# HOUSE *Calls*

Published by the Alachua County Medical Society

Winter 2017

## Addiction Medicine

# The Orthopaedic Institute

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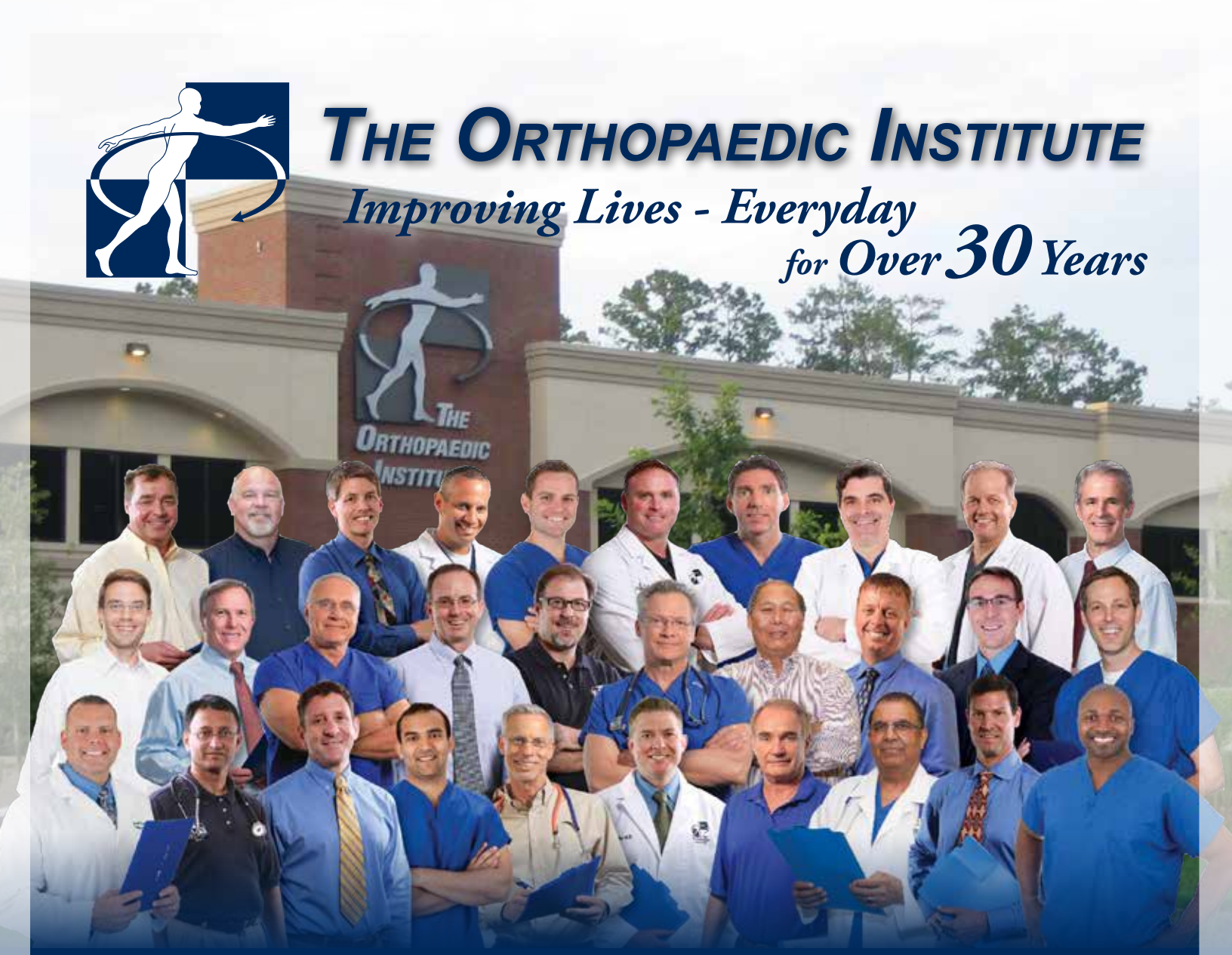


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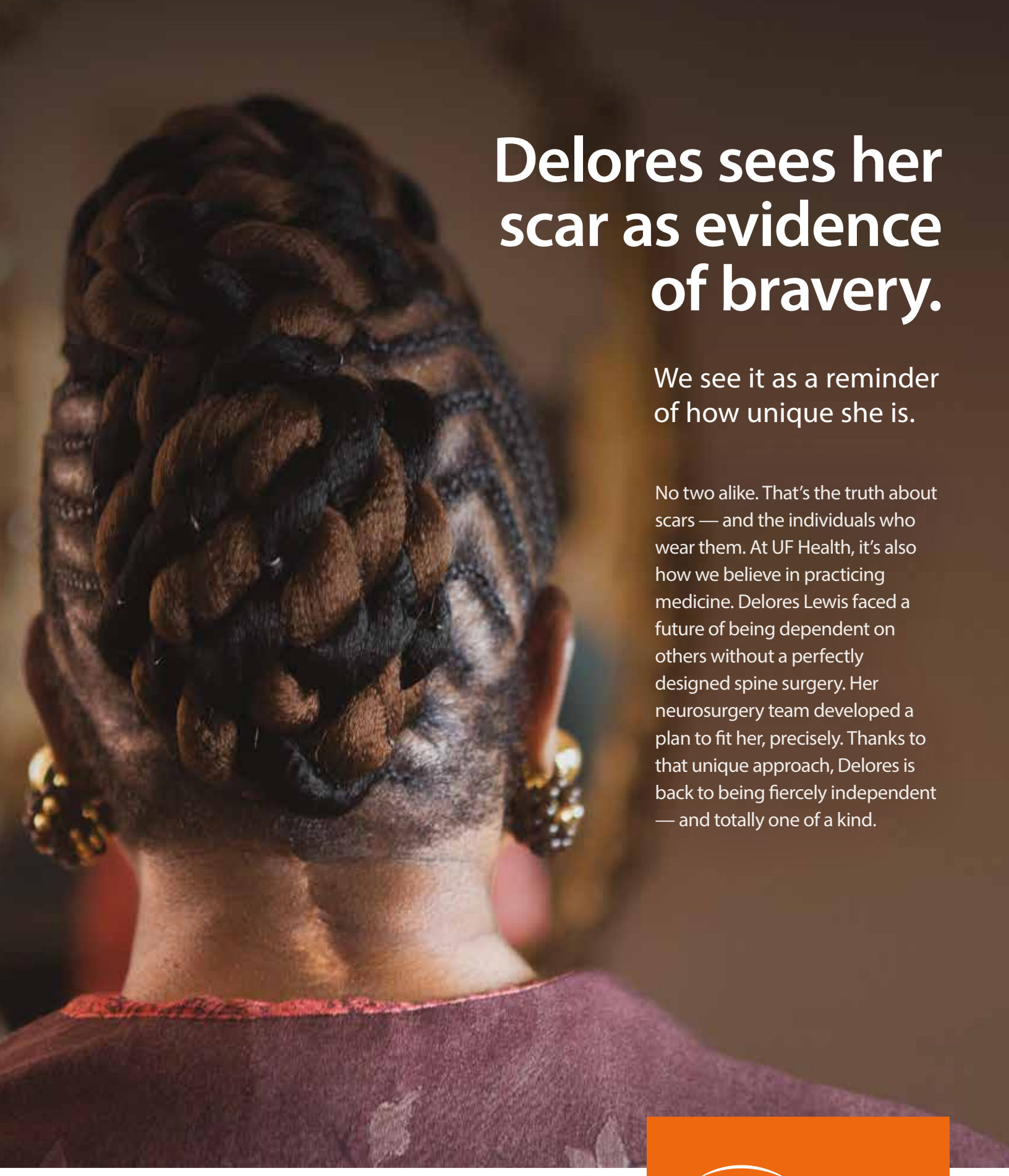

# Delores sees her scar as evidence of bravery.

## We see it as a reminder of how unique she is.

No two alike. That's the truth about scars — and the individuals who wear them. At UF Health, it's also how we believe in practicing medicine. Delores Lewis faced a future of being dependent on others without a perfectly designed spine surgery. Her neurosurgery team developed a plan to fit her, precisely. Thanks to that unique approach, Delores is back to being fiercely independent — and totally one of a kind.

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# HOUSE Calls

Winter 2017

# From the President's Desk

David E. Winchester, MD, MS, FACP, FACC

## Making Smart Investments in Your Profession

Most of us recognize the benefits of making financial investments. Smart decisions with finances make it possible to afford a nice home or car, to weather the difficult times, and to hang up our coats and stethoscopes at the end of a satisfying career. Despite these clear benefits, the distractions and tedium of day-to-day labor can make it easy to forget how important investing is. How often have you intended to make a contribution to your IRA or have a meeting with your financial planner only to realize 6 months later that you have forgotten and neglected the task?

Investing in your career has much in common with investing in your financial future. The benefits can be great, if done correctly; continued neglect can leave you wondering why you went down this road in the first place. Together, let us look at some of the ways that conventional wisdom from the world of finance parallels a solid investment in your profession and career.

Don't wait to start. In finance, the magic of compounding returns means that the earlier you get started, your returns become dramatically larger. Advisers suggest that you start putting away something when you are as young as possible, even if it doesn't seem like much. When it comes to medical careers, medical school seems busy until you get to residency. That seems busy until you get into practice. Practice seems busy until you are a partner in the group, and so on. I cannot recall any physicians who felt they had more time or that things got easier as they moved through their careers. My investment advice is to join professional societies early. I started early and the connections I have made continue to pay dividends for my career all the time.

