# MINUTES
# Opioid Epidemic Evaluation Study Committee

**Monday, October 16-17, 2017**

## MEMBERS PRESENT

Senator Dan Dawson, Co-chairperson
Senator Thomas A. Greene
Senator Kevin Kinney
Representative David E. Heaton, Co-chairperson
Representative Charles Isenhart
Representative Shannon Lundgren

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## I. Procedural Business

**Monday, October 16, 2017.** The first of two meetings of the Opioid Epidemic Evaluation Study Committee (OEESC) of the Legislative Council was called to order by Temporary Co-chairperson Heaton at 9:03 a.m. on Monday, October 16, 2017, in Room 103 of the State Capitol, Des Moines. The committee elected temporary Co-chairpersons Dawson and Heaton as permanent co-chairpersons and adopted the proposed rules unanimously. Senator Kevin Kinney was excused. The meeting was recessed at 4:49 p.m.

**Tuesday, October 17, 2017.** The second of two meetings of the OEESC was called to order by Co-chairperson Dawson at 9:06 a.m., in Room 103 of the State Capitol, Des Moines. The meeting adjourned at 3:05 p.m.

**Opening Comments.** Co-chairperson Dawson thanked Co-chairperson Heaton and the members who were in attendance to help the committee do the right thing. He said opioids have been around for thousands of years but as mankind has evolved so has drug usage. Co-chairperson Dawson said that what started off as a plant in a far-off land is now being isolated into a compound and manufactured for both a legal medical usage and a black market usage. He said he hoped the committee would start to provide solutions to the epidemic the state is facing with persons who are not normally prone to criminal activity becoming addicted to a highly addictive drug and descending into a lifestyle in which the person would not normally be involved. It is not just strangers but neighbors, friends, and family who are being victimized. He expressed hope that the committee could come up with a way to stem the tide of what is coming toward Iowa.

Co-chairperson Heaton thanked the legislators on the committee for their attendance to help make recommendations to address the opioid epidemic in the state. He noted that legislation involving opioids had been handled by the Public Safety Committee and would continue to be addressed by that committee but the General Assembly also should consider the health aspects of opioid use. Co-chairperson Heaton said that in 2016 there were 200 opioid or opioid-related deaths in Iowa, and the two things the committee needed to focus on are prevention and treatment. He stated that the committee was there to listen and evaluate options and hoped in the next legislative session to have legislation to address the opioid epidemic.

## II. National Conference of State Legislatures — National Perspective

Ms. Karmen Hanson, Program Director, Health Program, NCSL, provided an overview of state policy actions regarding the opioid epidemic across many sectors, including strategies relating to prevention, intervention, treatment, and recovery. Ms. Hanson suggested key questions to ask in developing policy, provided contact information for other NCSL staff who cover the areas of criminal justice and human services since addressing the opioid epidemic necessitates many policy sectors collaboratively addressing the issue, and stated that NCSL is available to discuss technical assistance options. Members discussed the need for programs to allow parents to retain custody of their children while seeking treatment; the need for transition programs for newly released inmates; the need for available and affordable treatment; the need for a more user-friendly prescription drug monitoring program (PDMP); and the need to provide a compassionate, individualized approach rather than a one-size-fits-all approach to pain management.

## III. University of Iowa Injury Prevention Research Center (IPRC) — Iowa Perspective

Dr. Carri Casteel, Associate Director, and Ms. Ann Saba, Communications and Research Coordinator, IPRC, provided an Iowa perspective on opioid misuse and treatment. The IPRC conducts outreach, research, and training relating to the prevention of violence and injury, with one area of expertise being prescription drug overdose.

