MINUTES OF THE MEETING
of the NEBRASKA
BOARD OF NURSING

Issues Forum

February 13, 2019

CALL TO ORDER

The meeting of the Nebraska Board of Nursing's Issues Forum was called to order by Patricia Motl, Board President, at 1:03 p.m., February 13, 2019, at the Staybridge Room, Staybridge Suites Lincoln I-80, 2701 Fletcher Ave, Lincoln NE 68504. Copies of the agenda were mailed in advance to the Board members, emailed to interested parties, posted outside the Licensure Unit within the Nebraska State Office Building, and posted on the Department of Health & Human Services website. Motl announced the location of an available copy of the Open Meetings Act within the room.

ROLL CALL

The following board members were present to answer roll call:

- Janet Andrew, LPN, *Board Vice-President*
- Anne Dey, RN
- Louise LaFramboise, RN
- Patricia Motl, RN, *Board President*
- Kristin Ruiz, RN
- Rita Thalken, *Public Member*
- Karen Weidner, RN, *Board Secretary*
- Katherine Werth, APRN

The following Board member arrived after roll call: Kristene Perrin, RN

The following Board members were absent: Angela Cuffe, LPN, Tag Herbek, *Public Member*, and Linda Stones, RN.

The following staff members from the Department and the Attorney General's Office were also present during all or part of the meeting:

- Ann Oertwich, RN, *Executive Director*
- Sherri Joyner, *Health Licensing Coordinator*
- Kathy Hoebelheinrich, RN, *Nursing Practice Consultant*
- Jacci Reznicek, RN, *Nursing Education Consultant*
- Anna Harrison, *Compliance Monitor*
- Matthew Gelvin*, Program Manager, DHHS Research, Policy, and Quality Improvement*
- Mendy Mahar-Clark, *Investigator*

A quorum was present, and the meeting convened.

ADOPTION OF THE AGENDA

MOTION: Thalken made the motion, seconded by Andrew, to adopt the agenda for the February 13, 2019, Board of Nursing Issues Forum..

Voting Yes: Andrew, Dey, LaFramboise, Motl, Ruiz, Thalken, Weidner, and Werth. Voting No: None. Abstain: None. Absent: Cuffe, Herbek, Perrin, and Stones Motion carried.

These minutes were approved by the Board of Nursing on March 14, 2019.

CHASEK PRESENTION

Tina Chasek, LIMHP, LADC, gave a presentation on substance use disorders and relapse. Chasek is an associate professor at the University of Nebraska-Kearny specializing in substance abuse counseling. She is also a member of the Nebraska Board of Alcohol and Drug Counseling (LADC Board).

Chasek noted that people outside of health care often do not understand the disease aspect of addiction. People often mistakenly think addiction is a matter of choice. The American Society of Addiction Medicine (ASAM) defines addiction as a "primary, chronic disease of brain reward, motivation, memory, and related circuitry. Chasek said that it can take up to 18 months of sobriety for brain scans of addicts to look like their pre-use scans. During this period of post-acute withdrawal, persons are especially vulnerable to stress-induced relapses. Relapses are more likely to occur among people who do not engage in recovery activities.

Relapse rates from substance use disorders, however are not higher than relapse rates for other chronic diseases such as hypertension and asthma. Statistics from one study [McLellan *et. al*., *JAMA*, 2000] show that 40-60% of people with substance use disorders experience a relapse after treatment. For both hypertension and asthma, the relapse rates are 50-70%.

Chasek gave an overview of the National Institute of Drug Abuse's principles of treatment: 1) No single treatment is appropriate for all individuals. Some people might need to go to detox, others do not. 2) Treatment should be readily available. People should not have to be on a three-month waitlist, for example. 3) Treatment needs to attend to the multiple needs of the individual, not just drug use. If a person has trauma for example, the treatment for drug use needs to address the trauma. 4) Multiple course of treatment might be required. In addition to aftercare and support groups, a person might need to return to treatment as a "tune-up." 5) Remaining in treatment for an adequate period of time is critical to treatment effectiveness.