Invest for the long term. When you are a resident, and you are finally earning a paycheck, the temptation to blow it all and reward yourself is strong. After all, you are now in your mid-twenties, you have been in school all your life, and you have decades to build a nest egg. Why would you bother investing? Many ask the same question of professional societies and organized medicine. Why should I bother joining, what is in it for me? Sometimes, there are specific and direct benefits such as a discount on insurance or no-cost CME. Often though, the benefits are deferred or indirect such as the power of a large physician group that shapes policy on Capitol Hill or the local wellness program that helps your neighbors be active and lose weight. Both financial and professional investments are best viewed through the perspective of deferred gratification.

Maintain a diverse portfolio. If you bought one share of Apple Computer stock during its IPO, you would be rich today. If you bought one share of Kaypro Computers, you would have nothing to show for it. Your financial investments need to be diversified across asset classes and investment horizons – a little in small-cap stocks, some in bonds, maybe a little in real estate or gold. Likewise, the return on investment in professional societies differs. Being a member of a national organization makes it possible to achieve substantial change while your individual contribution is quite small. Joining your specialty society gives you highly-focused experience, much like you might find investing in an industry in which you have specific knowledge and enthusiasm. Being a member of the ACMS gives you a great opportunity, not to change the UD healthcare system, but to engage with your peers and establish a community here in Gainesville. All these have different return-on-investment, and you should not "put all your eggs in one basket."

Shift your investments over time. As you get older, making changes in your investment portfolio is an important consideration of which to be mindful. The idea is that you change from riskier investments (like stocks) into safer investments (like bonds) so that if the market crashes 2 years before you plan to retire, you do not lose a substan-

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tial portion of your wealth. While investing your time in any given professional society is not likely to result in any substantial losses, we should remember that given the myriad of options for participation, you can have a series of successful and meaningful engagements during your career. I shared great experiences in the AMA with my medical school colleagues, many of whom went on to grow, expand, or build new organizations from the ground up. Policy wonks shifted into philanthropy, and social butterflies became intense researchers. Do not hesitate to be active in your profession – the experience will teach you something, even if it is only how to make the next step in your career.

Recognizing that time is money, let us draw this to a close. I hope you will consider investing with us in the ACMS; if you do our professionals Sally Lawrence and Jackie Owens stand ready to help you be an active member of our vibrant physician community.

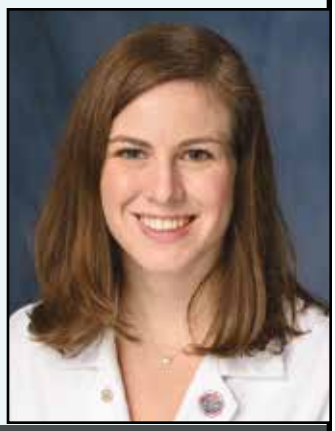
# The ACMS Welcomes New Board Members

## Dale Taylor, M.D.
### UF Health Hospitalist

The ACMS Board of Directors is pleased to welcome Dale Taylor, MD, Assistant Professor & Hospitalist, University of Florida College of Medicine as a Board Member.

Dr. Taylor graduated from the Florida State University College of Medicine. He then went on to pursue his graduate medical education in Family Medicine with the University of Florida Department of Community Health and Family Medicine. His medical interests include preventative medicine, women's health, sports medicine, and hospital medicine. In his free time, Dr. Taylor enjoys music, movies, outdoor activities, and college athletics.

## Lindsay McCullough, M.D.
### Resident, UF Health Internal Medicine



The ACMS Board of Directors is pleased to welcome Lindsay McCullough, MD, as a *Resident Physician Representative.*

Dr. McCullough is a second year Internal Medicine Resident at UF Health. A Florida native, she is proud to be a graduate of University of Florida's College of Medicine and one of the inaugural members of their Internal Medicine's Primary Care track. She is passionate about preventative medicine, medical education, and health policy. In her spare time, she enjoys spending time with her family and dog, attending concerts and musicals, reading, and yoga.

## Fan Ye, M.D.
### Resident, North Florida Regional Medical Center

The ACMS Board of Directors is pleased to welcome Fan Ye, MD as a *Resident Physician Representative.*

Dr. Ye is an Internal Medicine Resident at North Florida Regional Medical Center. After completing his Residency, Dr. Ye is interested in continuing to work closely with colleagues to provide quality care to improve the lives and well-being of our patients, families and community. In his spare time, he enjoys running, volleyball, music, cooking, Chinese calligraphy, and spending time with family.

# Opening a Cannabis of Worms

Jackie Owens, Interim EVP,
Alachua County Medical Society

As of this writing, more than half of the states have passed legislation to legalize medical marijuana in the U.S., many with the intent to legalize the recreational use of marijuana in the near future.[1] Of the arguments I have read for and against it, I have seen very little dialogue about the implications of cannabis on addiction and DUIs (Driving Under the Influence). When marijuana is involved, the National Institute on Drug Abuse (NIDA) refers to it as "Drugged Driving." This reference includes any use of illicit drugs or misuse of prescription drugs that can make driving a car unsafe.[3]

Between 2003 - 2012, there were 119,000 drunk driving deaths in the U.S., with 8,476 of those occurring in the state of Florida - and these numbers show a slight decline in the rates of drunk driving deaths from the past.[2] These deaths reported were for persons killed in crashes involving a drunk driver. Add the legalization of medical and/or recreational marijuana into that equation and the fatalities are certain to escalate.

**Effects of Marijuana**

The NIDA has established marijuana as an addictive substance with considerable short-term and long-term effects on public health and safety.[5]

According to the American Society of Addiction Medicine (ASAM), there are considerable developmental, neurological and physical long-term effects of marijuana use. Marijuana use during adolescence can cause long-term and/or possibly permanent adverse changes in brain development. THC causes memory impairment

## Marijuana and Cannabinoids

- The main psychoactive chemical in marijuana that produces the intoxicating effects desired by recreational users is delta-9-tetrahydro-cannabinol (THC).
- Marijuana contains more than 500 other chemicals, including more than 100 compounds chemically related to THC, called cannabinoids.
- The human body produces cannabinoids that are similar to those found in the marijuana plant. The areas of the brain that influence pleasure, memory, thinking, concentration, movement, coordination and sensory and time perception are affected by these endogenous cannabinoids. THC is able to take advantage of this similarity and attach to cannabinoid receptors on neurons in these brain areas, activating them and thus disrupting various mental and physical functions.
- Acting through the cannabinoid receptors, THC also activates the brain's reward system, which includes parts of the brain that respond to healthy pleasurable behaviors. THC is similar to other drugs of abuse in that it stimulates neurons in the reward system to release the signaling chemical dopamine at levels higher than typically observed in response to natural stimuli. This flood of dopamine contributes to the pleasurable effects that recreational marijuana users seek.

Source: National Institute on Drug Abuse (NIDA) 2015

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by altering how information is processed in the hippocampus – the brain area responsible for memory formation. Imaging studies show that regular marijuana use by human adolescents reveal impaired neural connectivity in specific brain regions that govern executive functions like memory, learning and impulse control compared to non-users. Evidence also shows that using marijuana during pregnancy results in babies that respond differently to visual stimuli, tremble more and have a high-pitched cry, suggesting problems with neurological development. Children exposed to marijuana prenatally are more likely to show gaps in problem-solving skills, memory and the ability to remain attentive in school.[5]

Studies estimate that 9% of people who use marijuana will become dependent on it, 17% if they started using it in their youth, and 25%-50% among daily users. The withdrawal syndrome is considered mild, however, involving irritability, mood and sleep difficulties, decreased appetite, cravings, restlessness and/or various forms of physical discomfort lasting up to two weeks.[5]

**How's My Driving?**

With respect to driving, marijuana can slow reaction time, impair judgment of time and distance, increase lane weaving, alter attention to the road and decrease coordination. Research shows that use of alcohol with marijuana made drivers even more impaired.[3]

Colorado has also seen the following related to the legalization of cannabis: an 87% increase in hospitalizations, a 48% increase in fatalities, and a 100% increase in DUIs from 2011 to 2014.[4]

After alcohol, marijuana is the drug most often found in the blood of drivers involved in crashes.[3] Tests for detecting marijuana in drivers measure the level of THC, however the role it plays in crashes is still unclear. Several studies have shown that drivers with THC in their blood were roughly twice as likely to be responsible for a deadly crash or to be killed than drivers who hadn't used drugs or alcohol. However, THC can remain in body fluids for weeks after use, and it is often found in combination with alcohol, cocaine or benzodiazepines, making the isolation of the marijuana effect very difficult to determine.[3]

When consumed, alcohol evenly saturates the blood and lungs, making it quantifiable in accurately determining the current effect on the brain at any given time. With marijuana, the height of the intoxication is not at the moment when blood THC levels peak, and levels don't rise or fall uniformly based on how much THC leaves and enters the bodily fluids. THC moves readily from water environments, like blood, to fatty environments. "Fatty tissues act like sponges for the THC - and the brain is a very fatty tissue. It's been proven you can still measure THC in the brain even if it's no longer measurable in the blood," says Marilyn Heustis, PhD, who headed the chemistry and drug metabolism section at the NIDA.[7]

According to Margaret Haney, PhD, a Professor of Neurobiology at Columbia University, "It's really difficult to document drugged driving in a relevant way, [due to] the simple fact that THC is fat soluble. That makes it absorbed in a very different way and much more difficult to relate behavior to" say [blood] levels of THC, or to develop a breathalyzer."[7]

An accurate testing method for marijuana impairment currently does not exist and many of the studies on marijuana have been too small, poorly designed or inconclusive.[6] In the interest of public health, safety and welfare, much more research is required before allowing marijuana to be legalized in additional states. The starting point of 119,000 drunk driving deaths in a ten-year period should be reason enough to pause.

