried not only because of their son’s death but because I had been prevented from being by their side during those final months.

Medicine is a business. However, at the very foundation of medicine is the patient-doctor relationship, which transcends market forces and clinic walls. I hope as we look at issues such as this we can remember the reason we entered this worthy vocation.

Name withheld upon request

Article misses important point

The article “The Hunt for New Recruits” (February, p. 18), which explores the challenges we recruiters face as we seek to fill open positions in primary care, missed the mark in stating that organizations such as Fairview have reduced the “administrative” burden on primary care physicians by increasing the number of nurse practitioners and physician assistants on their care teams. Our hiring of nurse practitioners (NPs) and physician assistants (PAs) has been on the rise and these professionals do work with our physicians. But here at Fairview (and elsewhere as well), they provide high-level primary care services to patients in partnership with the physician staff. The core mission of our NPs and PAs is to deliver high-quality patient care—not reduce the administrative burden on our physicians.

Lynne M. Peterson
Manager, physician recruitment
Fairview Health Services



More on morale

I share many of the concerns Dave Thorson raised in his Viewpoint column “Harbinger or squeaky wheels” (December 2012, p. 29) about physician morale and the state of the medical profession. I have to add that the biggest complaint I hear and share myself is not what Medicare, Medicaid or the private payers are doing. It is what our own organizations are doing.

Many of us have come to feel we are just cogs in the machine. We go to work, grind it out and go home. Meanwhile, I see lots of nonmedical workers around me who often do little to help us out. I see layers of bureaucracy that do not seem to be helping patient care. We ask for resources and are told there is not enough money, but when a specialist is hired, they get everything they want. We are constantly told we need to do more and to see more patients—again without additional resources.

I think morale in medicine is worse than when I started practicing. No doubt the reasons are many; but I think that as organizations get bigger, many of us feel smaller, less important and not listened to. Even though we are really the backbone of the system, you would never know it.

I want to emphasize that interactions with patients are still very important and meaningful to me. Also, I have plenty of work, am well-respected and, of course, am well-compensated. I don’t believe I should have done something different. But things could be better.

I wonder if others feel the same way.

Philip Stoyke, M.D.
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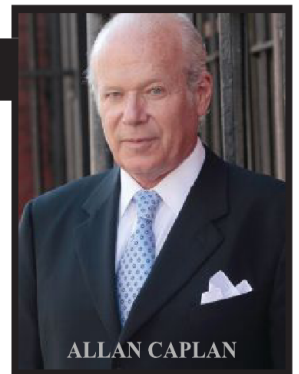


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State develops strategy for combatting abuse

The first-ever statewide strategy for addressing substance abuse was released last fall. Crafted by representatives from Minnesota state agencies, American Indian tribes and law enforcement, the report looks at substance abuse and addiction from multiple perspectives—prevention, intervention, treatment and recovery support. It also identifies emerging trends and priorities.

Reversing the rising tide of prescription opioid and heroin abuse in Minnesota was identified as the state’s No. 1 priority. Toward that end, it recommended three immediate steps:

- Training physicians in the basics of addiction, opioid prescribing and alterna-



tive approaches to pain management, and requiring them to have a certain number of continuing medical educa-

tion units on these topics as a condition of license renewal

- Training a range of front-line professionals including licensed addiction treatment providers, detox staff, law enforcement officers and first responders about prescription drug abuse, treatment options for opioid addicts and how to reverse an opioid overdose
- Increasing prescriber and pharmacist participation in Minnesota’s Prescription Monitoring Program and examining ways law enforcement might access the data.

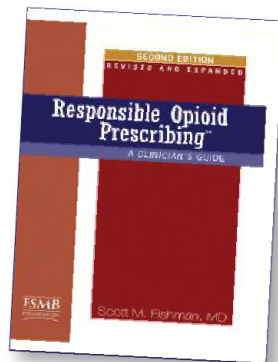
The report is available at:

<http://mn.gov/dhs/signature-initiative/SubstanceAbuseStrategy.jsp>

Resources for prescribing opioids

Among the resources for better prescribing are:

- The Federation of State Medical Boards’ Model Policy for the Use of Controlled Substances for the Treatment of Pain. This spells out optimal ways to evaluate a patient with chronic pain, create a treatment plan and use a written agreement for treatment. It can be downloaded at www.fsmb.org.
- *Responsible Opioid Prescribing: A Clinician’s Guide* by pain management specialist Scott Fishman, M.D. This book includes examples of controlled substance contracts and protocols for drug screening as well as practical tips for doing such tasks as documenting chronic pain visits in the medical



record. According to Minnesota Board of Medical Practice member Mark Eggen, M.D., “*Responsible Opioid Prescribing* should be read by every physician who prescribes controlled substances.” The book can be purchased at www.fsmb.org.

- “Safe Prescribing for Pain” and “Managing Pain Patients Who Abuse Rx Drugs,” two online courses from the National Institute on Drug Abuse and Medscape Education. Both use a case study to illustrate how to identify risk factors for drug abuse and safely prescribe for pain. The courses can be taken for credit and are available at www.drugabuse.gov/nidamed/etools.



Where drugs come from

People who abuse prescription pain medications get them from a variety of sources. Here’s a look at where drugs come from:

- 1 Obtained from a friend or relative **55%**
- 2 Prescribed by one doctor **17.3%**
- 3 Bought from a friend or relative **11.4%**
- 4 Taken from a friend or relative without asking **4.8%**
- 5 Obtained from a drug dealer or stranger **4.4%**
- 6 Other source **7.1%**

Source: Centers for Disease Control and Prevention, www.cdc.gov/homeandrecreationalafety/rxbrief

FDA acts on opioids

Physicians can expect to see more opportunities to learn about opioids in the coming months. That's because the Food and Drug Administration has mandated that drug manufacturers set up training programs and make available educational materials on the safe use of extended-release and long-acting opioids for licensed opioid prescribers starting this month.

The training will be funded by grants from product manufacturers and offered by independent continuing education providers. The training will include information on weighing the risks and benefits of opioid therapy, selecting appropriate patients for such therapy, managing and monitoring patients, and counseling them

on the safe use of these drugs. It also will emphasize how to recognize potential and actual misuse, abuse and addiction.

In addition, the FDA is supporting the Obama Administration's call to amend federal law so practitioners (eg, physicians, dentists) who request DEA registration to prescribe controlled substances are required to be trained on responsible opioid prescribing practices.

The FDA is also calling for improved science on opioids, patient education and new products for treating abuse and overdose.

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THE **medicine** OF **addiction**

More physicians are needed to treat patients with **alcohol and other drug addiction.**

BY SUZY FRISCH

As an internal medicine resident at Hennepin County Medical Center (HCMC) in Minneapolis, Anne Pylkas, M.D., often treated patients who had liver failure or suffered a trauma related to their abuse of alcohol or another drug. She would treat the overt medical problem but felt powerless to address the patient's substance abuse because she lacked expertise and resources. A desire to help such patients conquer their addictions led Pylkas to a relatively new field: addiction medicine.

"I want to help solve this medical problem that I think the medical world could be much more involved in," says Pylkas, a staff physician in the general internal medicine and addiction medicine divisions at HCMC who also has a private practice, the Medical Addiction Treatment Clinic, in Burnsville. "Addiction is a physical disease that needs physical treatment. It's a chronic disease that takes a physician to understand the underlying long-term effects."

Into the medical realm

In addition to being a complex brain disease with strong genetic underpinnings, addiction plays a major role in many insidious health problems including HIV, hepatitis, cirrhosis, cancer, heart disease and trauma, says Gavin Bart, M.D., Ph.D., associate professor of medicine at the University of Minnesota and director of HCMC's addiction medicine division. It affects people in every age group, ranging

"Addiction is a physical disease that needs physical treatment. It's a chronic disease that takes a physician to understand the underlying long-term effects."

Anne Pylkas, M.D.

from infants who were exposed to drugs before birth to seniors quietly addicted to prescription pain medication.

For those reasons, Bart argues that every medical specialty needs doctors who are trained to recognize and treat addiction. "One of the main barriers to treatment for addiction is the fact that there are not enough providers who can recognize all the great treatments we have available," he says. He also notes having primary care providers who are knowledgeable about addiction is important because many patients won't seek out the care of an addiction specialist.

To meet that need, the American Board of Addiction Medicine (ABAM) launched an effort in 2011 to train more physicians in addiction medicine, accrediting residencies or fellowships at 10 sites across the country.

The University of Minnesota's addiction medicine fellowship program was one of those that received accreditation. The fellowship is open to physicians who have



PHOTOGRAPH BY KATHRYN FORSS

completed residency in any specialty. It teaches them about diagnostic and motivational interviewing, how to recognize and care for patients with acute withdrawal symptoms, the pathophysiology of addiction, medications to treat addiction, in-patient care, and how to work with a multidisciplinary team that includes drug and alcohol counselors, nurses and other physicians. Fellows rotate between the Minneapolis Veterans Affairs Medical Center, HCMC, the University of Minnesota Medical Center, Fairview, and other sites. (The university has offered an addiction psychiatry fellowship since 1982. Addiction psychiatry is a recognized subspecialty that differs from addiction medicine.)

The move to train more physicians in addiction medicine comes in recognition

A specialty in the making

The American Board of Addiction Medicine (ABAM) is working toward having addiction medicine formally recognized as a specialty.

Established in 2007, the ABAM is seeking to have its residency and fellowship programs sanctioned by the Accreditation Council for Graduate Medical Education and is pursuing membership in the American Board of Medical Specialties (ABMS).

"This specialty is being created to save lives. There are 23 million Americans

who need treatment for substance abuse disorders, and 95 percent of them aren't aware of it and aren't getting it," says Gavin Bart, M.D., Ph.D., associate professor of medicine at the University of Minnesota and director of HCMC's addiction medicine division. "In order to save lives we need to increase the chance that physicians could better diagnose and treat these patients, and that patients and their families who want help would have a recognized specialty they could turn to." —S.F.



Pylkas divides her time between Hennepin County Medical Center and her private practice.

of the fact that 15 percent of the population will battle drug or alcohol addiction during their life, says Sheila Specker, M.D., director of the addiction medicine fellowship. In addition, overdose deaths from prescription drugs have never been higher, with 15,500 happening in 2009, according to the Centers for Disease Control and Prevention. New treatments are constantly emerging for drug and alcohol addiction, and these require new understanding and expertise on the part of physicians.

Practice areas

When physicians complete their addiction medicine residency or fellowship, some will return to their original practice—family medicine or pediatrics, for instance. Others may serve as medical directors of treatment facilities, do research, consult with health care organizations and insurance companies, or treat addicted patients at hospitals or clinics. They also will be prepared to take the ABAM certification exam.

Pylkas is waiting for results of her exam, which she took in late 2012 after completing her internal medicine residency at HCMC two years ago and working in the field for a required number of hours. (Doing an addiction medicine residency or fellowship isn't required for certification.) Minnesota currently has 29 ABAM-certified physicians.

Pylkas now divides her time between three locations. She spends one day a week in her Burnsville clinic, which opened in September 2012. There, she diagnoses addiction, develops treatment plans and guides patients through detoxification and

into recovery, often using prescription medications such as buprenorphine for opioid addiction. She also staffs HCMC's methadone clinic and works at the hospital's Coordinated Care Clinic, where she sees patients who are dealing with addiction in addition to other health problems.

Although some days are challenging, especially when patients take the frustration and pain of addiction out on her, Pylkas is happy with her work. "In the end, it's worth it. There are so many people I see who are

successful, whom we really, really help," she says. "You take someone with this horrible disease that is so life-altering, and they are in the depths of despair, and you help them through it. And if it happens again, you are there for them. Having that relationship with my patients is so rewarding." MM

Suzy Frisch is a Twin Cities-based freelance writer.

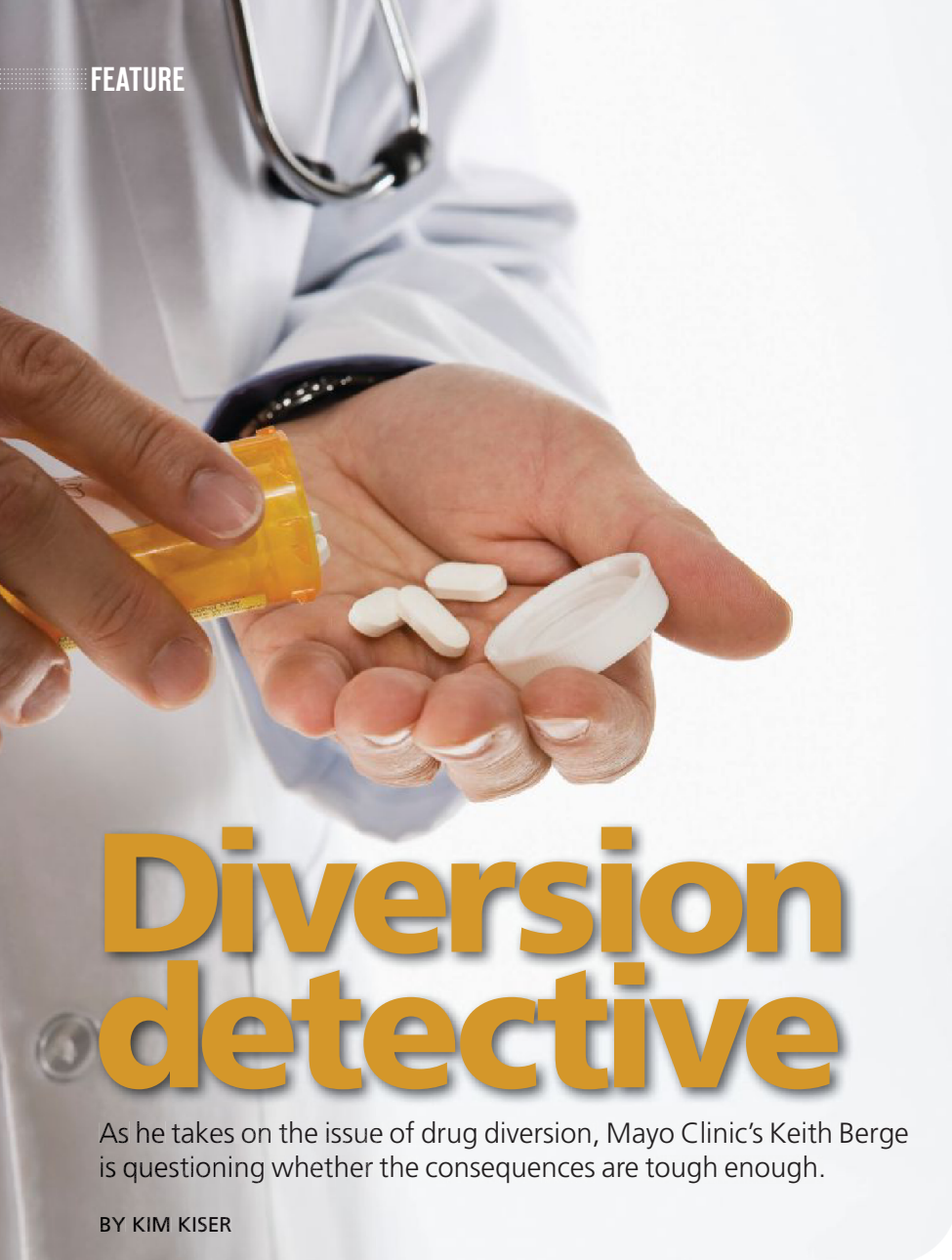
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Diversions detective

As he takes on the issue of drug diversion, Mayo Clinic's Keith Berge is questioning whether the consequences are tough enough.

BY KIM KISER

Keith Berge's voice grows intense when he talks about the case that launched Mayo Clinic's most recent drug diversion prevention effort: In 2008, a sedation nurse at Mayo's Immanuel St. Joseph's hospital in Mankato was caught stealing vials of fentanyl and then, after using the drug, refilling them with saline solution before returning them to storage for patient use. "There was a chance patients could have come to harm, but none of them did," he recalls.

The story made national headlines; the nurse was fired and prosecuted; and a Mayo task force that included Berge was charged with figuring out how to prevent this from happening again.

Berge was a logical choice for inclusion in this group. An anesthesiologist with a

long-standing interest in the issue of addiction among anesthesia providers, he had led an effort to prevent drug diversion in the OR in Mayo's Rochester hospitals and to deal with employees who were suspected of having addiction. "I've spent my career in anesthesia trying to prevent drug diversion," he says.

But he felt he could learn more and that through the task force he would meet others who had "the right answers" about how to prevent diversion. It turned out no one did. It also turned out no one was sharing what they did when they encountered such a situation. "I realized then we were missing a chance to learn from every one of these diversions," Berge says.

Looking and finding

The problem of drug diversion in the United States is tightly coupled with the increase in prescriptions for medications such as hydrocodone, oxycodone, hydro-morphone, morphine sulfate and fentanyl seen over the last 20 years. In 1991, 76 million prescriptions for opioids were filled in this country; by 2010, that number had risen to 210 million, according to the National Institute on Drug Abuse.

These narcotics, which work like the pain-relieving chemicals naturally produced in the body, are highly effective—and highly addictive. "A certain percentage of people who are prescribed these for legitimate reasons will slide into the addictive use of them, which requires diversion to obtain these drugs," Berge says. "And a certain percentage of those people work in health care and bring their addiction to work."

U.S. Drug Enforcement Administration data show that from 2005 to 2011 there were 250 reports of theft of controlled substances by health care workers (not including reports from retail pharmacies) in Minnesota. In 2006, 16 cases were reported; by 2010, the number had increased to 52.

Taking medications directly from patients is the most egregious form of diversion; others include calling in or writing prescriptions for controlled substances for oneself, altering prescriptions, taking medication from a supply or that has been discarded, taking a family member's medication and manipulating medication dispensing machines.

The Mayo task force, which included representatives from a number of departments including anesthesiology, pharmacy and safety and security, began their work by analyzing the path drugs took into and through Mayo hospitals—from their arrival at the loading dock, to their movement through the facility, to their dispensation or disposal. They looked for any place drugs could take a wrong turn. "We worked with all these identified vulnerabilities and one by one tried to fix them," says Berge, who by that time had been named chair of Mayo's newly established medication diversion-prevention committee.

Mayo also became more proactive about searching for diverters. Each of its larger hospitals designated an employee as the diversion-prevention coordinator and charged that person with looking for places where drugs could be stolen or tampered with. “They did simple things like looking at which care providers in an inpatient unit accessed the most controlled substances in a month,” Berge says. Was someone accessing them more than others on their unit? Did what they were doing warrant further investigation? “By doing something that simple, we found people who were diverting,” he says.

And the more they looked, the more they found.

Seventy-seven best practices

As the committee was developing its protocol for rooting out diversion in 2010, another crisis hit. This time, a radiation technologist at Mayo’s Jacksonville, Florida, hospital was suspected of stealing syringes of fentanyl and replacing the contents with hepatitis C-contaminated saline solution; one patient who received the tainted solution died. (In 2012, the tech pleaded guilty to 10 counts including one of tampering with a consumer product resulting in death.)

“It put the spotlight more intensely on the problem,” Berge says. That led to their drawing up a list of 77 “best practices” for preventing diversion of controlled substances, many of which were based on what Berge and his colleagues were already doing in the OR. The practices deal with storage and security, procurement, education, prescribing, dispensing and administration, inventory and record keeping, surveillance, investigation and response, and more. Berge says those practices are being implemented at all Mayo-affiliated hospitals. “It holds everyone in the system to the same standard,” he says.

As Mayo was rolling out its best practices, representatives from the Minnesota Department of Health and the Minnesota Hospital Association were convening a coalition to address the problem of drug diversion. The coalition included representatives from health care organizations,

the addiction treatment community, state licensing boards, law enforcement and other agencies. Berge, who is a member of the Minnesota Board of Medical Practice, represented that organization as well as Mayo Clinic.