The IPRC received funding from the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (CDC) for the period January through June 2017, to develop a state-specific stakeholder council to identify policy and program priorities to address prescription opioid concerns; to identify next steps in addressing priorities; and to identify ways to reach policymakers and other stakeholders with priority recommendations. The council discussed recommendations developed by the Johns Hopkins Center for Injury Research based on evidence-based strategies for reducing the opioid epidemic in eight topic areas: prescribing guidelines; the PDMP; pharmacy benefit managers and pharmacies; engineering strategies; surveillance; overdose prevention and harm reduction; addiction treatment; and community-based prevention strategies.

The council, composed of 38 stakeholders, was convened by the IPRC in April 2017, to identify what Iowa is doing to address prescription opioid issues, to propose new, or any changes to existing, policies and programs, and to identify policy and program priorities to address prescription opioid concerns. The stakeholders were asked to identify five priorities and to suggest next actionable program or policy steps.

The council identified the five priorities for actionable program steps as: providing training in pain management and opioid prescribing for those in medical school and for current licensed professionals; educating practitioners to recognize patients at high risk for opioid misuse and overdose; reducing barriers to using the Iowa prescription monitoring program (PMP), strengthening surveillance; and ensuring that Medicaid and other health plans adequately cover medication-assisted treatment and behavioral therapy.

**Committee Discussion.** The committee discussed the need for real-time data in updating the PMP; the need for county-specific PMP data; the role of local boards of health in increasing the participation of prescribers and dispensers of opioids in the PMP; and the need to improve the PMP so that prescribers, dispensers, and others naturally incorporate the PMP into their routine practice. Some practitioners find the current PMP cumbersome and are frustrated in using it. In other states, a practitioner pushes one button and is provided a historical profile of the patient. Other issues include the need to educate prescribers about the use of alternatives to prescribing opioids including using over-thecounter medications. IPRC research does show prescribing patterns have changed and opioids are being prescribed less, but it is unclear what alternatives prescribers are using. One outcome of the IPRC stakeholder council meeting was the conclusion that quality, useful data is lacking. Stakeholders want a coordinated approach, and data needs to be accessible to and entered by a variety of sources while maintaining confidentiality of the subject of the data. Without access to the data in the PMP by researchers, the only data is from death certificates and health insurance claims data, making it difficult to distinguish prescription opioid deaths from heroin deaths, polydrug deaths, and other drug-related deaths.

## IV. Professional Licensing Boards — Iowa Board of Nursing, Iowa Board of Medicine, Iowa Dental Board, Iowa Board of Pharmacy

**Iowa Board of Nursing.** Ms. Kathy Weinberg, Executive Director, Iowa Board of Nursing, provided an overview of the initiatives the board is taking to address the opioid epidemic. The initiatives include: disseminating the "Safe Prescribing of Opioids for Pain, and Reduction of Opioid Misuse" E-Blast series; launching a new website dedicated to opioid prescribing and the resources available; updating the Advanced Registered Nurse Practitioner rules concerning standards of practice for controlled substances; and establishing a program to assist nurses with impairments.

**Iowa Board of Medicine.** Mr. Mark Bowden, Executive Director, Iowa Board of Medicine, spoke about the board's activities and rules. He provided a historical perspective of the board's work and practitioner education, guidance, and directives relating to pain management dating back to 1997; and reviewed a summary of the approximately 200 opioid-related complaints relating to appropriate prescribing and pain management that the board has dealt with since 2011.

**Iowa Dental Board.** Mr. Phil McCollum, Associate Director, Iowa Dental Board, provided an overview of the board's activities including the board's review of the use of the PMP by licensees, the board's recently created opioid task force to develop guidelines and drug alternatives for prescribing specific to acute pain, and plans with the University of Iowa College of Dentistry to host a one-day symposium and develop continuing education programming.

**Committee Discussion.** With regard to requiring physicians to use the PMP, Mr. Bowden stated that the board supports registration and use of the PMP by physicians, and educates physicians about using it as a tool. While many physicians find the current PMP burdensome and cumbersome, with implementation of the proposed improvements making it more accessible and user-friendly, the objections and barriers will be eliminated.