Chasek showed statistics from a study that examined the relationship between duration of abstinence and the odds of experiencing a relapse [Dennis, Foss, & Scott (2007) *An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery*. *Evaluation Review,* 31(6)]. For people who have been sober for 12 months or less, only 36% remain abstinent for 7 years. It takes at least a full year of abstinence before the odds of relapse are less than 50%. For people who have been sober between one and three years, 66% remain sober. After three years of sobriety, the recovery odds remain stable and high. For people who have been sober between three and five years, 86% remain sober. For people who have been sober more than five years, the rate is still 86%. As a clinician, Chasek said she is more comfortable with a client being able to maintain sobriety if the person has been sober for three years

Dey asked if the chances for relapse were higher when a person returns to an environment similar to where they previously obtained an abused substance. Chasek said that if a person returns to a place where they previously used, there needs to be external monitors put in place. The person needs to know that someone is watching and will detect if they start using again. An addict might need to change his or her routine. If a person drives by his former meth dealer on his way to work, for example, he might need to use a different route to get back and forth from work.

Chasek reported that the LADC Board, based on her observations, wants to see a good-quality evaluation with a diagnosis. The also ask applicants to submit a letter describing what they have been doing to treat their disease since date of last use. When the board makes a recommendation for monitoring, they take into account the severity of the diagnosis (i.e. mild, moderate, or severe) and the date of last use. The board will give someone 'credit' for the time since last use if the person can demonstrate that he or she has been active in the recovery process during that time. If a person has been sober for one year, for example, and has been actively working a sobriety program during that one year, the board might recommend monitoring for two years rather than three.

Weidner noted that the Board of Nursing sees a great deal of variation in the quality of the evaluations it reviews. Weidner feels more confident using evaluations from the Licensee Assistance Program because the evaluators have communicated with collaterals (people who know the person being evaluated). Court-ordered evaluations, on the other hand, often do not include collaterals.

Chasek said the LADC Board faces the same issue. They have been told, however, that they cannot mandate that a person obtain an evaluation from the Licensee Assistance Program. The LADC Board will sometimes request that a person submit a more recent evaluation. If an evaluation does not include collaterals, they have sometimes asked the person to submit letters of recommendation. In cases where an evaluation is not adequate, she is more likely to lean towards recommending a longer period of probation (five years instead of three, for example).

Hoebelheinrich mentioned that when she talks with people who are applying to reinstate their licenses following disciplinary action, many tell her that they do not even recognize the person they were when the discipline occurred. Chasek affirmed this phenomenon. In addiction, Chasek said, people's worlds narrow down to obtaining the substance they crave. When they come out of that fog and start doing other things, it is as if they are living a new life.

Chasek said that people who refuse to talk about their substance abuse or who diminish their use ("I wasn't using that much") have probably not successfully recovered. When people have successfully recovered from an addiction, they are generally not ashamed of their previous use.

Another situation that makes Chasek cautious is when a person still associates frequently with current users including family members. She is also cautious when a person does not engage in at least one activity a week to maintain sobriety. The activity does not necessarily need to be attending a support group meeting. For some people, attending a yoga group, for example, might be a recovery activity.

Hoebelheinrich reported that sometimes materials submitted by applicants give the appearance that there might be a mental health or behavioral health issue in addition to a substance use disorder. Chasek said that a Licensed Drug and Alcohol Counselor can only diagnose substance use disorders. A co-occuring evaluation (i.e. one that address both substance abuse and mental health disorders) needs to be done by someone who is dually licensed.

Weidner said that when a person has completed treatment but hasn't complied with all the aftercare recommendations, such as obtaining a sponsor, it raises questions about how committed the person is to sobriety. Chasek said that when people leave treatment or an Intensive Outpatient Program, they need to have an aftercare plan, and it is vital that they begin adhering to the aftercare plan right away.