Over 12 months, the group crafted its “Road Map to Controlled Substance Diversion Prevention,” an eight-page document that incorporates many of Mayo’s best practices as well as those from other participating institutions. It also includes sample policies and procedures, training materials and reporting guidelines and requirements that providers can use when they suspect drug diversion has occurred. The Road Map was released in the spring of 2012 and is available at www.health.state.mn.us/patientsafety/drugdiversion/index.html.



Keith Berge, M.D.

Tough enough?

One issue that didn’t get resolved during the coalition’s discussions was when law enforcement should get involved in a case of diversion. “The reality is the majority of these cases have not been prosecuted,” Berge says, adding that law enforcement is starting to

take more of an interest in them.

Nor do they always come to the attention of the appropriate licensing board. Under Minnesota law, employers are obligated to report disciplinary action. “Firing someone for drug diversion is a disciplinary action. By law, it’s supposed to be reported to the board,” Berge says. “That said, I think many don’t [get reported].”

Some diverters may instead end up in the Health Professionals Service Program (HPSP). HPSP was created in 1994 as an alternative to board discipline. By law, health professionals and employers can refer a provider who is suspected of hav-

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ing chemical dependency or a physical or mental health problem that may impair their ability to do their job to HPSP rather than report them to their licensing board. (HPSP does report all cases of medication substitution as well as those in which drug diversion has resulted in harm to a patient to the licensing board, according to program manager Monica Feider.)

Feider says employers and employees choose HPSP because it is nondisciplinary and is designed to help participants get back to practicing their profession, if possible. The program monitors participants' progress through treatment, their work, their medications and their attendance at support groups. It also requires them to go through random drug testing.

Berge believes licensing boards should be alerted to every case of diversion. He is discussing strengthening the law that requires employers to report such cases with Sen. Carla Nelson (R-Rochester). He says concern arose after the story of a nurse who had been through HPSP-sponsored treatment three times in 15 years without the Board of Nursing knowing about it became public in 2011. (The nurse eventually reported himself to his licensing board.)

"People started realizing this is a huge patient-safety issue," Berge says, citing a Denver case in which 36 people were infected with hepatitis C as a result of diversion. "In the past, we've viewed this as a problem for the person, and let's help them with the problem. Now we're saying what about the patient? This behavior needs to stop, and if prosecution is the way to stop it, then I'm all in favor of criminal prosecution of these people."

But Feider is concerned that fear of prosecution may stop some people from getting the help they need. "By terminating someone, if there's someone else in that facility who wants to seek help for their addiction, it may deter them for fear of being disciplined or prosecuted," she says. "I think some of the things that are happening are actually building barriers."

Berge understands the concerns about people not seeking help if they fear they will lose their license or law enforcement will become involved. "We don't want them

to think this is a direct line to the police department or something," he says of HPSP, adding that the program plays an important role in helping individuals with addiction.

Whether the Board of Medical Practice or other licensing boards will seek changes

to the law remains to be seen. But Berge believes that for drug diversion to end, the message has to be clear: "If you steal from your patients, it could land you in jail." **MM**

Kim Kiser is senior editor of *Minnesota Medicine*.



Where to get help

Physicians and other health professionals who suffer from addiction have several options for getting help.

Health Professional Services Program (HPSP). This program was created in 1994 as an alternative to discipline by state licensing boards. Under Minnesota law, health practitioners can report themselves or a colleague with a potential impairment to HPSP or the appropriate licensing board. Employers and licensing boards also can report individuals to the program.

HPSP is for health professionals not only with addictions but also with mental health issues and physical problems that could compromise their ability to practice. According to Program Manager Monica Feider, more than 600 people are currently enrolled in the program. "We may be the first point of contact, or sometimes a person goes through the board process then comes to us," she says, adding that a number of people are referred through treatment programs or employee health programs.

Participants with a possible addiction are referred for a substance abuse evaluation, if they aren't already in treatment. HPSP then helps the person get into treatment.

Every participant must submit a quarterly update on how they are managing their illness. HPSP also monitors the quality of a person's work (often working with their supervisor or manager), the medications they are taking and their attendance at support groups. Participants are also subject to random urine toxicology screens.

The monitoring period can vary. Feider says that on average people stay in the program for about three years. If they do not comply with the conditions of the program, they are reported to their licensing board.

HPSP works with 17 state licensing boards for health care practitioners including the Minnesota Board of Medical Practice.

To learn more go to: www.hpsp.state.mn.us/index.htm or call 651-643-2120.

Physicians Serving Physicians. Created in 1981, Physicians Serving Physicians provides assessment, consultation, counseling, intervention, referrals and peer support for physicians who are affected by addiction. The program is open to physicians who are struggling or who are concerned about a colleague or family member who is.

In addition to serving those with alcohol or other drug dependency, the program provides information and referrals related to gambling, food addiction, sexual addiction and other concerns.

For more information go to: <http://psp-mn.com> or call 952-920-5582.

Hazelden's Health Care Professionals Program. Hazelden began offerings its residential treatment program for physicians, dentists, pharmacists and other health professionals at its Center City facility in 2010. Participants undergo medical, psychological, drug and alcohol, spiritual and psychiatric assessments, then participate in group therapy and counseling. Hazelden staff also address issues related to licensure, employment, professional practice and participation in monitoring programs.

For more information, go to: www.hazelden.org/web/public/addiction_treatment_health_care_professionals.page.—K.K.

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Stopping doctor- shoppers

Minnesota's Prescription Monitoring Program reduces abuse of controlled substances and improves care. So why aren't more physicians using it?

BY **Howard Bell**

Before Mankato family physician Keith Stelter, M.D., sees a patient coming in for an opioid or narcotic refill, he logs into the Minnesota Prescription Monitoring Program (PMP) website to see if that patient is getting controlled substances from another prescriber. After entering his user name and password, he types in the patient's name and birthdate in order to see a printable list of all controlled substance prescriptions filled for that patient in Minnesota during the past 12 months. Multiple prescriptions written by multiple prescribers in a short period of time is a red flag that a patient may be abusing or selling the drugs.

Altogether, the process takes about two minutes. "I treat several patients with chronic pain," says Stelter, who also serves as associate director of the University of Minnesota's family medicine residency program at Mayo Clinic Health System in Mankato. "The PMP helps me make sure I'm the only one prescribing for them and

that they're not using their supply too fast. It helps me confirm a patient's controlled substance history, document compliance to treatment and provide better care."

Stelter is one of the 8,200 physicians, physician assistants, advanced practice nurses, dentists, optometrists, podiatrists and pharmacists who are using the state's PMP. The PMP was started in 2010 to help curb the growing abuse, misuse and illegal trafficking of controlled substances, particularly opioids, by identifying "doctor shoppers"—patients who go from doctor to doctor to get multiple controlled substance prescriptions. Prescription pain killers accounted for 9.3 percent of admissions to Twin Cities area addiction treatment programs in 2011, according to the Minnesota Department of Human Services—up from 1.4 percent in 2000. The National Institute

on Drug Abuse notes that prescription drugs are now the No. 1 cause of drug overdose deaths and cause more deaths than motor vehicle accidents.

Pharmacies and other dispensers such as hospitals are required to report all schedule II to IV prescriptions they fill. They upload that information to the database along with the patient's name, the quantity and dosage of the drug, the date the prescription was filled and the name of the pharmacy that filled it. Most dispensers report daily. Prescribers can access that information through the PMP website once they register.

Prescriber use is growing—slowly

Forty percent of Minnesota's licensed pharmacists and about 30 percent of Minnesota's physicians are registered PMP



users, according to Board of Pharmacy Executive Director Cody Wiberg, who wrote the legislation that led to the creation of the PMP. Wiberg doesn't have a breakdown of use by specialty, but he says, based on conversations with physicians, "We know a high percentage of pain specialists and emergency physicians use it, and we suspect a majority of other users practice primary care." Thirty percent might seem low, he says, but it's a healthy number when you consider that many physicians rarely or never prescribe controlled substances and, therefore, have

no need to use it. "Obviously though, we'd like more prescribers to use it because the more who do, the more effective it is."

Prescriber participation in Minnesota is similar to that in neighboring states. In Iowa, 26 percent of prescribers and 50 percent of pharmacists use that state's PMP. In South Dakota, 25 percent of

prescribers and 55 percent of pharmacists use theirs.

Why don't more Minnesota doctors use it?

For one thing, they might have been scared off by an initial requirement to have a notarized signature to sign up to use it. Although that is no longer required, some physicians may think it still is, says PMP program manager Barbara Carter. Prescribers can now sign up online in a few minutes.

Laurel Hansen, M.D., a HealthEast family physician who uses the PMP asked some of her colleagues why they don't use it. "Some of them knew there was something like this available," she says, "but they didn't know the details or where to find it." Others haven't gotten around to registering or don't want to have to remember an ad-

ditional password, especially one that must be highly secure and changed every six months. Some feel they just don't have time to add one more step to the clinic workflow.

Hansen and her colleagues would like to see the PMP become part of their electronic medical record so that accessing it wouldn't require an extra step. She also would prefer that clinic support staff have access to it. "There's not enough time to look this information up ourselves," she explains.

The Board of Pharmacy eventually wants to embed PMP access into the most commonly used electronic medical record systems, Wiberg says, so that once a prescription is written on the EMR prescription form, the EMR automatically goes to the PMP and comes back with the patient's controlled substance prescription history.

In the meantime, to encourage prescribers and dispensers to sign up, Carter attends medical conferences and meetings statewide, bringing with her laptops and portable printers so prescribers and dispensers can sign up on the spot. At a recent meeting of 80 physician assistants in northern Minnesota, 30 who were not already in the system signed up.

Last summer, HealthPartners began a "mass registration" of its physicians and pharmacists, as well as nurses who search the database on a physician's behalf. The PMP doesn't know how many HealthPartners employees signed up because they don't require a user to list their employer, but Carter says a nurse supervisor told her more than 100 nurses registered.

Pharmacy chains are also encouraging their pharmacists to register. Last fall, Walmart began requiring its pharmacists in Minnesota and all other states with active PMPs to register with and use their state's system when dispensing oxycodone 30 mg. Walmart encourages, but doesn't require, its pharmacists to use PMPs before dispensing other controlled substances, according to Carter. Likewise, Walgreens may soon require all of its pharmacists to register to use a PMP; but it's not yet known for which controlled substances use will be required.

"We find doctor-shoppers on average two to three times per week. In those cases, the PMP will often show multiple ER visits and multiple prescriptions from multiple prescribers."

Sandra Eliason, M.D.

Working as it should

As yet, there's no hard data about whether Minnesota's PMP is effectively identifying doctor-shoppers. "We do know," Carter says, "states that have been at this longer than Minnesota have seen declines in the number of patients getting prescriptions from multiple prescribers at multiple pharmacies over short periods of time. We've heard from Minnesota prescribers and pharmacists who tell us they've used the PMP to identify doctor-shoppers and they have stopped writing prescriptions for them or declined to fill a prescription."

She says that at the same time they are not seeing a decrease in controlled substance prescribing, which suggests the PMP is not discouraging doctors from appropriately prescribing controlled substances. A 2009 study published in *Substance Abuse: Research and Treatment* found that states with PMPs reduced doctor shopping without having a "chilling effect" on medically appropriate prescribing.

Wiberg says physicians in Minnesota should not be concerned about "Big Brother" watching their prescribing patterns. "No licensing board can use the PMP to monitor a prescriber's prescribing patterns without first obtaining a search warrant or court order," he says. Similarly,

law enforcement agencies can access the data only after obtaining a search warrant.

Physician supporters

Sandra Eliason, M.D., a family physician at Fairview Riverside Primary Care Clinic in Minneapolis, is a strong supporter of the PMP. She says her clinic treats a number of patients with multiple complex medical conditions who also have co-occurring

behavioral or psychosocial conditions. She and her three colleagues search the PMP database for nearly every patient they see—about 150 per week. “We find doctor-shoppers on average two to three times per week,” she says. “In those cases, the PMP will often show multiple ER visits and multiple prescriptions from multiple prescribers.”

Eliason says she doesn't use the PMP as a “gotcha” tool. “It's not about catching them

but about giving them the best care. The PMP helps me feel more confident that I'm prescribing these drugs appropriately.”

Eliason says the PMP helps her coordinate care with other physicians who have also written controlled substance prescriptions for the patient. “I often talk with ER and pain clinic physicians to determine who's going to prescribe the drug and who's going to do the follow-up.”

Prescription Monitoring Program changes coming

The Minnesota Prescription Monitoring Program is a work in process. During the 2013 legislative session, the Board of Pharmacy will propose making these changes that, if passed, would take effect August 1, 2013.

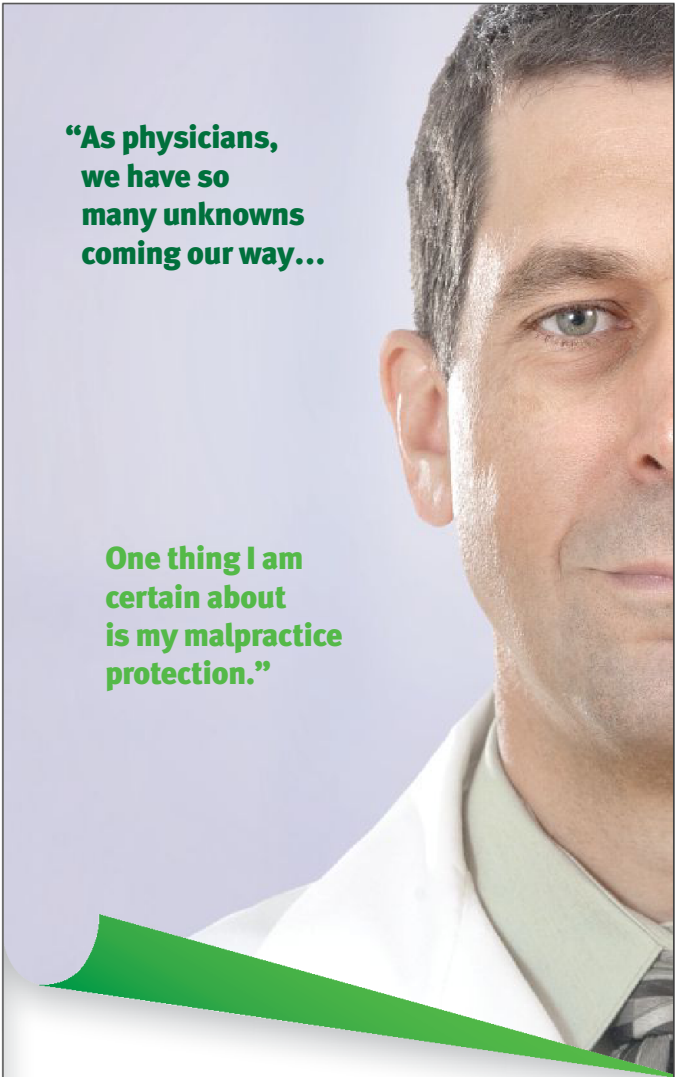
- Add schedule V drugs and tramadol to the list of prescriptions that pharmacists upload to the PMP. Tramadol works on opioid receptors in the brain. There's also evidence that some new schedule V drugs such as Lyrica (pregabalin) are being abused.
- Add veterinarians to the list of authorized PMP users. “We are hearing about more cases where people use Fluffy to doctor-shop,” says Cody Wiberg, executive director of Minnesota's Board of Pharmacy.
- Add medical examiners and coroners to the PMP Advisory Committee. Although they've always offered advice to the PMP, they have not had an official seat on the committee.
- Require that controlled substance prescriptions for people in nursing homes, assisted living facilities and hospice be reported to the PMP. “Unfortunately,” Wiberg says, “we're hearing many reports that staff and family of residents are phoning in false prescriptions or stealing the patient's meds.”
- Allow PMP staff to access prescription data that is more than 12 months old. Currently, data is kept in the active database for 12 months and then “de-identified” and archived. PMP staff cannot access archived information. “Allowing this will make it easier for us to do trend analysis, evaluate the PMP's effectiveness and further reduce doctor shopping,” Wiberg says.
- Allow prescribers and pharmacists to search the PMP for any patient they are treating, not just those for whom they are prescribing controlled substances or whose prescriptions they are filling. “This would help identify patients who are taking controlled substances, but not telling their doctor,” Wiberg says.
- Allow all health licensing boards to search the PMP for a licensee suspected of being a controlled substance abuser. Right now, only the Board of Pharmacy can do this.
- Authorize Minnesota Health Care Program (Medical Assistance and MinnesotaCare) investigative staff to use the PMP to monitor enrollees who have abused or diverted controlled substances. Currently staff is allowed to identify but not monitor these patients.
- Clarify that coroners and medical examiners are designated users of the PMP database.
- Add Health Professional Services Program (HPSP) staff to the list of authorized users. HPSP staff would use the PMP as an additional tool to make sure that chemically dependent health care providers enrolled in their program are not inappropriately receiving controlled substance prescriptions.
- Allow prescribers' names to be listed on patient profiles. Right now, that's optional, although Wiberg says the majority of prescribers who have signed up to use the PMP allow their names to be listed. “Without a name,” Wiberg says, “other PMP users may not know who prescribed each of the prescriptions in a patient's profile, which makes it harder to identify drug-seeking behavior. It also makes it harder for prescribers and pharmacists to communicate with each other.”
- Allow Minnesota's PMP to participate in a multi-state PMP data exchange system. “Our goal,” says Barbara Carter, PMP program manager, “is to first connect with bordering states, then expand to other states.” Physicians would have to do only one search to see all information about a patient in Minnesota and its surrounding states.—H.B.

Meanwhile, she tells patients that she's happy to care for them but won't prescribe a controlled substance unless it's medically appropriate and they sign a contract in which they agree to not get the drug from any other prescriber. "A high percentage of our patients stick with us under these terms," she says.

Stelter has yet to identify a confirmed doctor-shopper by using the PMP; but he says the PMP has yielded information that has raised his suspicions. "I once denied a controlled substance prescription because the PMP showed the patient was receiving a Suboxone prescription from a prescriber 50 miles away," he says. In fact, he's learned through the PMP that several of his patients had received a controlled substance prescription he wasn't aware of from another provider. "Drugs like Adderall, Ritalin, Ativan and clonazepam are the usual suspects that I need to know about and that can interact negatively with the drugs I'm prescribing." He now requires all of the physicians in his residency program to use the PMP before they see a patient who has or may get a prescription for a controlled substance.

Like Eliason, Stelter uses PMP information as a basis for talking with patients about other prescriptions they are taking, drug interactions and whether they're aware they're doing something they shouldn't be. "Whether these prescriptions are innocent or deliberate is the big unanswered question," he says, "but at least now, I know more about my patient, and that helps me provide good quality of care." MM

Howard Bell is a freelance writer based in Onalaska, Wisconsin.



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THE OPIOID

BY **JEANNE METTNER**

CRISIS

COMBATTING MISUSE THROUGH **BETTER PRESCRIBING**

Pain has always been a nemesis to human beings, but in the late 1990s, the quest to conquer it reached a fever pitch in the United States. Professional associations such as the American Pain Foundation were calling untreated pain an “epidemic.” In 1995, the American Pain Society championed a campaign that labeled pain the “fifth vital sign,” urging clinicians to assess it at every office visit just as they would a patient’s blood pressure, heart rate and respiration rate. Around the same time, drug manufacturers began aggressively marketing powerful, long-acting opioid formulations. They even enlisted some pain specialists to help create a body of scientific research dispelling concerns about the risk of addiction and dependence on these drugs.