With regard to the prescribing of opioids by dentists, Mr. McCollum stated that most prescribing of opioids by dentists is done for acute pain, such as with an extraction. The duration of a prescription varies, many times depending upon whether a procedure is scheduled near a weekend to address the potential development of a dry socket. Some dentists do not have the ability to prescribe controlled substances and use a different modality, believing that if 800 milligrams of ibuprofen cannot address the pain, the patient needs to return for followup care. With regard to requiring dentists to use the CDC guidelines that recommend the use of noncontrolled substances first, Mr. McCollum noted that the board is receptive to reviewing any approach for change, but regularly receives complaints that a dentist did not provide adequate pain medication when the dentist only provided ibuprofen.

The committee also discussed inclusion in medical school curricula of the use of alternative therapies and the lack of accessibility to and the affordability of treatment. Ms. Weinberg noted that in Iowa, ARNPs may prescribe independently as long as they are licensed to prescribe. The state needs to ensure that wherever a practitioner is located, the practitioner can prescribe to the highest level of their respective license to avoid barriers to prescribing or practicing. Mr. Bowden added that the issue is not only one of shortages in the physician workforce, but of shortages in a variety of professions. There are many types of health care professionals in the state that provide pain management, and all have a role to play within their scope of practice. National statistics place Iowa well below the national average in retaining physicians trained in the state as part of the workforce, and there is always a need for more specialists, including those treating addiction. There is also a need for a team approach to address addiction, including therapists, pharmacists, psychologists, and administrators who can coordinate the team.

**Iowa Board of Pharmacy.** Mr. Andrew Funk, Executive Director, Iowa Board of Pharmacy, stated the board is tasked with the distribution of legal prescription drugs through prescribing, dispensing, manufacturing, wholesaling, and retailing, as well as since 2009 managing the state PMP. Mr. Funk reviewed issues with the current PMP, the recently released Request for Proposals to update the PMP, proposed rules to allow for partial filing of prescriptions for Schedule II controlled substances under the Federal Comprehensive Addiction and Recovery Act, the board's operation of a medication disposal program, and education and outreach efforts.

**Committee Discussion.** In response to a question regarding the current PMP vendor, Mr. Funk stated that the current Iowa vendor, Appriss Health, is also the current PMP vendor in 45 other states. The problem is that the current state contract is outdated and the state is using outdated software. With regard to the board's hesitancy toward requiring prescribers and others to register with the PMP, Mr. Funk stated that because the PMP is antiquated, he would be cautious about a mandate. However, once the PMP is made more accessible and user-friendly, the technology is updated, and information is more accurate and timely, there will no longer be such significant drawbacks for practitioners to using it. Mr. Funk noted that in the future, users will be able to more quickly and readily have data available. With regard to integrating PMP information into electronic health records, Mr. Funk noted that the board is considering using the Iowa Health Information Network rather than utilizing individual software vendors to avoid interoperability issues. Regarding payment for integration, if the board relied on all controlled substances registration fees charged and collected in the state in order to fund the integration, the board would need to charge and collect the controlled substances registration fee every year, rather than every two years, and increase the fee by $30 annually. The current registration fee is $90 every two years. So if the board increased the fee to $120 annually, resulting in a net increase to each registrant of $150 every two years, sufficient funding would be available. If each registrant integrated the PMP into their EHR on their own, there would be a connection fee of roughly $7,500 and an additional per-user fee, annually. The cost of the upgrade to the PMP software will be paid for through $400,000 in grant funding that DPH helped to procure.