**References available upon request.**

# Robb House Endowment Donors

The Robb House was the home and medical clinic of Dr. Sarah Lucretia Robb and her husband, Dr. Robert Robb, from 1884 until the 1920's. The house was moved from its original location (East University Avenue) to 235 SW 2nd Ave in 1981 and restored in 1983 as the ACMS offices. The moving costs were approximately $20,000 and restoration costs were $80,000. The Alliance helped raise funds through various fund-raising efforts and established a Medical Museum with original artifacts from the Robbs.

Over the years, many objects have been donated by local physicians. The museum has been carefully tended by our museum curator, Ms. Florence Van Arnam, for more than twenty years. The Robb House is the only historic house in Florida which has been restored as a County Medical Society. It was also the first recognized Medical Museum in the state.

We have created an endowment through the ACMS Foundation to maintain this precious jewel. Our goal is a $100,000 endowment. The tentative plan is to draw a sum on an annual basis for maintenance purposes (paint, roof repairs, restoration projects, appliances, etc.].

A pledge at this time would be very helpful as a one-time gift. We also welcome pledges to be paid over a couple of years. You could also consider a bequest in your will or trust of $5-10,000.

Please help protect and maintain our beloved Robb House and the Museum, by sending your tax deductible contribution to: Alachua County Medical Society Foundation, 235 SW 2nd Avenue, Gainesville, FL 32601. Designate your gift for the Robb House Fund.

**Donors will be recognized in the ACMS magazine: *House Calls* and at future ACMS dinner meetings.**

## A Special Thank You to our generous Donors below!

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**Representative Clovis Watson, Jr.**

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# My Legislative Community

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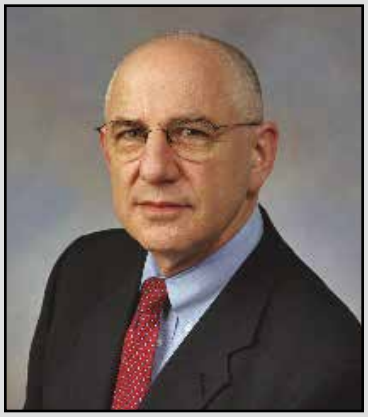
**Representative Elizabeth Porter**

## In Memoriam

It is with much sadness that we report that a beloved member of our medical family passed away....

**Kenneth R. Kellner, M.D., PhD.**
1947 - 2017



Kenneth Kellner, M.D., passed away on Saturday, January 14 at E.T. York Haven Hospice in Gainesville. Dr. Kellner was raised on Long Island, New York. He began his career with an interest in embryology at Union College, where he was an Eliphalet Nott Scholar. He attended the University of New York, Downstate Medical Center in the Combined-Degree Program, receiving both an M.D. and Ph.D. degree in1973. Dr. Kellner was the Director of the Third Year Clinical Clerkship in Obstetrics and Gynecology at UF for 25 years -with the program being recognized by the Association of Professors in Obstetrics and Gynecology as one of the best in the nation. In 2012, he was awarded the Lifetime Achievement Award by the College of Medicine Society of Teaching Scholars, only the eighth faculty member so honored. Since his retirement from clinical practice in 2012, Dr. Kellner continued to be active in student/resident education both at the College and Departmental level.

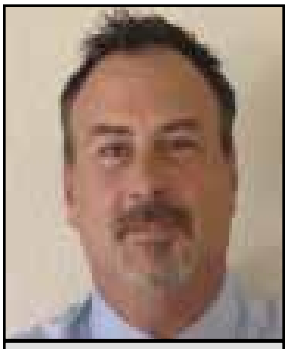
He is survived by his wife, Irene, by sons Adam (Tracy; Morgan, Aubrey), and Evan (Colleen; Ella, Ethan, and Daniel), and by his brother, Jon (Ro).

# Addiction as a Disease

Gregory L. Jones, MD, FASAM, FAAF, UF Health Florida Recovery Center
Scott A. Teitelbaum, MD, FASM, UF Health Florida Recovery Center
Jason Hunt, MD, Chief Fellow in Addiction Medicine, University of Florida
Trey Appleton, MD, Fellow in Addiction Medicine, University of Florida


Gregory Jones, MD


Scott Teitelbaum, MD,


Jason Hunt, MD


Trey Appleton, MD

Addiction has been a problem in society for as long as there has been a society. Over a decade ago, the American Medical Association classified alcohol abuse as a disease, and 40 years ago the AMA did the same with drugs. *As far as we can tell, no other diseases have required AMA approval.* But since that time, there has been a significant amount of research devoted to the neuroscience of addiction and effective methods for treating substance use disorders (SUD). Even though this science has taught us that addiction is a disease which hijacks the brain, recovery from addiction must involve a healing of the heart and soul as well as becoming physically separated from the substances.

The following is the definition of addiction as stated by the American Society of Addiction Medicine (ASAM):

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

This recent definition of addiction makes it clear that addiction is not about the drugs, it's about pathologic changes in the brain. The substance that a person uses is not what makes them an addict; it is not even the quantity or frequency of use of the drugs that makes a person an addict. The disease of addiction is about what happens in the brain when a person is exposed to rewarding chemicals and/or rewarding behaviors. Addiction is more about brain circuitry and neuroscience than it is about the substances or behaviors that "turn on" and hijack the brain's reward pathway. We have now recognized the role of memory, motivation, and its related circuitry that is involved in the manifestation and progression of addiction. We have learned that genetics, brain neurochemistry, environment, trauma and stress all play a role in addiction. Addiction is now accepted as a disease among the scientific community and most medical professionals.

**History of Addiction and Disease Concept,**

**Dr. Thomas Trotter (1788)**

– First to characterize as disease/ medical condition

**Dr. Benjamin Rush (1808)**

– "habitual drunkenness should be regarded not as a bad habit but as a disease"

**Abraham Lincoln (1842)**

– Non-alcoholics have "absence of appetite" rather than "mental or moral superiority"

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**Jellinek, E. M., The Disease Concept of Alcoholism, Hillhouse, (New Haven), 1960.**

– "victims of it were to be pitied and compassioned, just as are the heirs of consumption and other hereditary diseases"

The disease of addiction is no longer a concept. Addiction is a disease, just as cancer, heart disease, diabetes and other chronic illnesses. There is a pathophysiology (A defect or abnormal structure or function in an organ or organ system- such as the Prefrontal Cortex, Nucleus accumbens and Ventral Tegmental area (VTA) within the Brain; which leads to identifiable symptoms such as cravings, loss of control/ unmanageability, and continued use despite significant negative consequences. People who suffer from a SUD may not fully process long-term consequences of their choices. They seem to compute information less efficiently while in the throes of their addiction. Research has pinpointed changes in the brains of those that suffer from the disease of addiction. It is known that alcohol and drugs of abuse increase dopamine, a primary pleasure/reward chemical in the brain, which in turn causes actual changes at the genetic level in the brain. Coding for certain receptors and modulators of these receptors changes. Substance use disorders are influenced by actual physical changes in the frontal cortex which produce marked differences between the brains of people who suffer from addiction and those who do not. Dysfunction in the frontal cortex plays a major role in the analysis of situations and the decision-making process in these individuals. As a result of these changes in their brain structure and function, craving of the substance occurs. A person suffering from a SUD has cravings for alcohol and/ or drugs which may outweigh the love of their children, spouse, or job. As a result, this substance rules their world and often this need for the drug is much too intense to resist. To the patient with the disease of addiction, the substance is survival.

When there is an understanding of what really happens with the brain in addiction, it is seen that good people will do very bad things. Then, the behaviors of people in active addiction become more understandable. This behavior is moderated by alterations in brain function. This demonstrates that addiction is not just a social or moral problem, but an actual disease. If the person does not obtain treatment, the illness progresses over time and eventually results in the loss - sometimes loss of all that one holds dear. Typically, the things that an addict holds most dear are put at significant risk, and they are unable to control their use even in the face of the circumstances. This process of "hitting bottom" usually is the motivation that is needed to finally make the decision to get help. It is important to understand that the disease is not an excuse for the bad behavior. Rather, it provides an understanding of why their behavior becomes inconsistent with their basic morals and values. Addiction is not a pretty illness. Addicts must be responsible for their behavior and their recovery.

So, when the addict realizes they have a problem, then what do they need to do? All journeys begin with a first step and in every recovery program the first step is always the same… Admitting that you have a problem. If you do not believe that you have a problem, how can you possibly get better?

People should be responsible for their actions, and the addict is no different. For example, a diabetic has a medical illness which may be treated with medication. The diabetics that learn to manage their illness in the best way also take responsibility for their recovery. They begin to exercise, eat properly, test their blood sugar on a regular basis, and take their medications as prescribed. They begin to demonstrate a healthier lifestyle and they are proactive with their health. These individuals have a longer, healthier life span as opposed to those that say "poor me, I am a diabetic and there is nothing I can do about it except take my insulin". A key difference between diabetics and addicts is that with diabetes, there is no organization like M.A.D.D. (Mothers Against Diabetic Drivers). This same personal responsibility also applies to the addict. It is very easy for the addict to say "Poor me, I am an addict and it isn't my fault that I can't stop because I have a disease!" A responsible person instead says "Yes I have a disease, but I am in charge of me and I will do my part to overcome it." Treatment for addiction is necessary and it does work!

The following are the 13 principles of treatment as described by the National Institute on Drug Abuse (NIDA.)

**NIDA's 13 Principles of Treatment:**

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each patient's problems and needs is critical.

2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.

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3. **Effective treatment attends to multiple needs** of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.