Worries about safety also were alleviated by entities such as the Joint Commission, which noted in its 2000 pain-management standards that “there is no evidence that addiction is a significant issue when persons are given opioids for pain control.” In addition, the Federation of State Medical Boards in 1998 recommended that doctors not face regulatory action for prescribing even high doses of narcotics for pain.

As restrictions loosened, physicians began relying heavily on drugs such as oxycodone (Percocet), hydrocodone (Vicoden), fentanyl and sustained-release oxycodone (OxyContin). Medicine had written the last chapter on pain—we thought.

Fast-forward to 2013. A plethora of statistics tell a different story. Centers for Disease Control and Prevention figures show that between 1999 and 2008, the sale of opioids rose 300 percent. Now more than 14,800 people die annually from unintentional overdoses of opioids, a number that exceeds that of overdose deaths from cocaine and heroin combined. For every death reported, nine people enroll in substance abuse treatment, 35 visit emergency departments, 161 report they are abusing or dependent on opioid medications and 461 report nonmedical uses of opioids, according to the U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration. When asked about prescription drug use, about 9 million people report long-term (more than three months) medical use of opioids and about 5 million report nonmedical use of them (without a prescription or medical need).

In Minnesota, the number of overdose deaths from opioids has skyrocketed in the past decade—up 450 percent from 42 deaths in 2000 to 191 in 2010. (The overdose death rate is relatively low 7.2 per 100,000 people compared with the national rate of 1.9 per 100,000.) Legal distribution of all opioids increased 72 percent statewide between 2005 and 2011. A joint investigation by the *St. Paul Pioneer Press* and the *Duluth News Tribune* found that the largest increases occurred in Ramsey County and the northwestern corner of the state, and that Duluth had the highest

prescription opioid distribution rate in Minnesota—5,000 g per 10,000 population. Among the communities hit hardest were Indian reservations. On the Red Lake, White Earth and Leech Lake reservations, tribal leaders declared “public health emergencies” because of opioid misuse.

Not surprisingly, Minnesota’s physicians are rethinking their positions on opioid prescribing and pain management. “We’ve had 15 years of being hyper aware of patients’ pain and bending over backwards to do something about it, using these numeric scales and smiley faces to analyze and assess pain at every office visit, being encouraged to ask and treat,” says Paul Johnson, M.D., an internal medicine physician and director of Hennepin County Medical Center’s (HCMC) Coordinated Care Clinic.

“Now the pendulum is swinging back to, ‘We must first do no harm.’ Sure, when we give patients an opioid, they like the medication, and they like you for giving the medication; but are we really helping them to be more functional and meet other life goals? Those are the questions we need to be asking now more than ever.”

Johnson and others throughout Minnesota are asking such questions as they explore ways to improve their opioid prescribing practices and ensure these drugs are used safely and for legitimate purposes. Here’s a look at some of those efforts.



FORTY-MINUTE ASSESSMENT

For nearly a year, HealthPartners' primary care services team has had in place a systemwide opioid management strategy for patients seeking treatment for chronic pain. The centerpiece of this initiative is a requirement for a comprehensive 40-minute assessment with their primary care physician. Both new and established patients who have been taking opioids more than three months must be evaluated.

As part of the assessment, the patient takes a urine drug test, completes a brief pain inventory, signs a controlled substance agreement, completes a screening questionnaire for depression and reviews two pages of information on the appropriate use of opioids for chronic pain. The primary care provider reviews the patient's medical history, conducts the exam, helps the patient set goals, discusses the care plan, checks the state's Prescription Monitoring Program database to see if the patient has other prescriptions for controlled substances, and reviews with the patient the results of their drug test and pain and depression screenings. The patient may also receive medication counseling from a pharmacist during the visit.

The patient then signs the controlled substance agreement, which stipulates, among other things, that he or she will keep regular appointments, undergo periodic drug screens, obtain all prescriptions from a single physician and through a single pharmacy, and obtain refills no earlier than

the designated date and only during regular office hours (the idea being not to use the emergency department or urgent care for routine medical care or management of chronic pain). The document is then scanned and added to the patient's electronic medical record so other providers he or she may be seeing are aware of it.

"We look at patients' goals in terms of pain and function and their ability to do the everyday things they find important; we talk about safety in terms of where you keep your prescriptions, the side effects, and the potential for addiction, diversion and sedation," says Beth Averbeck, M.D., associate medical director of primary care at HealthPartners. "With this program in place, we have an opportunity to have a more open discussion with our patients about these medications."

Although it is too early to assess outcomes, researchers are collecting data on the degree to which the primary care program is being used. To date, more than 1,140 patients have undergone an assessment visit, 1,850 have opioid care plans documented in their electronic medical record and 1,250 have signed controlled-substance agreements. "The data demonstrate solid implementation of the program's systemwide approach," Averbeck says. "And with that comes consistency: No matter which physician or provider they see, patients will be hearing the same message."

PRE-OP PAIN CONSULTS

Two years ago, orthopedic surgeons and pain specialists at the University of Minnesota Medical Center, Fairview, noticed that the patients most at risk for postoperative pain were those who were already using opioids, had a history of chemical dependency or addiction, or had mental health problems, and decided to try to improve pain management in those populations.

Now, about a week before their surgery, at-risk patients undergo a consultation with a pain specialist who analyzes their situation, listens to their concerns and sets up a plan for managing their pain postoperatively. The plan includes using mindful meditation, guided imagery and anxiolytics, when appropriate, to deal with their anxiety. It also includes the use of pre- and postoperative analgesics that act at different levels of the pain pathway, rather than opioids alone.

The topic of tapering off opioids following surgery is also discussed. Involving patients in these talks gives them confidence about the pain management plan, says Orlando Charry, M.D., a pain specialist with Fairview's Pain Management Center and director of interventional services. "In

short, we are reassuring the patient that the surgical team has all their ducks in a row, including with their pain management."

Charry and his colleagues, who are studying how the initiative is affecting outcomes, found that at-risk patients who underwent a preoperative pain consultation had better pain control and were able to meet the goals of their physical therapy while having a shorter hospital stay than healthy patients who did not undergo a consultation. Among those who were on opioids long-term, none had to increase their dosage, and 20 percent were able to taper off of the medication. Notably, hospital costs for the preoperative consult group were 31 percent lower than those for the controls.

Charry and his team presented these and other findings at the International Association for the Study of Pain's 2012 World Congress on Pain. "From the context of a university medical center, where we are seeing complicated cases that are referred by other specialists, this was an especially surprising and positive finding," he says, adding that they are continuing to collect data.

TWO-TABLET LIMIT

Several years ago, Chris Johnson, M.D., was feeling frustrated by a scenario that was playing out repeatedly in the emergency department at Methodist Hospital. Patients with a history of opioid use would come in complaining of chronic pain, spend three or more hours receiving intravenous opiates such as Dilaudid, then either be hospitalized, sometimes for days, during which they received more IV opiates, or go home with another opioid prescription. “It was a very unsatisfying experience, that whatever the pain was—chronic headaches, chronic backache, chronic abdominal pain—the patient would come in tearful and desperate, and they would go through this process repeatedly,” recalls Johnson, an emergency medicine physician with Park Nicollet Health Services who works at Methodist. “You look for the long-term good, you want them to be independent, working, all the things that lead you to be happy and healthy. ... It just wasn’t helping.”

Johnson worked with Park Nicollet administrators to form a committee to look at the issue. He also began meeting with the medical directors of pain management clinics from throughout the Twin Cities to learn how they handled patients with chronic pain. The committee eventually developed a policy for Park Nicollet physicians. Says Johnson: “We learned that you can’t just tell the doctor, ‘Do the right thing’ without implementing a policy for support.” He explains that doing the right thing is often harder than doing the wrong thing. “Telling a patient ‘No, I will not give you this prescription’ can cause an individual physician to take on all these extra burdens and risks—an angry patient, prolonged office visits, delay of care of other patients, reports of complaints and dissatisfaction, and possibly reprimands.” He says having a system-wide policy takes the burden off the

physician and makes doing the right thing “almost as easy as doing the wrong thing.”

In 2009, the team implemented the policy in Park Nicollet’s urgent care centers and Methodist’s emergency department. Now when a patient with chronic pain presents with either a flare up of their chronic pain or new pain, the attending physician is expected to examine the patient for an acute condition and use the Minnesota Prescription Monitoring Program database to get information about

the individual’s prescription history. Patients with chronic pain who have been on opioids for more than three months are no longer given IV doses of opioids but instead get just two tablets of their prescription opioid. Johnson says the policy is working well. “It’s reduced admissions, discouraged emergency department visits and freed up resources to manage other issues,” he says.

SIGNS OF THE TIMES

Sanford Health’s pain management division has instituted a multifaceted initiative to decrease the incidence of opioid misuse. One aspect is educating physicians about opioid prescribing through grand rounds presentations, which are teleconferenced to Fargo, Sioux Falls, Bemidji, Walker, Bismarck, Thief River Falls and other Sanford locations. These sessions emphasize “how to treat pain, not how to stay out of trouble when prescribing drugs—and how to think of pain in such a way that the therapies you institute are working to restore function,” says William Dicks, M.D., a pain specialist and family physician who practices at the Sanford Clinic in Bemidji. Dicks has presented at and helped plan the grand rounds presentations.

One of Dicks’ primary concerns is that physicians are often too quick to prescribe opioids. “Pain still equals narcotics to so many physicians, and yet it’s been shown that ibuprofen and other NSAIDs are as effective for pain as hydrocodone,” he says.

Another part of the approach is to reduce the likelihood that patients will ask for opioids. For example, when patients are referred to the pain management clinic at Sanford Bemidji, they receive a packet of information, along with an introductory letter, before their first visit. “In that letter, we state that an appointment at the pain clinic does not mean we are going to treat you with narcotics, and in fact, we are going to discourage their use,” Dicks says.

In addition, Sanford has placed signs at the registration desks in its satellite clinics in Cass Lake and Walker, communities where drug abuse has been prevalent, that read: “No refill prescriptions for controlled substances will be given for chronic pain.” A clinic spokesperson says the signs and letter open the door to conversations with patients.

According to Dicks, Sanford’s initiative is reducing opportunities for opioid misuse and diversion. “It works beautifully,” he says.

PEER REVIEW

Paul Johnson, M.D., director of HCMC's Coordinated Care Clinic, became interested in the issue of opioid prescribing when he saw how varied physicians' practices were in terms of writing prescriptions, monitoring use of certain drugs and responding to potential misuse. For the past two years, he and his colleagues have been creating a standard approach that HCMC physicians can adopt with regard to opioid management. This includes getting them to regularly use the state's Prescription Monitoring Program database, accessing other states' monitoring programs and doing routine urine testing to check for opioid misuse in patients. "We need universal precautions—to screen everyone—because we really

can't tell who is misusing opioids, using them with other substances or illegally distributing them," he says.

In addition, HCMC created an opioid oversight committee in the fall of 2011. The group, which includes addiction specialists, primary care doctors, a pharmacist, a nurse and pain physicians, meets once a week over the noon hour to review particularly challenging cases submitted by other clinicians. The person requesting the review typically attends the meeting in order to present additional information, if necessary, and hear the ensuing discussion of the case. After the committee makes its recommendation, the physician "is able to go back to the patient and have those difficult discussions," Johnson says. "Having a group

DECREASING DOSES

In January 2012, the Minneapolis Veterans Affairs Medical Center started transitioning patients from sustained-release OxyContin to other opioids and reducing high-dose prescriptions to lower and safer doses.

Primary care physicians and other providers throughout the Minneapolis VA have undergone training, attended presentations and received support materials demonstrating the harm of prescribing opioids that exceed 200 mg morphine equivalent per day (MEQ/d). Now, every two months, primary care providers receive a list of patients who are considered high-risk opioid users—either because they are on OxyContin or because they are using opioids at doses that exceed 200 MEQ/d. "These higher doses are most likely to be associated with unintentional overdoses," says Erin Krebs, M.D., an internal medicine physician who has worked on the initiative. In addition to transitioning these patients to lower and safer doses of opioids, the VA offers them classes on coping with chronic pain; mind-body healing techniques such as biofeedback and meditation, yoga and tai chi; and other interventions.

By the end of 2012, the Minneapolis VA had seen an 88 percent decrease in the number of patients taking OxyContin, a 44 percent decrease in patients taking opioids at doses of 200 MEQ/d or higher, and even a 10 to 25 percent decrease in the number of patients on doses of 50 to 100 MEQ/d. Krebs and others involved in the initiative also have heard stories from patients that illustrate the program's success: "They tell us that as their dose is coming down, they are getting their life back," she says. "If you just keep upping the dose of pain medication in a patient, it can be hard to know if that patient is gaining anything at all."

AS OPIOID MISUSE CONTINUES TO GARNER ATTENTION,

physicians are rethinking the way they treat patients with chronic pain, and health systems are creating new policies around opioid prescribing. Even the American Pain Society, which espoused pain as "the fifth vital sign," has issued guidelines calling for the close monitoring of patients on prescription opioids for chronic pain. Still, research published in the February 2011 issue of the *Journal of General Internal Medicine* found that less than half of patients on opioid therapy are seen by their primary care provider at least once every six months—and only 8 percent underwent urine drug testing during their treatment.

Charlie Reznikoff, M.D., a general medicine physician at HCMC, believes that even with new policies in place, physicians will continue to face uncertainty when it comes to treating pain. "It's hard to find objective tests for pain, objective tests that provide answers to the questions, 'Am I giving too many opioids?' or 'Am I not giving enough?'" he says. Opioid prescribing, he insists, will always require physicians to invest their time, professional judgment and clinical acumen.

To some, legislation is the key to broad-sweeping reform. In Illinois, primary care doctors are now required by law to refer patients on long-term opioids for chronic

of peers review your circumstance and having the recommendation in your hip pocket is a really helpful thing.”

Although it's not yet known what effect this is having on opioid misuse among HCMC patients, the feedback the committee has received thus far from prescribers has been positive. Says Johnson, “Physicians tell us that they are more comfortable with the prescribing environment; they feel they have somewhere to go if they have a challenging patient.”

pain to a pain specialist. In Massachusetts, any doctor who wants to prescribe an opioid must first look the patient up on the state's drug-monitoring system. Minnesota has not yet passed such laws. But Sanford's Dicks is one who believes such legislation may be needed: “Things have to start happening legislatively,” he says. “There are just too many deaths, and too much ugliness. Misuse of these drugs is ruining families and disrupting lives.”

To others, the problem of opioid abuse won't be solved until more understand the roots of chronic pain. “Unfortunately, a lot of times, chronic pain is seen as something that is purely physical; but when pain has been going on for months, years or decades, it has to be looked at with a different lens—particularly the lens of mental and spiritual health,” notes Fairview's Charry. “If we forget those areas, we are missing the boat completely.”

Reznikoff agrees. “What if the culture of medicine would shift such that no one would ever prescribe opioids without thinking about other addictions and mental illness? Just to take those things into consideration would be a positive change.” **MM**

Jeanne Mettner is a Minneapolis-based freelance writer.



MNPMP

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tremely functional and shouldn't duplicate what can be done elsewhere. If it's meant to be an Expedia-like marketplace for people to buy policies, then it should group all policies that qualify and shouldn't exclude some. That is a contentious point of debate. We've had meeting after meeting about the exchange. It is a huge topic for legislators. If indeed Gov. Dayton is as good as his word and he wants to collaborate and make the exchange as good as it can be, and the committee chairs do the same, it will be a reasonably decent bill.

On expanding Medicaid

I question the affordability of expanding Medicaid. Times are different and legislators on the left should pay more attention to the fiscally sensible course. I appreciate their sense of humanity; but at some point someone has to pay for all of this. I believe they are making promises they may not be able to keep with money they hope they can keep borrowing.

A FEW MINUTES WITH ...

Rep. Jim Abeler, clinician and legislator

BY MELISSA MRACHEK

As a chiropractor, Rep. Jim Abeler (R-Anoka) knows a thing or two about adjustments. So, it shouldn't come as a surprise that when the Minnesota House of Representatives switched from Republican to Democratic control after last fall's election, Abeler, a 14-year political veteran, took the change in stride.

Although he may no longer be chair of the Health and Human Services (HHS) Finance Committee, Abeler still serves on that committee as well as the HHS policy committee. Through those groups, he will have a say about the health insurance exchange, expanding Medicaid and a number of regulatory changes coming out of the Affordable Care Act (ACA).

The *Physician Advocate* sat down with Abeler to talk about the shift in power at the Capitol and what he sees as the biggest issues for health care this year.

On being in the minority party

My phone rings a little less often now, so I will be leading in a different way. I will continue looking after the needs of the people and pushing for even better service with the same or a little bit more money. I'm looking forward to doing the best I can and offering advice when the committees will take it.

On the health insurance exchange

Minnesota Republicans, as a group, aren't fans of the insurance exchange. It's part of the Affordable Care Act, which was passed 100 percent to none in terms of one side versus the other. Whenever you jam something through, it's politically unpopular and the quality of the bill deteriorates. I want a Minnesota version of the exchange with as much local control as possible. So I'm talking to others about ways to make it better. I think the exchange needs to be ex-

On the primary care physician workforce

The issue of not enough physicians is something the medical community needs to grapple with internally or the state will grapple with it for them. It is best decided within the medical community because physicians may not like the solutions the state comes up with. The reality is we have to get more physicians to choose to go into areas of need such as primary care.

The ACA does provide for higher Medicaid Assistance reimbursement for primary care physicians for two years. But another aspect of the problem is the glamorization of specialty care and lack of interest in primary care. The future isn't in having more orthopedic surgeries or ophthalmologic advances; the future is in keeping people healthier and coordinating care at the street level. We have physician assistants,



PHOTO COURTESY OF MINNHOUSE OF REPRESENTATIVES

Rep. Jim Abeler juggles his legislative duties with running a chiropractic practice in Anoka.

nurse practitioners, community health workers, even community paramedics moving into the world of primary care,

while physicians vacate it in favor of specialties.

On support for new physicians

I tried to protect Medical Education and Research Cost (MERC) funding because it is necessary to support up-and-coming physicians. I also tried to reform the program to make it more focused on minority physicians so they could deliver more culturally competent care to minority populations. Unfortunately, I was unsuccessful.

There are real health disparities between our Hispanic, Native-American and African-American populations and the general population. It's on my mind. As a policymaker it is my job to worry about all 5.3 million Minnesotans, not just the 38,000 in my district. It's a policy issue about which the MMA could provide guidance and leadership and reach out to

those who really need the help. In simple terms, I would like to see MERC money directed more toward minority populations and certainly primary care.

On being a chiropractor and a legislator

I've been practicing chiropractic care for 34 years. During that time, I have made a lot of connections with people who have helped me in my role as a legislator. Hopefully, my perspective can help with much-needed health care reform, so we are able to better serve people in Minnesota.

I also hope private physicians will engage more with legislators. Physicians are very bright, respected and have expertise. If they would reach out and talk to their legislators, it would greatly help as we form policy.

MMA in action

In late January, **Dan Maddox**, M.D., MMA president, **Terry Ruane**, MMA director of membership, marketing and communications, and **Brian Strub**, manager of physician outreach, attended the Lake Superior Medical Society (LSMS) annual meeting in Duluth. At the meeting, the LSMS installed Jay Knuths, M.D., as its new president. Maddox discussed governance changes, the MMA's planned listening sessions and policy forums, the MMA's legislative priorities and the MMA Foundation.

Dave Thorson, M.D., MMA board chair, and **Robert Meiches**, M.D., MMA CEO, testified before separate committees at the Capitol in support of Medical Assistance expansion.

