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OPIOID ABUSE

Continuing Education Edition

2 CE credits

Journal IDA

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PERSONNEL

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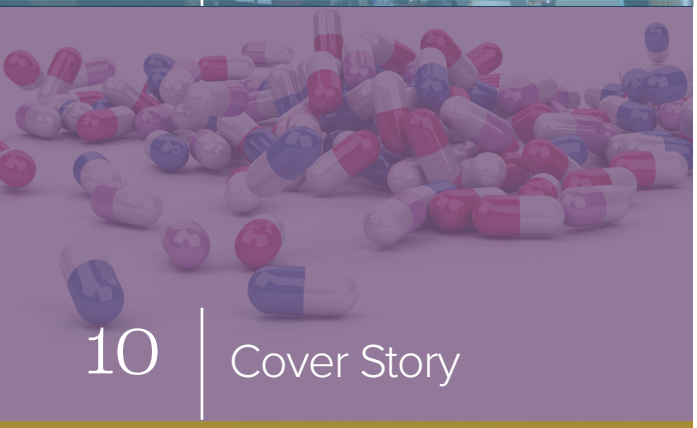


COVER STORY

MEMBER ZONE

Editor's Message

Next Man Up

Dr. Jack Drone

Wednesday morning, July 24, 2019. The date has been indelibly scribed in our show barn, my iPhone, in Eaglesoft, really everywhere. It was the day of our Jasper County Fair 4-H Wether Show. Just another day to most but one that the Drone family has been preparing for since January 4, 2019.

Feeding, exercising, treadmilling, supplements, drench… you name it and we have added it to our regimen in raising and showing sheep. The result was a very good summer of Open Shows. Mostly first places, some champions and a few Top Fives. The 4-H Competition week began with Graham's sheep winning Grand Champion in the Open Show, and Beck and Tate also had strong showings. The night before the 4-H Show, one of our lambs, Kevin, who was the Grand Champion on Saturday, had an allergic reaction/bite and was reddish and could barely be touched.

We stayed with him through the night and gave anti-inflammatory medication and Benadryl. He was better but not good. Graham was upset but focused. Tate, Graham and Beck were all in the first three classes of the day. Tate had a rough time in the ring and his lamb was second and not selected as Reserve Champion. Graham and Beck followed with a third and fourth in class with lambs who had never gotten lower than first all summer. Twenty minutes into the show and our three best lambs were in the pen and done. We had two entries left, Stanley and Ryan.

Graham's lamb, Stanley, was our best going into the summer, but he continued to grow. He ended up weighing 189 pounds. He was the heaviest in the show by 40 pounds, but he looked great. As we got him ready, I said a Hail Mary and asked for grace if we lost. Stanley was chosen for Champion Natural with his breed and the judge LOVED him. He called him a big gorilla.

Beck's lamb won his breed and the two went in for the Grand Champion Drive. The judge selected the runner up from Saturday's show for Grand Champion (not ours), but then he got on the microphone and said that he was going to use Stanley, AKA the big gorilla, for Reserve Grand Champion. It was not the most popular decision ever made at Jasper County, but I appreciated him taking a fly on a really great, big lamb. Graham's smile was as big as Stanley.

Was the day salvaged? Not for me. I am to the point in life where I seldom enjoy the wins, but I am haunted by the losses. We really could have done great with a healthy Kevin. But at dinner that night, the conclusion was that this would be a story shared for decades. The boys and Jana are sure that I will embellish it greatly. People and even sheep sometimes stand up and give us something totally unexpected. It is important to recognize these people who do so, whether they are present in our office, our personal life or within the IDA.

Our champions, Stanley and Graham, stood up that day and gave me something unexpected when I did not think it was possible. Where in our lives are these unexpected saves? If we knew they would not be unexpected…keep watch for them.

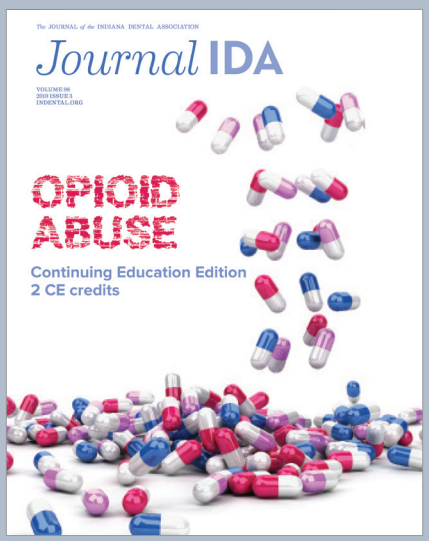
Journal Editor Dr. Jack Drone is a general dentist practicing in Rensselaer, IN. He can be reached at **jack@hillcrestdental.net**.

Tate, Graham, Beck and a friend pose with award-winning lambs Stanley and Ryan.

Why an Opioid CE Issue?

Why have a *Journal* focused on Opioids? It is the perfect way to serve our member dentists and demonstrate how the IDA works for you. The mission of the IDA is to support dentists, promote professionalism and to improve oral health. The topic of Opioids and the IDA's work with members embodies all three parts of that mission. This edition fulfills Indiana state requirement for opioid training for those who hold a CSR and is an excellent continuing education opportunity for all dentists.

See the inside back cover of this issue to find out how to complete the accompanying quiz and receive your CE credit to meet Indiana state requirements.



Meet Your 2019-2020 IDA President

Dr. Steve Ellinwood's Vision for 2020

Now that the 2019 House of Delegates has successfully concluded, IDA is moving forward under the leadership of our 2019-2020 president, Dr. Steve Ellinwood. As he explained in his presentation to the House of Delegates following his inauguration on June 15, Dr. Ellinwood's presidency will focus on the future and health of the IDA with what he calls Vision 2020.

"My big concern is getting a grip on Medicaid so that we can have a fair chance at meaningful discussions," he explained. "That system is getting pretty crazy and I think getting some IDA assets to get around it is important. I'm concerned about the loss of providers for the people who need that help."

Dr. Ellinwood wants to promote the IDA Trust more and continue to find the most effective ways to communicate with all groups of dentists. Transparency is also a priority for him. "I want to continue to foster the openness and transparency of the IDA and how we get things done," he emphasized.

The House approved a $50 dues increase to pay for the salary of a staff member who can provide additional support for advocacy and communications, and Dr. Ellinwood knows that making a smooth transition with the increase and new staff member will be important. He also knows that advocacy, both within the scope of IDA's existing activities and through the new staff member, will play a large role in his presidency. "There's a natural focus on advocacy at the presidential level. I'll always be concerned about our relationship with our government officials," he said.

Being part of the IDA leadership is a natural progression of Dr. Ellinwood's obvious commitment to organized dentistry. An IDA member since his graduation from IUSD in 1985, he has volunteered extensively on IDA's membership committee and served as chair. He also has volunteered as an Isaac Knapp trustee, assistant editor of the *Journal IDA* and the Council on Communications. In addition, Dr. Ellinwood has volunteered extensively with the larger ADA structure as an ADA delegate, Floor Leader and Reference Committee members.

Besides making contributions to organized dentistry, Dr. Ellinwood is well-known for his commitment to providing dental assistance to the less fortunate. He is the co-founder of Sonrisa Siempre (Smile Always), which provides a free annual dental clinic in Honduras with the help of volunteer dentists, hygienists and

assistants from around the country. Closer to home, he has volunteered his time and professional skills at the Indiana Mission of Mercy, the Matthew 25 clinic in Fort Wayne and Donated Dental Services.

Dr. Ellinwood also shares his expertise with prospective dental professionals by teaching at the Dental Education program at Indiana University Fort Wayne. He lectures on dental materials and oral pathology to students in the hygiene, assisting and dental lab technology programs.

The son of a Methodist pastor and school teacher, Dr. Ellinwood moved frequently around the state as a child due to his father's ministry. When he entered Depauw

LEFT: Dr. Ellinwood with his family at the Indiana Mission of Mercy in May: Son-in-law Aaron, daughter Alexa, wife Laura and son Chase.

BOTTOM: Dr. Ellinwood receives the Distinguished Service Award from outgoing IDA President Dr. Dan Fridh at the Midwest Dental Assembly in June.

University as a freshman, he really had no career plans or aspirations, but his roommate did: The roommate was determined to be a dentist and encouraged Dr. Ellinwood to consider it as well. He ended up spending a month shadowing the family dentist, and after that he was sold. Like his influential roommate, Dr. Ellinwood found his career aspiration, and both young men successfully followed through with their goals of completing dental school. The roommate is now a practicing dentist in Cincinnati.

Dr. Ellinwood operates what was until recently a solo practice, St. Joe Dental Care in Fort Wayne, and a love for dentistry clearly runs in the family: His son, Chase, graduated from IUSD in May and has joined his father part-time in the practice. Chase spends the other half of the week working as a dentist for the Neighborhood Health Clinic in Fort Wayne. Daughter Alexa works as a dental lab technician and is pregnant with Dr. Ellinwood's first grandchild. Dr. Ellinwood and his wife, Laura, have been married for 32 years and together they enjoy taking care of their cat and two dogs, cooking together and watching cooking shows.

As the year progresses, members will continue to hear from Dr. Ellinwood on Vision 2020 and the accomplishments of the IDA. In the meantime, Dr. Ellinwood is looking forward to serving members and leading organized dentistry in Indiana.

Executive Director's Message

Thanksgiving in the ER

Mr. Douglas M. Bush

While I don't customarily reprise old editorials, I made an exception for this special issue of the Journal IDA. *The story that follows was written three and a half years ago after my Dad's accidental narcotic overdose. Unfortunately, the statistics I cited in 2016 are outdated. The CDC now reports that an average of 130 Americans die each day from opioid overdoses...over 47,000 per year. The news is better for my Dad. After a nearly identical second overdose, doctors completely weaned him off of narcotics. The chronic pain that prompted the prescriptions never returned.*

From *Journal IDA*, Winter 2016

I sat in the hospital on Thanksgiving evening staring at my Dad's heart monitor while contemplating how quickly life lessons shift from theoretical to reality.

Just two days earlier I was visiting the East Central Dental Society giving a presentation on Ethics and Jurisprudence. While discussing the ethical principle of "nonmaleficence" ("do no harm") I shared information from several studies regarding the growing problem of prescriptive opioid overdoses. The statistics are staggering. According to the CDC, 44 people die each day from opioid-related causes – almost 17,000 a year. It is also estimated that for every death, 30 people present at hospital ERs with opioid-related complications.[1]

That latter statistic now includes my Dad. For 20 years he has lived with chronic pain. The doctors don't agree on a cause. He has been diagnosed with arthritis, polymyalgia rheumatic, fibromyalgia and degenerative disc disease. In all likelihood, it's a combination of all or some of above. The bottom line, for years he has been on fentanyl patches to control his pain. The week before Thanksgiving he suffered a minor stroke and a hard fall. After a short hospital stay, he was sent to a rehab facility. He was prescribed morphine 30 mg extended release tabs to help him with the breakthrough pain caused by the injuries.

When family went to visit him on Thanksgiving Day, he was in a deep sleep and couldn't respond when we tried to wake him. My wife, Alice, immediately went into ER nurse mode. She asked for a stethoscope to check out the "rattle" she heard in his lungs, and a pulse oximeter to check oxygen saturation. It was 77, far below a normal reading in the upper 90s. He was put on oxygen while we waited on the ambulance. A quick responding ER doctor determined that my Dad had overdosed and that in his deep drug-induced slumber he had aspirated. His temperature was rising and he was developing pneumonia. She pulled him off all of the pain meds and ordered IV antibiotics. The turnaround was remarkable. Within hours my Dad was awake, responsive and fever free. As I pen this article, he is back in the rehab hospital flirting with nurses and resuming his physical therapy. He is back on his patches, but his morphine dose has been reduced to 2 mg PRN.

So what went wrong? I'm not sure we'll ever know for sure. When attempting to get my Dad out of acute pain from the fall, perhaps the doctor didn't see or fully appreciate the significance of the pain medication he was already on. Or perhaps the 30 mg of morphine was not intended as a standing order and the rehab hospital staff continued to medicate him longer than was intended. In either case, the level of opioids in his system was more than he could process, resulting in an overdose with near tragic consequences.

So back to “nonmaleficence” and my discussion with the East Central dentists…

Opioid misuse and abuse is, and will continue to be, an issue for physicians and dentists. Opioid use has skyrocketed in recent years, increasing 300 percent in the past decade. Unfortunately, the number of deaths related to opioids has paralleled the increase in drug use. For ages 25-65, more people now die from prescription overdoses than are killed in automobile accidents.[2]

Regulators are responding to this grim reality. In 2014, the DEA reclassified hydrocodone combination products to “Schedule II” substances, subjecting them to tighter restrictions.

In Indiana, we have encouraged dentists to use the state’s INSPECT program as a tool for avoiding fraud from drug seekers and abusers. (See more on page 14 and www.in.gov/pla/inspect). Indiana is now considering legislation that would require physicians and dentists to run an INSPECT report before prescribing any narcotic. But aside from increased regulation, there are simple practical steps dentists can take to help insure the safe use of narcotics:

- Educate your patients about the dangers of using opioid painkillers for non-medical purposes. Many don’t know that misuse is illegal, dangerous and potentially fatal.
- Help keep unused narcotics out of medicine cabinets. Prescribe no more than is necessary. Encourage patients to follow label directions to promptly and properly dispose of unused meds.
- Maintain an accurate and up-to-date health history on your patients. Ask them about other medications they are taking. Ask if they have any history of drug abuse before prescribing a narcotic.

Opioids are true miracle drugs, providing pain relief and improved quality of life to thousands of patients, including my Dad. But they are the proverbial double-edge sword, with potential for great harm if used carelessly or abused. Fulfill your professional obligation to “do no harm” by helping your patients use pain medications in a safe, informed and responsible manner.

References

[1] Deadly Pain Pills, *Consumer Reports*, Sept 2014, 19-21.