4. **Treatment needs to be flexible** and to provide ongoing assessments of patient needs, which may change during the course of treatment.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.

6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.

7. **Medications are an important element of treatment for many patients,** especially when combined with counseling and other behavioral therapies. Methadone and Buprenorphine both help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol dependence. Nicotine patches or gum, or an oral medication such as bupropion, can help persons addicted to nicotine.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.

9. **Medical detoxification is only the first stage of addiction treatment** and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.

11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases,** and counseling to help patients modify or change behaviors that place them or others at ris of infection. Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process** and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

*Principles of Drug Addiction Treatment: A Research-based Guide* (NCADI publication BKD347) has been mailed to *NIDA NOTES* subscribers in the U.S. Copies of the booklet can be obtained from NIDADrugPubs.

In addition, attending mutual aid meetings, consulting with sponsors, abstaining from alcohol and drugs, attending 12-step programs and the desire to stay sober are all conscious decisions that must be made in order to remain clean. Addicts must also choose friends wisely, and get rid of the enablers of their disease and the other substance users

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involved in their life. To get/stay sober is a 24/7 job and the addict must be responsible for his life and lifestyle.

Unfortunately, when treatment is provided for substance use disorders, it too often comes at the most severe stages of the disease when successful treatment is much more difficult, thus requiring a much higher level of care which requires more resources. In most cases substance use disorders may go undiagnosed for many years. It can also be very difficult to access quality treatment and a person usually has to hit "rock bottom" prior to seeking help. All this makes it very difficult to treat in the latter stages. By this time patients have most likely lost their support and probably most of their resources. They are stigmatized by society and sometimes even by their families. We also know that a vast number of patients enter treatment as a result of the criminal justice system. Despite parity, there still remains a barrier to adequate long-term treatment coverage.

Nobody grows up wanting to become an addict or alcoholic (Diagnosed with a Substance use disorder). It's a medical and public health-issue not a moral or criminal justice problem. Only a small percentage of people with addiction are referred by their primary care provider.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic abuse and dependence on alcohol and illicit drugs. This effective tool involves: Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting. Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice. Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen positive in need of additional services.

Doctors and staff at UF Health Florida Recovery Center provide all levels of care for people suffering from drug addiction or alcohol addiction who need drug rehab or alcohol treatment. Our staff can provide medical consults, comprehensive labs and psychological testing for people who have an addiction and/or other psychiatric conditions.

The University of Florida College of Medicine has been a pioneer in training addiction medicine doctors and exposing medical students to this specialty, offering a Fellowship training in Addiction Medicine since 1992. As one of the largest addiction medicine fellowships, we have matriculated more than forty addiction-medicine professionals. American Board of Addiction Medicine (ABAM) fellows participate in a wide range of academic activities including clinical and basic science research, medical education, and patient care clinics. The fellowship offers training in inpatient detoxification, evaluation, treatment, and consults, as well as outpatient and partial hospitalization and treatment.

Dr. Scott Teitelbaum currently serves as the director of the UF Health Florida Recovery Center and is the training director for the UF Addiction Medicine Fellowship. Dr. Teitelbaum's success with the use of evidence-based addiction treatment has set a standard of quality care at the UF Health Florida Recovery Center and the Addiction Medicine Fellowship Program that has been recognized by the American Board of Addiction Medicine (ABAM). His commitment to the education of future addiction medicine professionals is evident in his numerous teaching awards and national lectures on these topics. He has treated patients from over 40 states and is a highly sought-after expert in the field of addictions medicine.

In order to help solve the problem of inadequate long-term substance abuse treatment, an action announced in March of this year by the American Board of Medical Specialties (ABMS), recognizing addiction medicine as a specialty, is expected to propel physicians more aggressively into the mainstream of addiction treatment, helping to overcome historical barriers to their greater involvement. The ABMS recognition will elevate addiction medicine's visibility among both medical students pursuing training and the general public seeking treatment options.

In a statement issued to mark this milestone, ABAM President Robert J. Sokol summed up its significance: "This landmark event, more than any other, recognizes addiction as a preventable and treatable disease, helping to shed the stigma that has long plagued it. It sends a strong message to the public that American medicine is committed to providing expert care for this disease and services designed to prevent the risky substance use that precedes it."

Know **Science** NO stigma!

# Treatment of Pain and Addiction to Pain Medications

**Jesse A. Lipnick, MD, Fellow ABPM&R, American Board Anesthesia Certified in Pain Management, Fellow AANEM, SIMED Rehabilitation Medicine**

Jesse Lipnick, MD,

**Treating Pain in the Setting of Addiction: What Are the Choices?**

How should we, as physicians, treat pain in a patient with addiction? We evaluate these patients daily in our medical practices, and there are a number of issues that we should consider. The first is whether or not we are really dealing with an addict, as it is often not clear. The addict may not advertise his situation, or worse, may not even realize that he is affected by addiction. Our second task is to appropriately diagnosis the patient. Even in the non-addict, our task of appropriately separating diagnoses with overlapping signs and symptoms can be challenging. Each patient describes his pain differently, as pain is a subjective symptom. In addition, painful conditions are not mutually exclusive and the addict is usually subject to the suspicion that he is inflating his condition to obtain a prohibited substance. Finally, the question arises as to whether or not the presenting complaint justifies the use of a narcotic or some other potentially addictive medication. Ideally, treatment of the painful condition and resolution of the illness should be sufficient to relieve pain.

For this short essay, let's define addiction as a primary neurobiological disease marked by craving and excessive use of a particular substance, by excessive concern with obtaining that substance and by a loss of control over obtaining and using it. In addition, the addict uses this substance even though it harms him. Most of us are familiar with addiction to cigarettes or to alcohol. We have all seen the smoker who gets distressed by the loss of a lover to emphysema, and who smokes to cope with the stress. We see a husband who drinks alcohol and who loses his spouse and his job and the love of his children, but can not stop drinking. These patients are clearly addicts because they continue the use of these substances despite the consequences.

Even though the act of profiling is not politically correct, we associate addiction with known risk factors: Personal or family history of addiction, male gender, youth, smoking cigarettes, depression, bipolar disorder or other psychological diagnoses, and the advent of recent life stressors - such as a divorce, the loss of a loved one or the loss of a job. Statistically, these factors do predict a higher incidence of addiction, and yet they do not diagnose your specific patient. We may see telltale signs in the history and the physical exam, such as "tract marks" on the arm or a recent unexplained cachexia. Most of my cigarette smokers who try to quit wind up gaining weight because losing one form of comfort in smoking a cigarette motivates the addict to find another source of oral comfort in eating. Of course, we are all sensitive to the increased attention that the addict requires. I refer to the multiple requests for early refills or to the creative stories of lost medication. I do not know how I might react if I hear another patient accidentally dropping the meds into the sink or leaving the meds on the seat of the convertible while going into Wal-Mart or the dog eating the medication of interest.

Our next challenge is that addiction may not be absolute. Patients exhibit a range of addictive qualities and it is not always clear when a given patient passes the threshold of addictive use. Does the person who takes one extra pain pill per month qualify as an addict? How about the person who takes an extra pill every week or every day - or the person who takes the entire month's supply of medication in two days? These scenarios represent a spectrum of misuse and loss of control on the part of the patient, and deciding the point at which a patient becomes a danger to himself is most challenging.

Florida Statute 893 asks each of us physicians to assess a patient for the risk of misuse or abuse of a controlled substance before we prescribe it. Even though most of us believe that we are good judges of a patient's character, it is difficult to tell the addict from the non-addict in a clinical setting. Confusion arises as non-addicts may exhibit signs that we consider to be danger signals. Take the elderly woman who gets an upset stomach

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from every narcotic medication except Hydromorphone. No one is further from addiction than this patient, and yet, she will clearly tell you that she wants you to prescribe one of the most addictive narcotics that you know. On the other hand, addicts who are aware of their affliction will actively obfuscate to mislead you to conclude that addiction does not play a role in their care.

We should consult the Florida Prescription Drug Monitoring Program, the PDMP or E – Force, before prescribing narcotic medication, particularly in the treatment of chronic pain. This database comprises a record of dispensing of all controlled substances in our state. The pharmacist who dispenses a controlled substance to any patient must record that dispensing in the database, and this information is readily available to any physician or designated staff who consults the database. Of course, any patient who is obtaining a controlled substance illegally is most likely obtaining it from family or a friend. History should also indicate previous drug usage, arrest, discharge from a medical practice for inappropriate drug use, smoking and family history as risk factors for addiction. The challenge here is that we, as caregivers, can not tell if the patient has as much pain as he says he does, and we may be misled to believe that a patient needs pain medication when in fact, he is really trying to satisfy an addiction.

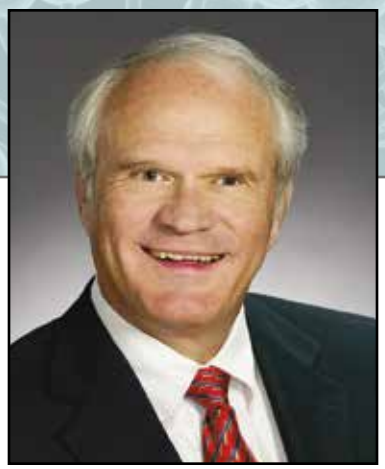
So let's assume that you determine that the patient is an addict, either because he told you or because you figured it out on your own. He still has a painful condition and you still want to treat him, so what do you do next? First, please consider consulting a specialist, who deals with pain and addiction. Consult a Physical Medicine and Rehabilitation specialist, an anesthesiologist, a psychiatrist, neurologist, rheumatologist, or any specialist with fellowship training in addiction. Your task is to treat the painful condition without causing the patient to relapse. I would also be open and honest with the patient and tell him that your goal is to treat him and not cause a relapse and that you are concerned about that possibility. While our medical challenge is to relieve pain, I also try to keep our first priority in mind: Do no harm.