Strub and **Juliana Milhofer**, MMA policy analyst, met with Tamiko Morgan, M.D., and Andrew Kiragu, M.D., of the Minnesota Association of Black Physicians to discuss membership, listening sessions, policy committees and other ways physicians can become more involved with the MMA.

Janet Silversmith, MMA director of health policy, discussed Minnesota's health insurance exchange effort at a meeting of the Shakopee Rotary (by invitation of a Shakopee physician) in early February.

Meiches, **Silversmith** and **Dave Renner**, MMA director of state and federal legislation, met with the Minnesota Department of Health's Health Policy Division Director Diane Rydrich and Health Economist Stefan Gildemeister in February to discuss key projects including provider peer grouping and the MMA's legislative priorities.

RIGHT: New LSMS President Jay Knuths, M.D., (right) receives the ceremonial sledgehammer from George Apostolou, M.D.

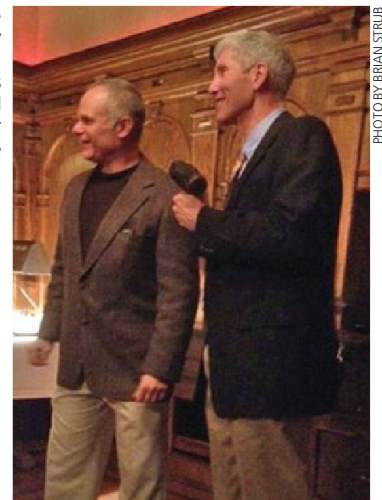


PHOTO BY BRIAN STRUB

BELOW: Robert Meiches, M.D., MMA CEO (left), testifies on behalf of Medical Assistance expansion. Here, he sits next to the bill's author Rep. Thomas Huntley (DFL-Duluth).

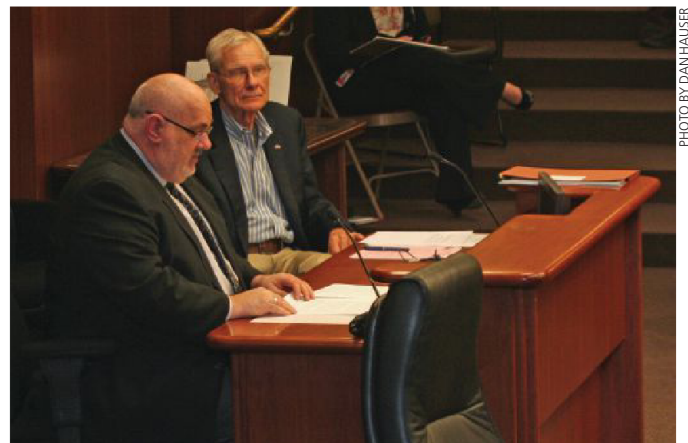


PHOTO BY DAN HAUSER



While waiting for their legislators, Jake Prunuske, M.D., (left) George Apostolou, M.D. and Robert Nesheim, M.D., converse in a Capitol corridor.



Dave Renner, MMA director of state and federal legislation, addresses physicians, residents and medical students before sending them to meet with their legislators.



Christopher Wenner, M.D., a solo practitioner in Cold Spring, meets with Sen. Michelle Fischbach (R-Paynesville).



Rep. Erin Murphy (DFL-St. Paul), House Majority Leader, discussed a variety of health care topics during a 20-minute Q&A with physicians.

White coats take over Capitol for a day

Physicians, residents and medical students from across Minnesota gathered February 7 for the MMA's Day at the Capitol event.

The annual event provides an opportunity for physicians to meet face to face with their state legislators and to network with each other.

Rep. Erin Murphy (DFL-St. Paul), House Majority Leader, answered questions posed by those in attendance on a variety of issues from the expansion of Medicaid to the creation of a Minnesota-based health insurance exchange.



Lisa Erickson, M.D., a board member of MEDPAC, the MMA's political action committee, addresses members after Day at the Capitol while Eric Dick, the MMA's manager of state legislative affairs, looks on.



Medical students watched a brief House floor session during Day at the Capitol. They include (from left): Ann Bergstrand, Mike Kalinoski, Courtney Moors, Thomas Baron and Eric McDaniel.

Where there's smoke ... raise the price

Nearly one out of five Minnesotans still smoke despite the millions of dollars spent on advertising and PR campaigns to get them to quit. And although anti-tobacco messaging has been everywhere you look—on billboards, in the skyways, on buses—for some time, 625,000 Minnesotans still smoke and 6,800 Minnesota kids become smokers every year.

Smoking is obviously still a problem—a big problem. In Minnesota, tobacco use is responsible for more than 5,100 deaths each year, and tobacco use results in nearly \$3 billion in health-related costs every year.

Telling people to stop isn't enough. Rather, studies show that the best way to deter young people from beginning to smoke and encourage adults to quit is to hit them in their wallets. A 10 percent increase in the price of cigarettes has been shown to reduce the number of young people who start smoking by 6.5 percent. That's why increasing the tax on cigarettes and other tobacco products is one of the MMA's top priorities for the 2013 legislative session. An increase of \$1.50 per pack would convince more than 30,000 Minnesotans quit and prevent 41,200 fewer Minnesota children from smoking into adulthood.

Minnesota currently taxes tobacco at \$1.23 per pack, which puts us at 28th in the nation in terms of how much we tax cigarettes. By increasing the tax on tobacco, we will prevent kids from taking

up smoking, encourage adults to quit and reduce smoking-related health care costs.

We further support using the added tax money from tobacco to help fund the Medical Education and Research Cost (MERC) fund and the Statewide Health Improvement Program (SHIP). Both have suffered drastic budget cuts in recent years.

Established in 1996, MERC was created to help teaching hospitals and clinics offset a portion of the costs of clinical training. MERC has been funded by three principal means: a portion of the state's cigarette tax; a percentage of state spending under the Prepaid Medical Assistance Program; and the University of Minnesota federal matching funds that come through transfers and other mechanisms. We'd like to see an even larger portion of the tobacco tax go to re-fund (and possibly increase funding for) clinical training.

The need for clinical training has never been greater. The United States already has a shortage of physicians, in particular primary care doctors. And with the Affordable Care Act, more people will have access to health care and thus need doctors. MERC funding was cut in 2011. We need not only to reverse that cut but expand funding of the programs that will train the next generation of doctors.

Funding SHIP is a cost-effective investment in the health of Minnesotans. Through SHIP, the Minnesota Department of Health works with communities to help them reduce the burden of chronic disease, particularly by preventing obesity and tobacco use. For example, through SHIP,



Dan Maddox, MMA President

PHOTO BY STEVE WEVERKA

“Studies show that the best way to deter young people from beginning to smoke and encourage adults to quit is to hit them in their wallets.”

schools are working with local farmers to bring fresh produce to lunchrooms so students can eat better. SHIP allows local communities to determine which things they can do to help their residents live longer and healthier lives. Let's keep these programs strong.

So let's do it. Let's raise the price of tobacco, which will prevent kids from starting and encourage adults to stop smoking. And let's use the money we collect to fund medical training and prevent chronic conditions. Sounds like a multiple-win to me.

News briefs

MMA makes a case for expanding Medical Assistance

The MMA's board chair and CEO testified before House and Senate committees in January regarding the expansion of Medical Assistance (MA), Minnesota's version of Medicaid.

In mid-February, both the House and the Senate passed legislation expanding the program to adults with annual incomes up to 138 percent of the federal poverty level. Gov. Mark Dayton quickly signed it into law.

The MMA made MA expansion a 2013 legislative priority. However, it remains concerned about other related issues.

"The long-term sustainability of the Medical Assistance program requires the state to adequately pay for physician services provided to Medical Assistance enrollees," MMA Board Chair Dave Thorson, M.D., told the Senate's Committee on Health, Human Services and Housing at a January 30 hearing. "Minnesota physicians have had their fee-for-service rates frozen for 13 years," he said, pointing out that Minnesota currently ranks 47th out of 50 states on its MA fee-for-service payment rates for physicians.

The week before, MMA CEO Robert Meiches, M.D., shared similar comments with the House Health and Human Services Policy Committee. Despite the stagnant rates, Minnesota physicians continue to fully participate in the program. "Physicians care about their patients; they want to serve," Meiches said.

According to the Department of Human Services, increasing MA to 138 percent of the federal poverty level will provide coverage to 87,000 Minnesotans. MinnesotaCare already covers 53,000 of those people; 34,000 are currently uninsured. Those covered by MinnesotaCare will see better coverage for less cost by switching to Medical Assistance.

In addition to providing more Minnesotans with access to care, the expansion is expected to save the state more than \$1

billion over the next two biennia. Under the Affordable Care Act, the federal government will pay 100 percent of the cost of the expansion for new enrollees during the next two years; the feds' contribution will be reduced to 90 percent after that. Currently, Minnesota and the federal government share the costs of Medicaid 50/50.



Move to increase the tobacco tax gains footing

Another MMA legislative priority—increasing the amount tobacco products are taxed—gained momentum at the Capitol early in the session. (See Viewpoint on page 29.)

Several lawmakers introduced bills that would significantly increase the tax. Currently, Minnesota ranks 28th out of the 50 states in terms of how much it taxes tobacco.

In addition, Gov. Mark Dayton suggested upping the ante on tobacco as part of his proposed budget, calling for a 94-cents-per-pack increase to the cigarette tax. This is a departure for the governor who in the past has voiced his dislike of increased taxing on tobacco, calling it too regressive.

"We like what we are seeing in terms of the tobacco tax," notes Eric Dick, the MMA's manager of state legislative affairs. "Study after study has shown that raising the price on tobacco deters youths from starting and gets adults to stop smoking."

Little cigars legislation introduced

Along with increasing the tobacco tax, the MMA is advocating for changing how

"little cigars" are classified. Little cigars are flavored products often marketed to youths.

Currently, because of a tax loophole, they are less expensive than cigarettes, even though they are nearly identical to them.

In late January, Sens. Kari Dziedzic (DFL-Minneapolis) and Carla Nelson (R-Rochester) introduced similar bills that would reclassify little cigars as cigarettes.

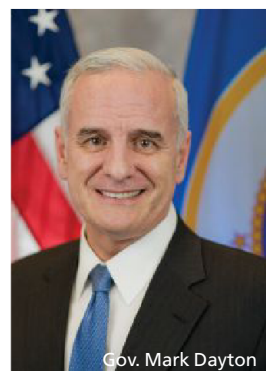
"These little cigars are very appealing to youths," says Eric Dick, the MMA's manager of state legislative affairs. "They need to be taxed and treated like cigarettes so kids are discouraged from buying them."

Governor proposes restoring MERC, SHIP funding

In his proposed budget, Gov. Mark Dayton recommends restoring funding to the Medical Education and Research Cost (MERC) program back to \$49.5 million, the level at which it was funded prior to budget cuts in 2011.

MERC dollars are used to fund clinical training for medical students, residents and students in other health professions. Dayton also called for re-funding most of the State Health Improvement Program (SHIP). Funding for SHIP was cut as part of the 2011 budget agreement. Dayton wants to see an investment of \$40 million over two years.

"We are pleased with many aspects of the governor's proposed budget," says Dave Renner, MMA director of state and federal legislation. "He is recommending providing health care access to those who do not have it currently. He's also proposing an increase in Medical Assistance payment rates to physicians and other providers, as well as increasing funding for medical



Gov. Mark Dayton

PHOTO COURTESY OF MN GOVERNOR'S OFFICE

training. These are three of the MMA's legislative priorities for the session."

Health insurance exchange on a fast track

On the first full day of the 2013 session, Sen. Tony Lourey (DFL-Kerrick), with bipartisan support, introduced SF 1, which would create a Minnesota-based health insurance exchange. Since then, the bill has wended its way through a series of committee hearings. A similar bill has been introduced in the House (HF 5) by Rep. Joe Atkins (DFL-Inver Grove Heights).

The exchange bills are on the fast track because a final version must be approved by both the House and the Senate and signed by the governor before March 31 to meet a deadline imposed by the Centers for Medicare and Medicaid Services.

Although Lourey's bill was introduced with bipartisan support, Republicans have taken issue with several provisions: the overall cost to run the exchange's board, the 3.5 percent health plan assessment that would fund the exchange and the board's role as the "active purchaser." Lawmakers must decide whether they want the exchange to have an "active purchaser" model, which means the exchange would only include qualified health plans, or a "clearinghouse" model, which means it would include all insurance products that meet modest criteria.

Meanwhile, the MMA is advocating that the final version of a bill allow for physician involvement on the exchange's board.

MMA officials go to Washington

MMA President Dan Maddox, M.D., and President-Elect Cindy Firkins Smith, M.D., were in Washington, D.C., in February to attend an AMA meeting and discuss the sustainable growth rate (SGR) and other health care issues with several members of Minnesota's congressional delegation.

Maddox, Smith and MMA staff met with Sen. Al Franken (D), Rep. Erik Paulsen (R), Rep. Collin Peterson (D) and staff from the offices of Sen. Amy Klobu-



MMA President-Elect Cindy Firkins Smith, M.D., and President Dan Maddox, M.D., await members of Sen. Amy Klobuchar's staff in Washington, D.C.

PHOTO BY DAVE RENNER

char (D), Rep. Betty McCollum (D), Rep. John Kline (R) and Rep. Tim Waltz (D).

The MMA group asked the lawmakers to finally fix the SGR problem, increase the cap on the number of residency slots funded through Medicare, avoid further cuts to graduate medical education funding, and reauthorize funding for the National All Schedules Prescription Electronic Reporting (NASPER) program to help fight prescription opioid addiction, abuse and diversion.

"The AMA meeting was a valuable meeting for the MMA," Smith says. "It provided us the chance to meet one on one with our members of Congress and let them know how SGR is impacting our practice. The good news is they were very responsive and agree it is time to stop this flawed funding formula."

"Members of the Minnesota congressional delegation have been very supportive of MMA issues and are more optimistic than ever that we may be able to repeal SGR," says Dave Renner, MMA director of state and federal legislation. "The new CBO estimate for the 10-year cost of eliminating SGR is helping our argument. That cost has dropped more than \$120 billion." Renner says the House Ways and Means Committee has developed an outline of principles to replace the SGR that appear consistent with the MMA's policies.

Expanded task force continues to examine MMA governance

The task force that will dissect, and potentially rebuild, the MMA's governance model began meeting in January—and with a few more members.

The group, which is being referred to as Governance 2.0, takes its direction from the 2012 House of Delegates resolution to "continue its discussion of the recommended model for a new governance structure as developed by the Governance Task Force and approved by the Board of Trustees and Executive Committee, in order to gather more member input on the proposed model and further define the details needed for full implementation."

"If the MMA plans to change its governance model, then we need to ensure that our members understand it and are comfortable it will provide them with input on future public policy development," says MMA President Dan Maddox, M.D.

The expanded task force includes more members from Component Medical Societies. It will meet three to five times during the first quarter of 2013 with the goal of providing a final report to the MMA board in May. Its recommendations will eventually go to the 2013 House of Delegates for action.

↳

Task force members include:

- Ken Kephart, M.D., Twin Cities Medical Society (chair)
- Beth Baker, M.D., Twin Cities Medical Society
- Juan Bowen, M.D., Zumbro Valley Medical Society
- Stuart Cox, M.D., Twin Cities Medical Society
- Don Jacobs, M.D., Twin Cities Medical Society
- Fatima Jiwa, M.D., Twin Cities Medical Society
- Paul Matson, M.D., Blue Earth County Medical Society
- Robert Moravec, M.D., MMA Speaker of the House
- David Sprout, M.D., Lake Superior Medical Society
- Rahul Suresh (medical student), Zumbro Valley Medical Society

MMA launches podcast

In an effort to engage and inform Minnesota physicians about timely topics, the MMA has launched “The MMA Podcast” on its website and on iTunes.

MMA staff will regularly add new podcasts dealing with issues important to MMA members. The first six podcasts address the MMA’s legislative priorities for the 2013 session.

“This is a great way to communicate with our members who are always on the go,” says Terry Ruane, the MMA’s director of membership, marketing and communications. “Members can subscribe to the podcast through iTunes and listen on their phone, tablet or computer.”

Members also can listen to each podcast online at www.mnmed.org/publications/TheMMAPodcast.

DHS sets Medicaid payment rates for primary care

In January, the Minnesota Department of Human Services (DHS) announced plans for implementing an Affordable Care Act provision increasing Medicaid payment rates for specified services provided by primary care physicians between January 1, 2013, and December 31, 2014.

Services eligible for the enhanced payment include Evaluation and Management (E&M) codes 99201-99499 and vaccine administration codes (90460-90461 and 90471-90474).

To be eligible for the enhanced reimbursement, physicians must first self-attest that they practice family, general internal or pediatric medicine. As part of that attestation, they must specify that they are board-certified in one of those eligible specialties or subspecialties and/or that 60 percent of their Medicaid claims for the prior year were for the E&M codes eligible for enhanced payment. Both fee-for-service and managed care claims are included in the calculation of the 60 percent criteria.

For physicians enrolling in Medical Assistance for the first time, 60 percent of all billings in the previous month must have been for the covered services.

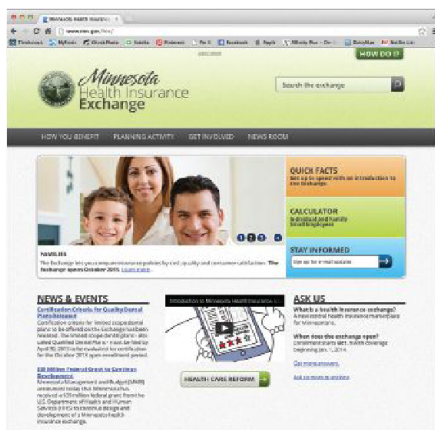
DHS has developed an attestation form that eligible physicians must complete and

submit by fax to the department. You can find the form at <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-5211-ENG>.

The MMA urges physicians to complete this by April 1. Submission of the attestation form by that date ensures that eligible services provided since January 1, 2013, will be paid for using the enhanced rates. For attestation forms submitted on or after April 1, 2013, the enhanced rates will only apply to services effective the first of the month in which the form is received by DHS.

The enhanced rate will be the higher of a) the Medicare Physician Fee Schedule rate in effect for the year in which the service was performed (either the 2013 or 2014 Medicare Physician Fee Schedule rate) or b) the rate using the Relative Value Unit for the calendar year in which the service was performed, multiplied by the 2009 Medicare conversion factor. If the physician’s submitted charge is lower than either of the applicable Medicare rates, the physician’s submitted charge will be paid.

Final guidance for Medicaid managed care compliance with the enhance payment rates is expected soon. The MMA will provide its members with details as they are released.



State unveils new website to explain exchange

The State of Minnesota has unveiled a new website that provides information on the health insurance exchange’s progress.

The website includes a video on how the exchange will work, a calculator that helps individuals and small employers figure out what they qualify for, and news about the exchange’s creation. In addition, visitors can submit questions they have on the exchange. Find the site at www.mn.gov/hix.



Kenneth Flowe, M.D.

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Kenneth Flowe, M.D., chief medical officer for Rice Memorial Hospital in Willmar, has been named a Fellow of the

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MINNESOTA
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Moving addiction treatment into the 21ST century

Our treatment system needs an overhaul.

BY ANNE PYLKAS, M.D.

Addiction affects 16% of the U.S. population, or 40 million people.¹ That's more than diabetes, cancer or heart disease. It contributes to trauma and more than 70 diseases including cancer, HIV, heart disease and liver disease.² The financial cost of addiction overwhelmingly falls to the public sector; \$468 billion is spent annually in this country on addiction and its consequences.³ Despite the enormity of this preventable and costly health problem, medicine has not adequately addressed the issue of treating addiction. This has had disastrous consequences.