[2] http://www.cdc.gov/drugoverdose/data/overdose.html

Mr. Doug Bush is serving his 23rd year as IDA Executive Director. He can be reached at **doug@indental.org**.

The Dentist's Role in Addressing the Opioid Crisis

Doug Bush

It's called an epidemic, and rightly so.[1] According to the CDC, 70,000 people died of drug overdoses in 2017, making it a leading cause of injury-related deaths in the United States. Almost 68 percent, 47,000, involved prescription opioids. By comparison, 32,000 people are killed in automobile accidents each year.[2]

There is finger pointing. Some blame pharmaceutical companies for touting the benefit of prescription painkillers while understating the risk of addiction. Others point to the medical establishment. In the 1990s there was widespread belief that pain was improperly assessed and undertreated. In the late 1990s, the Joint Commission published pain standards and in 1999, California's legislature adopted regulations requiring licensed health care facilities to include pain as an item to be assessed at the same time as vital signs are taken. The American Pain Management Society (APMS) published recommendations that included a 10-point scale for assessing pain and in 2000, the Veterans Health Administration implemented a National Pain Management Strategy that including an APMS logo that declared, "Pain: The 5th Vital Sign." This language quickly fell into common use in health care settings.[3]

With hindsight, even the Federal Drug Administration (FDA) was at fault. When Oxycontin was introduced in 1995, the FDA approved labeling that stated iatrogenic addiction was "very rare." These claims were heavily marketed to physicians and the public. Due to growing evidence to the contrary, in 2001 the FDA required removal of the labeling, but overstated safety claims continued to be widely repeated. From 1997 to 2007, the number of opioid prescriptions dispensed almost doubled, increasing from 97 million, to 184 million.[4]

According to the CDC, the rise in opioid overdose deaths can now be seen in three distinct waves:

1. The first began in the 1990s with the sharp rise in the prescribing of pharmaceutical opioids.

2. The second began in 2010 as an increase in overdose deaths involving heroin.

3. The third began in 2013 with an increase in deaths involving synthetic opioids, including illicitly-manufactured fentanyl.[5]

One should not be shocked by these "waves." Once addicted to legitimate prescriptions, patients turned to illegitimate drugs that are easier and more affordable to obtain. Therefore, one fundamental step in preventing opioid addiction is limiting unnecessary patient exposure to the drugs. This speaks to dentists' role addressing the opioid epidemic.

According to the National Institute of Dental and Craniofacial Research (NIDCR), dentists prescribe approximately 6.4 to 8.0 percent of opioid analgesics. Of special note, dentists are the highest prescriber group for patients between the age of 10 and 19, largely related to acute pain management after third molar extractions.[6] Some researchers feel that at this point in their development, adolescents' brains are especially susceptible to drug abuse and addiction. Dr. Nora Volkow, director of the National Institute on Drug Abuse contends, "When drug abuse begins at a young age, it can become a particularly vicious cycle. Research shows that the earlier a teen first uses drugs, the likelier he or she is to become addicted to them or to become addicted to another substance later in life."[7]

This is one of the reasons the American Dental Association has aggressively worked to educate dentists regarding their role in addressing the epidemic. In a January 2018 message to members entitled, "Preventing opioid abuse from the dental chair," then ADA President Joe Crowley urged members to reflect on how they manage dental pain and to take specific steps to keep opioid pain relievers from harming patients and their families. He advised:

- First, consider using non-narcotic pain relievers as a first line of treatment. The data on opioids finds they are not as effective as other treatments and are associated with more adverse events. Often, some combination of nonsteroidal anti-inflammatory drugs (such as ibuprofen, naproxen, etc.) and acetaminophen or aspirin can be just as effective.

- Second, when an opioid pain reliever is indicated, consider prescribing fewer pills in accordance with the latest pain management guidelines and your own state law. If your state allows it, partial filling may be an option. A federal law enacted in 2016 permits dentists to request that their prescriptions be partially filled, subject to state law. It also allows pharmacies to dispense the remaining portions in increments without further authorization from the prescriber.

- Third, it goes without saying that we should counsel our patients about the benefits and drawbacks of using opioid analgesics, especially how these drugs can be addictive. We should also instruct them how to safely secure, monitor and dispose of them at home. Most people who abuse prescription opioids get them for free from a friend or relative, and those drugs are often obtained from the home medicine cabinet and sometimes the trash.

- Fourth, learn to recognize when a patient might have a substance use disorder or be prone to addiction. We should all know how to briefly counsel these patients and refer them for appropriate treatment. It can be an uncomfortable conversation, but it's one we need to have and know how to have it.[8]

Closer to home, the IDA has been involved in educating its members about the opioid crisis. In recent years, the epidemic has been addressed in Ethics and Jurisprudence presentations, has been part of IDA Annual Session programming, and has been addressed in print publications and on the IDA website. More recently, free online webinars have been offered to members, as well as this special issue of the Journal of the Indiana Dental Association.

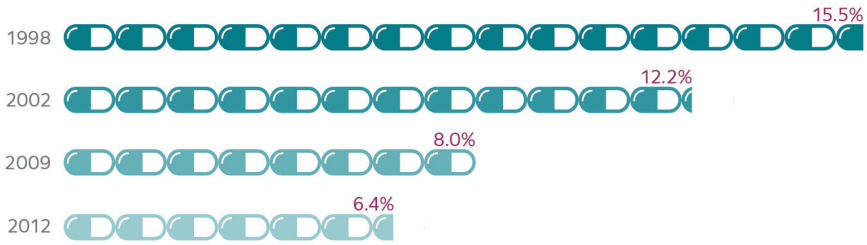
Legislatively, the IDA supported SEA 226, a 2017 law that limited opioid prescriptions to a seven-day supply. Further, in 2018 the IDA worked with Sen. Randall Head (R-Logansport) on a bill requiring health care practitioners to receive regular continuing education on opioid prescribing. Based on input from IDA, SEA 225 tied the CE requirement to controlled substance registration (CSR) not licensure, meaning heath care providers who do not prescribe opioids are not subject to the requirement. Further, based on IDA input, the law that went into effect in July 2018 includes a sunset provision, requiring the opioid epidemic and need for CE requirements to be reevaluated by the year 2025.

continued on page 13

HPI Health Policy Institute
ADA American Dental Association®

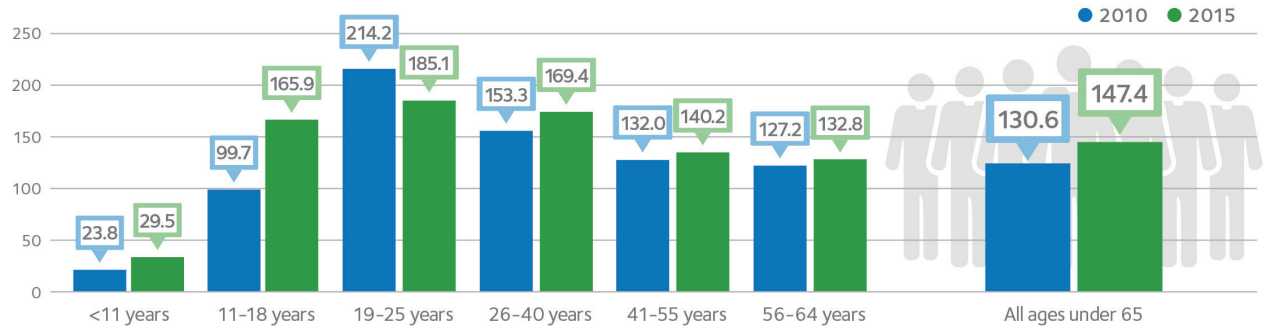
Opioid Prescribing by Dentists

PERCENTAGE OF TOTAL U.S. OPIOID PRESCRIPTIONS THAT ARE PRESCRIBED BY DENTISTS[1,2]



In 2012, dentists accounted for **6.4%** of total U.S. opioid prescriptions, or 18.5 million.[2]

NUMBER OF OPIOID PRESCRIPTIONS BY DENTISTS PER 1,000 DENTAL PATIENTS WITH **PRIVATE INSURANCE**, BY AGE GROUP[3]



Note: Data exclude individuals 65 years and older. Calculated as the total number of opioid prescriptions prescribed by dentists divided by the total number of individuals with a dental visit among those enrolled in both medical and dental insurance, multiplied by 1,000.

DAYS' SUPPLY AND QUANTITY OF PILLS PRESCRIBED BY DENTISTS AMONG PATIENTS WITH **PRIVATE INSURANCE** FOR 2010-15[3]

Median Number of Days' Supply:
3 DAYS

Median Quantity of Pills Prescribed: **20**

For more resources on prescription opioids in dental offices, please visit **ADA.org/opioids**.

Sources:

1 1998 and 2002 data was obtained from Rigonic, G. C. Drug Utilization for Immediate- and Modified Release Opioids in the U.S. Silver Spring: MD. Division of Surveillance, Research & Communication Support, Office of Drug Safety, Food and Drug Administration, 2003 available at **https://www.fda.gov/ohrms/dockets/ac/03/slides/3978S1_05_Rigoni.ppt**. The 2009 data was obtained from Volkow, N.D., McLellan, T.A., Cotto, J.H., Karithanom, M. and Weiss, S.R., 2011. Characteristics of opioid prescriptions in 2009. *JAMA*, 305(13), pp.1299-1301.

2 The 2012 data was obtained from Levy, B., Paulozzi, L., Mack, K.A. and Jones, C.M., 2015. Trends in opioid analgesic–prescribing rates by specialty, US, 2007-2012. *American Journal of Preventive Medicine*, 49(3), pp.409-413.

3 Gupta N., Vujicic M., Blatz A. Opioid prescribing practices from 2010 through 2015 among dentists in the United States: What do claims data tell us? *JADA*. Available from: **http://bit.ly/2pwiawX**

For more information, visit **ADA.org/HPI** or contact the Health Policy Institute at **hpi@ada.org.**

One of the five Principles of Ethics of the ADA is the call to "Do No Harm." Nowhere does this principle apply more critically than to the existing opioid crisis and the dentist's responsibility to treat and prescribe to patients in a manner that keeps them comfortable, while limiting exposure to the addictive dangers of opioids.

–State Sen. Randy Head

More information and resources regarding opioids, safe prescribing, and other resources, may be found online at www.ADA.org/opioids.

References

[1] CDC. Understanding the Epidemic. Centers for Disease Control and Prevention website. https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed July 2, 2019.

[2] CDC. Centers for Disease Control and Prevention. Motor Vehicle Crash Deaths: How is the U.S. doing?" Centers for Disease Control and Prevention website. https://www.cdc.gov/vitalsigns/motor-vehicle-safety/index.html. Accessed July 2, 2019.

[3] Joint Commission. The Joint Commission's Pain Standards: Origins and Evolution. The Joint Commission website. https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf. Accessed July 2, 2019.

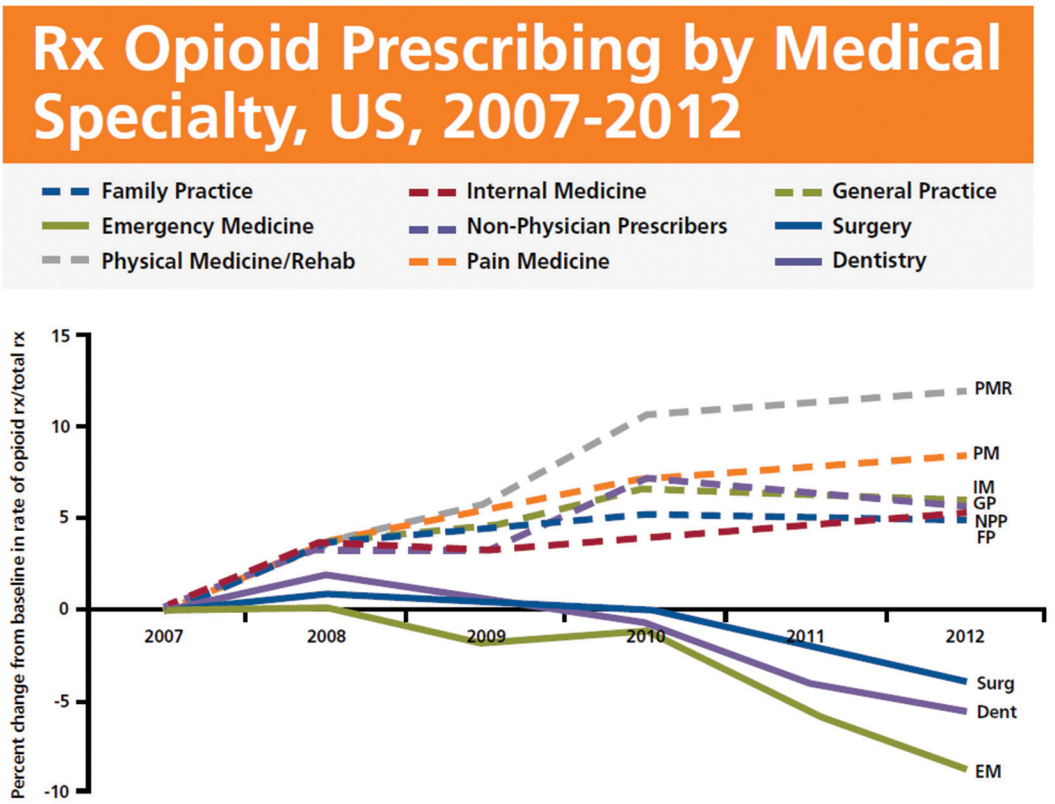
[4] Ibid.

[5] CDC. Understanding the Epidemic. Centers for Disease Control and Prevention website. https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed July 2, 2019.

[6] NIDCR, The Role of Dentistry in the Prevention of Opioid Drug Misuse and Abuse. National Institute of Dental and Craniofacial Research website, https://www.nidcr.nih.gov/grants-funding/funding-priorities/future-research-initiatives/role-dentistry-prevention-opioid-drug-misuse-abuse. July 2018. Accessed July 2, 2019.