## V. Treatment Providers

**Mercy Turning Point Treatment Center (MTP).** Ms. Malissa Sprenger, Coordinator, Mercy Turning Point Treatment Center, located at Mercy Medical Center in Dubuque, provided an overview of activities in the Dubuque area including the services provided by MTP and establishment of an opioid response team. Ms. Sprenger's recommendations included: advancing responsible, evidence-based prescribing practices; increasing access to opioid overdose reversal drugs and advancing protections including Good Samaritan laws; providing adequate and meaningful health care coverage for treatment including for non-drug treatment alternatives; requiring participation by practitioners in the PMP; increasing treatment capacity including through establishment of a public long-term treatment facility for those with complex needs; expanding the health workforce to include expertise in addiction, prevention, treatment, and rehabilitation; providing and supporting resources for the full spectrum of providers necessary for a whole-person approach to an individual's physical, behavioral, and social supports; broadening community awareness, engagement, and education across all stakeholders to break down barriers and reduce stigma; and enhancing data collection and data sharing as well as communication, transparency, and accountability among all stakeholders.

**Area Substance Abuse Council (ASAC).** Ms. Barb Gay, Executive Director, ASAC, located in Cedar Rapids, provided an overview of ASAC's services in a five-county area that include prevention, treatment, and recovery services. ASAC provides Medication Assisted Treatment (MAT), which allows the brain sufficient time to heal from the effects of addiction over a longer treatment period, resulting

in successful recovery. ASAC uses Vivitrol in the injection form, but Ms. Gay expressed concern with reimbursement in the future as health care coverage for Vivitrol changes from a pharmacy benefit to a medical benefit. Ms. Gay stated there are also issues with the limited number of prescribers for MAT medications, a great part of which is due to the stigma attached to treating people with addictions. ASAC has developed a shared database to link patients to a variety of support services.

**United Community Services Healthcare (UCS).** Mr. Mike Polich, Chief Executive Officer, United Community Services Healthcare, provided a historical perspective on substance use disorder treatment in the Des Moines area, and described the evolution of UCS and the services UCS provides. UCS is a certified Opioid Treatment Program (OTP) providing MAT services. Mr. Polich explained that OTPs are accredited by a Substance Abuse and Mental Health Services Administration (SAMHSA)-approved accrediting body and are required by federal law to provide medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medications. Mr. Polich said that UCS is hoping to leverage its OTP license to establish medication units in remote areas using telehealth to prescribe. Mr. Polich explained the costs associated with OTPs and medication units and noted that there is uncertainty about how third-party payers will bill the OTP for medications provided through a medication unit, and stated that the communities in which medication units are established will have to be educated about stigma and opioid addiction.

**Prelude Behavioral Services (PBS).** Mr. Ron Berg, Director and Chief Executive Officer, Prelude Behavioral Services, described the residential and outpatient services, transitional housing, and other services in Des Moines and Iowa City for those with gambling, mental health, and substance use disorder issues. Mr. Berg stated PBS serves all 99 counties, and both urban and rural areas, with 99 beds for residential treatment and halfway services. Mr. Berg said that an average waiting period for admission to treatment is nine and one-half days. Mr. Berg said that PBS is beginning to provide MAT services and is in the process of completing a community needs assessment to participate in the SAMHSA State Targeted Response grant received by the Department of Public Health in order to act as an opioid-informed community in addressing opioid misuse. MAT services need to be more accessible and in order to maintain and sustain adequate substance use disorder resources in the future, there needs to be a foundation in a solid business model and reimbursement rates must be sufficient. The response to the opioid crisis, as with any other substance abuse crisis, is hampered by the stigma still associated with drug and alcohol abuse. All stakeholders have a role in improving collaboration to address the epidemic.

**Committee Discussion.**

**Addiction — Drug Most Often Used.** In response to a question regarding the drug to which people in treatment are most often addicted, Ms. Gay noted that while the majority of patients do start with a prescription drug and move to heroin when the prescription becomes hard to obtain or too expensive, some patients start with heroin because it is less expensive. Ms. Sprenger noted that at MTP, 80 percent of patients started their addiction with prescriptions. MTP is also seeing an increase in fentanyl usage, both legally and illegally manufactured in the hubs of Chicago and Milwaukee. The collaboration between treatment centers and law enforcement has increased because of the safety issues for law enforcement in dealing with these very dangerous and complex drugs.