The reality is that most people who need treatment never receive anything that resembles evidence-based care. How can this be when cost-effective interventions for addiction are available? A 15-minute counseling session with a primary care doctor about reducing hazardous drinking, for example, can be as cost-effective as colonoscopies and flu shots.⁴

The root of the problem is that physicians themselves have not been adequately trained to screen for, diagnose and treat addiction. Every day, addicts are seen in emergency rooms, primary care clinics and psychiatrists' offices by physicians

who don't know what to offer them or where to refer them for treatment. Any medical student can tell you how to treat a GI bleed, but many physicians don't know how to treat alcohol addiction. Instead of addressing it, physicians and medical researchers have instead focused on its consequences.

In addition, many of those who have been charged with treating addiction, generally chemical dependency counselors, have not been trained in the neurobiology of addiction. Although requirements for chemical dependency counseling vary widely, a number of states require less than a bachelor's degree to be licensed and only one state requires master's level training.⁵ As a result, counselors are often unprepared to handle the complicated psychiatric and medical needs of the patients they treat.

Many of the programs they work for do not use evidence-based treatment strategies but instead rely on unproven ones that are based in belief rather than science. Some offer lavish accommodations for exorbitant price tags. Most are not held accountable for providing care that is consistent with medical standards. Evidence clearly shows that opioid agonist treatment (ie, treatment with methadone or buprenorphine) is the most effective way

to manage opioid addiction and that 80% of patients treated for opioid addiction will relapse without it.⁶⁻⁸ Yet many chemical dependency treatment programs don't offer opioid agonist therapy; some don't believe in it. These programs continue to receive federal, state and private funding to provide other types of care.

Further ensuring that chemical dependency care is inadequate is the fact that, at least in Minnesota, it is generally paid for in an episodic fashion. Patients will be approved for 200 hours or 21 days of treatment by their insurer. There generally is little to no additional funding for ongoing care. It is not reasonable to think that a disease as complex as addiction could be treated in 200 hours or over the course of 21 days.

Evidence-based care

So how do we move the treatment of addiction into the 21st century?

Instead of offering patients a patchwork of programs, we need to treat them the same way we do those with any other chronic disease—with care provided by a multidisciplinary team that in this case includes primary care physicians, specialty physicians and chemical dependency treat-

ment counselors, all of whom follow current evidence-based treatment standards.

The importance of recognizing the different stages of addiction and providing treatment throughout the continuum cannot be overstated. Often it is treated as an “all-or-nothing” diagnosis, when in reality, addiction ranges in severity. Treatment ought to reflect that range. For those with the least severe cases, brief counseling and medication management by a primary care physician may be effective. But to handle such cases, primary care physicians need to be versed in use of medications such as naltrexone, acamprosate and disulfiram, the three FDA-approved medications for alcohol addiction. They also should be trained to prescribe buprenorphine, which is approved for the treatment of opioid addiction in an office setting. Patients with severe cases and who may be facing serious medical, social and psychological consequences might require residential support in a chemical dependency treatment program. Those with acute exacerbations of the disease, such as relapse or overdose, may require hospitalization.

Essentially, we need to move away from episodic treatment of addiction and toward a chronic care model. Such a change will require nothing less than a complete overhaul of our current addiction treatment system. Physicians will need to learn to screen, diagnose and manage addiction. And we'll need more physicians who are trained in addiction medicine to do hospital consultations and handle referrals.

There are signs that these changes are starting to occur. Many primary care residency programs are beginning to educate their residents about addiction. There are new residencies and fellowships in addiction medicine, and the American Board of Addiction Medicine is moving toward gaining subspecialty recognition by the American Board of Medical Specialties. Addiction psychiatry residencies are working to increase the number of physicians in their programs.

Accreditation standards for chemical dependency treatment programs will need to be upgraded and based on evidence

rather than belief. New standards should require that patients have access to a physician trained in addiction medicine and that treatment programs demonstrate quality and use evidence-based standards of care, including opioid agonist treatment for opioid addiction, in order to receive payment. Counselors who do not meet certain educational standards should be supervised by those who have at least master's-level training. Licensure, grants, payments and contracts for service should be awarded only to programs that or professionals who meet these standards.

A changed understanding

In order for these changes to occur, we need to truly view addiction as a disease rather than a moral failing or a lack of willpower. Although most adults in the United States recognize the role of genetics and biological factors in addiction, approximately one-third still consider addiction a sign of a lack of self-control.⁹ Often addiction is considered a social problem. Although it definitely has social consequences (it contributes to homelessness, automobile accidents, criminal activity and other problems), the evidence overwhelmingly shows that addiction is a complex chronic disease of the brain that causes dysfunction in the reward, motivation and memory circuitry. It is caused by a combination of genetic susceptibility and chronic administration of a drug.^{1,10,11} Viewing addiction as a moral failing, like laziness, rather than as a disease of the brain, like depression, allows people to believe it can be treated by those who focus on character correction rather than by properly trained medical professionals.

Clearly, addiction has disastrous and costly consequences. What isn't clear is how to close the gap between our vast knowledge about addiction and our current way of treating it. The causes of this gap are multifactorial and assigning blame will not bring us closer to a solution. What may move us is awareness that proper treatment of addiction will bring better outcomes for patients. As devastating as the opioid epidemic is, it has increased awareness of the treatment options for ad-

diction. One of those, office-based administration of buprenorphine, has garnered interest in medication management of addiction in the primary care community.

I would like to believe that proper treatment will improve job satisfaction for physicians, who are hungry for the ability to help suffering addicts, as well as for addiction counselors, who feel starved for the support they deserve. **MM**

Anne Pylkas practices internal medicine and addiction medicine at Hennepin County Medical Center and privately in Burnsville.

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Why doctors prescribe opioids to known opioid abusers

How cultural attitudes and financial disincentives affect the prescribing habits of physicians.

BY ANNA LEMBKE, M.D.

Prescription opioid abuse is an epidemic in the United States. In 2010, there were reportedly as many as 2.4 million opioid abusers in this country, and the number of new abusers had increased by 225% between 1992 and 2000.¹ Sixty percent of the opioids that are abused are obtained directly or indirectly through a physician's prescription. In many instances, doctors are fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but they prescribe them anyway. Why? Recent changes in medicine's philosophy of pain treatment, cultural trends in Americans' attitudes toward suffering and financial disincentives for treating addiction have contributed to this problem.

Throughout the 19th century, doctors spoke out against the use of pain remedies.² Pain, they argued, was a good thing, a sign of physical vitality and important to the healing process. Over the past 100 years, and especially as the availability of morphine derivatives such as oxycodone (Oxycontin) increased, a paradigm shift has occurred with regard to pain treatment. Today, treating pain is every doctor's mandated responsibility. In 2001, the Medical Board of California passed a law requiring all California-licensed physicians (except pathologists and radiologists) to take a full-day course on "pain management." It was an unprecedented injunction. Earlier this year, Pizzo and Clark urged health care providers as well as "family members, employers, and friends" to "rely on a person's ability to express his or her subjective experience of pain and learn to trust that expression," adding that the "medical system must give these expressions credence and endeavor to respond to them honestly and effectively."³ It seems that the patient's subjective experience of pain now takes precedence over other, potentially competing, considerations. In contemporary medical culture, self-reports of pain are above question, and the treatment of pain is held up as the holy grail of compassionate medical care.

The prioritization of the subjective experience of pain has been reinforced by the modern practice of regularly assessing patient satisfaction. Patients fill out surveys about the care they receive, which commonly include questions about how adequately their providers have addressed their pain. Doctors' clinical skills may also be evaluated on for-profit doctor-grading websites for the world to see. Doctors who refuse to prescribe opioids to certain patients out of concern about abuse are likely to get a poor rating from those patients. In some institutions, patient-survey ratings can affect physicians' reimbursement and job security. When I asked a physician colleague who regularly treats pain how he deals with the problem of using opioids in patients who he knows are abusing them, he said, "Sometimes I just have to do the right thing and refuse to prescribe them, even if I know they're going to go on Yelp and give me a bad rating." His "sometimes" seems to imply that at other times he knowingly prescribes opioids to abusers because not doing so would adversely affect his professional standing. If that's the case, he is by no means alone.

A cultural change contributing to physicians' dilemma is the "all suffering is avoidable" ethos that pervades many aspects of modern life. Many Americans today believe that any kind of pain, physical or mental, is indicative of pathology and therefore amenable to treatment. (The recent campaign to label "grief" a mental disorder is just one small example of this phenomenon.) At least some segments of our society also believe that pain that's left untreated can cause a psychic scar, leading to psychopathology in the form of post-traumatic stress; thus, doctors who deny opioids to patients who report feeling pain may be seen not only as withholding relief, but also as inflicting further harm through psychological trauma. Trauma today is seen not just as causing illness, but also as conferring a right to be compensated.⁴ No one understands this belief better than addicted patients themselves, who use their awareness of cultural narratives of illness and victimhood to get the prescriptions they want. One patient summed

it up in this way: “I know I’m addicted to [opioids], and it’s the doctors’ fault because they prescribed them. But I’ll sue them if they leave me in pain.”

Furthermore, for physicians, treating pain pays, whereas treating addiction does not. The mainstays of treatment for addiction are education and effective counseling, both of which take time. Time spent with each individual patient is medicine’s least valued commodity, from a financial reimbursement perspective. That’s especially true in emergency department settings, where physicians are often evaluated on the numbers of patients seen, rather than the amount of time they spend with each one. Clinicians will not take time to educate and counsel patients about addiction—even if they know how—until they are adequately reimbursed for doing so. Currently, it is faster and pays better to diagnose pain and prescribe an opioid than to diagnose and treat addiction. Busy emergency physicians who would like to refer patients with addiction for appropriate treatment have few resources to call on.

To be sure, the recent shift in medicine’s and society’s approach to pain represents a response to long-standing neglect of patients’ subjective experience of pain, as well as an increasing incidence of chronic pain syndromes in an aging population. Although this shift has no doubt benefited many persons with intractable pain that might previously have been undertreated, it has had devastating consequences for patients with addiction and those who may become addicted owing to lax opioid prescribing.

Some short-term changes that can help address this problem include mandating that all physicians complete a continuing medical education course on addiction, just as, since 2001, they have been required to complete one on pain treatment. Physicians need to learn to conceptualize addiction as a chronic illness that waxes and wanes—an illness similar to diabetes, heart disease, or other chronic illnesses that are influenced by patients’ behavior. Physicians can master strategies for brief interventions that have been shown to reduce substance misuse without taking too much of clinicians’ time and that are effective even in emergency department settings. In my opinion, all physicians in every state should have access to a database for prescription drug monitoring and should be required by law to query the database before writing an initial prescription for opioids or other controlled substances. Laws to this effect have already been passed in a handful of states including New York and Tennessee. Physicians must also be made aware of new billing codes that allow them to pursue reimbursement specifically for addiction counseling.

But the problem of doctors prescribing addictive analgesics to patients with known or suspected addiction will be solved only when the threat of public and legal censure for not treating addiction is equal to that for not treating pain and when treating addiction is financially compensated on a par with care for other illnesses. The former will occur only when addiction is considered a disease by medicine and society, for only then will it be treated as a legitimate object of clinical attention. The latter will occur only when time spent with patients is valued as much as prescriptions and procedures.

In the meantime, countless patients come to emergency departments and doctors’ offices throughout the country every day reporting pain and receiving opioids despite known or suspected addiction. Health care providers have become de facto hostages of these patients, yet the ultimate victims are the patients themselves, who are not getting the treatment for addiction they need and deserve. **MM**

Anna Lembke is in the department of psychiatry at Stanford University in Stanford, California.

From NEJM. Lembke A. Why Doctors Prescribe Opioids to Known Opioid Abusers. 2012;367(17):1580-1. Copyright © 2012. Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

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The Rampant Abuse of Prescription Pain Medications

BY CAROL FALKOWSKI

Opioid abuse has become a national and state public health crisis. This article reviews the extent of the problem in Minnesota, the relationship between prescription opioids and heroin, and the nature of addiction. It also describes what every physician can do to help remedy the situation.

Opioid abuse has become a public health crisis of unprecedented proportion that encompasses addiction, overdose, crime and death. The root of the problem is the nonmedical use of prescription medications including Vicodin (hydrocodone), OxyContin (oxycodone), Opana (oxymorphone) and methadone. Nationally, 35 million people (14% of the population 12 years of age and older) have used prescription pain relievers for nonmedical reasons at least once in their lifetime. Roughly 12 million have reported doing so in the past year.¹

The largest national survey of adolescents found that 15% of high school seniors reported using prescription drugs in 2012 (compared with 36% who reported using marijuana and 63% alcohol).² Of the estimated 3.1 million persons 12 years of age and older who used drugs illicitly for the first time in 2011, 22% reported that their first drug was a psychotherapeutic drug and 14% reported it was a pain reliever; 67.5% reported their first drug was marijuana.³

Opioids are widely available. The number of prescriptions for opioids dispensed annually by U.S. pharmacies grew 48%,

from 174 million in 2000 to 257 million in 2009.⁴ These medications find their way on to the street in a number of ways: Pharmacies are robbed. Homes are invaded. Medicine cabinets are emptied. Dispensers and prescribers, their employees and other health care providers pilfer them. People share them with friends. Some even feign pain, get prescriptions from multiple doctors and then sell or trade those drugs for heroin and other illicit substances.

Societal Impact

As a nation, we have experienced historic shifts: Drug-induced deaths now outnumber motor vehicle deaths, and overdose deaths from prescription opioids outnumber deaths from heroin and cocaine combined.⁵

Law enforcement is scrambling to keep up with the illegal activity surrounding opioid use. The number of dosage units of oxycodone seized by law enforcement in Minnesota increased 174% from 2010 to 2011.⁶ Heroin-related arrests rose 90% during that time.

The health care system has felt the impact as well. From 2009 to 2011, addiction treatment admissions for “other opiates,”

mostly prescription opioids, rose 26.5% in Minnesota. In just one year, from 2010 to 2011, addiction treatment admissions for heroin rose 46.7%.⁷ In the Twin Cities, admissions to addiction treatment programs for heroin and other opioids accounted for 21.5% of total admissions in the first half of 2012, second only to admissions for alcohol (46.5%). (Heroin abuse is more prevalent in the Minneapolis/St. Paul metro area, and prescription opiate abuse is more so in nonmetro areas.)

Of the heroin users entering treatment in the Twin Cities during the first half of 2012, more than 40% were between 18 and 25 years old. Many became addicted by using prescription drugs. Why is that the case?

Research has shown that if opioid addicts can get quality heroin at an affordable price, they invariably switch to heroin. That heroin sells for 25 cents per pure milligram compared with up to \$1 per milligram for a prescription opioid makes the transition more likely. In 2007, 2008 and 2009, the heroin in Minneapolis was purer and less expensive than that in any other U.S. city where Mexican heroin was sold.⁸

The Nature of Addiction

Addiction affects multiple brain circuits, specifically those involved in reward and motivation, cognition, memory and inhibitory control over behavior. The vast majority of people who take prescription opioids as medically directed will not become addicted. But some will. About 50% of the variance in the likelihood of any individual developing addiction can be explained by genetic predisposition and the other half is explained by environmental factors (Figure).

A person with a family history of addiction is more likely to develop addiction than a person without a family history of addiction. (Still there are many people with such a family history who do not develop addiction.) Environmental factors including not having a bond with an adult during childhood, growing up in a chaotic home, being exposed to the pro-substance abuse attitudes of others or suffering adverse childhood experiences (eg, sexual abuse or child abuse or neglect) also increase the likelihood of addiction.

Age of onset of use factors in as well. The younger a person is when they first use, the more likely they are to develop addiction.

Often, trauma, change or stress triggers the onset of addiction. This is why the development of an addictive disorder may coincide with such events as leaving home, moving, losing one's job, sexual assault, criminal victimization, death of a loved one or divorce.

One profile of today's opioid addict is a person who seeks medical treatment for a debilitating disease or injury. When such an individual uses potent opioids to relieve pain addiction may ensue. This is especially true of those with pre-existing genetic or environmental vulnerabilities or both.

Another is the person who abuses whatever substances he or she can easily acquire including marijuana and alcohol. Several years ago, methamphetamine and crack cocaine were readily available. Now pills and heroin are part of the mix.

Treatment of Opioid Addiction

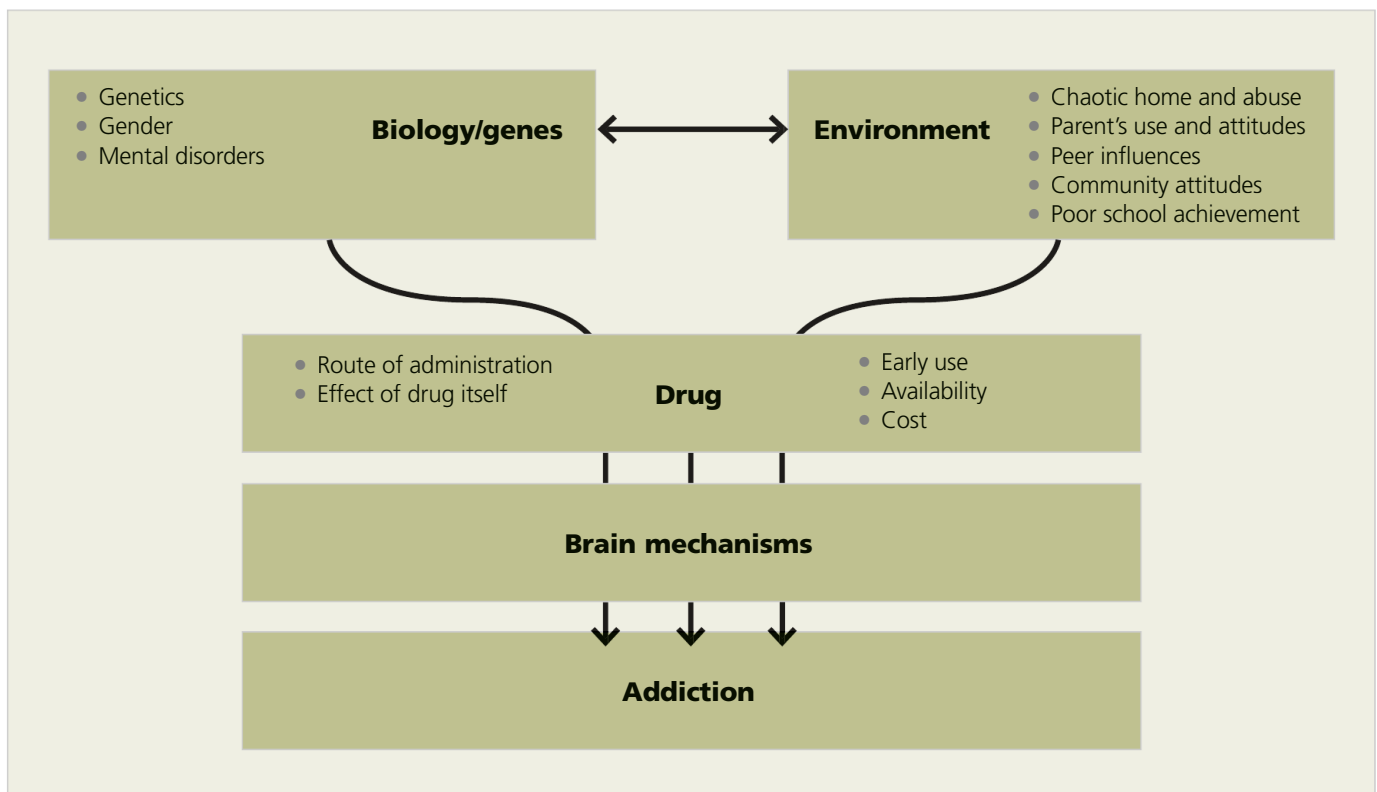
Most people who need treatment for addiction do not receive it. Of the 21.6 million persons (8.4% of those 12 years of age and older) who needed treatment for an illicit drug or alcohol addiction in 2011, only 2.3 million people actually received it.³

The goal of treatment is to assist the individual in stopping drug use, maintaining a drug-free lifestyle and restoring their ability to function productively within the family, at work and in society. Effective treatment requires paying attention to all of the patient's psychosocial and medical comorbidities. Because addiction is a chronic disease with behavioral components, addicts must change their behavior in order to manage it over the course of their lifetime, just as a patient with diabetes, hypertension or asthma must do.