[7] NIDA. Brain in Progress: Why Teens Can't Always Resist Temptation. National Institute on Drug Abuse website. https://www.drugabuse.gov/about-nida/noras-blog/2015/01/brain-in-progress-why-teens-cant-always-resist-temptation. January 27, 2015. Accessed July 2, 2019.

[8] ADA. A message from the ADA president: Preventing opioid abuse from the dental chair. American Dental Association website. https://www.ada.org/en/publications/ada-news/2018-archive/january/a-message-from-the-ada-president. January 22, 2018. Accessed July 2, 2019.



American Journal of Preventive Medicine. Trends in Opioid Analgesic-Prescribing Rates by Specialty, U.S., 2007-2012. Sept. 2015; 49(3):409-13.

About the Author

Mr. Doug Bush is serving his 23rd year as IDA Executive Director. He can be reached at doug@indental.org.

Inspecting Opioids:
A Look at Indiana's INSPECT Prescription Monitoring Program

Jay Dziwlik, CAE, MBA

Ed Popcheff

After reading this article the reader will learn the following objectives:

- *Understand the Indiana Board of Pharmacy Prescription Monitoring program.*
- *Learn how dentists participate in the INSPECT program.*
- *Learn how this may help with opioid prescribing and opioid abuse*
- *Provided further resources*

What is INSPECT?

Indiana and the state Pharmacy Board have been in the business of tracking prescriptions for over 25 years, but it was not until 2006 that the Indiana INSPECT Prescription Monitoring system was created by the passing of Indiana Code IC 35-48-7. The INSPECT electronic monitoring database has been used by practitioners and dispensers since, and though initially it was a voluntary program for dentists, it has recently been mandated for any practitioner who holds a controlled substance registration (CSR).

How Does INSPECT Work?

Indiana INSPECT is an online secured database that both registered practitioners and dispensers can access to check patient prescribing histories and to enter records of their patient prescriptions. This database collects a patient's controlled substance prescribing history in one location to assist with patient care and to help with any abuse or diversion of controlled substances. All Indiana controlled substance prescriptions are required to be submitted within 24 hours by the pharmacists/pharmacy. Many upload directly in real time via a secured system. Indiana INSPECT also interfaces with other states' prescription monitoring programs. These synchronizations occur periodically and may not reflect real-time, up-to-the- moment prescriptions from other states.

The INSPECT database is private and secured since it includes each patient's name, address, ID numbers, date of birth, national drug codes, dispensed dates, quantity dispensed and both the prescriber's and the dispenser's United States Drug Enforcement Agency (DEA) registration numbers.

INSPECT
Indiana Board of Pharmacy Prescription Monitoring Program
www.inspect.IN.gov

There are several groups who have access to the information collected by INSPECT, including health professionals who are licensed to prescribe or dispense controlled substances, prescriber delegates (advance practice nurse and nurse practitioner), law enforcement, court staff/probation officers, the Attorney General's office and licensing boards. Patients do not have access to this information. Dentists also can check their own records to see what prescriptions are being dispensed on their CSR/DEA number. It is a good way to help ensure there is no diversion on their prescribing registrations.

How Should a Dentist Interact With INSPECT?

First, if you are a dentist with a Controlled Substance Registration you will have to register with Indiana INSPECT under current Indiana and Federal laws. It is a good tool in stopping "doctor shopping" drug seeking behavior. Registration is connected to your CSR and you can get more information at the Indiana INSPECT website: https://www.in.gov/pla/inspect/.

Second, every time you are considering a prescription of a controlled substance, check Indiana INSPECT. You are legally required to run an INSPECT report prior to prescribing. The report will provide you with accurate information to assist with diversion, prevention and the best patient care.

Third, check your own prescribing history and see if there are any improprieties on your own CSR/DEA registration. It's easy to see if someone else is using your prescribing numbers for their own purposes.

How Does INSPECT Help You in Prescribing Opioids and Preventing Abuse?

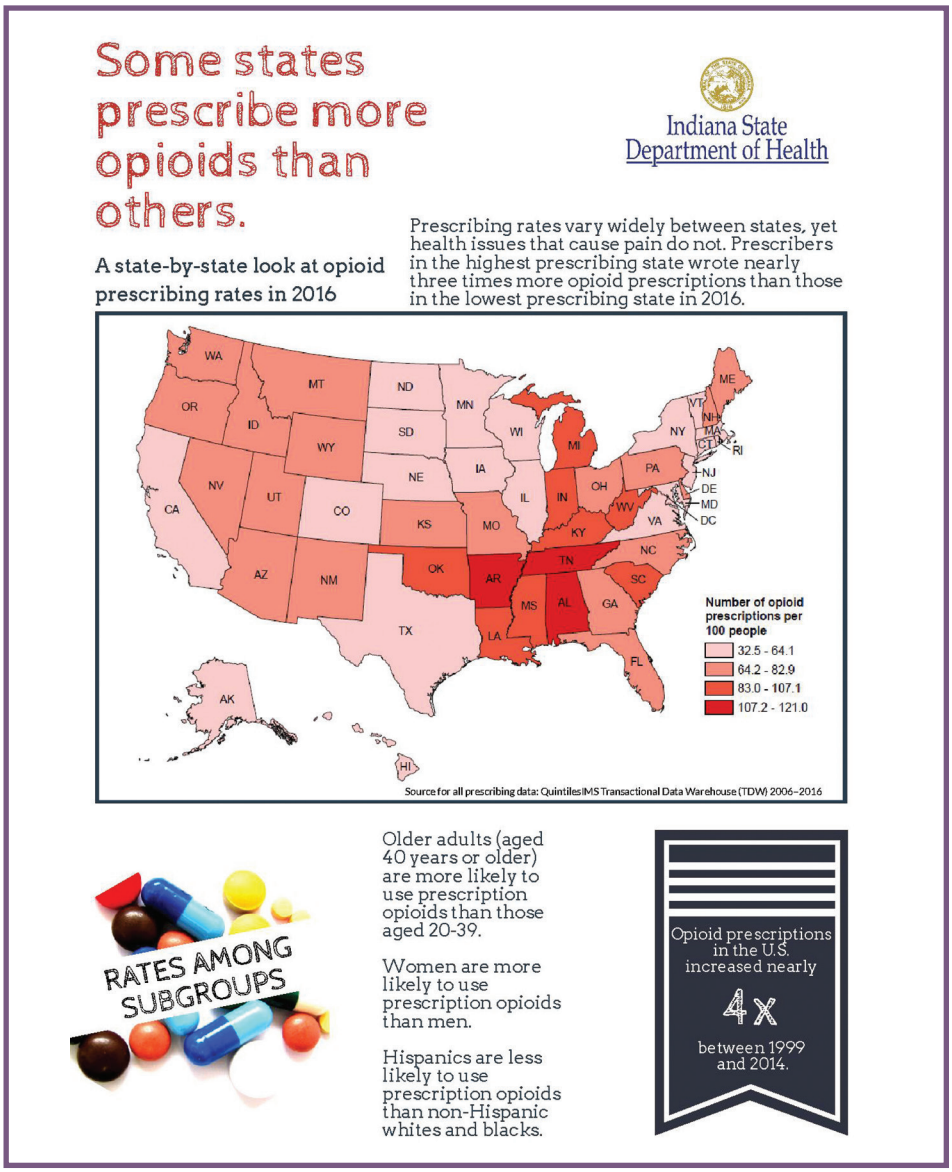
INSPECT helps ensure that only those who have properly prescribed opioids have access to them. It gives you valuable information when determining whether or not to prescribe opioids. It is a tool to identify patients who are "doctor shopping" for opioids.

Is INSPECT Easy to Use?

The early versions of INSPECT had a reputation for being slow and confusing, with some bureaucratic burdens as well. The system is now much faster and easier to use.

About the Authors

Jay Dziwlik is IDA's Assistant Executive Director and can be reached at **jay@indental.org**. Ed Popcheff is IDA's Director of Governmental Affairs and can be reached at **ed@indental.org**.



If you've ever wondered about the need for INSPECT, this graphic from the Indiana State Department of Health demonstrates the explosion in opioid prescriptions between 1999 and 2016. The graphic also shows that the rate of prescriptions in Indiana far exceeded most other states during that period.

Controlling Dental Pain With Minimal or No Opioid Analgesics:

An evidence-based, multimodal approach

Mark A. Saxen, DDS, PhD

Defining the Problem

Prescription drugs rank second only to marijuana as the nation's most common type of misused drug.[1, 2] According to the 2015 National Survey on Drug Use and Health (NSDUH), approximately 11.5 million adults misused prescription analgesics in the prior 12 months (misuse being defined as excessive use; use without a prescription for the patient taking the drug, and any other intentional use outside of the prescriber's instructions). The misuse of drugs containing codeine, hydrocodone and oxycodone, the opioids most commonly prescribed by dentists for the management of dental pain[3], has risen to alarming levels over the past two decades. A 2016 Status Report from the Centers for Disease Control identified prescription drug overdose as one of the most important public health problems and concerns facing the country today.[4] It is estimated that 1.4 percent of the United States population ages 12 and older misused prescription pain relievers in 2015, with the greatest consumption between the ages of 18 and 25. The same survey cited above found the number of new, non-medical users of prescription opioids increased from 600,000 in 1990 to over 2.4 million in 2004.[5]

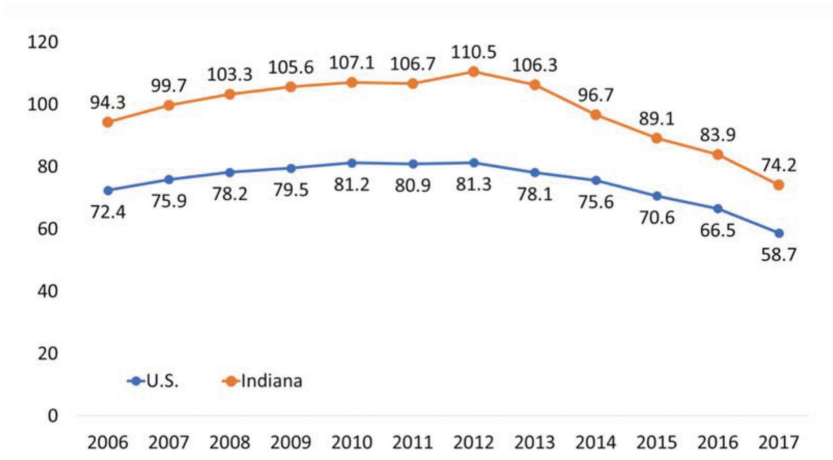
In addition to misuse, prescription drug diversion, which is defined as the unlawful channeling of prescription drugs to the illicit marketplace, is also a major concern. Examples of diversion include but are not limited to: the illegal sale of prescriptions by physicians and pharmacists; doctor shopping by individual patients; theft; forgery and alteration of prescriptions by healthcare workers and patients. Although diversion can take place at any point between the drug manufacturer and patient, the prescription of excessive amounts of drugs contributes significantly to the risk of diversion, as up to 71 percent of prescribed postoperative doses go unused.[6]

Although current media reports seem to be predominantly focused on the diversion of fentanyl, the less potent opioids commonly prescribed in dental practices have been shown to be the most commonly diverted opioids. In a nationwide study of new diversion cases reported to U.S. regulatory agencies between 2002 through 2006, hydrocodone was consistently found to be the most commonly diverted and misused drug, having been identified in 34 to 42 percent of diversion cases. Oxycodone ranked second, with a range of 17 to 28 percent over the five-year survey period. Fentanyl, methadone, morphine and hydromorphone were mentioned in only small proportions of the diversion cases reported.[7]

In 2017, Indiana providers wrote 74.2 opioid prescriptions for every 100 persons (Figure 1) compared to the U.S. average of 58.7 prescriptions (CDC). Only nine states had a higher opioid prescribing rate than Indiana. Although the 2017 rate represents more than a 31 percent decrease from a peak of 107.1 opioid prescriptions per 100 persons in 2010, these data should compel Indiana prescribers to examine and improve their prescribing practices.

Figure 1

Indiana and U.S. Opioid Prescribing Rates Per 100 Persons



The U.S. and Indiana opioid prescribing rate per 100 persons. Source: CDC and IQVIA Xponent 2006–2017.

Populations at Elevated Risk with Opioid Prescriptions

Adolescents and young adults are particularly vulnerable to prescription drug abuse. Patients under 18 who receive a provider-prescribed opioid have been shown to have a 33 percent greater risk of engaging in nonmedical opioid use by the age of 23.[8] Most people use drugs for the first time when they are teenagers, and even brief exposures to opioids at this period of life can have unanticipated consequences. The most recent survey of illicit drug use by the National Institute of Mental Health showed that 54.1 percent of the individuals using illicit drugs for the first time were under 18 years of age.[4] In patients who have not received previous opioid therapy, the risk of converting from short-term to long-term opioid use begins after the fifth day of exposure.[9] Special care should be taken to limiting the duration of opioid exposure in young patients. (Figure 2)

In addition to adolescents, adults with a pertinent medical history represent another category of dental patients at risk. Patients with obstructive sleep apnea, pulmonary disease, renal and hepatic disease and those on a regimen of systemic centrally-acting drugs are of particular concern. These patients are typically not opioid naive (as are most adolescents receiving prescription analgesics) but rather are at risk of experiencing unanticipated or exaggerated side effects of opioid medications.