Reznicek asked about situations where a person lives in a small community and might not have access to all the resources available in more metropolitan areas. Chasek said the concern was semi-valid. Most communities have some sort of support group. If there is not a support group, there are other resources such as a church. Persons can also participate in support groups online through programs such as SMART Recovery.

Oertwich asked about the frequency of evaluations. Chasek said that she prefers seeing an evaluation completed within the past six months. She also wants to see a letter from the applicant describing what they have been doing since the evaluation was completed.

Weidner asked if a diagnosis that includes the phrase "in sustained remission" means that the person has been sober for at least one year. Chasek affirmed that it does indicate sobriety for at least one year, but that one should also look at whether the person has been in a controlled environment (such as jail) during part of that time or has been on maintenance medication.

Chasek noted that there is often a stigma attached to maintenance medications even within the recovery community. People involved in Alcoholics Anonymous, for example, are sometimes told that if they are using any drug that they are not truly in recovery. Anderson reported that the topic of medication-assisted treatment has been discussed at national meetings of state attorneys general, and she believes its use is becoming more acceptable. Thalken asked whether it substituted one addiction for another. Chasek said that the substitute drug is not technically addictive. The medications used to treat opiate abuse, for example, allow the part of the brain that craves the substance to settle down and block the receptors in the brain that uptake the abused substance.

Oertwich asked how the LADC Board was dealing with marijuana, given its legalization in some states and the inability to test if someone is impaired by its use. Chasek said that they do not generally see cases where someone is using just marijuana. She noted that when withdrawing from marijuana, mood issues sometimes arise.

2:03 p.m. *Meeting went into recess.*
2:20 p.m. *Meeting reconvened.*

DISCUSSION

Weidner asked about situations where applicants come to speak before the Board. Joyner noted that under the Open Meetings Act, boards need to make reasonable accommodations for members of the public to speak at board meetings. The Licensure Unit policy is to allow applicants who request to speak to the Board to do so with the conditions that applicants understand that what they say will be part of the public record, that applicants cannot be present during closed session, that applicants can speak for 5-10 minutes maximum, and that applicants cannot ask the Board any questions nor can the Board ask the applicant questions. If an applicant for reinstatement from discipline requests a hearing to appeal a board recommendation, there is an opportunity for the board and applicant to ask questions.

LaFramboise asked why the Board cannot require people to obtain an evaluation from a list of particular providers. Anderson said that asking an applicant to do something that they are not required to do by statute or regulation raises legal concerns. Joyner noted that when notifying an applicant that a board has requested an evaluation, some Licensure Unit staff send the applicant a letter that includes a list of components, including collaterals, that must be included in the evaluation.

LaFramboise noted that some evaluators seem to 'soften' the evaluation, as if to make it more palatable to the client. Mahar-Clark said that when she receives an evaluation without a diagnosis the evaluation is usually a copy that was given to the patient. Anderson noted that LADC and mental health professional can withhold information from records that they provide to a client if they think the information might harm the client.

Mahar-Clark ask if any of the evaluators at the Licensee Assistance Program were dually-licensed. Gelvin confirmed that Michelle Hruska was dually-licensed but that the Licensee Assistance Program can only do substance use disorder evaluations. Members discussed when it would be appropriate to request that an applicant or licensee undergo a mental health evaluation. Harrison noted that some people cannot address their mental health issues until they have experienced a period of sobriety. Members agreed that a mental health evaluation should only be requested when there is evidence of a problem. Oertwich said that she and Gelvin would talk with the Licensee Assistance Program to see what they can do when there is an indication of mental health issues.

Werth, Dey, Ruiz and other members expressed interest in re-evaluating the Board of Nursing's recommendations in light of the information presented by Chasek. Anderson said she did not think she had enough information yet to warrant a change, but that the information that has been collected recently is an improvement on what she previously had access to. Oertwich said that additional data from the National Council of State Boards of Nursing (NCSBN) will be available in May 2019. NCSBN's project includes an examination of alternative to discipline programs.