A number of medications are used to help addicts re-establish normal brain function, prevent relapse and diminish craving. Those used to treat opioid addiction are:

FIGURE

Why People Get Addicted



- Methadone—an opioid pain reliever that eliminates withdrawal symptoms and relieves drug cravings. It has been used for more than 40 years and can only be dispensed in the context of an opioid treatment program.

- Buprenorphine—a partial opioid agonist. Available since October 2002, a buprenorphine monotherapy product, Subutex, and a buprenorphine/naloxone combination product, Suboxone, can be prescribed in a physician's office.

- Naltrexone—an opioid receptor blocker used to help prevent relapse. Only an individual who has stopped using opioids can take this drug. If a person contin-

ues to use opioids while taking it, they will experience severe withdrawal symptoms.

- Naloxone—a short-acting opioid receptor blocker that is used to reverse overdoses.

Although these medications are both effective and available, many treatment providers in Minnesota remain reluctant to use them.

What Physicians Can Do about Opioid Addiction

The challenge for physicians is reducing the nonmedical use of prescription opioids while ensuring that patients with legitimate needs have access to them. Toward

that end, physicians need to do several things.

First, they need to become educated about addiction, pain management, opiate prescribing and addiction treatment. Formal training about addiction is often lacking in medical school and residency programs. Therefore, many doctors do not recognize it and lack the skills to confidently address a patient's high-risk drinking and drug-taking behaviors, much less treat an addiction or even make an informed referral to an addiction specialist. In addition, doctors need to become familiar with the range of medication-assisted and abstinence-based treatment options for persons who are addicted. They also need to learn about optimal opioid-prescribing practices⁹ including effective strategies for managing chronic and acute pain such as patient contracting and requiring regular follow-up visits for those using opioids long-term.

Second, physicians need to screen all patients for substance abuse. Doctors routinely screen for hypertension and obesity during office visits. When patients are found to have elevated blood pressure or body weight, physicians discuss with them how their behaviors may be contributing to their condition. Not so with drinking and drug-taking. There may be a question or two about them on a routine history form, but these behaviors are rarely, if ever, discussed. One approach for screening and doing a brief intervention in primary care and emergency room settings is Screening, Brief Intervention, and Referral to Treatment (SBIRT). This is a proven, evidence-based method for identifying, preventing and reducing problematic use, abuse and dependence on alcohol and illicit drugs.

Third, physicians need to learn about the ways addicts seek prescription medications. Many doctors lack an appreciation of the extreme, often unbelievable, lengths to which addicts will go to acquire prescription opioids. It is not just a convincing acting performance (of a patient in severe pain of persistent and undetermined origin) that can fool you. Addicts have been known to injure themselves, rip out their own sutures after a surgical

Additional Resources

From the National Institute on Drug Abuse (www.drugabuse.gov)

- Managing Pain Patients Who Abuse Rx Drugs
- Safe Prescribing for Pain

Developed in 2012 by the National Institute on Drug Abuse and Medscape Education, these courses provide practical guidance for screening pain patients for substance use disorder risk factors and identifying patients who may be abusing their medications.

- NIDAMED: Medical & Health Professionals

This website provides many science-based resources including drug use screening tools, alcohol screening tools, drug abuse information, addiction information, treatment information and materials for patient education.

From the National Institute on Alcohol Abuse and Alcoholism (www.niaaa.nih.gov)

- NIAAA Clinician's Guide Online Training

Video Cases: Helping Patients Who Drink Too Much. Ten-minute cases and evidence-based clinical strategies for managing patients with different levels of severity and readiness to change. Free CME/CE credits for physicians (AAFP approved) and nurses through Medscape.

- Rethinking Drinking

This is a package of educational and self-assessment tools designed for anyone interested in looking at their own alcohol consumption.

From the Substance Abuse and Mental Health Services Administration (www.samhsa.gov)

- SBIRT - Screening, Intervention, and Referral to Treatment and other tools at the SAMHSA-HRSA Center for Integrated Health Solutions
- Behavioral Health Treatment Services Locator for finding local treatment options
- CSAT Buprenorphine Information Center, Center for Substance Abuse Treatment

procedure, or use their children, relatives, elderly strangers and even their pets to get pain medications.

Fourth, when dealing with a known opioid abuser, physicians need to consider implementing an overdose-prevention strategy. Over the past decade, community-based opioid overdose-prevention services have expanded throughout the United States. In these programs, the opioid antagonist naloxone hydrochloride is dispensed to persons who use opioids or to their family members, friends and service providers who can administer it during an emergency. An injection of naloxone can reverse the potentially fatal respiratory depression caused by overdose and has been found to be effective in reducing overdose mortality.¹⁰

Fifth, physicians should use the state's Prescription Monitoring Program (PMP). Minnesota's PMP is a web-based tool that can help prescribers and dispensers identify individuals engaged in "doctor-

shopping." The PMP tracks patients' prescription history for controlled substances (Schedule II-IV).

Because the problem of opioid addiction is complex and its tentacles are deeply embedded in our culture, physicians alone cannot be expected to solve it. However, as the prescribers of opioids, they play a pivotal role in preventing misuse of these drugs and in identifying and treating people who are addicted. **MM**

Carol Falkowski is author of *Dangerous Drugs*; former Drug Abuse Strategy Officer, Minnesota Department of Human Services; and the founder and principal of Drug Abuse Dialogues.

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Opioid Use and Abuse

A Pain Clinic Perspective

BY DAVID SCHULTZ, M.D.

Prescription opioid abuse has become the biggest drug problem facing the United States, surpassing abuse of cocaine, methamphetamines and heroin combined. For physicians treating patients with chronic pain, deciding whether to prescribe opioids, especially long-term, can be a challenge. This article describes the history of the opioid abuse problem in the United States, new agents that are effective but less prone to abuse, and tools physicians can use to evaluate whether a patient is a candidate for prescription opioids or other options for pain control.

Patient 1 is a 72-year-old male who has chronic lower abdominal pain after multiple surgeries for a benign-but-painful bladder condition. He is managed on long-acting morphine (MS Contin 300 mg per day) and states he has been doing well on this regimen. He has had good pain relief and improved functional ability; he has an active social life, participates in family activities and volunteers in the community. This man was referred to a pain clinic because his doctor told him he needed to “get off morphine.” He is awake and alert on interview and says he wants to continue morphine and does not want to consider invasive procedures or implantable pain-control options.

Patient 2 is a 34-year-old male who is managed on long-acting oxycodone (OxyContin 240 mg per day) to relieve chronic pain associated with lumbar disc disease and multiple spinal fusion surgeries. He is completely disabled and says he spends most of his time at home in bed. He rates his quality of life as poor and says he is in economic distress. He has a past history of alcohol abuse, although he

currently denies problems with chemical dependency. He grimaces and moans during examination. His affect is flat, and he appears somewhat somnolent. He wants to increase his dose of OxyContin.

These are examples of the types of patients primary care physicians refer to pain clinics. Although Patient 1 and Patient 2 are quite different, both use opioids daily to manage their pain.

Opioids: The Good and the Bad

Historically, there has been little consensus among physicians as to the appropriate use of opioids. Some prescribe them quite liberally while others refuse to prescribe them at all. In view of recent trends regarding prescription drug abuse and diversion, the issue of long-term opioid management for chronic benign pain has been pushed to the center of an intense national debate over best medical practices. In Minnesota, the Minnesota Medical Association recently convened a task force to make recommendations on this issue.

Over the past decade, the number of prescriptions written for opioids in the United States has increased dramatically.

At the same time, abuse of prescription opioids has surpassed that of cocaine, methamphetamines and heroin combined, making opioid abuse the single biggest drug problem facing U.S. law enforcement agencies.¹ Nonetheless, most physicians have little training in addiction medicine or in the use of opioids to manage patients with chronic pain.

Physicians who attended medical school in the 1970s and '80s were taught that opioid medications were not appropriate for treating chronic pain because of the significant risk of addiction. This conservative philosophy began to change in the 1990s as drug companies created new, powerful, long-acting opioid formulations and aggressively marketed them to doctors. At the same time, prominent physicians began to advocate the liberal use of opioids, and leading medical journals published articles encouraging their use for chronic benign pain. These forces combined to rapidly increase the number of opioid prescriptions written for both acute and chronic benign pain.

It is now coming to light that the drug manufacturers not only sponsored many of the medical studies supporting the use of opioids for benign pain but also paid physicians to advocate for their use.² Regardless of past influences on prescribing habits and the current opioid abuse epidemic, the most important question facing physicians now is how best to manage patients with chronic benign pain. Are long-term opioids appropriate or not?

The drug companies would have physicians believe opioids are entirely appropriate for moderate to severe pain of any type, and in many cases, this argument has some merit. Manufacturers are increasingly bringing new and improved forms of opioids to market, and some have novel abuse-resistant properties such as crush-resistant OxyContin (Purdue Pharma) and a new morphine-naltrexone combination pill called Embeda (Pfizer) that blocks opioid effects when crushed. These advanced, abuse-resistant formulations may ultimately prove useful at reducing opioid abuse.

Moreover, most physicians would agree that chronic benign pain can be devastating and that opioids are effective at relieving this pain. Many patients achieve pain relief and see major improvements in their ability to function and quality of life when they use long-term opioids. It is also true that the many powerful and effective opioid formulations are easy for doctors to prescribe and are well-liked and well-tolerated by patients.

Opioids are also relatively safe with regard to organ toxicity. Although overdose can cause death from respiratory depression, opioids do not harm the liver, kidneys or other organs even at high dosages, and side-effects such as constipation, nausea and somnolence are often manageable. In many ways, opioids are safer than acetaminophen, which may cause liver injury, and non-steroidal anti-inflammatory drugs such as ibuprofen and naproxyn,

which may raise blood pressure, damage kidneys and cause GI bleeding.

To Prescribe or Not to Prescribe: Tools that Can Help

Because doctors have little time to spend with patients, are concerned about potential side effects from NSAIDs and acetaminophen, and are increasingly rated on patient satisfaction, it is easy to see why opioid prescriptions have soared.

On the other hand, opioid addiction is commonly seen in pain clinics, and recent studies suggest that as many as 20% of patients referred to pain clinics have chemical dependency issues.³ Emergency room visits for prescription opioid abuse and overdose have steadily increased over the past 20 years, and more than 15,000 people die annually from prescription drug overdoses.³ A study published in *JAMA Internal Medicine* in January 2013 found that people taking a moderate dose of opioids were 29% more likely to be injured while driving compared with those on low-dose opioids; those on high-dose opioids were 42% more likely to be injured than those taking low doses of these drugs.⁴

When working with a patient who has chronic pain, there is no single right answer regarding opioid management. Physicians must evaluate each case on its own merits. The challenge is to prescribe opioids appropriately for those patients who experience pain relief and functional improvement when using them while avoiding them for those who are at risk for abuse, diversion and reduced functional ability. Most experts would agree that to withhold opioids from patients who need them goes against our responsibility as physicians to effectively treat pain; most also would agree that prescribing opioids to an addicted patient could lead to disaster.

Several tools are available to help physicians appropriately select, manage and monitor patients being considered for opioid management:

- Addiction risk screening tests, eg, the CAGE questionnaire⁵ and the Drug Abuse Screening Test (DAST)⁶

- An opioid contract⁷
- The Minnesota Prescription Monitoring Program database (<http://pmp.pharmacy.state.mn.us/>)
- Urine drug screening.

To see how these can be used to select appropriate patients for opioid management, let us return to the two patients considered at the beginning of this article. Both completed the DAST and underwent a urine drug screen. The pain specialist then checked the Minnesota PMP to see if they had previous opioid prescriptions.

Patient 1 scored 2/10 on the DAST (low risk for opioid abuse), had no unexpected prescriptions in the PMP and was positive only for morphine (expected) on the urine drug test. He seems to be doing well on daily oral opioids and is experiencing good pain relief and improved functional ability. He has a chronically painful condition that is not readily treated with nonaddicting medications, surgery or pain clinic injection procedures, and he is not interested in pursuing implantable pain control options such as spinal cord stimulation or intrathecal drug delivery. The pain specialist discussed options with the patient and his referring physician. Together, they decided that the referring physician would continue to prescribe morphine, and the patient would sign an opioid contract, return to the pain clinic once or twice a year to have his functional ability monitored, undergo urine drug screening and review alternatives to morphine management. The opioid contract clearly states the risks of opioid addiction, the possibility of prosecution for DUI if involved in a motor vehicle accident, and the grounds for dismissal from the opioid management program (taking more than prescribed, obtaining opioids from other physicians without disclosure, and aberrant drug-seeking behaviors).

Patient 2 scored 6/10 on the DAST (high risk for opioid abuse), had prescriptions for Vicodin from several different physicians in the PMP, and tested positive for THC on urine drug screening. He has poor pain control despite being prescribed

high doses of oral opioids, poor functional ability and is at high risk for abuse of prescription opioid medication.

Patient 2 also may be at high risk for opioid diversion because there is evidence of illicit drug use (marijuana) and he admits to financial distress. With OxyContin selling for \$1 to \$2 per mg on the street, some patients have a strong incentive to divert opioids for financial gain.

In addition, the pain specialist suspects that opioid-induced hyperalgesia (OIH) might be contributing to this patient's uncontrolled pain. OIH is a paradoxical phenomenon in which high-dosage opioid use causes pathological sensitization of the peripheral and central pain-sensing nervous system. Patients with OIH typically experience pain relief as they are weaned off opioids.

Overall, Patient 2 is a poor candidate for long-term oral opioid therapy and should be weaned from opioids. Weaning may prove difficult and is best done with multidisciplinary pain management, which may include interventional pain treatments, physical therapy and cognitive-behavioral treatment in a structured chronic pain program. If drug use persists despite attempts at weaning, he may be a candidate for a specialized detoxification and chemical dependency program.

Although Patient 2 is at high risk for opioid addiction, he has been diagnosed with neuropathic pain from chronic radiculopathy, has had multiple spine surgeries and does require some form of effective pain management. Ultimately, he may prove to be a candidate for targeted drug delivery using an implanted intrathecal infusion pump since delivering opioids and ancillary medications directly to the spinal cord does not fuel addiction. Intrathecal opioids bind to spinal cord pain receptors and relieve pain at exceedingly low doses without affecting brain cells. Therefore, targeted drug delivery by means of an implanted drug pump allows for separation of the opioids' pain-relieving effects from side effects such as euphoria, somnolence

and possible addiction. The addition of local anesthetic to the intrathecal opioid infusion (off-label) provides a synergistic neural blockade, blocking pain nerve conduction at the spinal level thereby improving pain relief and reducing opioid requirements.

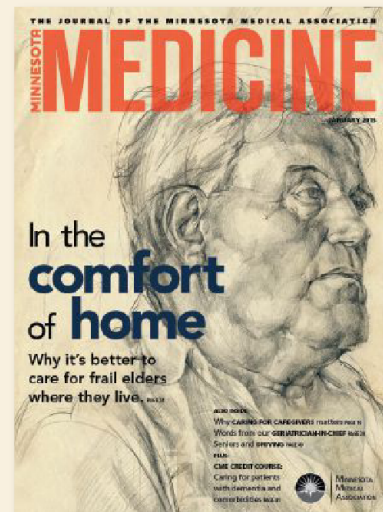
Conclusion

Prescription opioids are a double-edged sword. For some patients, these powerful medications can relieve chronic pain and improve quality of life with low risk of addiction. For others, they can lead to addiction and its associated consequences. When working with a patient who has chronic pain, physicians must evaluate each case on its own merits before prescribing opioids or suggesting other ways of addressing their pain. Board-certified pain specialists have expertise and training in managing these challenging patients and can partner with primary care doctors for better outcomes. **MM**

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A Comprehensive Response to the Opioid Epidemic

Hazelden's Approach

BY MARVIN D. SEPPALA, M.D.

For years, treatment professionals have debated the virtues of medication maintenance versus psychosocial therapies for treating opioid addiction. In its response to the opioid crisis, Hazelden is attempting to bridge the difference by using a treatment protocol that involves both the conservative use of safe medications and psychosocial therapies while maintaining the ultimate goal of abstinence. This article discusses the recent and precipitous rise in opioid use, abuse, dependence and overdoses in the United States; the physician's role in creating and solving the problem; and Hazelden's unique approach to caring for people with opioid addiction.

Systematic changes in the approach to pain management, both in terms of physician practice and patient expectations, have resulted in a dramatic increase in the use of opioids to treat pain. Today, people in the United States make up 4.6% of the world's population but consume 80% of the global supply of opioids, including 99% of the hydrocodone produced.¹⁻³

Physicians' prescribing practices have corresponded with increased abuse of and dependence on these drugs, an uptick in emergency room visits and addiction treatment center admissions, and a frightening increase in overdose deaths.

The Opioid Epidemic

Opioid users include individuals of all ages and from all backgrounds. For many, the path from medicine bottle to heroin needle is swift; users find that, as their prescription supplies dry up and their doctor-shopping options run out, heroin becomes a cheaper, more readily available

alternative. Here in Minnesota, the heroin is the strongest and purest authorities have ever seen.

Although statistics cannot capture the agony and grief families suffer when they lose someone to opioid addiction, the facts do illustrate the problem we are facing. According to the Centers for Disease Control and Prevention:

- Prescription opioid overdoses killed nearly 15,500 people in the United States in 2009—more than five times the number killed by these drugs in 1999
- In 2010, about 12 million people in the United States (12 years of age and older) reported nonmedical use of prescription opioids in the past year
- Nearly half a million emergency department visits in 2009 were the result of people misusing or abusing prescription opioids
- Deaths from drug overdose, driven by the increase in prescription opioid abuse, now outnumber those caused by car accidents.

Hazelden has seen an increase in the number of patients seeking treatment for opioid addiction at its facilities. At our main campus in Center City, Minnesota, the percentage of adults seeking treatment for opioid addiction rose from 19% in 2001 to 30% in 2011. At our facility for young adults and adolescents in Plymouth, Minnesota, 15% of patients sought treatment for opioid addiction in 2001 compared with 41% in 2011. The impact on young people is especially troubling. Because our brains are not fully developed until we reach our mid-20s, early exposure to opioids can cause permanent neurological changes and behavioral consequences.

The national epidemic of opioid addiction and the corresponding increase in the number of related accidental deaths demands a groundswell of support to address the issue. And as medical professionals, we must recognize the role we play not only in treating this disease, but also in creating it.

Why Recovery from Opioid Addiction is Different

One thing physicians need to understand is that individuals addicted to opioids are extremely vulnerable. They are:

- Hypersensitive to physical and psychic pain, putting them at greater risk of relapse. Prolonged use of opioids leaves users much more sensitive to pain, limiting their ability to tolerate even minor stressors during the early stages of abstinence. This places them at high risk for relapse.
- More likely than other patients to leave treatment before completing it. Treatment providers have noted increases in early discharges, primarily because patients leave against medical advice. Incomplete treatment undermines the chance of successful recovery. Opioid addicts who are not motivated to recover often only complete detoxification and do not engage in addiction treatment.
- At higher risk of death from accidental overdose during relapse. The risk of accidental death from opioid addiction increases after people withdraw and remain abstinent for a period of time, as they lose their tolerance. If they relapse on an opioid dosage they were accustomed to prior to abstinence—when they had higher tolerance—overdose is likely.