Acute Inflammatory Pain Processing

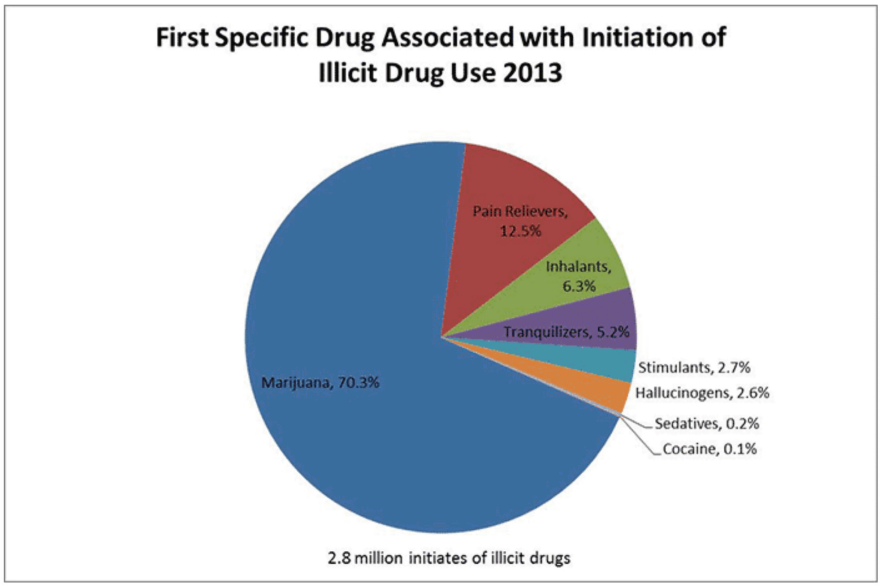
Acute pain is a dynamic and complex phenomenon. It begins when tissue damage initiates inflammation in the damaged tissue, which results in the release of peptides from sensory nerve endings. These peptides increase sensitivity to thermal, chemical and mechanical stimulation, a process referred to as inflammatory sensitization. The nerves responsible for this process are called primary afferent neurons. The dental pulp contains sensory nerve endings in high concentration, as does periosteum, bone, ligament, proximal tendons, the temporomandibular joint capsule and blood vessel walls.

Primary afferent neurons are the most distant parts of the sensory nervous system, being found within end organs and tissues. They are also classified as peripheral nerves because are located outside of the spinal cord. Primary afferent neurons, or first order neurons, transmit information about tissue damage in the teeth and face to a new set of neurons in the spinal cord, called second order neurons. Synapses act as relay points between primary and second order neurons. Second order neurons transmit pain signals from the peripheral tissue to the brainstem while integrating information from the tissues in several other different locations. The intensity of the pain signal can be increased or decreased in second order neurons; a process called neuromodulation. Certain analgesic drugs work on receptors, including opioids, act in these second order neurons to inhibit the transmission of pain to the brain. The synapses are also important sites of neuromodulation. Descending inhibition is a form of neuromodulation that results in the diminishing or blockade of pain signals that originated in the peripheral tissues and are ascending to the brain in second order neurons.

The brainstem marks the final major relay point in the process of pain transmission, sending pain signals from

continued on page 18

Figure 2



The misuse of prescription pain relievers is the second most common form of illicit drug use in the United States

Source: NIDA. (June 25, 2015). Nationwide Trends. Retrieved from https://www.drugabuse.gov/publications/drugfacts/nationwide-trends on June 19, 2019.

the brainstem to the cerebral cortex and other higher centers of the brain while also receiving signals from neurons that originate in the cortex and end in the thalamus. These neurons, also called third-order neurons, are the site where consciousness becomes a part of the pain experience. The effect of consciousness on pain perception ranges from simple awareness to the effect of past, learned responses to pain. Opioids also work on receptors located in third order neurons.

The Time Course of Pain

Normally, acute pain naturally fades and disappears after tissue damage is resolved and repaired. The set of programmed, biological responses to tissue damages run their course and perception of heat, cold and touch returns to normal levels. Inflammatory dental pain usually peaks within three to five days after tissue damage occurs, however it can last for several days to weeks, depending upon the severity of tissue damage. The great majority of dental pain is acute and inflammatory in nature.

Sometimes pain persists after tissue repair is completed, a process known as chronic pain. Chronic pain is usually maintained as a result of changes in within the central nervous system. It may be related to incomplete healing in the peripheral tissues at the site of the original damage; persistent malfunction of second and third order neurons; and learned behaviors that modify the awareness of sensation.

The treatment of chronic pain is difficult, and typically involves drugs that do not affect the process of inflammation. Opioid medications are usually poor choices for chronic pain. A deep understanding of the pathophysiology and prognosis of conditions related to chronic pain is required for adequate management of chronic orofacial pain.

Figure 3 summarizes the pain processing system while indicating the site of action of several types of pain therapies. When pain is allowed to persist over several days, natural neuromodulation occurs at all levels of the pain system. This can result in the perception of referred pain that seems to be coming from nearby, undamaged tissues. Functional physiologic responses, such as trismus, altered occlusion, or limiting jaw movement can also occur. As a general rule, the longer pain is allowed to remain untreated, the more complex it becomes, making treatment and resolution of the pain more difficult. Early, complete therapy of the cause of acute pain (e.g., removal of an inflamed pulp; tooth extraction or incision and drainage of an abscess) is most often the simplest and effective strategy for managing dental pain.

Choosing Pharmacological Targets for Dental Pain Management

Fortunately, most dental pain is highly responsive to treatments that do not include the use of opioid medication. Two recent meta-analyses of over 350 randomized trials and 45,000 medical and dental patients clearly demonstrated that NSAIDS are remarkably effective for postoperative pain and the combination opioid analgesics (e.g., Vicodin, Lorcet, Tylenol with codeine, etc.) are

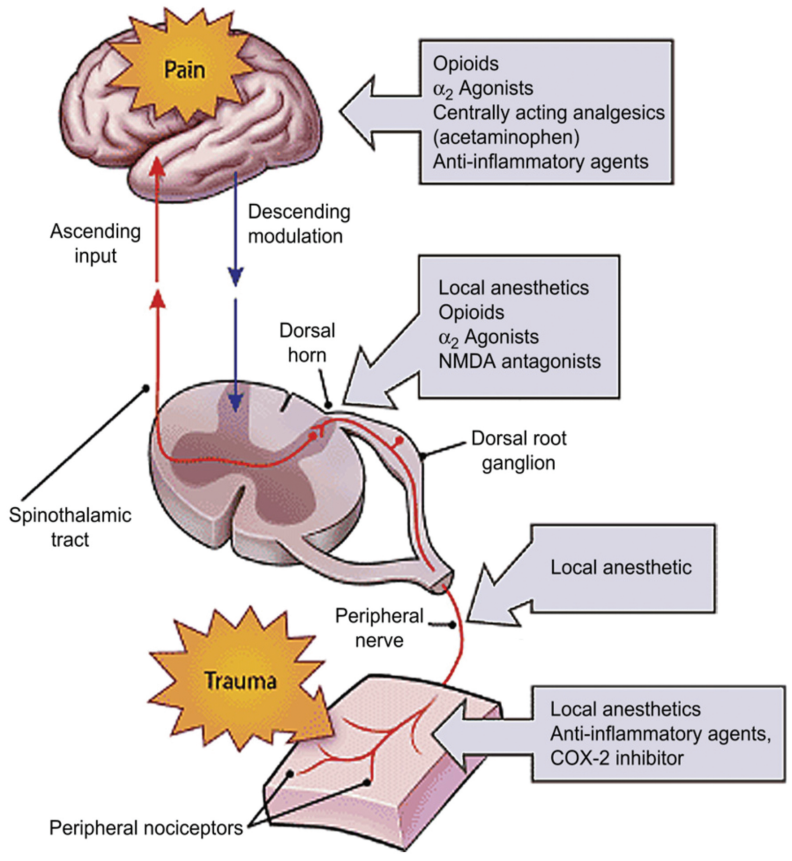
associated with high levels of nausea, vomiting, constipation and other adverse effects.[10, 11] In a 2016 JADA Commentary, Moore and colleagues opined that the persistent popularity of prescribing opioid analgesics for dental pain reflects a outdated understanding of the dental scientific literature.

Evidence for the efficacy of combination opioids was published in the 1970s, forming the basis for the pain management strategies taught in dental and medical schools at that time. In the decades that followed, pain research methodologies improved significantly, allowing for more sensitive and accurate comparisons of NSAIDS and other non-opioid analgesics with combination opioid analgesics. The results of research in the decades that followed established the superior efficacy of non-opioid analgesics, particularly in the setting of third molar extractions.[12, 13]

Moderate to severe dental pain is most effectively controlled when multiple sites in the pain system are targeted with drug therapy, a process termed multimodal pain therapy. The combination of nonsteroidal anti-inflammatory agents and acetaminophen (also called paracetamol), is a very effective method for controlling acute inflammatory dental pain.[14] This approach blunts peripheral inflammatory sensitization in primary afferent neurons while also providing central nervous system actions. Nonsteroidal anti-inflammatory drugs such as ibuprofen work primarily to reduce peripheral inflammation. Acetaminophen lacks significant anti-inflammatory actions but acts with the central nervous system to produce descending inhibition of pain signals in second order and third order neurons.[15]

Both NSAIDS and acetaminophen are associated with a number of adverse effects. NSAID effects include alterations in renal function, effects on blood pressure, hepatic injury and platelet inhibition which may result in increased bleeding.[16] The risk of NSAID side effects is minimized when they are used for 10 days or less.[17] Severe liver toxicity can occur when excessive doses of acetaminophen are taken. Maximum daily dose of acetaminophen is 4 grams and includes maximum allowable amount of acetaminophen administered by all routes including oral, rectal, and IV and from all acetaminophen containing products. The combination of oral NSAIDS (e.g., ibuprofen) and acetaminophen further reduces the risk of toxicity since the combination provides more effective pain relief than either agent alone.[18]

Figure 3



Multimodal pain treatment is achieved by simultaneously targeting different components of the pain pathway. Opioids block pain transmission in the brain and spinal cord, however their effectiveness is often limited by side effects. The use of drugs to act on other targets often produces equal or better pain relief with fewer side effect.

Modified from Gottschalk A, Smith DS. New concepts in acute pain therapy: preemptive analgesia. Am Fam Physician 2001;63:1981;

Local anesthetics provide an additional, important component to multimodal pain management by blocking inflammatory sensitization at both the site of tissue injury and attenuating pain transmission in second and third order neurons in the central nervous system. The biggest drawback of this longstanding cornerstone of dental pain relief is the short duration of action. Local infiltration and inferior alveolar nerve blocks typically provide anywhere from 30 minutes to 4 hours of relief depending upon the degree of tissue injury and the type of local anesthetic agent. Eight or more hours of relief can be obtained by using long acting agents such as bupivacaine to perform appropriate intraoral nerve blocks (e.g., Akinosi, Gow Gates and Maxillary blocks). Liposomal local anesthetic preparations provide dentists with the ability to place a specially engineered bolus of local anesthetic at the site of tissue damage, allowing for the local anesthetic to be slowly and continuously released over up to 72 hours.[19] All of these techniques are highly dependent upon the decisions and skill of the operator. A solid understanding of neuroanatomy and the pharmacologic properties of local anesthetics maximizes the effectiveness of local anesthetic administration.

Pharmacological Treatment vs. Definitive Therapy in the Emergency Setting

While this article has focused on the pharmacological management of dental pain, drugs and anesthetics are no substitute for prompt, definitive dental treatment. Unfortunately, dental pain continues to account for a significant proportion of hospital emergency room and urgent care visits, where dental treatment is routinely managed with a prescription in lieu of definitive therapy.[20] A study of Medicaid recipients found that patients with a dental condition were three times more likely to receive an opioid from a nurse practitioner as from a dentist.[21] While dentists have demonstrated a significant decrease in the number and amount of opioids prescribed for dental pain, no reduction in the rate of opioid analgesics for dental conditions has been noted in emergency facilities.[22] The lack of access to emergency dental care is a complex and multi-faceted issue with profound professional, economic, educational and ethical considerations. The re-integration of dental and medical emergency care is a very compelling goal in our current setting of opioid crisis and diminishing access to dental care and may be among the most effective approach to solving these two urgent public health needs.[23]

Summary

Opioid prescriptions by dentists continue to be a significant contributing factor to the current opioid crisis. When comparing all prescribers across the United States, Indiana physicians and dentists rank 10th in the number of opioids prescribed to patients. Multimodal therapy is a technique for maximizing pain relief through use of two or more different drugs that act through different mechanisms. Evidence gathered over the past four years demonstrates superior pain relief provided by NSAIDS along with acetaminophen when compared to fixed combination opioid analgesics. Advances in local anesthetic preparation and deliver provide an additional tool for multimodal therapy. Although multimodal therapy is superior to the use of opioid combination analgesics for the relief of most moderate to severe dental pain, prompt definitive treatment remains the cornerstone for relieving dental pain and minimizing the risks that accompany prescription opioids.

References

[1] National Drug Intelligence Center. (2011, August). National drug threat assessment 2011 (Product No. 2011-Q0317-001). Johnstown, PA Source http://www.justice.gov/archive/ndic/ Last accessed June 16, 2019

[2] Hughes, A., Williams, M. R., Lipari, R. N., Bose, J., Copello, E. A. P., & Kroutil, L. A. (2016, September). Prescription drug use and misuse in the United States: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. Source: https://samhsa.gov/data/ Last accessed June 16, 2019

[3] Suda KJ, Durkin MJ, Calip GS, et al. Comparison of Opioid Prescribing by Dentists in the United States and England. JAMA Netw Open. Published online May 24, 20192(5):e194303. doi:10.1001/jamanetworkopen.2019.4303 Last accessed June 16, 2019

[4] Prescription Drug Overdose. PSR Status Report. Available at https://wwwn.cdc.gov/psr/NationalSummary/NSPDO.aspx last accessed June 18, 2019

[5] National Survey on Drug Use and Health. The Substance Abuse and Mental Health Services Administration (SAMHSA). Nationwide trends. June 2015. Available at: https://www.drugabuse.gov/publications/drugfacts/nationwide-trends. Last accessed June 16, 2019

[6] Bicket MC, Long JJ, Pronovost PJ, Alexander GC, Wu CL. Prescription opioid analgesics commonly unused after surgery: a systematic review. JAMA Srug 2017;152:1066-1071.

[7] Inciardi JA, Surratt HL, Lugo Y and Cicero TJ. The Diversion of Prescription Opioid Analgesics

[8] Miech R, Johnston L, O'Malley PM, Keyes KM and Heard K. Prescription opioids in adolescence and future opioid misuse. Pediatrics 2015; 136(5):e1169-e1177.