Anderson said she would like more information on how medications used to treat addiction could impact the results of a drug screen, such as whether testing can distinguish between suboxone, for example, and other controlled substances. LaFramboise asked if the Medical Review Officer who reviews drug screens for licensees on probation can tell if positive results for people who take prescribed controlled substances are within acceptable parameters. Anderson and Harrison noted that the Medical Review Officer only knows if the person has a valid prescription. If a screen shows an unusually high number for a prescribed medication, an investigation would need to be opened to determine if the number is indicative of a relapse.

Hoebelheinrich said that if the objective is to help people then we should provide support to people whose licenses have been suspended or revoked due to concerns about public safety. Harrison said that due to shortages of health care workers in smaller communities, she is familiar with situations where a hospital or larger community pulls together to ensure that a disciplined health care worker gets the support he or she needs because they do not want to lose a health care worker..

A member of the public spoke about the posting of petitions for disciplinary actions and discipline orders on the Department's website. She said that details from the documents sometimes get spread through social media. She said that it can be very hurtful to licensees who may have disclosed information under conditions that they thought were confidential.

3:20 p.m. *Meeting went into recess.*
3:56 p.m. *Meeting reconvened. Perrin arrived at the meeting.*

STULL PRESENTATION

Todd Stull, MD, introduced himself. He is a psychiatrist with over twenty years of treating addiction. He is employed as a Senior Associate Athletic Director for the University of Nebraska, where he also acts as the Medical Review Officer for drug testing of athletes. He currently serves as Chair for the Nebraska Board of Medicine.

Stull began his talk by summarizing the seven foundations, or "7 Fs," that enable people to perform at their best level: sleep, food, feelings, family and friends, fitness, fun, and feedback.

When health care professionals get into trouble, the cause is often due to mental health issues, substance abuse, and/or cognitive impairment. The common psychiatric problems seen among health care professionals are depression, anxiety, marital/relationship issues, and personality disorders. Of these problems, Stull said that personality disorders, such as narcissistic personality or obsessive compulsive disorders, might pose a greater hindrance to the ability to practice effectively. For depression, Stull said that when treating athletes with depression, he generally tries to keep them working with their teams, sometimes using an adjusted schedule or monitoring. He noted, however, that individual differences should be taken into account; some people cope by sticking to a routine while others want to take a break from their routines.

Stull noted that some of the seminal studies in relapse rates came from the field of organ transplantation. At one time, substance abuse evaluations were generally required prior to liver transplants because the underlying reason for the transplant often stemmed from IV drug or alcohol use. These studies showed that once a person was sober for three years, risk of relapse was minimal.

Stull said that just as no one wakes up and says they want lung cancer, no one wants to have an addiction. He said that addiction was not about willpower. Addiction occurs at the cellular level of the brain. A person who develops an addiction becomes a different person at the cellular level.

Stull, referring to a Federation of State Physician Health Program study, noted that states monitor physicians with substance use disorders for varying time lengths. Alaska, for example, monitors physicians with mild substance use disorders for five years while in Washington the length is one year. In general, however, the length of monitoring is typically 1-3 years for mild disorders and 3-5 years for severe disorders. For cases of significant mental health problems, the length of monitoring is often 1-2 years. One of the findings of the Federation study was that when a five-year standard for monitoring was in place, physicians were less likely to self-report substance abuse because they wanted to avoid five years of probation.

Stull advised that the mild, moderate, and severe descriptors are not the only factors that determine a person's risk for relapse. An individual might have additional risk factors for triggering a relapse, such as going through a divorce or problems at work. The most solid predictor for risk of relapse is the length of time that a person has been following a sobriety program. He suggested that the greater challenge is not so much determining the length of monitoring but creating an environment where people do not feel that they are being punished for having an addiction.