There are multiple alternatives to narcotic medication in addressing pain. It is always best to determine the mechanism of pain and to specifically interrupt it. For example, an anti-inflammatory medication is useful in an inflammatory disorder. Neurogenic pain responds well to antidepressants or to anticonvulsant medications. Medications that address pain and do not risk an addictive response include Acetaminophen and a large variety of non-steroidal anti-inflammatory medications, which I will not list individually here. Other adjunctive medications that help pain include antidepressants. A generation ago, we learned that the Serotonin non-selective medications (SSRIS) were the best for treating pain as Norepinephrine activates spinal column interneurons to depress the cephalad transmission of pain, i.e. The Gate Theory of Pain. More recently, SSRIs have also been associated with lessening pain as they allay the anxiety that patients associate with pain and thereby improve the experience of pain. We have gone from using amitriptyline and the other Tri-cyclic antidepressants only to using Venlafaxine, Duloxetine, Fluoxetine, Citalopram and even Escitalopram. Next is the common use of anticonvulsant medications to reduce pain, with proposed mechanisms that range from stabilizing ephaptic transmission in peripheral nervous tissue to reducing neurogenic inflammatory mediators in the CNS. We have used Gabapentin for as long as I can remember and now, Pregabalin has pain indications as well as anticonvulsant uses.

In addition to the use of non-addictive medication, we should also focus on establishing patient mobility, both of the body from one place to another, and also of individual parts of the body that may have lost full mobility due to injury or pain, and I believe that a fundamental rule of recovery, and life in general, is that mobility reduces pain, and I refer here to the use of physical therapy to restore mobility. Physical exercise has the added benefit of increasing heart rate, improving strength and encouraging endorphin production. On the more passive side, massage and chiropractic care also establish appropriate mobility and reduce pain. In the hospital setting, patient mobility predicts recovery from an illness and ultimately, it also predicts health and patient survival. As each of these areas is a complete discipline in itself, I will not go into specifics regarding the various types of physical mobility-based intervention. Finally, do not forget that Interventional Pain Management strives to target the source of chronic back and neck pain specifically and to treat it without the use of addictive medications, and surgery may also be necessary to correct anatomic dysfunction and hopefully to eliminate the source of pain.

In closing, it is a particular challenge to treat the patient with addiction for a painful condition. While we hope to help the patient heal, we are wary of risking the patient's abstinence or even causing the patient to become addicted unexpectedly. This type of patient requires close attention with frequent office follow up. In addition, we should consult appropriate specialists who closely follow risk factors for misuse or abuse of addictive medication. We also assess the patient for risk as part of the medical history. We then diagnose the patient's condition and finally, we treat the patient with techniques that do not incite addictive potential. Finally, this process only works for the patient's benefit if he actively wants to heal and works with you, the physician, to avoid the drain of addiction.

# Medical Marijuana Initiatives in Florida



**Scott Medley, MD**

**(Dr. Medley is a retired Family Physician, Hospitalist, and Chief Medical Officer, and currently volunteers with Haven Hospice.)**

**A Brief History –**

One of my favorite activities in retirement is teaching classes to the wonderful Volunteers at Haven Hospice (HH). Many people find it surprising that about one-third of the Volunteers at HH are pre-med, pre-nursing, or pre-physician assistant students. Combine these students in our classes with our middle-aged and Senior Volunteers, and we have some titillating discussions about many topics. One of those topics involves the use of Medical Marijuana (MM) in Florida. So I have made a cursory review of this subject, which I thought would fit nicely in this *HOUSE CALLS* issue devoted to Addiction Medicine.

But first, a few generalities about MM. Many people seem to forget that marijuana is still a U.S. FEDERAL "Schedule 1" drug, and therefore cannot be legally "PRESCRIBED" in the U.S. The Food and Drug Administration (FDA) has, as of October 12, 2016, kept marijuana as a "Schedule 1" drug on the basis of its "high potential for abuse" and the absence of "currently accepted medical uses". [(1)] MM, however, usually can be legally "CERTIFIED" for eligible patients by physicians "QUALIFIED" in states where MM is legal. As one can predict, state laws governing the use of MM vary widely. Although it is difficult to keep abreast of ever-changing state laws, as of this writing about 25 states have approved various forms of MM laws.

There is significant controversy about which symptoms MM actually helps. Generally, the most common diseases and symptoms treated are nausea and pain secondary to cancer and its treatments; epilepsy; spasticity secondary to neuromuscular disease such as multiple sclerosis; neuropathic pain; and nausea and anorexia due to HIV infection and treatments. As will be discussed below, Florida voters have recently approved a measure to significantly increase the number of "Debilitating Medical Conditions" for which MM may be "CERTIFIED".

Groups who caution the use of MM assert that any good which can be derived from MM must be balanced with its hazards: potential for addiction, balance difficulties, confusion, lethargy, fatigue, hallucinations, nausea, diarrhea, and others.[(1),(2)] Also, please see the excellent points made by our Interim EVP Jackie Owens in her article in this issue of *House Calls.*

As for Florida, though discussions about MM have been ongoing for many years, let us begin our story in the Spring of 2014 with legislative passage of "The Florida Compassionate Medical Cannabis Act". This Act made eligible for MM permanent Florida residents with cancer, chronic seizures and severe muscle spasms. The MM was approved in the form of an oil, often formulated in olive oil or food, and smoking marijuana was still illegal. This oil form of MM was coined "Charlotte's Web", after 5-year-old Charlotte Figi, who suffered from chronic epilepsy and was one of the first recipients of this MM. To oversimplify, MM has two main components-cannabidiol (CBD), which is the "medical component", and Tetrahydrocannabinol (THC), which induces the "psychoactive high". "Charlotte's Web" was required to be very high in CBD (>10 %), and very low in THC (<0.8%).[(3)] Thus, this "non-high" producing product became known as "boring pot", or, more colorfully, as "hippie's disappointment!"

An Amendment to the Florida Constitution to legalize the broader use of MM was rejected by voters in the Fall of 2014, narrowly lacking the 60% required for passage of Constitutional Amendments in Florida.

Fast forward to the Spring of 2016 when the Florida

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Legislature approved MM for "the terminally ill." For purposes of this law, "terminally ill" meant that the patient had less than one year to live, an estimation which had to be certified by two physicians licensed in Florida. This bill went on to authorize the use of full strength MM for these patients.

This brings us to the General Election of November 8, 2016 and the inclusion of "Amendment 2" on the ballot. As noted above, this Florida Constitutional Amendment widely broadened the definition of "Debilitating Medical Conditions" for which MM could legally be used. In addition to those conditions listed in paragraph 3 above, Amendment 2 would include indications for glaucoma, post-traumatic stress disorder (PTSD), Crohn's disease, and Parkinson's disease. But the Amendment goes further, and states, in its most controversial clause: "or other debilitating medical conditions as the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential risks for a patient".[4] It is this last clause which opponents of the Amendment termed a "loophole" which would allow the "certification" of MM for most any patient by unscrupulous physicians. Opponents might go on to state, "Florida just managed to rid itself of narcotic 'pill mills', only to be potentially replaced by 'marijuana mills.'"

These opponents go on to say that allowing doctors to recommend MM for such a wide variety of unspecified conditions amounts to "de facto legalization" of marijuana.[5] They are also concerned about the adverse effects of cannabis, as outlined above.[2]
Proponents of MM advocate that hundreds of thousands of Floridians will benefit from this treatment and that the benefits far outweigh the risks.

At any rate, Amendment 2 passed by some 70% of the vote and has gone into effect on January 3, 2017. Opponents of the measure included the Florida Medical Association, the Florida Sheriffs Association, the Florida Chamber of Commerce, and the Drug Free Florida Committee. The Amendment was supported by, among others, the American Civil Liberties Union (ACLU), the AFL-CIO, Planned Parenthood, the Florida Democratic Party, and several other Democratic Organizations. Interestingly, trial lawyer John Morgan was an outspoken supporter of Amendment 2, and his law firm, Morgan and Morgan, contributed more than half of the $12.5 million raised by the political committees supporting MM in the past three years.[5] I'll let our readers draw their own conclusions about this last development.

So what will be the result of passage of this Amendment allowing MM to be so much more widely available? And does this mean that the approval of "recreational marijuana" is on the horizon in Florida? I guess we'll find out in 2017 and beyond. Stay tuned, and Happy New Year!

**References available upon request**

## ACMS We Care Physician Referral Network

The We Care Physician Referral Network is a community-based initiative that coordinates volunteer physicians, dentists, hospitals, and ancillary providers to meet the medical and dental needs of uninsured and poor Alachua County residents. It is a partnership of public and private institutions, agencies, and individuals that responds to the health care needs of the community's under-served population. A health care board provides guidance to the program in response to community health issues and evaluates the efficacy of the agency's programs. The initiative started over twenty-five years ago in response to an overwhelming need for medical services for low income, uninsured residents of Alachua County.

Since 1990 the program has received over 25,000 requests for volunteer medical and dental care. More than half of those requests were met by volunteer professionals. The cumulative total of volunteer medical and dental services provided exceeds $80,000,000.00 (value to December '15).