[9] Shah A, Hayes CJ, Martin BC, Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 2006-2015, MMWR Mor Mortal Wkly Rep 2017; 66:265-269

[10] Moore RA, Wiffen PJ, Derry S, Maguire T, Roy YM and Tyrrell I Non-prescription (OTC) oral analgesics for acute pain: an overview of Cocchrane reviews. Cochrane Database Sys Rev 2015;11:CD010794.

[11] Moore RA, Derry S, Aldington D, Wiffen PJ. Adverse events associated with single dose oral analgesics for acute postoperative pain in adults: an overview of Cochrane Reviews. Cochrane Database Sys Rev 2015;10:CD011407.

[12] Moore PA, Dionne RA, Cooper SA and Hersh EV. Why do we prescribe Vicodin? JADA 2016;147(7):530-533.

[13] Au AH, Choi SW, Cheung CW, Leung YY. The efficacy and clinical safety of various analgesic compounds for postoperative pain after third molar surgery: a systematic review and meta-analysis. PLoS ONE.2015;10(6):e0127611.

[14] Derry CJ, Derry S, Moore RA. Single dose oral ibuprofen plus paracetamol (acetaminophen) for acute postoperative pain. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD010210. DOI: 10.1002/14651858.CD010210.pub2.

[15] Hargreaves KA and Abbot PV. Drugs for pain management in dentistry Aust Dent J. 2005 Dec;50(4 Suppl 2):S14-22

[16] Ong CK, Lirk P, Tan CH, Seymour RA. An evidence-based update on nonsteroidal anti-inflammatory drugs. Clin Med Res. 2007;5(1):19–34. doi:10.3121/cmr.2007.698

[17] Hersh EV, Moore PA, Ross GL. Over-the-counter analgesics and antipyretics: a critical assessment. Clin Ther 2000;22:500–548

[18] Juri L. Pedersen, Michael E. Crawford, Jorgen B. Dahl, Jannick Brennum, Henrik Kehlet; Effect of Preemptive Nerve Block on Inflammation and Hyperalgesia after Human Thermal Injury. Anesthesiology 1996;84(5):1020-1026.

[19] Lewis AN. Liposomal bupivacaine (Exparel) available at https://www.pharmacytimes.com/publications/health-system-edition/2013/january2013/liposomal-bupivacaine-exparel. Last accessed June 16, 2019

[20] Okunseri C, Dionne RA, Gordon SM, Okunseri E, Szabo. A Prescription of opioid analgesics for non-traumatic dental conditions in emergency departments. Drug Alcohol Depend 2015;56:261-266.

[21] Janakiram C, Chalmers NI, Fontelo P et al. Sex and race or ethnicity disparities in opioid prescriptions for dental diagnoses among persons receiving Medicaid JADA 2018;149(4):246-255.

[22] Somerman MJ, Nora D, Volkow MD. Commentary: The role of the oral health community in addressing the opioid overdose epidemic JADA 2018;149(8):663-665.

[23] A Costly Dental Destination. Pew Children's Dental Campaign. Pew Center for the States. February 2012 Available at pewtrusts.org Last accessed June 19, 2019.

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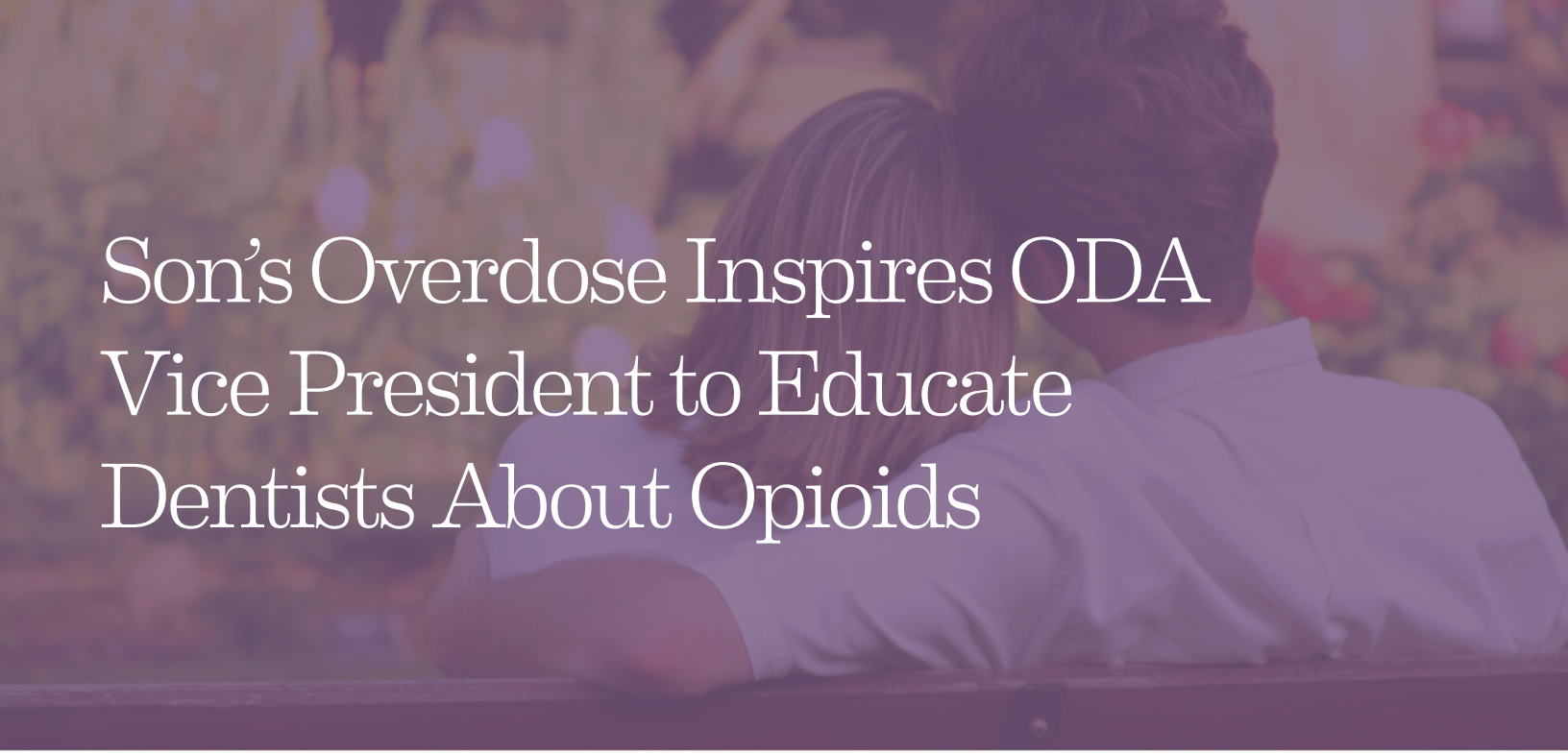

Son's Overdose Inspires ODA Vice President to Educate Dentists About Opioids

By Jackie Best Crowe, ODA Managing Editor
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More than 170 people die each day from drug addiction in the U.S. One of those is Sean Herman, son of Ohio Dental Association Vice President Dr. Sharon Parsons, who died from an overdose in 2016. Since then, Dr. Parsons has worked to educate dentists on the dangers of over-prescribing opioids and how addiction is affecting families.

"I want people to understand more about addiction," Dr. Parsons said. "And I want them to realize that we know very little about addiction as health care providers. Dentists and physicians both get very little education about addiction."

Herman was a typical kid who excelled academically and was active in sports growing up. "Sean was extremely bright," Dr. Parsons said. "He was in the gifted program in elementary, middle and high school. And he had a wicked sense of humor. But he wasn't always innocent either – in high school he definitely snuck beer and pot, all those things boys will do that their mom doesn't want them to do."

Herman was accepted into the Scholars Program at The Ohio State University and was a political science major. During his junior year, a friend invited him to ride dirt bikes on a farm. Although Dr. Parsons warned him against going because it was finals week, he went anyway. He got hurt, but didn't seek medical attention.

"A guy in the house next door handed him some pills and said 'take these, you'll be fine.' And that was the beginning," Dr. Parsons said.

It didn't take long, and he became addicted to Oxycontin. She said she could notice a difference in how he acted–he seemed not totally with it or like he was half a beat behind. She asked him several times about what was going on, and after pressing him he eventually told her about his addiction.

Herman went to rehab and came out clean, but he quickly fell back into addiction, Dr. Parsons said. He learned that heroin is the same as opioids but easier to find and less expensive, and he soon began shooting heroin.

She said he went through periods of being clean and then back into addiction, known as the "addiction waltz" that happens to many addicts as they keep repeating steps one, two and three in recovery programs.

During one period of sobriety where he was seeing some success with staying clean, Herman went on a whitewater rafting trip with his NA group, and hurt himself on the trip. He had ankle surgery, and the doctor prescribed him narcotics. His addiction started up again.

Shortly before Herman died, he seemed to be on a path to getting clean again. He had gone through detox and had gotten a job. Dr. Parsons had agreed to let him move back in

with her because he seemed to be doing well. He began moving in on a Saturday and planned to finish the following Monday. But on Sunday night, he overdosed on a drug laced with fentanyl and passed away.

"The fallout was really huge," Dr. Parsons said. "The collateral damage, so to speak. It not only affected my son, it left my whole family without a family member."

Dr. Parsons' mother died later that same day, and doctors believe that she had a heart attack from the shock of what happened with Herman.

"Just one handful of pills devastated my family," she said. "If we can find other means to help combat pain, I think we can help prevent a lot of future problems. I want people to know it can happen to anyone. Addiction doesn't discriminate. There's hardly anyone who has not been touched by someone being affected by drug addiction."

Dr. Parsons said dentists should not assume they have not contributed to addiction because oftentimes they may never know whether or not a patient has become addicted to opioids after receiving a prescription.

"My son was so ashamed, if he got something from a doctor he would have never gone back to that provider for more," Dr. Parsons said. "People don't know whether they've been the initial thing that got someone addicted or not. Just because no one has come back to you asking for more, that doesn't mean what you prescribed didn't cause a problem."

People between the ages of 13 and 26 are most at risk for becoming addicted to opioids because their brains are still forming, Dr. Parsons said. "In that age range, if exposed to an opioid, you're five times more likely to become addicted," she said. "That's middle school, high school, college sports and wisdom teeth removal. I would really caution people about prescribing opioids to that age range."

Dr. Parsons said she wants to emphasize to dentists the importance of educating themselves about prescribing opioids and the risks of addiction.

"Dentists don't realize how big of a role we actually played in creating the problem," she said. "No one did it on purpose, I think they just didn't know, and that's why we need to become educated so we do know in the future. Some people do just decide to try heroin, but the vast majority use heroin when they can't afford opioids, and the majority does not survive. Our goal is to try to create fewer future addicts."

Over the last couple of years, Dr. Parsons has been working to educate dentists by speaking to groups about opioid addiction along with her friend and colleague Dr. David Kimberly, who is an oral surgeon in Akron.

Drs. Parsons and Kimberly now present CE on opioid prescribing to dentists in Ohio. Their first presentation took place at the 2017 ODA Leadership Institute.

Dr. Parsons' younger son, Michael Herman, was in his first semester of dental school at University of Detroit Mercy when his brother overdosed. Dr. Parsons said he has become an

advocate on this issue as well, and they plan to speak at the dental school together about opioid addiction.

Dr. Parsons said that the parents of addicts are watching health care providers and specifically dentists very closely to see how they are responding to the opioid epidemic. She said many parents are mad, and they feel that their children's addiction began when they got their wisdom teeth removed. She said organized dentistry is in a good position to help change the perception and present dentists as responsible prescribers.

Dr. Kimberly agreed. "Organized dentistry has allowed the dental profession to speak with one voice to the public and to the legislature showing that dental professionals are responsible and concerned health care practitioners," he said.

One way the ODA is working to improve this perception and help curb opioid prescribing is through an Interim Policy on Opioid Prescribing that was passed by the Ad-Interim Committee in March, Parsons said. The policy supports opioid prescribing CE for dentists, among other things.

Dr. Parsons said it's also important that we change the conversation about opioids. "I want people to know it can happen to anyone," she said. "I want them to be open-minded and not judgmental. There was such a stigma associated with this that my son was very ashamed for a long time and didn't want to talk about it. I was more open than he was. If the stigma had not been there, he probably would have gotten help sooner. We have to be open about it and talk about it."

Oral Surgeon Changes Prescribing Practices Because of Addiction Story

When Dr. David Kimberly, an oral surgeon in Akron, heard about the overdose of Dr. Parsons's son, it affected him personally.

"It was a slap in my face when I saw that a young person who is a family member of someone I care about was injured as a direct result of the types of medications that I am prescribing," Dr. Kimberly said. "After stepping outside of my training and reflecting on my prescribing habits, I wondered 'Am I really doing what's best for my patients and the community?'"

Dr. Kimberly decided to do an audit of the prescriptions he was writing, and he said the numbers were alarming. "Our practice made a decision that we were going to start cutting back on narcotics prescribed," he said. "We have gone from prescribing 30 tabs of Percocet to eight now for an average set of wisdom teeth. We also prescribe five days' worth of ibuprofen. What we have found is that our patients now are actually in less pain than when they were relying on the narcotics alone. We're not just obtunding them with narcotics; we're actually treating the cause of their pain."

Dr. Kimberly said he now uses both NSAIDs and Tylenol to their maximum efficacy and he relies on narcotics only as a rescue medication if needed. His practice has also increased patient education with regard to pain control, and often this starts with the "Start Talking" informed consent form that parents or guardians must sign for minors. He talks about using narcotics as a rescue and about what to expect after surgery. "We are altering the expectations of patients. Knowledge is power. Knowing what to expect alleviates a lot of anxiety," he said.

Dr. Kimberly said the response from his patients has been very positive. "The parents are ecstatic," he said. "The patients are much much happier because they are not sick to their stomach, and they're getting better pain relief. I don't hear from patients as often for insomnia, nausea and pain."