Regarding the use of marijuana, Stull noted that we really do not know how many people die each year directly from use of marijuana, although most people accept that it would be hard to overdose on marijuana. We do know that approximately 480,000 people in the U.S. die annually from the effects of tobacco and 90,000 die from alcohol-related causes. Marijuana does cause psychomotor deterioration and decreases motivation.

Stull said that there is still a place in medicine for prescribing opiates, noting that he has prescribed opiates with tapering off.

Stull supports medication-assisted treatment for addiction. He was one of the first physicians in Nebraska to prescribe morphine for addiction outside of a methadone clinic when it became legal to do so in 2000. He does not, however, necessarily like the term "medication-assisted treatment." He said that when people take medication for high blood pressure, it is just called "treatment." Stull said that the most effective treatment for heroin addiction is methadone. Stull believes that most people with moderate or severe opiate addictions will need lifelong treatment with opiate antagonists such methadone due to the rewiring of their brains from addiction.

Regarding relapse data, Stull said that there is strong evidence that health care providers have better outcomes than the overall population. Disadvantaged or poor populations have worse outcomes.

Weidner asked about co-morbidity with mental health issues. Stull said that the second most important determinant of relapse rate (after length of time person has been working a sobriety plan) is untreated mental health issues. He noted that there is a high rate of co-morbidity of substance use disorders and depression.

Dey asked if people are more likely to relapse if they return to the same setting where they previously accessed drugs, as in cases where a health care worker diverted drugs from an employer. Stull thought relapse was more likely in these situations, which is why it is important to take steps to mitigate opportunity, such as placing an alcoholic on Antabuse.

Dey noted the difficulty in determining what other factors are going on in a licensee's life (such as divorce) that could impact their likelihood of relapse. Taking these factors into account also poses a challenge because the Board wants to be consistent with its recommendations. Stull noted that a good evaluation can include life stressors.

Weidner asked if people who have injected drugs need to be monitored longer. Stull said that the route of administration was once considered an indicator of severity, but that it might no longer be a valid indicator given the increased potency of some drugs available in oral and inhaled form, such as marijuana edibles or methamphetamine.

Harrison asked Stull if he thought that Nebraska's PDMP (Prescription Drug Monitoring Program) will deter addiction. Stull said there is hope that it will, but that people who want a substance find a way to get it. He noted that the state-level PDMPs do not always communicate with each other, and that some users will see an additional provider in another state to avoid detection. Stull said that when he worked at a methadone clinic approximately 80% of the clients were also addicted to prescription medications. Many clients purchased from elderly persons who sold their prescribed medications to make extra money.

Dey asked if making others aware of a person's addiction could hinder the person's ability to return to work and practice successfully. Stull said that some people want to tell everyone about their addiction and others do not. To some degree, these individual differences should be respected, but Stull thought that the person's inner circle at work should know about the addiction.

Stull said that when working with an addicted athlete, he begins by focusing on what the person has control over, such as attending meetings or showing up for testing, rather than whether the person is still using. He noted that asking the person for too much information is counterproductive. The person might shut down. Instead, he advised carefully choosing which items you want to look at based on effectiveness.

When assessing a person's needs for monitoring, Stull advised looking at the length of time a person has been working a sobriety plan and the frequency of "touches" with recovery activities, such as attending meetings. He would rather see a person go to three 20-minutes meetings a week instead of one 60-minute meeting. He also advised that effective recovery activities can vary from person to person. Returning to the hypertension analogy, Stull noted that a person with high blood pressure might try different medications, such as calcium channel blockers or beta blockers, before finding something that works. Alcoholics Anonymous (AA) does not work for everyone. In some ways AA can be easy – meetings are free and readily available – but it is not a good fit for some people.

Weidner asked about cases where people who have been diagnosed with an alcohol use disorder still continue to drink socially. Stull said that some people can pull it off, but it is rare, and he advised against steering people down that rabbit hole.

CONCLUSION AND ADJOURNMENT

There being no further business, the meeting adjourned at 5:05 p.m.

Respectfully submitted,

Sherri Joyner
Health Licensing Coordinator