# Pain Management and Addiction

John A. Bailey, MD,
SIMED Interventional Pain Management

**INTRODUCTION**

Having completed fellowships in Pain Medicine as well as Addiction Medicine, and practicing on the "front line" for many years, I can affirm that pain management is one of the most challenging medical specialties. In no other specialty are physicians expected to spot deception; undergo inspections by licensing Boards and regulatory authorities such as the DEA; be second-guessed by often well-meaning pharmacists, insurance companies, and even by other physicians who do not know what they don't know. Patients often show up already on dangerous and excessive regimens, with insufficient medical records, many of them down to their last pill, facing excruciating and dangerous withdrawal, lacking sufficient insurance coverage or facilities for needed inpatient detox.

**EVALUATING FOR PAIN, ADDICTION and OTHER COEXISTING DISORDERS**

Chronic pain and addictive disorders frequently coexist. Evidence suggests that the stress of chronic untreated pain may predispose to addiction. Conversely, the medications used to control pain such as chronic opioid analgesics may also trigger neuroplastic changes resulting in addiction, especially in those who are genetically vulnerable.

Caring for patients with coexisting addiction and pain is challenging. Addiction "short-circuits" and "hijacks" the brain, resulting in deception towards caregivers, as well as self (denial). In fact, addiction is often described as "the only disease that tells you you don't have it". Opioid analgesics trigger reward and survival brain pathways much like food, sex and nurturing. Thus on a subconscious basis, opioid analgesics can be equated with survival. In the addicted brain, a hijacking occurs where destructive addictive behaviors such as lying to obtain opioids can suddenly make perfect sense and the brain is essentially hijacked to the point where the addict seems powerless to stop the behavior.

Because pain is subjective and can exist without physical findings, we are forced to rely heavily on what our patients tell us. Thus, addiction compromises the most useful tool we have in pain management, the patients' accounts of their pain history and the efficacy of our treatment plan. Licensing boards and regulatory authorities expect us to spot deception. However, a recent study showed that most physicians are unable to do so and though physicians in all specialties are deceived by factitious disorders such as malingering or Munchhausen's syndrome, only in Pain Management, where controlled substances are prescribed, can missing deception result in arrest and loss of licensure.

Besides seeking medications to satisfy addiction and ameliorate physical discomfort, pain patients may also seek controlled medications to inappropriately treat psychiatric disorders such as chronic depression, anxiety, and PTSD. If these coexisting problems are not recognized and treated, neither pain nor the coexisting disorder will improve. Furthermore, patients may be seeking these medications to abuse or get "high", achieve euphoria, much like with alcohol. The difference being they can choose to just stop the inappropriate use, whereas with addiction, treatment is generally needed.

Patients may also be inappropriately seeking pain medictaion to avoid the discomfort of physical withrawal. While often occurring in the patient suffering from addiction, physical withdrawal is not synonymous with addiction. Many medications that are not abused such as paroxitine, baclofen, clonidine, duloxitine or venlafaxine can result in withdrawal if abruptly stopped and not tapered.

Pain patients who suffer from addiction may argue over drug type and quantity and there is a high incidence of psychiatric comorbidity.

**INITIAL EVALUATION**

In addition to a history and thorough physical exam, a proper initial evaluation of a potential pain patient should include addiction screening, addiction/opioid risk assessment and stratification, as well as a psychological screening. The use of standardized tests such as the SOAPP (Screener and Opioid Assessment Tool), ORT (opioid Risk Tool) and Beck depression inventory can be helpful. Patient records are needed along with clear-cut documentation of an actual pain condition if the cause has been diagnosed. If not, diagnosis must precede treatment.

**RED FLAGS**

What follows is a list of red flags from the literature and per-

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sonal experience that point towards an increased risk of addiction, abuse, and diversion.

- Young age
- Knowing too much about controlled medications
- Life relationship, job problems
- Teenage tobacco, cannabis
- Drug related tattoos, burns from "popping" cannabis seeds
- Physical findings- "tracks", Hepatitis B, C; HIV; Abnormal liver function tests
- Focus on opioids and lack of interest in non-controlled drug medication therapies such as interventional techniques
- Predisposing Psychiatric illnesses- i.e., PTSD, Bipolar disorder, depression
- Withdrawal symptoms, intoxication symptoms
- Use of street terms such as "Roxies", "Xanny bars", "bars"
- Discharge from other Pain Management physicians
- Personal or family history of addiction
- Tobacco use
- History of physical, emotional or sexual abuse
- Thrill-seeking personality
- Lack of objective findings
- Exaggeration of physical symptoms
- Lack of documentation
- Request for specific, highly abused medications
- "Process "addictions- food, sex, gambling
- Lack of honesty in history (arrests, treatments, etc.)
- Driving long distances or paying cash
- Refusing to divulge contact information or not signing information releases
- History of ER visits, multiple doctors, multiple pharmacies
- "I have a high pain tolerance"
- "Allergic" to less reinforcing, less abused opioids
- Cannot produce urine for testing

**MANAGING COEXISTING PAIN AND ADDICTION**

Co-managing pain in those recovering from addiction is possible with the goal of minimizing pain and the likelihood of relapse. Because addiction is a disease, and not a group of separate diseases, those who have a history of alcoholism are at risk of losing control of any scheduled medications. The administration of a non-opioid reinforcing drug such as alcohol or benzodiazepines will also wake up the addictive midbrain circuits and increase cravings for opioids. Therefore, all addictive dopamine-increasing drugs are considered unsafe in those in recovery, and their use must involve a careful weighing of risks and benefits.

There are several basic principles in the medical management of these patients.

- Avoid opioids if possible

- Non-opioid therapies- Interventional modalities, NSAIDS, gabapentin, pregabalin, etc.

-if opioids are deemed necessary, avoid the use of short-acting opioids or breakthrough pain medications (rapid release medications are more reinforcing). Long-acting opioids should be carefully chosen with attention paid to the ease of defeating the delivery system. For example, conventional morphine can be crushed, snorted, or injected, as can most controlled-release morphine preparations. Newer preparations of morphine have an opioid antagonist embeded ("Embeda") in the matrix to discourage inappropriate use.

Buprenorphine should also be considered if an opioid is required. There are several preparations and generics are available. In higher dosages, these can precipitate withdrawal in those already on opioids. An understanding of the pharmacology of these medications is necessary and is a whole lecture in itself. They can be prescribed for pain by any doctor with a schedule 3 DEA license, but if used in addiction treatment as an opioid replacement, an "X" DEA is necessary. However, insurance companies will often only cover the cost if prescribed for addiction - requiring an often frustrating and unsuccessful preapproval process.

-Avoid Soma, Fiorinal/Fioricet, tramadol and benzodiazepines. Many cases of addiction have been reported with all of these medications.
-Avoid most sleep medications. Medications such as zolpidem, eszopiclone, and zaleplon should be avoided in the vast majority of patients with pain, especially those with a history of addiction, drug abuse, or even strong addiction risk factors.

Avoid stimulants. If a stimulant is indicated to counteract opioid sedation or to control a medical condition such as sleep apnea or narcolepsy, use of long-acting controlled-release forms or the "stimulant like" wakefulness medication, modafinil, is preferred.

Psychiatric comorbidity such as PTSD, depression, bipolar disorder, etc., should be managed, and consideration should be given to utilizing a psychiatrist or psychologist.

**MONITOR RECOVERY**

It is necessary to monitor recovery efforts. Questions regarding AA or NA meeting attendance are helpful. It is reasonable to inquire about meeting location and time. Meeting schedules are readily available over the internet and can be checked. Furthermore, it may be helpful to ask if it is okay to talk with the patient's recovery sponsor. Questions such as "what is the 6th step in AA/NA" are useful since the steps are recited at the beginning of every meeting, and are easily recalled by those who are actually attending them.

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**MONITORING**

Tight control of medications and monitoring should be utilized. Return visits should be frequent and urine drug testing (consider witnessed) should be used with confirmatory send-offs that cover a wide range of abusable drugs which are not measured in conventional office screens. Do pill counts on return visits.

Watch for signs of deterioration such as weight loss, depression, withdrawal symptoms, anxiety, needle marks, less attention to grooming, relationship problems, and work problems. Missing appointments, not being able to produce urine, "lost" or "stolen" medication, and "running out early" are very worrisome. Furthermore, be prepared to have the patient readmitted into treatment if necessary. It is helpful to have established ties with addiction medication specialists.

**DRUG TESTING**

For all pain management patients, routine random drug testing should be done at least twice a year. In those with a history of addiction or aberrancy, consideration should be given to more frequent testing. The commonly used 5-panel test (SAMHSA 5) is insufficient for pain management screening since it may not pick up many commonly used prescription drugs such as hydrocodone, methadone, hydromorphone, fentanyl, clonazepam, methylphenidate, zolpidem, and carisprodol. Specialized tests that pick up most abused prescription and street drugs are available. Most good testing companies have experts and Medical Review Officers available to help.

Urine drug testing has limitations. For example, alcohol is not detected by urine drug testing. However, a useful urine screen for recent alcohol consumption is ethyglucuronide (EtG) levels. EtG testing reliably detects alcohol consumption up to around eighty hours. The usual cutoff for a positive test is around 500 ng/ml, though purposeful alcohol consumption usually results in much higher levels.

Hair testing is extremely accurate, difficult - if not impossible - to defeat and has become available for most controlled and illicit drugs. Results are not affected by hair dye or bleaching. If head hair is absent, axillary, pubic or chest hair may be used. Fingernail clippings can also be tested. Limitations of hair testing include recent drug use within the past week. Because THC levels in hair are relatively low, hair testing may not reliably pick up occasional cannabis use.