He said now when he does get a call about pain, it's a red flag that something might be wrong so he has the patient come into the office.

Dr. Kimberly encourages other dentists to take a hard look at prescribing practices and consider prescribing fewer narcotics. "Sometimes the training that you received doesn't keep up with the realities of current practice and patient needs," he said. "Don't be hesitant to change your prescribing practices for fear that you're not going to alleviate patients' discomfort. The combination of patient education and effective use of non-narcotic pain control is extremely potent, and everyone's surgical experience benefits, including your own."

A Conversation About Well Being

Treating the Impaired Dentist

Kathy Walden

This edition of the Journal IDA *focuses primarily on problems and prevention related to opioid abuse around the U.S., but the issue of Substance Use Disorder (SUD) among dentists is one that should not be ignored. Just like the general public, dentists can have their own struggles with alcohol and drugs, but specialized help is available: As part of its commitment to supporting Indiana dentists, IDA offers confidential support and treatment through the Well Being program.*

At the heart of Well Being is Candace Backer, LCSW, LCAC, a licensed clinical social worker and licensed clinical addiction counselor who primarily treats substance abuse disorders (SUD) but can provide clinical coordination for related mental health conditions, including potential thoughts of suicide. As the Well Being clinical coordinator, she incorporates a comprehensive monitoring program and advocacy approach to document recovery and the safety of a dentist's practice.

Backer founded a similar program for the Indiana State Medical Association 30 years ago and created Well Being for the IDA in 1994. Before then, "treatment" for impaired dentists consisted of well-meaning but untrained colleagues who took it upon themselves to stage rudimentary, and usually unsuccessful, interventions.

The program is administered through IDA's Well Being Subcommittee, currently chaired by Dr. Stephen Pritchard. The committee oversees policies and procedures related to Well Being, reviews treatment statistics and updates the manual for procedures. The committee also reviews cases, though only after Backer has removed all personal and identifying details. Dr. Pritchard has volunteered on the committee almost continuously since the 1980s and serves as a sounding board for treatment plans and unique situations.

Backer notes that her biggest challenge is the reluctance among dentists to seek help for SUD, even though in the end, the vast majority are tremendously grateful for Well Being's assistance. The unwillingness to access help is mainly rooted in misconceptions about SUD and treatment, myths that Backer and Dr. Pritchard are determined to eradicate.

Well Being Coordinator Candace Backer, LCSW, LCAC, and Well Being Subcommittee Chair Dr. Stephen Pritchard.

MYTH: Educated professionals like me shouldn't have addiction problems

FACT: Experts estimate that 10 to 15 percent of the general population struggles with drugs or alcohol, and Backer says it's reasonable to expect that SUD affects the same approximate percentage of medical professionals, including dentists.

"Dentists are unique and we know that most of them are practicing in an office by themselves where they're the top dog and everyone else is at a lower level," said Backer. "It's easy for them to float with problems under the radar, but those problems will eventually catch up with them."

Dr. Pritchard believes the dentist personality also plays into embarrassment and reluctance to seek help. "Dentists are perfectionists, and I think that in general they hold themselves to a higher standard," he said. "When they fall off their pedestal, they immediately start beating themselves up over it. They know there's a problem but they don't want to admit it, and when they can't be perfect they start self-medicating."

Backer has a reassuring note for those who do seek treatment: Medical professionals have a 75 to 80 percent chance of staying in continuous recovery, which is a much higher rate than the general population.

MYTH: No one knows how to help me

FACT: Backer's decades of experience in treating medical professionals have given her unique insight into the needs of impaired dentists. "There are specialized approaches to treating many different populations, so it makes sense to have a specific course of treatment for dentists," she said.

Dr. Pritchard agrees. "Well Being offers special insights into the particular problems of dentists that most people don't have the experience or training to offer," he said. "We deal with the psyche of dentists and help them understand that they're in a safety-sensitive occupation where they can harm people if they're impaired, and we have to treat their unique needs."

MYTH: Everyone will find out

FACT: Well Being commands the strictest standards of confidentiality. Backer strips all identifying information from case files before sharing them with the Well Being subcommittee, and IDA staff are never made aware of the identity of dentists who come in person to speak with Backer. Ultimately, she is the only person who is aware of the name and circumstances of dentists who seek out her help. In more severe cases such as overdoses, Backer has arranged for treatment in facilities that specialize in helping dentists with SUD. These programs preserve the dentists' anonymity, but more importantly, they tailor their services toward the unique needs of dentists who need help.

MYTH: They'll turn me into the State Board of Dentistry

FACT: Backer emphasizes that this is a step that she has had to take only a handful of times in the past 25 years, and only if a dentist is too impaired to practice dentistry and refuses assistance from anyone. Otherwise, she has no imperative to communicate a dentist's SUD with state officials.

MYTH: I'll lose my practice

FACT: "This is understandably a common concern with dentists, but the reality is that there are solutions," said Backer. "I've helped with keeping the dentist's spot filled and keeping the office running. We know you're worried you'll lose your job, but eventually the problems will come to surface and patients will complain, and you risk losing your practice anyway."

Dr. Pritchard said the fear of a practice closing also contributes to the reluctance of hygienists and other staff members to report or even acknowledge evidence of a dentist's SUD. Because the majority of dental offices are solo or small practices, staff fear that a dentist going into treatment will result in the loss of their own jobs. He echoes Backer's reassurances that temporary replacements can be found to keep a practice running during a dentist's absence.

MYTH: It will cost too much money

FACT: IDA offers Well Being as a member benefit and as a service to dentists in general. Participants pay for their treatment, as well as the cost of follow-up monitoring, and IDA members pay substantially less than non-members. Donations to the program, which come through annual renewals and the IDA website, help subsidize the cost. "Dentists sometimes worry they can't afford it, but they can't afford not to do it. Missing days of work and losing patients will eventually cost far more," said Dr. Pritchard. "If someone remains compliant with treatment, it changes the course of their life in a positive way."

Backer and Dr. Pritchard are proud of Well Being's positive results over the years. "At the completion of the program, the vast majority of dentists are eternally grateful," said Backer. "They love me, they love the program, and they have loyalty to the IDA because of this member benefit."

About the Author
Kathy Walden is IDA's Director of Communications. She can be reached at **kathy@indental.org**.

▶ **See the signs of an impaired dentist on page 28**

Your Donations Help!

Dear IDA members,

I would like to extend my personal thanks for your voluntary contributions to the IDA Well Being Program. Without your assistance, the Well Being Program could not exist and we could not continue to have the positive impact on the lives of Indiana dentists. Please continue your voluntary donations and encourage your colleagues to do the same. To donate online, visit the IDA website: www.indental.org/product/well-being-donation/.

With gratitude,
Steve Pritchard DDS
Chair of the IDA Dentist Well Being Subcommittee

Signs of the Impaired Dentist

- *Smell of alcohol*
- *Calling in sick frequently*
- *Erratic behavior*
- *Deteriorating personal hygiene*
- *Confusion or slow responses, either physically or verbally*
- *Irritability*
- *Pattern of personality changes*
- *Increasing patient complaints regarding standard of care or bedside manner*
- *Missing drugs from the office supply*
- *Arrests or citations for driving under the influence*

Need Help for Yourself or an Impaired Dentist?

Contact Candace Barker at wellbeing@indental.org, or 800-562-5646, ext. 1010.

Backer emphasizes the role of anonymity in Well Being, for both the dentist and the reporting party. "You can call anonymously and explain the situation to me. We have an internal rule that we want more than one staff member confirming the situation, after which we reach out and talk with the dentist."

Well Being is a safe place to seek help for substance abuse. It exists to provide the specialized support and counseling that impaired dentists need.

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Better Living Through Chemistry

Dr. Jay Asdell

A few years ago, I was reading about some law changes in the Indiana legislature relating to the prescribing of opioids. My good friend Congresswoman Jackie Walorski and I were scheduled to meet to discuss other oral surgery issues. At the end of our meeting, I brought up the topic of opioids and the news I was starting to hear about a national epidemic. As the result of our conversation, Jackie and her staff contacted the ADA and AAOMS and she became instrumental in pushing legislation to combat the now national emergency opioid epidemic. It was then that I decided I was going to significantly alter my post op pain management philosophy.

From the beginning of my career as an oral surgeon in 1986, it was my standard operating procedure to write a prescription for 15 tablets of a narcotic with one refill. (total of 30 tablets) for the pain management of third molar surgery. These prescriptions were written without ever thinking about the possibility that not all tablets would be used. In actuality, an average of only 3-5 tablets were probably ever used which left quite a surplus. Therein lies the potential for abuse.

For over three years now, my post-operative pain management protocol has included the primary use of ibuprofen and acetaminophen to manage mild to moderate post op discomfort. My personal extreme change of prescribing protocol started with anecdotal evidence of success, but the protocol has now been studied and verified by the University of Minnesota Department of Oral Surgery, as described in the chart on page 31. (Tompach et al Opioid Protocol after Third Molar Extraction. J Oral Maxillofac Surg 2019)

My protocol today involves using ibuprofen and acetaminophen for post-operative discomfort for routine and surgical single tooth extractions. I have even used this protocol for multiple extractions or more involved surgical procedures, with great success. I continue to prescribe a small amount of opioids (usually five) after third molar surgery; however, several patients have told me that not all of the pain meds were used. There are also alternatives being developed including ultra-long-lasting local anesthetics (Exparel). The big concern for all practitioners has been that annoying after-hours phone call asking for more pain meds. I have found with the right post op instructions and the use of these non-narcotic meds that the worrisome post op call is rare.

We can all agree there is a national crisis involving opioid use. The number of opioid prescriptions in the U.S. more than doubled from 76 million in 1991 to nearly 207 million in 2013. Every day more than 115 people die after overdosing on opioids. The economic burden of prescription opioid abuse, dependence and overdose is estimated to $78.5 billion each year. President Trump declared the opioid situation a national emergency in October 2017. However, I am convinced with proper education of patients and providers the crisis will subside. It will take time and take a huge change in prescribing protocol and philosophy, but it can be done.

The state of Indiana currently requires two hours of opioid education every two years for any professional who holds a CSR. From a personal standpoint, I feel this requirement should be terminated after several cycles, as we are all very well informed about the pharmacology of opioids. It is scheduled to sunset in 2025. There is also a seven-day limit for prescribing narcotics in Indiana. The IDA has recently incorporated opioid CE in their CE portfolio. There are several other places where opioid CE can be obtained.

The FDA has also put together an "FDA Blueprint" for Health Care Providers involved in the Treatment of Patients with Pain. It can be found on the FDA website.

Dentists prescribe approximately 6.4-8.0 percent of opioid analgesics and are the highest percentage prescriber group for patients between 10 and 19 years of age. On a positive note, in 2010, dentists were the third highest prescribers of opioid medications but today have since fallen to fifth. Dentistry is doing its part to end this national epidemic. We have turned the corner with the battle against opioid addiction. However, this fight needs to continue on a daily basis.

It is critical that the dentist's post op instructions convey the message that Tylenol or Advil are more than capable of handling the discomfort the patients will anticipate. We all know the mental part of pain can be just as strong as the physical portion. I feel it is critical that the post op instructions clarify the potency and efficacy of the non-narcotic pain medications. The effect of the instructions and the meds is synergistic in the effort to control discomfort.

University of Minnesota School of Dentistry
Acute Postoperative Pain Opioid Prescribing Guidelines

If NSAIDS can be tolerated:

Pain Severity	Analgesic Recommendation
Mild	Ibuprofen (200-400 mg) q4-6 hours prn for pain
Mild to Moderate	**Step 1:** Ibuprofen (400-600 mg) q6 hours: fixed intervals for 24 hours **Step 2:** Ibuprofen (400 mg) q4-6 hours prn for pain
Moderate to Severe	**Step 1**: Ibuprofen (400-600 mg) with APAP (500 mg) q6 hours: fixed interval for 24 hours **Step 2**: Ibuprofen (400 mg) with APAP (500 mg) q6 hours prn for pain
Severe	**Step 1:** Ibuprofen (400-600 mg) with APAP (650 mg) with (5mg) hydrocodone q6 hours: 3-day supply. **Step 2:** Ibuprofen (400-600 mg) with APAP Ibuprofen (400-600 mg) with APAP (500 mg) q6 hours: prn for pain

If NSAIDS are contraindicated:

Pain Severity	Analgesic Recommendation
Mild	APAP (650-1000 mg) q6 hours prn for pain
Moderate	**Step 1:** APAP (400-600 mg) with hydrocodone (5 mg) q6 hours: 3-day supply. **Step 2:** APAP(650-1000 mg) q4-6 hours prn for pain
Severe	**Step 1:** APAP (650 mg) with hydrocodone (5 mg) q6 hours: 3-day supply. **Step 2:** APAP(650-1000 mg) q6 hours: prn for pain

In conclusion, it is critical that all dentists take this opioid crisis seriously and work to do everything possible to solve it. Everyone should take a close look at the way they prescribe narcotics and understand the tremendous value of ibuprofen (Advil, Motrin) and acetaminophen (Tylenol). With the concerted effort brought forth by the research and clinical experience, this horrible nationwide opioid crisis will thankfully go away.

About the Author
Dr. Jay Asdell is an oral surgeon in South Bend. He has been in practice since 1986, was the 2016-17 IDA President and currently serves as chair of the IDA Nominating Subcommittee and is a member of the IDA Insurance Trust Board. He can be reached at **hoosieroms@gmail.com**.

Opioid Ethics Refresher
Patient Scenarios to Consider

Jay Dziwlik, CAE, MBA

Ed Popcheff

Most dentists think they're correctly handling their prescribing, but are they really? It isn't until you read some commonly reported scenarios that one sees the need to refine thinking about the ethics of opioid prescriptions. Below are five prescribing scenarios that are "real life" and have been reported to the IDA, with names and minor details changed. Think through each of these scenarios and determine how you would handle each situation. The Scenarios Unpacked: Thoughts and Tips on the next page will help you see if your potential responses are appropriate.