**Coverage for Treatment.** With regard to coverage for treatment by insurers, Mr. Polich stated that reimbursement varies by provider and is inconsistent. Ms. Gay supports an increase in reimbursement for residential care and coverage for the increased lengths of stay necessary to provide adequate time for patients to recover. It was also noted that coverage for nonpharmacological therapies is important.

With regard to public and private coverage for treatment, Mr. Polich stated that, anecdotally, about 20 percent of patients are Medicaid recipients when they become addicted and that in some states, having a diagnosis as a person with an addiction, alone, makes a person categorically eligible for Medicaid. Under SAMHSA programs, pregnant women are given priority in obtaining treatment. Some of the largest expenses are babies born with withdrawal symptoms to women addicted to opioids or other addictive drugs. Withdrawal from methadone compared with withdrawal from other opioids is generally easier for babies. ASAC has a residential home for pregnant women and a woman can remain to receive treatment and live with the child after her child is born. ASAC also provides wraparound services like therapeutic daycare and other individualized services. Once a woman is finished with treatment, ASAC has services to help the woman and her child transition to other housing and services.

**Treatment for Youth.** With regard to treatment for youth, Ms. Gay stated that ASAC only provides MAT for adults, but does have residential treatment for youth. ASAC also has outpatient treatment for youth co-located at local schools. In the most recent Iowa Youth Survey conducted by DPH that asked youth about their perception of the harm of alcohol, tobacco, and prescription drugs, youth rated the harm of alcohol and tobacco high and rated the harm caused by prescription drugs low. MTP has observed an increase in youth using opioids from medicine cabinets, and a local heroin awareness group in Dubuque is engaging youth to educate them about the human costs of opioid use. There is a need to educate all youth about the harm caused by the misuse and abuse of opioids, even at very early ages.

**OTPs.** Mr. Polich noted there are currently five OTPs in Iowa, many of which are private and operate on a cash-only basis. He reiterated that there are many state and federal regulations associated with establishing an OTP. Treatment program personnel generally have to be specially educated to be able to provide MAT. He is hopeful that UCS can leverage their OTP accreditation to establish medication units utilizing telehealth.

**Proper Use of Pain Medications.** Mr. Berg stated that people need options to address pain, and pain medications have their side effects like any other medication. If a pain medication is taken appropriately, as prescribed, a patient will usually have no ill effects. Developing symptoms of withdrawal depends on the dosage and other conditions.

**Involvement of Law Enforcement.** Mr. Berg noted that with urban law enforcement there is a frustration with being called to the same address multiple times with no alternatives for help. In Iowa City, PBS started a pilot project with law enforcement to offer a person with a substance use disorder the choice between release from custody or seeking treatment. Although there has been minimal success with this approach, the pilot project is continuing.

## VI. Managed Care Organizations

**Anthem Insurance Companies, Inc. (Anthem).** Mr. Eric Bailly, Business Solutions Director, Anthem Insurance Companies, Inc., spoke about Anthem's efforts at the national level to address the opioid epidemic. He expressed Anthem's commitment to reduce the levels of prescribed opioids within its network of providers by 35 percent by the end of 2019, and to double the number of consumers who receive behavioral health treatment as part of MAT for opioid addiction. Mr. Bailly described Anthem's comprehensive strategy including addressing the areas of prevention, treatment and recovery, and deterrence.

**UnitedHealthcare (UHC).** Dr. KellyAnn Light-McGroary, Chief Medical Officer, UnitedHealthcare, explained that UHC's goal over the next two years is to use a multipronged approach to reach at least 75 percent compliance with the CDC opioid prescribing guidelines for providers; to increase participation in MAT for those patients needing MAT by 50 percent; and to increase staff, customer, provider, and

member education in attacking the opioid problem. She explained that UHC's comprehensive strategy includes addressing the areas of prevention, treatment, recovery, and harm reduction.