Urine drug testing is fairly accurate and noninvasive. Measurements of temperature, specific gravity and urine pH are helpful in identifying aberrancy. Urine temperature should be 90-1000 F within 4 minutes of voiding. Temperatures outside of this range suggest substitution, or possibly dilution with another liquid such as tap water. A creatinine that is less than 20 mg/dl or specific gravity less than 1.003 suggests dilution, often accomplished by the ingestion of copious amounts of liquids. A pH of less than 3 or greater than 11 suggests adulteration. "Clean" urine and devices that keep urine warm and are difficult to visually detect are available over the internet.

**ABERRANCY**

It is important to carefully go over the opioid agreement and clinic rules on the first visit. If the patient is thought to be suffering from addiction or a relapse, an addiction medicine referral or treatment should be considered. Patients who refuse to go to addiction treatment should probably be tapered off all controlled medications. Often, the wish to have their pain controlled is a powerful motivator to get these patients into treatment. If the patient is at risk to themselves, many states have laws whereby patients can be mandated to an inpatient evaluation.

**DIVERSION**

Urine drug screens that are negative for the drugs that are being prescribed and requests for drugs that have high street value are very concerning. If malfeasance is proven, reporting the patient to the authorities should be considered.

Receiving opioids for pain mandates a high degree of responsibility. Missing appointments, "lost" or "stolen" medications, and attempts to reschedule early imply a lack of responsibility which may negate the use of opioid therapy for pain. I generally ask for a police report in the event of stolen medications and rarely replace them. Pill counting is an extremely useful tool. Patients need to always bring their pill bottles for counting. Care should be taken to watch for early appointments and to write "do not fill by…(date)" if they need to come in early for scheduling reasons.

Recently drug diversion, improper prescribing practices, and lax patient monitoring, has led the Florida Board of Medicine to organize a task force of pain medicine physicians to develop uniform guidelines and recommendations concerning pain clinic practices, standards of care, and educational requirements. Also, plans are in place to soon incorporate a prescription monitoring program. These measures will hopefully put an end to improper practices, "pill mills", and "doctor shopping" and allow legitimate pain medicine physicians to better monitor the medications that their patients are taking.

**CONCLUSION**

Addiction and chronic pain often occur together. Like any other medical disorder, patients who are suffering from addiction need diagnosis and treatment. If they have coexisting addiction and chronic pain, both must be addressed or neither condition improves. As pain medicine practitioners, we are in a good position to recognize and diagnose addiction and to help these patients get into treatment.

# Startling Statistics

*The following statistics are recent data from the Centers for Disease Control and Prevention (compiled by Jackie Owens, ACMS Interim EVP).*

Drug overdose deaths nearly tripled during 1999–2014. In 2014, among 47,055 drug overdose deaths, 61% involved an opioid. During 2013–2014, deaths associated with the most commonly prescribed opioids (natural/semisynthetic opioids) continued to increase slightly; however, the rapid increase in deaths appears to be driven by heroin and synthetic opioids other than methadone.

**Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2014–2015**

| Characteristic | Natural and semisynthetic opioids | | | Methadone | | |
|---|---|---|---|---|---|---|
| | 2014 | 2015 | | 2014 | 2015 | |
| | No. (Rate) | No. (Rate) | % change in death rate, 2014 to 2015 | No. (Rate) | No. (Rate) | % change in death rate, 2014 to 2015 |
| **Overall** | 12,159 (3.8) | 12,727 (3.9) | +2.6 | 3,400 (1.1) | 3,301 (1.0) | -9.1 |
| **Sex** | | | | | | |
| **Male** | 6,732 (4.2) | 7,117 (4.4) | +4.8 | 2,009 (1.3) | 1,939 (1.2) | -7.7 |
| **Female** | 5,427 (3.3) | 5,610 (3.4) | +3.0 | 1,391 (0.9) | 1,362 (0.8) | -11.1 |

| Characteristic | Synthetic opioids other than methadone | | | Heroin | | |
|---|---|---|---|---|---|---|
| | 2014 | 2015 | | 2014 | 2015 | |
| | No. (Rate) | No. (Rate) | % change in death rate, 2014 to 2015 | No. (Rate) | No. (Rate) | % change in death rate, 2014 to 2015 |
| **Overall** | 5,544 (1.8) | 9,580 (3.1) | +72.2 | 10,574 (3.4) | 12,989 (4.1) | +20.6 |
| **Sex** | | | | | | |
| **Male** | 3,465 (2.2) | 6,560 (4.2) | +90.9 | 8,160 (5.2) | 9,881 (6.3) | +21.2 |
| **Female** | 2,079 (1.3) | 3,020 (1.9) | +46.2 | 2,414 (1.6) | 3,108 (2.0) | +25.0 |

Source: Centers for Disease Control and Prevention; December 29. 2016

# ACMS Board Highlights

**Alachua County Medical Society Board of Directors Meeting Minutes**
**November 1, 2016**

*Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, November 1, 2016 at The Cardiac and Vascular Institute.*

**Secretary's Report:** Dr. Hayes presented the following for membership: Chasen Croft, MD, Michael Jansen, MD, and Elmer Croushore, MD. Dr. Taylor moved, seconded by Dr. Grow to accept the proposed new members. The motion was carried by the Board.

**Treasurer's Report:** Dr. Ryan presented the YTD balance sheet and P & L statements. Revenue was 115% of projected; and expenses were 88% of projected. Dr. Taylor moved, seconded by Dr. Winchester to approve the Treasurer's report. The Board approved the report.

**President's Report:** Dr. Winchester discussed the current vendor list and accepted ideas from the Board on potential new vendors and advertisers for future events.

Committees:
Meetings are in progress for an Awards Committee, EVP Search Committee and Bylaws Revision Committee. No additional report was presented at this time.

Physician Engagement/Membership: Dr. Winchester asked Board Members to follow the ACMS Facebook page and share events with other friends and physicians. Dr. Winchester also discussed setting up a monthly social hour to be held on the 4th Tuesday of every month beginning in January 2017. All members and physician residents will be invited. Staff has agreed to find sponsors for the event with the first event being held at First Magnitude Brewery on January 24th.

The ACMS Spring Family Formal was discussed regarding venue, date and entertainment preference. Dr. Hayes recommended recognizing a local charity with the event. Volunteers for this Committee were accepted and include Dr. Winchester, Dr. Hayes, Dr. Grow, and Ms. Owens.

Community Engagement/Membership: The Board discussed the upcoming March 2017 Dinner Meeting with the 8th Circuit Judicial Bar. Dr. Winchester recommended inviting County Commissioner Hutchinson to include a local government perspective on the panel. The date was confirmed to be March 14th at the Hilton UF Conference Center.

Dr. Winchester mentioned that Dr. Massoomi had not been able to participate as planned in the capacity of Director of Physician Outreach and Engagement and that ACMS will proceed with social programming as noted above.

Doctor of the Day in Tallahassee is scheduled for March 2017. Drs. Winchester, Dragstedt and Riggs will provide personal testimonies on their positive experiences as past Doctor of the Day to be sent to the membership and posted on Face Book. Physicians interested in becoming an FMA Delegate for 2017 should contact Dr. Dragstedt.

**EVP Report:** Dr. Lawrence discussed upcoming ACMS CME program topics for 2017.

# ACMS HAPPENINGS

## Practice Management Luncheon
### Napolatano's Restaurant
**November 3, 2016**

L to R: Mr. John Roberts, VP, Commercial Banking at Community Bank & Trust of Florida; Ms. Julie Kniseley, Human Resources Manager at James Moore; and Ms. Madeleine Mills, VP, Marketing Manager at Community Bank & Trust of Florida.

Mr. Jay Hutto, CPA with James Moore CPA'S and Ms. Robyn Gann with Interventional Medical Associates.

L to R: Ms. Stefanie Denney; Ms. Brenda Valdez; and Ms. Theresa McFarland.

## Downtown Arts Festival
### Gainesville, Florida
**November 5, 2016**


Scott Medley, MD, *House Calls* Executive Editor and Ms. Janice Werksman, in the Haven Hospice booth at the Downtown Arts Festival.

L to R: Neel Karnani, MD, Keynote Speaker; Patricia Goldblatt, MD; and Alan A. Goldblatt, MD.

Allan March, MD; and Mr. Eric Godet, Haven Hospice VP Organizational Advancement.

## ACMS November Dinner Meeting
### at Haven Hospice
**November 15, 2016**

Daniel Duncanson, MD; and Sally Lawrence, PhD, ACMS EVP.

L to R: Brent Seagle, MD; Leonard Furlow, MD; Mrs. Libby Furlow; and Mrs. Kathryn Seagle.

# HAPPENINGS ACMS

L to R: Jackie Owens, ACMS Interim EVP; Gayle Mattson, Haven Hospice President; and Suzanne Norris, Haven Hospice VP Business Development.

John Boon, MD and
Catherine C. Boon, MD.

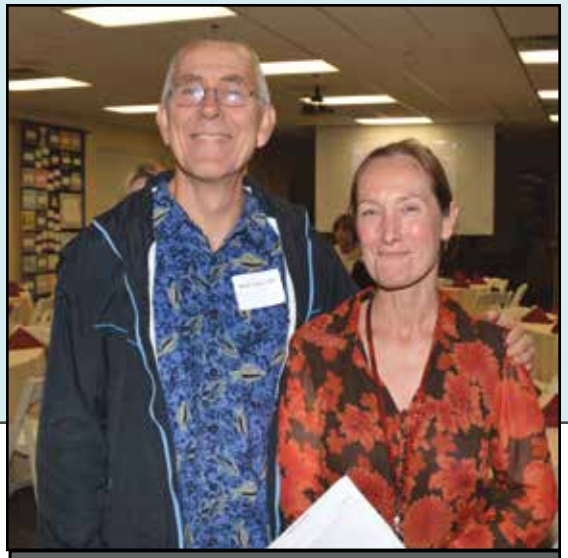
Caroline Rains, MD, ACMS Past President; and Robert G. Ashley, MD.