SCENARIO 1: You have just completed a dental procedure on Mary and the two of you are discussing healing and recovery, including use of ibuprofen and acetaminophen for controlling some of the pain. Mary explains to you her sensitivity to pain and says those OTC medications often don't help her with pain. She prefers a prescription for hydrocodone, which has proven to be very effective for her in the past. How do you respond? What would you do?

SCENARIO 2: You are considering an opioid prescription for patient Paul based on the procedures completed today. When you pull up the Indiana INSPECT report, you see many opioid prescriptions for many pills from several other physicians. How do you handle this situation?

SCENARIO 3: Today you are seeing a new patient, Abby, for a possible extraction. After examining Abby you determine she does need the extraction. Reviewing the medical history form, Abby has indicated in her history she has struggled with addiction. What are some of the questions and conversations you would have with Abby? How might you proceed?

SCENARIO 4: You have finished up a dental procedure with Mark, who suffers from chronic neck and back pain and is under a physician's care. Based on the procedure today, you would typically provide a prescription for pain. What kind of questions would you ask Mark? How would you deal with Mark?

SCENARIO 5: You are seeing patient Bruce for the first time. The staff have warned you that "something is not right." He is acting oddly. As you are beginning your examination, Bruce is slurring, you notices red eyes and a rash on both arms. Bruce is restless. His behavior and the conversation is leading you to a suspicion of some sort of substance abuse. What should you do?

Scenarios Unpacked: Thoughts and Tips

SCENARIO 1: Anytime a patient is telling you, a trained professional, what you should do is a red flag that should give you pause. Patient self-disclosures are excellent and necessary, but it is never a substitution for your training, skill and experience. Adverse reactions are always a consideration, but in the case of a patient knowing and naming their preferred opioids, there should be caution. In this situation you should check the INSPECT prescription database and share with the patient the typical treatment protocol for the procedure, including alternating non-opioid medications. You should ask the patient to follow this protocol and explain that your office will check back in the next two days.

SCENARIO 2: As a dentist, you did the right thing and checked INSPECT for a prescription history as you were considering prescribing an opioid. When you see a history that puzzles you as a practitioner, it is wise to take a step back and ask questions, refer to the other practitioners and not add to the prescriptions. Dentists faced with this situation can explain: "You are under the care of Dr. X, and they are prescribing many medications, so I am referring you back to them for any prescriptions. On this procedure today I would have prescribed what you've already been prescribed by Dr. X."

SCENARIO 3: As a dentist, one of the most sensitive areas of prescribing opioids centers on the area of addiction relapse. No practitioner wants to set back the addiction recovery of a patient. This patient revealed her history, so you will want to have an up-front conversation about recovery and the fact that you will not prescribing any opioids in an effort to continue that recovery. Many addicts report their relapse began as they left the dental office with a prescription. You may want to develop your own regular conversation with any potential opioid prescriptions to try to mitigate any potential addictions or relapses.

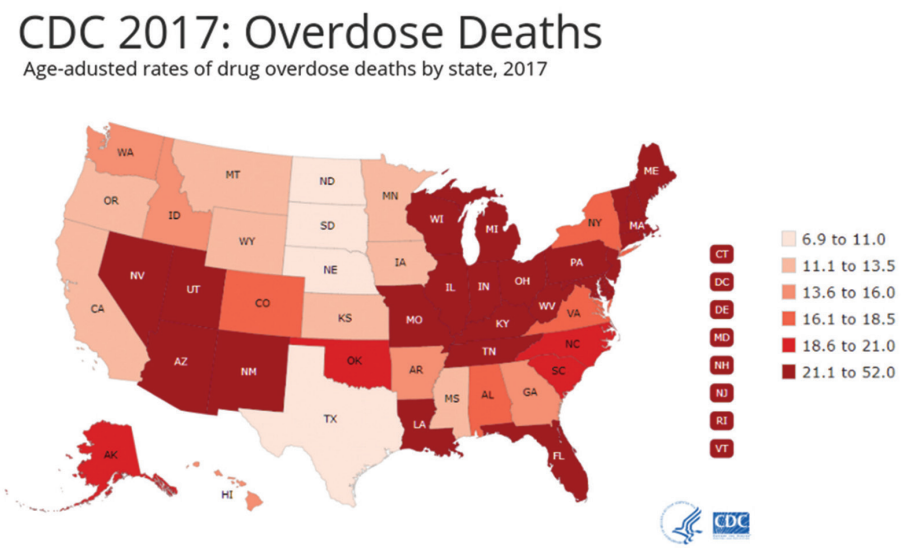
SCENARIO 4: Chronic pain is a difficult situation and seems to be more and more common in patients. Some tips in handling this situation including obtaining a thorough patient history to help you understand the source and care of this patient's condition. Any potential opioid prescription should be carefully reviewed in INSPECT for prescribing information and history. Lastly, clear coordination with any other health care providers is critical. Patients who are suffering from chronic pain deserve coordination between practitioners. Calling a physician prior to prescribing is a worthwhile part of your effort to do what is best for the patient.

SCENARIO 5: In a short visit it's often difficult to definitively say if somebody is an addict, but there are clear physiological symptoms, including:

- Cravings for drugs
- Sleepiness
- Numbness and inability to feel pain
- Sedation
- Depressed respiration
- Small pupils
- Itching, flushed skin and/or rash
- Nausea
- Slurred speech
- Constipation
- Tolerance to drugs

Practitioners need to be prepared to ask questions and direct patients to resources. Questions may include: "You seem restless, what's going on?" or "To get you the best care, I need all the information: Are you taking any other substances that might affect my treatment of you?" or even something more straightforward: "You are exhibiting some signs of addiction. Do you need some help?" These may not be comfortable conversations, but they could be life saving.

Lastly, your office should have references to resources within your community to help those in need. Some offices just leave them in the restroom or out in the waiting area for patients to pick up.



About the Authors
Jay Dziwlik is IDA's Assistant Executive Director and can be reached at **jay@indental.org**. Ed Popcheff is IDA's Director of Governmental Affairs and can be reached at **ed@indental.org**.

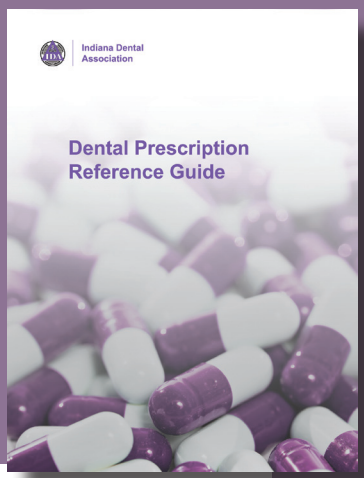
See the Best Practices for Opioid Prescribing on page 34

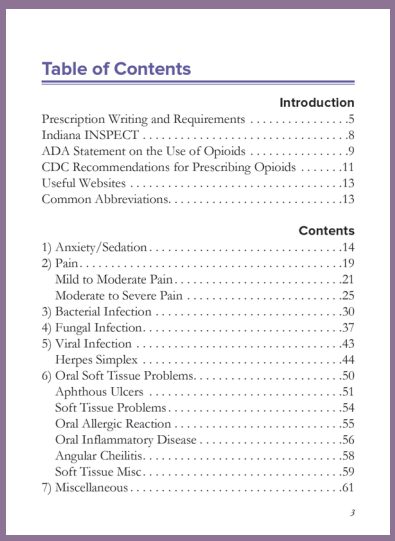
Best Practices for Opioid Prescribing

- *Always check INSPECT for prescription history*
- *Ask lots of questions of patients and other health care providers*
- *Consult with pharmacists and physicians when you have questions*
- *Consider opioids as a last resort in pain management*
- *When you do prescribe, be conservative in amounts, daily supplies and dosages*
- *Never prescribe opioids to children, to yourself or outside your scope as a dentist*

Dental Prescribing Help from the IDA

The IDA Dental Practice Committee has published a prescription reference guide as an aid in prescribing medications for the treatment of dental patients. This newly revised and updated pocket-sized prescription guide was created *for* dentists *by* dentists. Reviewed extensively by a team of experienced dentists and pharmacists with safety, dosages and dental-specific help in mind, the Guide is intended to provide a handy, convenient reminder on basic prescribing information for medications commonly used in dental practices. It is small enough to fit in every operatory drawer or is a great gift for your referring offices. This Guide is invaluable for your daily practice needs.





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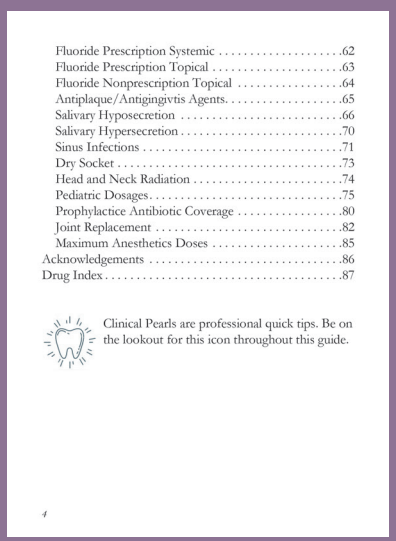

Clinical Pearls are professional quick tips. Be on the lookout for this icon throughout this guide.

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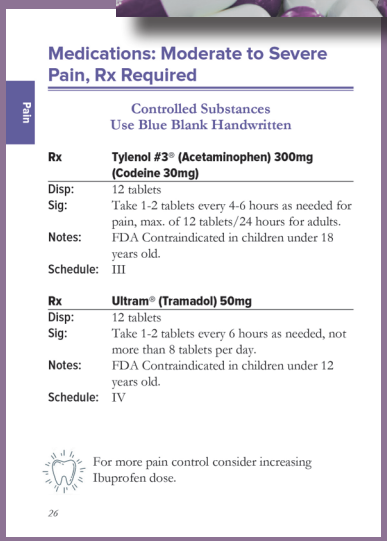

Pain

Medications: Moderate to Severe Pain, Rx Required

Controlled Substances Use Blue Blank Handwritten

Rx	**Tylenol #3® (Acetaminophen) 300mg (Codeine 30mg)**
Disp:	12 tablets
Sig:	Take 1-2 tablets every 4-6 hours as needed for pain, max. of 12 tablets/24 hours for adults.
Notes:	FDA Contraindicated in children under 18 years old.
Schedule:	III

Rx	**Ultram® (Tramadol) 50mg**
Disp:	12 tablets
Sig:	Take 1-2 tablets every 6 hours as needed, not more than 8 tablets per day.
Notes:	FDA Contraindicated in children under 12 years old.
Schedule:	IV

For more pain control consider increasing Ibuprofen dose.

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IDA Members $25 each, $20 per copy for 20+ copies • **Non-Members** $50 • **IUSD Students** $15

Order online today at **indental.org/product/dental-prescription-reference-guide/**

I have been using the Indiana Dental Association Dental Prescription Reference Guide a little over a year now and it has become an indispensable tool in my office. At 92 pages, the guide book has all of the information I need to make well informed and pertinent decisions for my patient's specific issues. It is a compact resource with a very easy to use layout that contains prescribing tips and precautions, generic and trade names of the most commonly prescribed medications, pediatric dosages, and the most up to date laws and regulations for Indiana dentists.

In light of the current opioid crisis, I find the recommendations and alternatives for prescribing opioids especially helpful. Knowing that the reference guide was researched and vetted by several Indiana pharmacists, general practitioners and dental specialists has given me greater prescribing confidence and improved communication with my patients and pharmacists. Thank you IDA for providing another outstanding member benefit!

–Dr. Karen Ellis, general dentist

Prescribing Scope for Dentists

Jay Dziwlik, CAE, MBA

Determining a scope of practice is something every practitioner goes through as they begin seeing patients. Scope is determined by the convergence of licensing, education training and a level of skill and experience shown by a practitioner. Scope applies also to prescribing practices as well.

In Indiana, your ability to prescribe controlled substances comes from three places: The Indiana State Board of Dentistry, Indiana Pharmacy Board and the U.S. Drug Enforcement Agency. The Indiana State Board of Dentistry outlines in its statutes that the scope is derived directly from the dental license IC 25-14-1-23 section (4). **"A dentist can prescribe controlled substances that treat lesions or diseases of the human oral cavity, teeth, gums, or maxillary or mandibular structures."**

The Indiana Pharmacy Board's Controlled Substance Registration (CSR) is required for dentists who prescribe any controlled substances. It also lays out your scope with the following: **"Licensed pharmacists of this state may fill prescriptions of licensed dentists of this state for any drug necessary in the practice of dentistry" IC 25-14-1-23 (f).**

The U.S. Department of Justice Drug Enforcement Administration (DEA) is an additional requirement for a scheduled drug prescription. All DEA registrations are administered through the Diversion Control Division. All CSR registrations are connected to your Indiana dental license and need to be connected to a practice location. DEA registration is required for each practice location.

The new continuing education requirement for two hours of continuing education on the topic of Opioid Addiction and Opioid Prescribing is tied to the renewal of your Indiana Controlled Substance Registration. If you wish to maintain your Indiana CSR, you will need to complete the two-hour requirement prior to license renewal on **March 1, 2020**. This requirement will be in place for the next two licensing cycles until year 2025. DEA registrations are on a different renewal cycle running every three years from the time you renewed.

Opioid and scheduled drugs commonly utilized in a dental practice vary, but all require a CSR and DEA registration.

Component 140

In Component 140, Indiana's component dental societies have the chance to showcase their members' achievements, reflect on past events or provide information about upcoming opportunities for members.

Indianapolis District Dental Society

Tuesday, September 17 and Tuesday, October 1

Practice Preparation & Implementation Seminars, 6-9 p.m. Members: $20. Includes dinner and both sessions. Long term Practicing **or** new dentists. Topics of finance, associateships, tax, accounting, equipment and real estate plus much more. Contact IDDS at 317-471-8131 or info@indydentalsociety.org to register by **September 13**.