**AmeriHealth Caritas Iowa, Inc. (AmeriHealth).** Dr. Victoria Sharp, Chief Medical Officer, AmeriHealth Caritas Iowa, Inc., spoke about integrative models for chronic pain management and addiction treatment. She explained that AmeriHealth's three areas of activity focus on proactive initiatives to prevent opioid misuse; treatment options and challenges in Iowa; and the use of overdose reversal drugs. She said that AmeriHealth uses a multifaceted approach including identifying at-risk members; monitoring for overprescribing and reaching out to providers to discuss cases; offering provider education on non-opioid pain management options such as physical therapy, occupational therapy, and chiropractic services; using pharmacist telephonic outreach to address overutilization; using a pharmacy lock-in program that requires a member to use only one pharmacy; including member education in its newsletter; and using a holistic approach to integrating care management by merging behavioral health support with physical treatment. Dr. Sharp explained Medicaid members have limited access to injectable Vivitrol as Vivitrol can only be administered in a physician's office and is thus costly and time intensive for physicians. While naloxone is available without a prescription, Iowa Medicaid members are not able to participate due to regulatory limitations. Dr. Sharp recommended increasing access to Vivitrol and MAT by working with DHS to explore options for delivering the injectable form of Vivitrol; working with DHS to allow Medicaid members to participate in the standing order program to ensure access to naloxone; continuing a multifaceted approach by involving providers, members, families, law enforcement, and others to provide a more accessible, efficient, and productive addiction treatment environment; and expanding the available education resources for prescribers and other practitioners on evidence-based pain management treatment and substance use disorders.

**Committee Discussion.** In response to a question regarding the flexibility of Medicaid MCOs to incorporate the cost of legislative mandates to provide substance use disorder treatment services to Medicaid members, including pregnant women and those newly released from prison, into their per-member per-month (PMPM) reimbursement, all of the representatives stated that good communication is important, that they see the need and want to increase services, and that, as insurance companies, making sure that adequate treatment exists for substance use disorders is important to everyone because undertreated or untreated substance use disorders increase health care costs. As to whether the current PMPM rate negotiated with the state includes sufficient reimbursement for additional services to address the opioid epidemic, the representatives said they would take this issue back to their respective organization for consideration. The representatives all supported the idea of working with local communities to develop tailored responses to the opioid epidemic within the scope of their contracts.

## VII. Iowa Physical Therapy Association (IPTA)

**Overview.** Mr. Matt Bravard, Iowa Phyisical Therapy Association, described the "#ChoosePT" campaign launched by the IPTA following the release of the 2016 CDC guidelines which included recommendations for safer alternatives for management of acute and chronic pain. Since the release of the CDC guidelines, IPTA has been involved in other efforts to increase public awareness, to provide patient education regarding options to address and avoid pain, and to educate the public. Mr. Bravard explained that physical therapy provides an evidence-based, high-quality approach to treating pain. Third-party payers generally impose limitations on physical therapy treatments such as the number of weeks allowed or visits covered, and utilization of physical therapy does depend on a patient's goals and the experience of the patient's physician with physical therapy.

**Committee Discussion.** In response to a question regarding insurance coverage for physical therapy as a method of treating pain, Mr. Bravard noted that there are usually limitations on the number of weeks or visits that physical therapy is covered. While a provider may request an extension for coverage, providers have varying success with having the extension approved by the third-party payer and a patient may end up paying for therapy out of pocket. Physical therapy is generally accepted as a reasonable alternative to address pain, but there are barriers, especially with chronic pain. When asked whether doctors are naturally inclined to utilize and incorporate physical therapy into their practices as an option to address a patient's pain, Mr. Bravard stated that physical therapy is regarded by the medical community as a means for working toward a common goal and that physicians and physical therapists generally do work well together. However, utilization of physical therapy does depend on the patient's goals and the experience of the physician with physical therapy.