Three “Pathways” to Recovery

To give our patients the best chance of long-term recovery, Hazelden has added new treatment tracks or pathways specifically for those with opioid dependence. The new programming includes changes to our traditional group therapy and lectures and involves extended, adjunctive medication-assisted treatment (MAT).

The term “adjunctive” is used to emphasize that medications alone are not adequate for treating a condition as complex as opioid addiction. MAT will only be employed as an adjunct to, and never as a

substitute for a 12-step, abstinence-based recovery program. The aim of MAT is to engage patients long enough for them to complete treatment, acquire new information, establish new relationships and become solidly involved in recovery.

At Hazelden, all opioid-dependent patients who have significant symptoms of withdrawal will initially receive buprenorphine/naloxone and other medications to make their transition off their usual opioid as comfortable as possible. Once stabilized, the patient is evaluated by our medical, clinical and case management teams. They meet and decide which of three treatment pathways to recommend.

No Medication Pathway

Patients on this pathway will be gradually tapered off of buprenorphine/naloxone, usually over one to two weeks while in residential treatment. Patients may experience minor withdrawal symptoms during this period, but most can be managed with other nonaddictive medications. Those who take this pathway participate in the same treatments and groups as everyone else.

In general, those for whom this pathway is recommended have more limited experience with opioids, do not meet criteria for MAT (for example, intermittent use of opioids, but not dependence on them) or refuse medication.

Buprenorphine/Naloxone Pathway

Buprenorphine/naloxone is a combination of two medications in a film that dissolves under the tongue. It is used daily, and patients remain on this regimen for six to 18 months. Buprenorphine is a partial opioid agonist, which means it can block opioid withdrawal and cravings; but it only has partial effects compared with most opioids. Patients may experience minor opioid withdrawal when buprenorphine/naloxone is discontinued, but their symptoms are not as severe as those experienced when withdrawing from their “opioid of choice.” Naloxone decreases the likelihood of abuse of buprenorphine.

Studies examining buprenorphine for the treatment of opioid dependence are

positive overall.⁴⁻⁷ Buprenorphine inhibits craving, reduces the chance of relapse and increases the chance patients will complete treatment. It is effective for both youths and adults; patients who use it are more likely to participate in self-help groups. Nonetheless, treatment dropout rates are high, and illicit use of buprenorphine and diversion are possible, requiring adequate monitoring and oversight.

Extended-Release Naltrexone Pathway

Naltrexone is an opioid receptor antagonist; it blocks opioid receptors in the brain, so opioids have no effect. If patients use opioids while naltrexone is in their system, they will not get high. Naltrexone itself has no euphoric effects and does not cause dependence, withdrawal or respiratory depression. Extended-release naltrexone is a depot formulation of naltrexone that is injected in the buttocks once every four weeks; patients remain on the regimen for six to 18 months.

Naltrexone should not be used if a patient has recently taken medications that contain opioids, opioid street drugs or buprenorphine. It can cause severe, acute withdrawal in this situation. If someone stops naltrexone and returns to using opioids or any other drug, including alcohol, they are at great risk for relapse to full blown addiction and at a high risk of opioid overdose.

Studies of extended-release injectable naltrexone for opioid dependence show positive results.⁸⁻¹¹ They reveal increased retention in treatment, reduction in opioid craving and prevention of relapse. One study of adolescents and young adults revealed increased retention in treatment and improved abstinence outcomes.¹⁰

Medication-assisted treatment for opioid dependence with naltrexone and buprenorphine/naloxone is supported by scientific research and recommended by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), Washington Circle

(a policy group devoted to improving care for substance use disorders) and the Veterans Administration. Anyone who is addicted to opioids may be eligible for these medications. The decision whether to use them is based on an individualized medical assessment, as there are contraindications such as pregnancy or significant liver or respiratory disease.

The Drug Question

The announcement that Hazelden, which developed the 12-step “Minnesota Model” of addiction treatment, was introducing MAT into its treatment protocols was met with some criticism. However, the escalating death rate associated with opioid use and addiction demanded a specific, evidence-based solution.

A person who has addiction and is taking medication to treat it is not unlike a postsurgery patient who is using pain medication. The medication, if used as directed and not for the purpose of becoming intoxicated, can greatly assist in recovery. We view those working a recovery program while using naltrexone or buprenorphine/naloxone as prescribed as being in recovery in much the same way as those in Overeaters Anonymous and Sex Addicts Anonymous. In those programs, participants define which foods and behaviors constitute recovery and relapse. They continue to eat and to have sex consistent with defined recovery, but not in the same way they did during active addiction.

Opioid addicts using buprenorphine have a treatment dropout rate of approximately 50%. One reason is that many physicians prescribe buprenorphine alone, without any other form of treatment. Addiction is a complex brain disease that alters reward, motivation, memory and the related circuitry. These alterations manifest in biological, psychological, social and spiritual dysfunction. Thus, treatment must address more than just the biological manifestation of this disease.

Our use of medications in the treatment of opioid dependence is adjunctive to the psychosocial therapies and 12-step philosophy at the core of the Hazelden model.

Our new opioid dependence treatment program builds on the foundation of our current model while adding medications that have been proven to engage people in treatment longer, thus improving their likelihood of abstinence. These new treatment protocols focus on all aspects of opioid dependence and engage people over a longer period of time. We also provide patients with “recovery management,” supportive activities such as recovery coaching, behavioral monitoring and urine drug screens, that are essentially equivalent to disease management for other chronic illnesses. Family and community support, along with these recovery management interventions, can help an individual establish a new, drug-free lifestyle.

Medications for opioid dependence can be considered a short-term solution for interrupting the vicious cycle of opioid use. Improved psychosocial functioning, improved relationships and an altered lifestyle come from the experience of good recovery and offer the opportunity for long-term change.

The Physician’s Responsibility

Doctors play an important role in reducing the risks associated with overuse of opioids. We can learn about treatment of chronic pain and appropriate opioid prescribing. We can prescribe opioid painkillers only for those who truly benefit. We can use prescription monitoring programs to evaluate our patients prior to prescribing opioids. But we also need to be realistic about describing potential pain relief, especially to patients with chronic pain, and we need to hold our patients accountable for the appropriate use of these powerful and dangerous medications.

It is essential that physicians recognize that we contribute to the opioid epidemic by overprescribing. However, we are positioned to be part of the solution as well by educating ourselves and providing comprehensive, responsible treatment. ■■■

Marvin Seppala is chief medical officer at Hazelden. He is author of *Clinician’s Guide to the 12 Step Principles* and a co-author of *When Painkillers Become Dangerous*, and *Pain-Free Living for Drug-Free People*, Hazelden Publishing.

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Neonatal Drug Withdrawal

BY JANE E. BARTHELL, M.D., AND JEANNE D. MROZEK, M.D.

In recent years, the number of babies exposed to both illegal and prescribed drugs during pregnancy has increased. This has led to an increase in the number of babies born with addiction. This article describes the signs of neonatal drug withdrawal and suggests a comprehensive approach to preventing and treating it.

Case: *Baby A was born to a 24-year-old woman whose history included methamphetamine and narcotic use. After learning she was pregnant, the mother was concerned for her child's well-being and entered a methadone program. The pregnancy was complicated by preterm labor leading to delivery at 35 +3/7 weeks of gestation. The infant transitioned normally in the first few hours following birth, and oral feedings were initiated with infant formula. At approximately 60 hours of age, the infant became increasingly irritable and difficult to console. Emesis was noted following multiple feedings, and the infant appeared tremulous. Septic and metabolic work-ups were normal, but a urine toxicology screen was positive for opiates. The infant was started on a morphine treatment protocol that required dosing every three to six hours until symptoms abated. The infant required hospitalization for three weeks, during which he was weaned off medication and demonstrated consistent feeding and growth. A multidisciplinary team including physicians, social workers, and representatives from Child Protective Services and home health services were all involved in the discharge process. Follow-up was done by the primary care physician in collaboration with the hospital's pain and palliative care team.*

During the past few decades, the number of newborns exposed to both prescribed or illegal drugs during gestation has grown both in Minnesota and throughout the United States. National data indicate that 4.5% of pregnant women between 15 and 44 years of age use illicit drugs; this is likely an underestimate.¹ These babies often suffer from drug withdrawal. For infants who have been exposed to opioids, the constellation of clinical findings associated with withdrawal is referred to as neonatal abstinence syndrome (NAS).

The incidence of withdrawal syndrome in newborns has increased in recent years. According to the American Academy of Pediatrics, use of the ICD-9 code for drug withdrawal syndrome in newborns (779.5) increased from 7,600 newborns in 1995 to nearly 12,000 in 2008.¹ The number of newborns diagnosed with drug withdrawal syndrome in Florida increased 10-fold from 1995 to 2009.¹ Between 2000 and 2009, the national incidence of newborns at risk of withdrawal due to intrauterine exposure to drugs increased from 1.20 to 3.39 per 1,000 live hospital births per year.² In addition, use of medically prescribed drugs during pregnancy contributes to an increasing incidence of fetal exposure.

Given these realities, most physicians who care for pregnant women and their

infants will encounter drug-using mothers or drug-exposed infants. It is critical that primary care physicians in all settings are knowledgeable about preventing, recognizing and treating drug-using women and babies withdrawing from drugs.

Prevention is the ultimate goal. Thus, caring for women who may be or are pregnant begins with counseling before and during gestation. Physicians have traditionally screened pregnant women for drug use by interview. However, most pregnant patients will deny using or having used drugs. In 24% to 38% of cases in which there is a positive maternal urine or infant meconium screening test for cocaine, the mother will deny ever using the drug.^{3,4} Although physicians and nurses may think they can predict who might be using drugs, they do not know who truly is "at risk." Random screening based on social factors is discriminatory and, therefore, illegal. However, well-documented indications for drug screening exist. These include lack of prenatal care, placental abruption, preterm delivery and intra-uterine growth restriction. Toxicology screening of mothers with known risk factors is appropriate. Ideally, hospitals and clinics should develop policies for screening such women and consistently use them to identify those in need of further care.

Identifying Drug Withdrawal

The appropriate and timely treatment of a neonate in drug withdrawal begins with care providers, most often nurses, identifying and documenting the signs and symptoms using the Finnegan scoring system. In a newborn, these symptoms fall into three categories: central nervous system disturbances (eg, high-pitched crying, sleep abnormalities, seizures), respiratory/vasomotor system disturbances (eg, hyperthermia, frequent yawning or sneezing, tachypnea) and gastrointestinal system disturbances (eg, excessive sucking, poor feeding, loose stools).

The Finnegan Scoring system, more recently utilized as the Modified Finnegan Neonatal Abstinence Severity Score, identifies the 20 most common signs of withdrawal. The signs are then ranked from 1 to 5 according to their pathological significance. Frequent yawning (more than three to four times in a half hour), for example, scores a 1, whereas generalized convulsions scores a 5. (Infants at risk of narcotic withdrawal are assessed for signs 30 to 60 minutes after each feeding.) Generally, infants going through withdrawal will have signs in each of the three categories. Consecutive scores of 8 or greater are deemed symptomatic of drug withdrawal and management of those symptoms should be initiated.

Toxicology screens of at-risk newborns can be done using urine or meconium. These are send-out tests for many hospital laboratories.

The timing of the urine collection can affect the results. Ethanol can be detected in neonatal urine for only six to eight hours after maternal drug use. Short-acting barbiturates and cocaine may be detected up to 24 to 36 hours, whereas cannabis and opiates may yield a positive screen for two to four days. Methadone may register positive three days after the mother's use, and amphetamines can be detected for up to five days.

Prior drug use might be missed with urine screening alone. Drug deposition in meconium begins as early as 12 to 13 weeks of gestation. Testing of meconium, which is easier to obtain than urine, has

been shown to increase the detection of fetal exposure by 28% compared with maternal reported history alone.⁴

Caring for the Neonate

Treatment of infants with symptoms related to maternal drug use varies based on the type of drug to which they were exposed *in utero*. In the case of maternal opioid use, inpatient management is warranted for monitoring as well as medical treatment. The average length of hospitalization for a drug-addicted newborn is 16 days,² but it can exceed a month.

Infants Exposed to Opioids

Whether natural or synthetic, opioids activate mu receptors in the central nervous system to produce supraspinal analgesia. They also can cause sedation, euphoria, miosis, respiratory depression and decreased GI motility. Opioids inhibit release of noradrenaline at synaptic terminals; but as tolerance develops, the rate of noradrenaline release increases to normal. An abrupt cessation of exogenous opioids causes a supranormal release of noradrenaline that results in symptoms of withdrawal.

Treatment of infants going through NAS involves a number of tactics. Placing the child in a dark, quiet room with minimal stimulation, warm bundling and on-demand feedings are a few things that can help to soothe an infant. Numerous drugs have been tried for managing NAS; the most common ones are morphine, methadone, benzodiazepines and phenobarbital. In the case study, morphine was the drug of choice. Recently, buprenorphine has been shown to be better than methadone for treating opioid-addicted women during pregnancy, as neonates exposed to buprenorphine have less severe symptoms of NAS.⁵ As more studies are done, this drug may indeed become more routinely prescribed for women and their babies.

Infants Exposed to Stimulants

Neonatal symptoms after *in utero* exposure to central nervous system stimulants such as cocaine or methamphetamines has not been clearly defined. Symptoms that

may appear two to three days after birth include irritability, hyperactivity, tremors, high-pitched crying and excessive sucking. These behaviors may actually be the result of a drug's stimulant effect and not signs of withdrawal. Methamphetamine use increases the chance that an infant will be small for its gestational age.⁶ Other known complications include preterm delivery, placental abruption, intrauterine growth restriction, low birth-weight and decreased head circumference. Fetal vascular disruption leading to complications within the central nervous system, genitourinary system, and limb reduction defects and/or intestinal atresias also has been described.⁷ Long-term problems in these infants are difficult to attribute, as multiple confounders often exist.

Infants exposed to stimulants primarily need supportive care.

Infants Exposed to SSRIs

Selective serotonin reuptake inhibitors (SSRIs) are the most frequently used drugs for treating depression. Since their introduction in the late 1980s, case reports, adverse drug reaction reports and prospective studies have all linked third trimester use of SSRIs to a constellation of neonatal signs and symptoms. SSRIs are known to cross the placenta, and their metabolites are known to affect cardiovascular and respiratory function, as well as circadian rhythm during gestation.

Signs of *in utero* SSRI exposure include continuous crying, irritability, jitteriness/tremors, shivering fever, hypoglycemia, seizures, hypertonia/rigidity, tachypnea, respiratory distress, feeding difficulties and sleep disturbances. These signs can present within several hours of birth to several days after. These are nonspecific symptoms and the infant may need to be evaluated for sepsis or other medical problems.

In the case of SSRI exposure, symptoms may be caused by withdrawal or serotonin toxicity. Autonomic hyperactivity (fever, tachycardia, tachypnea, diaphoresis); and neuromuscular abnormalities (tremor, clonus, hyperreflexia, and hypertonia) can be observed in both SSRI withdrawal

and toxicity. Neonatal symptoms resulting from maternal SSRI use are treated with supportive care without narcotics. Grzeskowiak, Gilbert and Morrison described neurodevelopmental assessments at 2 to 6 years of age following *in utero* exposure to SSRIs.⁸ They described intact cognitive abilities but an increased risk for social and behavioral abnormalities in this population. They went on to say such findings are difficult to interpret given the presumed underlying maternal psychopathology that initially warranted treatment.

The Next Step

Institutions and providers already are developing expertise in managing women who require support for drug use during pregnancy and neonates who require support for drug withdrawal. Ideally, support for these patients would begin with care of the mother before she becomes pregnant and continue with care of the infant post-discharge.

A comprehensive clinical program should include these components:

- Prenatal consultation for women with known drug use to discuss maternal management, neonatal implications and the course of hospitalization for the neonate; narcotic and/or SSRI use should not be abruptly stopped, as cessation requires medical management
- Ongoing support and drug counseling for women during and after pregnancy along with weaning of medically unnecessary drugs
- Inpatient management of newborns with weaning of drugs if feasible
- Outpatient care of the newborns by primary care providers with the support of pain and palliative care teams if requested
- Social services involvement for each mother and infant throughout hospitalization as well as following discharge
- Early intervention referrals for all patients who need additional services
- Follow up with developmental/behavioral pediatricians through early childhood
- Systematic collection of data for future research.

As illustrated by the case described at the beginning of this article, comprehensive care involves meeting the needs of the mother and the infant. For this infant, the results were optimal: he was discharged to home on no medications and followed a normal growth trajectory. At 18 months of age, he had reached normal developmental milestones.

Achieving such optimal results for mothers who are using both prescribed and illicit drugs during pregnancy as well as for newborns at risk for withdrawal begins with awareness and must be followed by collaboration among multiple specialties. By taking such a comprehensive approach, we can turn a bleak situation into a bright one and provide the care our most vulnerable patients need. **MM**

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PRESCRIPTION OPIOID ABUSE

Finding a feasible solution

States employ different legislative strategies to curb misuse.

BY JULIANA MILHOFER, J.D.

Prescription opioids clearly provide relief from the agony and stress that can accompany pain. But they also are driving addiction and crime and have become the center of what many have deemed a public health epidemic. Approximately three out of four prescription drug overdoses in the United States involve prescription opioids.¹ Additionally, these drugs play a role in approximately 15,000 deaths and more than 340,000 emergency department visits each year.^{2,3}

Prescription opioid abuse creates more than just a burden on public health; it also carries with it significant economic costs. A study published in the *Clinical Journal of Pain* in 2011 estimated that the total cost of nonmedical use of prescription opioids in the United States was \$53.4 billion in 2006.⁴ It also found misuse of oxycodone, hydrocodone, propoxyphene and methadone accounted for two-thirds of the total economic burden.

States have enacted a variety of measures to curb abuse of these drugs. Those addressing this problem through legislation have had to balance the need for patient access to appropriate, effective pain treatment with the responsibilities of public health, law enforcement and the medical community.

Legislative prescriptions

Concern about misuse of prescription medications is not new. Some states began requiring physicians to conduct physi-

cal exams on patients before prescribing certain medications and set limits on the number of days' supply and the quantity of pills prescribed and/or dispensed as early as the 1970s.⁵ By the 1980s, a handful of states required patients to present identification before getting a prescription filled to help ensure that the person receiving the medication is the same person for whom the drug was prescribed. Additionally, some states began taking steps to prohibit "doctor shopping" (when a patient obtains controlled substances from multiple providers without the prescribers knowing that the patient has other similar prescriptions).

By the early 1990s, more powerful, long-acting pain medications had been introduced and were being prescribed more liberally for acute and chronic pain. With the increase in use came an increase in abuse. In 2007, the federal government passed legislation requiring tamper-resistant prescription forms for all prescriptions covered by Medicaid. Many states quickly followed suit, passing laws of their own that mandated the use of tamper-resistant prescription forms for all patients, not just those who were eligible for Medicaid, and for all prescriptions. A few states passed laws aimed at pain clinics as well as Good Samaritan laws that protect individuals who seek assistance either for themselves or for another person who is experiencing a drug overdose from criminal charges.

Three states, three approaches

Because the prescription drug abuse problem has manifested differently in different parts of the country, states' responses to the issue have varied. Here we examine briefly how three states that have had some of the most severe problems with prescription opioid abuse have addressed the issue through legislation.