Thursday, September 19
President's Fall Workshop | The Opioid Crisis; "Primum Non Nocere"
The Garrison Conference Center, 6002 N. Post Road

Fulfills the 2 hour CE requirements for CSR renewals. Guest Speaker is Dr. Timothy Kelly. Buffet dinner at 6:30 p.m, workshop is from 7–9 p.m. **Cost:** Member dentists $25, all others $50. Registration is required by **September 1**. To register, contact IDDS at info@indydentalsociety.org or 317-471-8131. **For active (not retired) dentists only.**

Thursday, September 26
New Members Social
Big Woods Speedway, 1002 Main Street

6:30–8:30 p.m. All members in practice 10 years and under are new dentists and are welcome. Graduates from 2009 through 2019 are invited. No charge, but pre-registration is required by **September 16**. To register, contact IDDS at info@indydentalsociety.org or 317-471-8131.

Friday, October 4
Ethics Seminar
Hillcrest Country Club, 6098 Fall Creek Road

9–11 a.m. Effective for this licensing period ending March 1, 2020, dentists and dental hygienists must receive 2 CE credits in ethics. This will fulfill your licensure requirement. All dentists and hygienists are welcome. Registration deadline is **September 27** and cost is $10 per person. To register, contact IDDS at info@indydentalsociety.org or 317-471-8131.

Wednesday, October 9
Fall General Membership Meeting and 5/10 Year Member Recognition
The Garrison Conference Center, 6002 N. Post Road

Social Hour 5:30, dinner and business meeting at 6:30. Guest Speaker: Mr. John Meeks and military war dog hero Brutusz on "Honoring our Silent Heroes." Registration deadline is **September 30.** To register, contact IDDS at info@indydentalsociety.org or 317-471-8131.

Friday, October 11
OSHA/BLS
Hillcrest Country Club, 6098 Fall Creek Road
OSHA 9–11 a.m., BLS 11:30–3:00. Please register yourself and your staff at **www.indental.org/oc** or contact Heather Smith at IDA 317-634-2610. Lunch will be served to those attending BLS. Register today–space is limited.

Share Your Events With Us!

Keep fellow members updated on what your component is doing! Share events, fundraisers, meetings and social gatherings with IDA for publicity in the quarterly *Journal*. Email IDA Director of Communications Kathy Walden with details at **kathy@indental.org**.

Change

Dr. William B. Risk

Change is all around us. All day long we adjust our activities to the changes that are constantly happening. What is the temperature? Is it raining? Why is the dog acting so funny? Does he need to go to the vet? Our lives are governed by change.

But change isn't always random. A lot of time is spent on planning. Thinking about the changes we want to have happen in our lives. Our education required us to deal with a great amount of change, much of it unpredictable, as we learned about dentistry and prepared for a significant change in our lives. And what is dentistry? Dentistry is a profession where we often make significant, changes in other people's lives.

We can't avoid change. In recent years technology has driven a lot of the change we are experiencing. How many times have we seen ads for upgrading our phones? There are always new apps for us to obtain to make our existence easier and more enjoyable. Computers, tablets, laptops and phones are many of the ways we have at hand to just communicate and help deal with change.

In our dental practices change seems to be accelerating. Almost always as the reps come into the office, there is a new product available. Notices for learning about new and better ways for treatment arrive in the mail daily. At our dental conventions the number of new and better innovations seem almost endless. This includes not only the new products but also the new and better ways to treat our patients' situations. It seems as if the only thing about dentistry that isn't changing these days is human anatomy and human physiology. These advancements in how we can provide better care for our patients is one of the more exciting aspects of this profession.

There are also the changes that others have decided are needed for our profession. Recently our state legislators decided all healthcare professionals need additional education in the prescribing of opioid compounds. These policymakers are also considering other matters that affect dentistry. There are problems with how Medicaid dental benefits are provided. The insurance industry has also provided us with a number of issues not the least of which are assignment of benefits and non-covered services.

Lurking in the background is the dental therapist. Should dental care be delivered in this manner? Is this a desirable change? Our legislators will decide this for the state of Indiana. But just as we took action and entered dental school and created change for ourselves, we can also take action and guide or maybe even prevent change in these other areas. All it takes is communication with your local state legislators.

It is important that they receive important information from their constituents concerning legislative matters. These men and women rely on this kind of information to help them make the right decision for Hoosiers. Go to their fund raisers. Visit their websites. Sign up for their newsletters. Our legislators are public servants and try very hard to be approachable. Help plan and guide the changes for the future of dentistry by participating in the process. IDA Director of Governmental Affairs Ed Popcheff can help with the contact process if needed.

With all of the advancements in technology and newer and better materials bringing more change in the future, remember this: In dentistry there will always be trauma, malocclusion and temporomandibular dysfunction.

About the Author
Dr. William B. Risk is a general dentist practicing in Lafayette, IN. He can be reached at **wriskdds@gmail.com**.

classifieds

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POSITIONS AVAILABLE

Associate Dentist Wanted
Columbus Dental Group (Home of Columbus Advanced Family Dentistry and Columbus Pediatric Dentistry) in Columbus, IN is looking for an Associate Dentist to fill in our thriving family practice. We are a well-established practice with a growing patient population. This is a full-time position for the right candidate who is passionate about caring for our patients. We are looking for an associate that cares about providing the best possible treatment to our patients. An associate who is able to build relationships based on integrity, respect, and commitment. Great opportunity for a dentist looking to join an established practice, and is willing to provide excellent dentistry to an established patient base. Must be licensed in Indiana. If interested, email your resume to marvinpavlov@icloud.com.

Associate Dentist - Shelbyville
We are looking for an associate dentist. Full time position, opportunity to buy into the practice, wonderful staff. Office is located 30 minutes southeast of Indy in Shelbyville. Please email all resumes to millerddsinfo@sbcglobal.net.

Part time General Dentist - Merrillville and Munster
Part time general dentist needed for Merrillville and Munster, with potential for full time in the future. We are searching for a skilled Dentist with excellent communication skills to join our professional team. The ideal candidate for this position has worked with patients of all ages, is proficient in performing regular checkups and complex dental procedures and is committed to the highest quality of care. Those who are qualified and in search of a long-term career opportunity are encouraged to submit a resume today. Contact: Mendee Regalado at mendeetaylor@yahoo.com.

PRACTICES AVAILABLE

Indianapolis North side - Well Established General Family Practice with 8 treatment rooms
Excellent transition opportunity! Private Practice, fee for service, long term staff, room for growth, loyal patient base of over 35 years. For details fax resumes, 317-776-3003.

West Central Indiana - Well-established Endodontic practice. Excellent transition opportunity! Updated technology with CBCT. Gross Revenue $701K. Real estate available. For details contact Henry Schein Professional Practice Transition Sales Consultant Michael Kamp, 317-506-5310, Michael.kamp@henryschein.com. #IN124

Clinton County, IN - Well-established General Family Practice with four (4) treatment rooms. Excellent transition opportunity! Real Estate is available. For details contact Henry Schein Professional Practice Transition Sales Consultant Michael Kamp, 317-506-5310, Michael.kamp@henryschein.com. #IN128

Northwest Indiana - 5 op $470K revenue practice around 32 hrs only M-Th/wk. Dr looking to retire and sell well-kept standalone building on major road in growth area of town. #IN130

Northwest Indiana - Newer practice (18 mo), 7 ops with new equipment collecting half million annually. Building also for sale with space for other tenants to pay rent. Only about a 40 min. drive from downtown Chicago. #IN131

Indianapolis - Great opportunity for a four (4) op practice with growth potential. Shares building with a medical practice. Technology investments have been made within the practice, including iCAT CBCT and digital x-rays. For details contact Henry Schein Professional Practice Transition Sales Consultant Michael Kamp, 317-506-5310, Michael.Kamp@henryschein.com. #IN132

Jefferson County, IN - Extraordinary opportunity in the heart of the county with five (5) ops and 40 new patients per month. Located in a highly desirable, growing community. Real estate also for sale along with the practice sale. For details contact Henry Schein Professional Practice Transition Sales Consultant Cindy Schonert, 618-240-4274, cindy.schonert@henryschein.com. #IN133

Rush County, IN - Established, five (5) operatory General Practice. Practice with many updates and real estate available in professional office park. Great opportunity! For details contact Henry Schein Professional Practice Transition Sales Consultant Michael Kamp, 317-506-5310, michael.kamp@henryschein.com. #IN135

members

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FIRST DISTRICT DENTAL SOCIETY

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My Favorite Membership Benefit...

> The connections and friendships help to create a better dental environment in Indiana!
>
> –Dr. Tom Blake
> Isaac Knapp District Dental Society

members

Please contact Jody Cleary, IDA Director of Membership & Financial Services, with all member updates. Jody can be reached at Jody@indental.org or 800-562-5646.

In Memoriam

Dr. Ronald R. Bartosiak of Mishawaka and former member of the North Central Dental Society, passed away June 4, 2019. Dr. Bartosiak graduated from Indiana University School of Dentistry in 1977.

Dr. Raymond A. Burris of Indianapolis passed away June 17, 2019. Dr. Burris graduated from Indiana University School of Dentistry in 1966.

Dr. Ronald J. Munson of Marion passed away May 28, 2019. Dr. Munson graduated from Indiana University School of Dentistry in 1980.

Dr. Robert D. Windsor of Middlebury passed away June 11, 2019. Dr. Windsor graduated from Indiana University School of Dentistry in 1978.

What's Your Favorite Word?

Dr. Michael D. Rader

The greatest talk show host of all time wasn't named Johnny; nor was he Jay, Dave or Larry. The greatest wasn't Oprah either. According to James Lipton, host of Bravo Network's "Inside the Actor's Studio," that honor belongs to Bernard Pivot. If Pivot doesn't sound familiar it's probably because you haven't watched much French television. Pivot hosted an hour long weekly prime-time French literary talk show devoted to literature and authors. The format was very simple; either a one-on-one interview with a single author or an open discussion with four or five authors. Pivot's unmatched success lies in his use of the Proust Questionnaire.

Made popular by the French writer Marcel Proust as a Parisian parlor game, the questionnaire probes the subject's personality, tastes, and values. Seemingly simple, open-ended questions seek to reveal the true nature of a person. Lipton, a self professed Francophile, uses the same simple format when interviewing famous actors and directors. He traditionally begins by asking his guests, "What is your favorite word?" The responses vary greatly. Some are silly, others philosophical; but all are fascinating and illuminating.

If you were a guest on Mr. Lipton's program how would you answer his signature question? What word captures the essence of your personality or philosophy of life? It's tough, isn't it? Just about when you've selected a favorite word a better candidate often appears.

The Proust Questionnaire came to mind recently while reading Dietrich Bonhoeffer's book, "Letters and Papers from Prison." Bonhoeffer, a dissident German theologian, was imprisoned by the Gestapo from April 1943 until his execution on April 9, 1945. Bonhoeffer's calm demeanor had a profound and lasting impression on both prisoners and guards alike. A British officer imprisoned with Bonhoeffer remembered, "Bonheoffer always seemed to me to spread an atmosphere of happiness and joy over the least incident and profound gratitude for the mere fact that he was alive." Bonhoeffer's writings frequently refer to gratitude. Bonhoeffer wrote from prison, "In normal life we hardly realize how much more we receive than we give, and life cannot be rich without such gratitude."

Research studies support Bonheoffer's beliefs. In a *Scientific American* article, "Why Bronze Medalists Are Happier than Silver Winners" researchers studying the reaction of participants at the awards ceremonies at several Olympic Games found that Bronze medalists are generally more outwardly happy, displaying more positive body language and broad smiles. This apparent contradiction is explained by a well known theory in psychology; a person's achievements matter less than how that person subjectively perceives their achievement.

Counterfactual thinking, which means that people compare their objective achievements to an idealized outcome, would predict a silver medalist likely to focus on failing to win the gold medal while the bronze medalist is more likely to focus on almost not winning a medal at all. The bronze medalist, while objectively achieving less is happier with himself and third place while the silver medalist is doomed to perpetually lament "I was so close!"

Other studies published in the Journal of Happiness Studies indicate that journaling, specifically keeping a diary of what one is grateful for produces increases in happiness. Gratitude relieves stress, materialism and harmful negative self-comparisons.

Whether gratitude is a byproduct of deeply held religious or philosophical beliefs or by studies on happiness it seems clear that in an American culture obsessed with materialism, conspicuous consumption and wealth all of which encourage covetousness perhaps reflecting upon and expressing our gratitude might lead towards a more healthy and balanced perspective.

Maybe the answers to life's biggest questions are pointed out by the smallest, most innocent philosophers. "Piglet noticed that even though he had a Very Small Heart, it could hold a rather large amount of Gratitude."- A.A. Milne, Willie-the-Pooh

Gratitude; it's my favorite word.

About Dr. Rader

Dr. Michael D. Rader practiced joyfully (mostly) in South Bend for 37 1/2 years and was a long time contributor to the IDA Journal. His regular column, The Last Word, was highly anticipated and had many loyal fans. While usually light hearted, it was always thought provoking. Dr. Rader passed away in March 2018. His remaining columns are being published posthumously.

How to Receive Credit for this CE Issue

Thank you for taking the time to read the articles and examine the facts and figures in this special opioid CE edition of the *Journal IDA*. Any Indiana professional who holds or applies for a CSR must obtain two hours of opioid abuse CE by the next license renewal date of **March 1, 2020**, but this is an excellent CE opportunity for any dentist, regardless of CSR status.

Now that you have finished reviewing this *Journal IDA*, you are ready to take the online quiz and receive two hours of continuing education credit. The cost of the quiz and certificate of completion is **$25** for members, **$110** for non-members. To access the online quiz, visit our website:

www.indental.org/product/opioid-journal-2019/

If you prefer a paper version of the quiz, email laurie@indental.org to request a mailed or emailed copy. Regardless of how you choose to take the quiz, upon completion with a score of 80 percent or higher, you will receive a certificate from IDA. You may re-take the quiz if you are not satisfied with your score.

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The information in this edition expires on August 31, 2121.

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