## ACMS November Dinner Meeting
### at Haven Hospice
**November 15, 2016**

L to R: Mrs. Faye Medley; Scott Medley, MD, *House Calls* Executive Editor; Stefanie Lord, MD, Haven Hospice Associate Medical Director.

L to R: Mrs. Roslyn Levy, Past Alliance President; Norman Levy, MD, ACMS Past President; and Sally Lawrence, PhD, ACMS EVP.

L to R: Susan Ragsdale, Florida Health MQA; Glenn Rousseau, MD; Sally Lawrence, PhD, ACMS EVP; and Teri McLean, Haven Hospice ARNP.



Mack Tyner, MD; and Geraldine S. Bichier, MD, Haven Hospice Associate Medical Director.

## ACMS November Dinner Meeting
### at Haven Hospice
**November 15, 2016**

UF Medical Students: Ms. Andrea Sanchez and Ms. Nicole Ruiz.

L to R: Rogers L. Bartley, MD; Mrs. Cherise Bartley; and Charlene Stefanelli, Haven Hospice Professional Liaison.

L to R: Ms. Audrey Williams, with Haven Hospice; Mrs. Ava Gossinger; and Gary T. Gossinger, MD.

# The Robb House Historic Marker Dedication
## November 17, 2016


L to R: David Winchester, MD, ACMS President; Mark V. Barrow, MD, ACMS Past President; and Scott Medley, MD, ACMS Past President and *House Calls* Executive Editor.

Mrs. Florence Van Arnam, Robb House Museum Curator, being honored for her work at the Robb House Medical Museum by Betsy Burch, of the Colonial Dames XVII Century, Abraham Venable I Chapter.

Mrs. Libby Furlow and Mrs. Glenna Brashear in the Robb House Parlour.

Mrs. Arlene Colon, Alliance President and John Colon, MD, ACMS Past President.

L to R: Mark V. Barrow, MD, ACMS, Past President; Mr. Michael Wright; and Mrs. Harriet Wright, Great, Great, Granddaughter of Drs. Robert I. and Sarah Lucretia Robb.

L to R: Mr. Jerry W. Benton, Sally Lawrence, PhD, receiving a Business in Greater Gainesville 2016 Impact Award, and Mr. Scott Costello.

David Winchester, MD, ACMS President, and Cherylle Hayes, MD, ACMS Secretary.

## 2016 Gainesville Business Magazine Impact Awards

### Hilton UF Conference Center

**December 5, 2016**

Sally Lawrence, PhD, ACMS EVP, and Ms. Portia Taylor, PhD, Impact Award Lifetime Achievement Award Winner.

L to R: Ms. Grace Horvath; Scott Medley, MD, *House Calls* Executive Editor; Ms. Dana Nemenyi, and David Winchester, MD, ACMS President.

Allison Grow, MD, ACMS Board Member and Mrs. Florence Van Arnam, Robb House Museum Curator.

# HAPPENING ACMS

L to R: Representing Florida Credit Union; Ms. Janene Manning; Gary Schmidt; and Evan Pitts, Senior Vice President.

Mr. Christopher L. Nuland, Esq., Keynote Speaker.

## ACMS January Dinner Meeting
### at Sweetwater Branch Inn
### January 17, 2017

Mark Barrow, MD, ACMS Past President and Preston Green, MD.

L to R: Rogers Bartley, MD; Mercedes Pernice, MD; and Lateya Foxx, DO.

David Winchester, MD, ACMS President.

# ACMS January Dinner Meeting

## Sweetwater Branch Inn

**January 17, 2017**

L to R: Steven Reid, MD; Elmer Croushore, MD; and John Leibach, MD.

Gregory Snodgrass, MD and Cherylle Hayes, MD, ACMS Secretary.

Lateya Foxx, DO, and Jing Liu, MD

Evan Pitts, Senior Vice President Florida Credit Union awarding the door prize to Wilda Murphy, MD

L to R: Scott Medley, MD, *House Calls* Executive Editor; James Gershow, MD; Thomas Young, MD; and Michael Dillon, MD.

# Make America Healthier Using Incentives and Prioritized Benefits

**By Allan March, M.D.**

The key to revising Obamacare without increasing costs is to incentivize consumer and provider behaviors in ways that will increasingly reduce the financial burden of chronic disease and improve workers' health and productivity.

It is possible to extend benefits to all taxpayers, Medicaid Expansion enrollees, and their dependents ages 18 to 65-years while retaining the exemption for preexisting medical conditions. It is also possible to discontinue the individual and employer mandates. This can be achieved by shifting the emphasis from competition between insurers to incentives for consumers and providers. Here is the proposed revision.

First, people will enroll in a single health insurance policy for each geographic region at the healthcare.gov marketplace. Using the same Website, enrollees will then select their primary care medical and dental providers. Specialists who incorporate primary care services in their practice and, where permitted, independently practicing nurse practitioners will be included as primary care providers.

Second, primary care providers will create a preventive care plan for each enrollee and encourage compliance thereto. These providers will also upload each enrollee's plan to the regional health information exchange (HIE) and monitor each enrollee's compliance. Each plan will emphasize evidence based care that prevents illness, screens for disease, or prevents their sequelae. Pharmacies will monitor and report adherence to medications that are critical to preventing or managing chronic disease. The tracking of preventive care plans will be facilitated by new ICD-10 and CPT codes and recent pharmacy management software applications. Aggregate compliance data will be available to insurers for the purpose of assessing actuarial risk.

Third, insurers will offer a single high-deductible insurance plan that covers essential benefits, includes a health savings account (HSA), and waves copayments for preventive care and preventive medications. For each region a private insurer will be selected every 7 years through competitive bidding similar to the process used by the Department of Defense for selecting Tricare insurers.

Fourth, people earning 0 to 400% of the federal poverty level will receive federal subsidies on a sliding scale. HSA rewards will periodically be given to enrollees demonstrating compliance with their preventive care plans. To increase the value of HSA funds, money in HSA accounts will be transferable to HSA accounts of other enrollees. This will make it possible for one enrollee to subsidize the cost of medical care of a friend or family member who is likewise enrolled.

Fifth, people under age 35-years will be incentivized to enroll by receiving a monetary award in their HSA account upon enrollment. Enrollees under age 35 who comply with their preventive care plans will also receive a bonus award each year upon renewal of their enrollment.

Sixth, providers will be rewarded financially for satisfying their patients and improving their patients' self-reported health as recorded on EQ-5D question-

*Continued on page 33*

*Continued from page 32*

naires. The EQ-5D measures mobility, self-care, usual activity, pain/discomfort, and anxiety/depression. Administration of these questionnaires will become part of the meaningful use requirements for electronic medical records. Patients will submit their satisfaction and EQ-5D data electronically to the HIEs using their patient portals or kiosks at their providers. The primary obstacle to storing and tracking this data is the lack of a unique national patient identifier, which needs to be added to the HIPAA privacy regulations.

Seventh, provider compensation will be modeled on the Center for Medicare and Medicaid Services (CMS) payment reform programs that reward performance measures such as quality care, meaningful use of electronic records, clinical practice improvement, and appropriate utilization of monetary resources. Patient satisfaction and EQ-5D data will be added to these performance measures. This will permit providers to assess and improve their own progress toward the national goals of reducing health costs and improving the health of their patients.

Eighth, budget neutrality will require the fulfillment of five requirements. First, insurers must prioritize insurance benefits and limit policy coverage according to what can be funded. The Oregon Health Service Commission's list of prioritized benefits, https://www.oregon.gov/oha/healthplan/Pages/priorlist.aspx, can serve as a model. Second, CMS must be willing to grant waivers to states that wish to include Medicaid Expansion enrollees. Third, the revision must retain Obamacare cost cutting reforms related to Medicare. Fourth, to maximize future cost savings, preventive care compliance data must be retained by the HIEs for the lifetime of each enrollee. The data must also be the property of the enrollees and be accessible to future insurers. And fifth, the revision must discontinue agricultural subsidies that contribute to obesity and introduce taxes on products which cause disease or injury.

This proposed revision of Obamacare offers several advantages. First, enrollees compliant with their preventive care plans will at age 65 demand less medical care than otherwise, thus dampening the trajectory of rising Medicare costs. Second, year to year churning of low income enrollees will be reduced by offering one plan and one insurer for 7 years. Third, providers will lower their overhead by having fewer insurers to whom they must file claims. Fourth, charitable contributions to another person's medical expenses will be empowered by the transferability of HSA funds from one account to another. And fifth, physicians will be empowered to improve their performance by receiving feedback regarding their patients' self-reported health.

Now is a great time to change the paradigm of traditional health care and adopt incentives that extend the health of young workers and improve the health of older workers. Comments are welcome.

Allan March, MD is a retired physician executive and former Medicare, Medicaid, and Tricare provider.

*The Alachua County Medical Society provides news and opinion articles as a service to our readers. Statements and opinions expressed in these articles are solely those of the author or authors and may or may not be shared by the staff and management of the Alachua County Medical Society.*

Alachua County Medical Society
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CHANGE SERVICE REQUESTED




## Dr. Klodell is now providing services at his new practice, located at North Florida Regional Medical Center.

My overarching passion and goal is to provide each patient with the best possible care. Care that I am proud to have helped deliver and especially care that I would be pleased to have any family member receive. It is my pledge that each patient will receive an individualized plan including a focused strategy for patient comfort, all while safely performing their procedure in the least invasive way possible. We must increase not only the quantity of life, but also the quality. Our goal is to help each patient not only live longer, but live better.

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