Florida

For a number of years, Florida was at the epicenter of the prescription drug abuse epidemic. Individuals flocked to Florida's pain clinics, which became known as "pill mills," for prescription opioids such as oxycodone. These facilities were prescribing and dispensing controlled substances either outside the scope of standard medical practice or in violation of state law.⁶ Many of them only accepted cash as payment. As a result, many pain clinics in Florida became venues for drug trafficking.

What exacerbated the issue was the fact that in Florida, pain physicians had the ability to sell the drugs they were prescribing. These physicians were designated "dispensing doctors."⁷ The Drug Enforcement Administration showed that the top 50 practitioners who were dispensing oxycodone were all located in South Florida, and Broward County became known as the "Painkiller Capital of the United States."⁷

Patients who came to the clinics that were dispensing opioids were asked to submit an MRI and take a drug test. In-

vestigations found that the drug test results often were not actually used or were falsified. In many cases, whether MRIs actually showed evidence of an injury was irrelevant to the medical treatment, as the pain clinic operators only wanted to have something on file in case their practices were questioned.⁷

These practices ultimately contributed to the overdose deaths of many. Between 2003 and 2009, Florida saw a 264.6% increase in overdose deaths attributable to oxycodone.⁸ By 2009, prescription drug deaths in the state had surpassed those caused by heroin, cocaine and other illicit drugs. By 2010, Florida had earned the nickname “Oxy Express.”

In response to all of this, Florida passed laws requiring pain clinics to register with the state’s Department of Health and prohibiting doctors from dispensing prescription opioids directly to consumers.^{9,10} Those laws took effect in 2011 and the state quickly realized a change. According to a 2012 report by the Florida Department of Law Enforcement, the state saw a decrease in deaths attributable to prescription drugs for the first time in a decade.¹¹ From 2010 to 2011, the number of deaths related to oxycodone dropped 17.7%.¹²

Washington State

In Washington State, a sevenfold increase in prescription opioid-related hospitalizations between 1995 and 2007 and an increase in the average daily dose prescribed to patients receiving workers’ compensation benefits during 2008 raised red flags among officials.¹³ State lawmakers responded with some of the strongest measures in the United States, enacting the country’s first dosage threshold. They required that physicians prescribe no more than an average daily morphine equivalent dose of 120 mg or greater without first consulting with a pain specialist.^{14,15} In addition, Washington mandated that doctor-patient agreements for chronic opioid use include periodic urine testing.

These new rules, which only apply to the use of opioids for chronic pain not related to cancer, have been met with mixed responses. Some have argued that they do

not allow physicians to use their clinical judgment and may even make some reluctant to prescribe opioids. Others have said they are evidence-based and offer needed guidance to physicians treating patients with chronic pain.

Kentucky

In 2008, when Kentucky ranked sixth nationally in overdose deaths related to prescription opioids, the state’s Legislature began looking for solutions to the problem.^{16,17} A law passed in April of 2012 requires prescribers to register with and use the state’s prescription monitoring database before writing or refilling a prescription for opioids.¹⁶ Starting in July of 2013, the state’s prescription monitoring database will be updated every 24 hours, a significant change from the weekly updates that are currently taking place.¹⁶

Broader approaches

On November 1, 2011, the CDC released a report about prescription painkiller overdoses in the United States¹⁷ and recommended that states launch prescription monitoring programs (PMPs) and use data obtained from those programs and from Medicaid and workers’ compensation to help identify improper prescribing practices. The CDC also called for states to increase access to treatment for substance abuse, pass laws aimed at curbing prescription opioid abuse and encourage professional licensing boards to take action against the inappropriate prescribing of opioids.¹⁷

Since then, a number of states have enacted laws including ones requiring providers to perform a physical exam on a patient before prescribing opioids, requiring a patient to show identification when getting a prescription filled for such drugs and ensuring that an individual who seeks assistance for either themselves or another individual during an overdose is provided immunity from prosecution or mitigation at sentencing (ie, protection from a criminal charge for possession of a controlled substance).⁵

In April of 2011, the Office of National Drug Control Policy released its

prescription drug abuse prevention plan, “Epidemic: Responding to America’s Prescription Drug Abuse Crisis.”¹⁸ The plan provides an outline for educating the public and health care providers, tracking and monitoring the prescription and dispensation of controlled substances (through prescription drug monitoring programs), disposing of medications (to reduce drug diversion) and supporting law enforcement to put an end to improper prescribing practices (pill mills and doctor shopping). It also emphasizes the importance of the states, the medical community and the federal government working together.

One strategy that both states and the medical community are embracing is the use of PMPs. Pharmacies and other dispensers can electronically submit data to their PMP; that information is then collected, monitored and analyzed. In some states, providers can check to see if a patient has received prescriptions for a controlled substance from another provider.¹⁹ As of November 7, 2012, 42 states including Minnesota had operational PMPs. Seven (as well as the District of Columbia and Guam) are in the process of creating one. Missouri is the only state that neither has a PMP nor has passed legislation authorizing the creation of one. As states begin using and evaluating their PMPs, they will find areas for improvement. Some have found that sharing data across state lines is effective, and a move toward interstate operability of PMPs may be in the not-so-distant future.

Minnesota’s laws

Minnesota has not been immune to the problem of prescription opioid abuse. During 2011, one in five admissions (20.2%) to addiction programs in the Twin Cities metro area was for heroin or other opiates (compared with 8.7% of admissions in 2005).²⁰ In September 2012, the Minnesota Department of Human Services released its first-ever state substance abuse strategy; it called for making abuse and addiction related to prescription opioids and heroin an immediate policy priority.²¹ ↪

Minnesota has several laws in place that address the misuse and abuse of prescription drugs.²²⁻²⁵ In addition to the law that established the PMP is one that requires that a prescription for an opioid be based on a documented patient evaluation (including an examination) that establishes a diagnosis and identifies any underlying conditions a patient may have or any contraindications to treatment. Another sets limits for prescription drugs (eg, no prescriptions for a Schedule II substance may be refilled). Minnesota also requires that prescriptions for Schedule II substances either be printed or written in ink, and include the handwritten signature of the prescriber or be transmitted electronically or by fax. Finally, under Minnesota law, no person may dispense a Schedule II or III controlled substance without requiring the person purchasing the controlled substance to present valid photo identification, unless the person for whom the controlled substance prescription is written, or the person purchasing the controlled substance, is known to the dispenser. (This requirement does not apply if the purchase is covered in whole or in part by a health plan or other third-party payer.)

Conclusion

The problem of prescription opioid abuse has manifest differently in every state, and each will need to figure out its own strategies for stopping it. Whether Minnesota will follow the path other states have taken to address it remains to be seen. The problem will likely challenge physicians and legislators for some time. As we seek solutions, physicians will need to balance their duty to provide effective relief for those with legitimate pain against the need to identify drug seekers and prevent abuse. And legislators will need to respect their need to do that. **MM**

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MMA Task Force

In November of 2012, the Minnesota Medical Association (MMA) formed a task force to 1) raise awareness among Minnesota physicians about the nature and extent of the problems associated with prescription opioid addiction, abuse and diversion; 2) examine specific strategies for improving physician management of opioid prescribing; 3) identify and disseminate to physicians resources and tools for opioid prescribing best practices; and 4) facilitate MMA participation in multidisciplinary, community-wide conversations/coalitions aimed at addressing prescription opioid addiction, abuse and diversion.

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- Orthopedic Surgery
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- Pediatrics
- Psychiatry
- Pulmonary/Critical Care
- Radiation Oncology
- Rheumatology
- Urologist

For additional information, please contact:

Kari Bredberg, Physician Recruitment
karib@acmc.com, 320-231-6366

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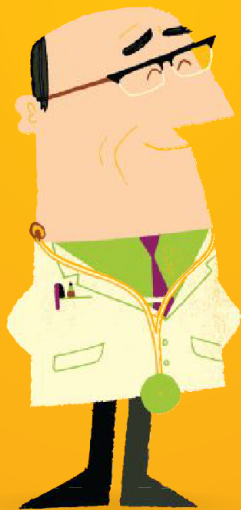
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We have part-time and on-call positions available at a variety of Twin Cities' metro area HealthPartners Clinics. We will be opening a new Urgent Care clinic in Hugo, MN in the spring of 2013! Evening and weekend shifts are currently available. We are seeking BC/BE full-range family medicine and internal medicine pediatric (Med-Peds) physicians. We offer a competitive salary and paid malpractice.

For consideration, apply online at healthpartners.jobs and follow the Search Physician Careers link to view our Urgent Care opportunities. For more information, please contact diane.m.collins@healthpartners.com or call Diane at: 952-883-5453; toll-free: 1-800-472-4695 x3. EOE



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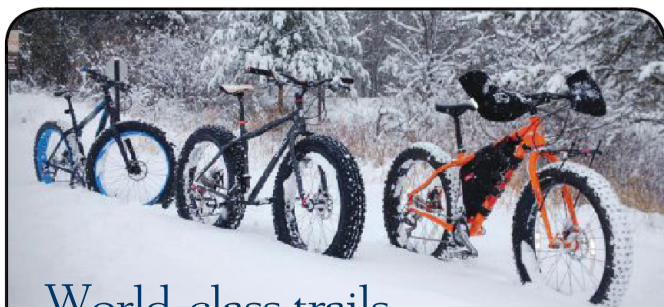
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- Hospitalist
- PA, Orthopaedic Surgery
- PA, Family Medicine



Contact: Todd Bymark, tbymark@cuyunamed.org
(866) 270-0043 / (218) 546-4322 | www.cuyunamed.org

Medical Director

Metropolitan Health Plan (MHP)
Hennepin County
Minneapolis, MN



Hennepin County's MHP, a state certified HMO, is seeking a Medical Director to provide oversight medical administration functions and assist in providing strategic leadership to enhance services to members. Hennepin County offers a comprehensive compensation package and an atmosphere that promotes dedication and commitment to public service. Hennepin County was listed in *Minnesota Monthly* magazine as 1 of 48 "Great Places to Work".

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- Hospitalist – STACH, Daytime & Nocturnist
- House Physician
- Internal Medicine – Clinic, Walk In Care
- Medical Care for Seniors – Physician & NP/PA
- Medical Director – Emergency Medicine
- Medical Director – Hospitalist Medicine
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Tele-Intensivist

VA Midwest Health Care System (VISN 23)
And Minneapolis VA Health Care System (HCS)

The Minneapolis VA HCS, in association with the VA Midwest Health Care Network (VISN 23) has full-time and part-time opportunities for the position of Tele-Intensivist. This position involves attending in our state-of-the-art Tele-ICU facility located at the Minneapolis VA HCS. The Tele-ICU is a regional program with responsibilities to all medical centers in the Network and additional sites as the program expands. The Minneapolis VA HCS is a tertiary care teaching hospital affiliated with the University of Minnesota, located in Minneapolis, Minnesota — a major metropolitan area with multiple universities, excellent schools, museums, cultural activities, professional sports teams, and beautiful outdoor surroundings.

Candidates must be Board Certified or Board Eligible in Critical Care by an ABMS Board of Medicine, Surgery, Anesthesiology or Emergency Medicine.

The ideal candidate has outstanding clinical and interpersonal skills. Qualified candidates will be eligible for faculty appointment at the University Of Minnesota School Of Medicine, academic rank commensurate with experience.

The VA offers a competitive salary commensurate with experience, using VA's market based physician pay system and a generous federal benefits package. A possible recruitment/relocation incentive may be authorized for this position.

To apply, please visit www.usajobs.gov. Send CV and applications to Human Resources Management Service (attention Joan Potter, One Veterans Drive, HRMS-05, Minneapolis, MN 55417). Call HRMS at 612-467-2060 or Dr. Robert Bonello at 612-467-3381 or email Robert.bonello@va.gov for additional information. The VA is an Equal Opportunity Employer.

Family Medicine

HealthPartners Medical Group - Hugo, Minnesota



We are actively recruiting exceptional full-range BC/BE family medicine physicians to join our primary care team at our new Hugo clinic, scheduled to open in May 2013. This is a full-time family medicine (no OB) position and is outpatient only. Our primary care team will include family medicine physicians, pediatricians, advanced practice providers and chiropractic services. We will be partnering with pediatricians from Children's Hospital and Clinics of Minnesota. Previous Epic experience is helpful, but not required. We use the Epic medical record system in all of our primary care and specialty care clinics, and admitting hospitals.

HealthPartners Medical Group continues to receive nationally recognized clinical performance and quality awards. We offer a competitive salary and benefit package, paid malpractice and a commitment to providing exceptional patient-centered care. For more information, please contact diane.m.collins@healthpartners.com or call Diane at 952-883-5453; toll-free: 800-472-4695. Apply online at healthpartners.jobs and search for Job ID 25408. EOE



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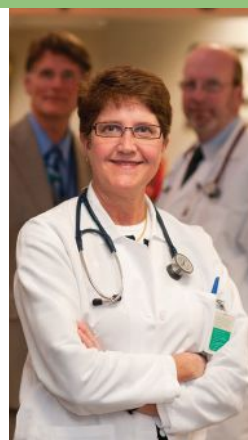
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EOE/AA



Associate Medical Director

Tele-ICU (Virtual ICU) Program

VA Midwest Health Care Network (VISN 23)
and Minneapolis VA Health Care System (HCS)



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The Minneapolis VA HCS, in association with VISN 23 is seeking a staff physician to fill the position of Tele-ICU Associate Medical Director. VISN 23 is comprised of VA facilities in North and South Dakota, Nebraska, Iowa and Minnesota. The Tele-ICU is a Network program with responsibilities to all medical centers in the Network and additional sites outside the Network as the program expands. The Minneapolis VA HCS is a tertiary care teaching hospital affiliated with the University of Minnesota, located in Minneapolis, Minnesota — a major metropolitan area with multiple universities, excellent schools, museums, cultural activities, professional sports teams, and beautiful outdoor surroundings.

Candidates must be Board Certified or Board Eligible in Critical Care by an ABMS Board of Medicine, Surgery, Anesthesiology or Emergency Medicine.

This position reports directly to the Tele-ICU Medical Director and includes attending in our state-of-the-art Tele-ICU facility located at the Minneapolis VA HCS as well as quality control, administrative oversight and participation in the continued development of the VISN 23 Tele-ICU program — the first of its kind in the VA system. Duties include working with multiple ICU programs, both rural and those with academic affiliations, to bring state of the art technology and evidence-based care practices to intensive care. The successful applicant may be afforded opportunities to assist in development of resident and fellowship training programs for Tele-ICU medicine and in research regarding its effectiveness.

The ideal candidate has outstanding clinical skills and a demonstrated interest in quality improvement. Previous administrative experience and/or focus on graduate

medical education and clinical quality improvement is desirable but not required. Qualified candidates will be eligible for faculty appointment at the University Of Minnesota School Of Medicine, academic rank commensurate with experience.

The VA offers a competitive salary commensurate with experience, using VA's market based physician pay system and a generous federal benefits package. A possible recruitment/relocation incentive may be authorized for this position.

To apply, please visit www.usajobs.gov. Send CV and applications to Human Resources Management Service (attention Joan Potter, One Veterans Drive, HRMS-05, Minneapolis, MN 55417). Call HRMS at 612-467-2060 or Dr. Robert Bonello at 612-467-3381 or email Robert.bonello@va.gov for additional information. The VA is an Equal Opportunity Employer.



Opportunities available in the following specialty:

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Southeast Clinic

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Pine Island Clinic
Plainview Clinic

Hospitalist
Rochester Hospital

Internal Medicine
Southeast Clinic

Orthopedic Surgeon - Joints
Southeast Clinic

Sports Medicine
Orthopedic Surgeon
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Send CV to:

OlmstedMedical Center
Administration/Clinician
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Rochester, MN 55901
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Family Medicine

St. Cloud/Sartell, MN

We are actively recruiting exceptional full-time BE/BC Family Medicine physicians to join our primary care team at the HealthPartners Central Minnesota Clinics - Sartell. This is an out-patient clinical position. Previous electronic medical record experience is helpful, but not required. We use the Epic medical record system in all of our clinics and admitting hospitals.

Our current primary care team includes family medicine, adult medicine, OB/GYN and pediatrics. Several of our specialty services are also available onsite. Our Sartell clinic is located just one hour north of the Twin Cities and offers a dynamic lifestyle in a growing community with traditional appeal.

HealthPartners Medical Group continues to receive nationally recognized clinical performance and quality awards. We offer a competitive compensation and benefit package, paid malpractice and a commitment to providing exceptional patient-centered care.

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An immediate opportunity is available for a BC/BE general orthopedic surgeon in Bemidji, MN. Join our 3 existing board certified orthopedic surgeons in this beautiful lakes community.

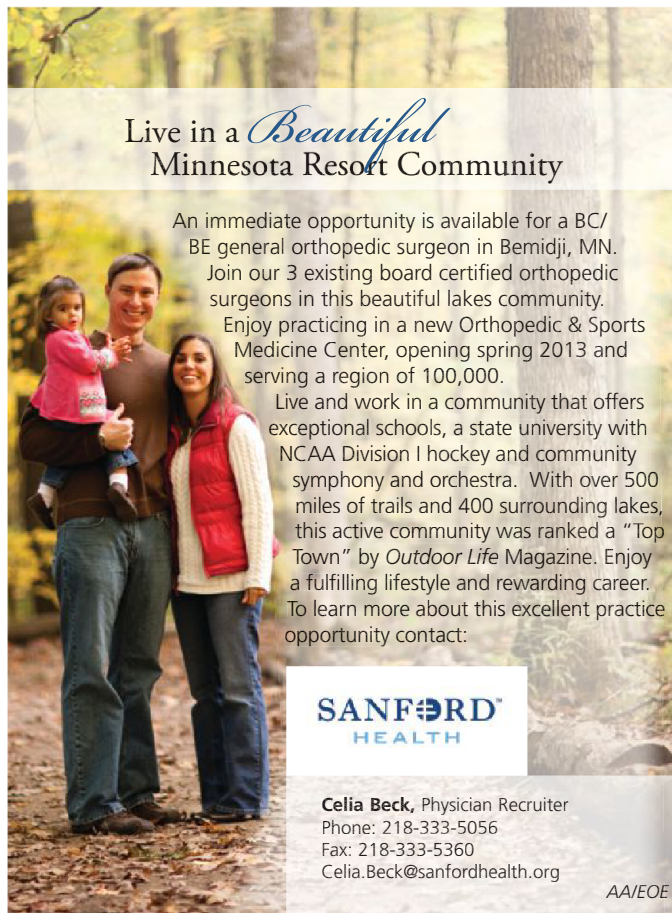
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The Sioux Falls VAHCS is currently recruiting for the following healthcare positions.

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- Neurologist
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For more information, contact:
Alexandria Clinic
Attn: Tim Hunt, Administrator
610-30th Ave W,
Alexandria, MN 56308
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Additional information and application at
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UMN is an EEO employer.

Hypnos

BY GREGORY A. POLAND, M.D.

Trepidation, concern, *a vision*.
Slow motion inside a tunnel of images
That rapidly narrows.
It's me watching me—*how* can this be?
And then—unaware.
No dreams, no thoughts, just a void.
This void, a time I can't recount and can't recall.
I cannot resist it and soon succumb.

Then, awake!
Cool air rushing to my face.
A soft voice saying, "awaken,"
Her eyes saying "live!"
But I can't recount, I can't recall.
Where did I go, and what did I do?
How could I have felt no pain?
Just...nothing...a void.

And soon, life rushes in.
Decisions to make
People to talk to,
Healing to seek.
But I can't recount, I can't recall.
Where did I go?
And what did I do?

Then awareness—I was with You.
The *I Am* who formed me touched my soul
And sent me back
A job to do.
Grant me strength and sight and understanding.
But I can't recount
I can't recall.
From Nyx to Hypnos to Aurora—a healed man.

Gregory Poland, M.D., is with Mayo Clinic in Rochester.

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