## VIII. Iowa Chiropractic Society

**Overview.** Dr. Wes Nybreg, President, Iowa Chiropractic Society, noted that chiropractic care offers an alternative approach to pain management. Chiropractors do not prescribe medications, but address neuro-musculoskeletal conditions through adjustment. Chiropractic is a drug-free, noninvasive, and cost-effective alternative to opioids for pain management.

**Committee Discussion.** In response to a question relating to the relationship between chiropractors and MCOs regarding reimbursement for treatment of pain, Dr. Nyberg noted that at times MCOs have restricted access to chiropractic care by requiring prior authorization from a medical doctor. He has also experienced a reduction in the number of visits and overall reimbursement as limitations on the use of chiropractic care.

## IX. Department of Justice

Mr. Nathan Blake, Deputy Attorney General for Policy, Department of Justice, discussed opioid use and enforcement in Iowa. He noted that there is not good data available to know about all those addicted to opioids who are not seeking treatment or have not died. He reviewed the ongoing multistate opioid investigation involving 40 states and the District of Columbia against five pharmaceutical manufacturers and three distributors. Potential claims include the safety and effectiveness of long-term use; false claims of low addiction risk and pseudo-addiction; and false claims on risks of overdoses. Other city, county, and state lawsuits are also pending. Iowa is a leader in the multistate action, but is also developing research for a strong state case as an option for a quicker resolution. Without advocating for any one option, Mr. Blake listed potential options for the state to address the opioid epidemic including prescription limits; PMP requirements and the checking of IDs before dispensing prescriptions of controlled substances; making opioid reversal drugs more available and affordable; and the provision of Good Samaritan and Overdose Immunity laws, syringe services programs, prescription drug take-back programs, mandated provider training on addiction risks, and MAT funding.

## X. Iowa Harm Reduction Coalition (IHRC) and Bureau of HIV, STD, and Hepatitis (DPH)

Ms. Sarah Ziegenhorn, Executive Director and Co-founder, and Mr. Jonathan Birdsall, Legislative Advocacy Director, Iowa Harm Reduction Coalition; and Mr. Randy Mayer, Bureau Chief, Bureau of HIV, STD, and Hepatitis, DPH, described the incidences of HIV and Hepatitis C Virus (HCV), which is an increasing but separate epidemic exacerbated by the needle use associated with the opioid epidemic. They described the HIV and HCV epidemic and proposed the establishment of a syringe

services program (SSP) as a means of addressing this epidemic. The presenters described the bimodal age distribution of diagnoses of HCV. Those in the 46-to-70-year-old age range at the time they are diagnosed were infected many years ago, and while at risk for complications, have little ongoing transmission. Those in the second age group, in Iowa, those 15 to 39 years of age, have ongoing transmission. In 2000, there were approximately 50 people in the latter age group diagnosed with HCV, but in 2016, there were almost 700 cases, or a 1,100 percent increase since 2000, indicating an epidemic of people sharing needles for injection drug use. As to providing treatment for HCV, since the medications for Hepatitis C are expensive and budgets are limited, under current Medicaid and Department of Corrections policies, only those who have a cirrhosis score of F-3 or F-4, indicating they have been infected for a long time and are in the later stages of the disease during which liver failure, severe liver disease, or liver cancer has developed, are treated. Under this policy, the number of liver deaths will be reduced, but it will not slow the spread of HCV by averting the number of new infections among those who are injecting. If a more aggressive approach is taken and all those infected, including those with fibrosis scores of F-1 and F-2, were treated, 280,000 new infections could be averted. The presenters recommended that to address the HIV and HCV epidemic, the state establish an SSP by modifying the state's existing drug paraphernalia law (Iowa Code section 124.414) and also authorize DPH to establish an SSP and develop the parameters of the program through rulemaking. They provided examples of other states' programs and provided draft legislation for Iowa. They also suggested that the best way to address the Medicaid and Department of Corrections prioritization of Hepatitis C treatment policies is for the state to negotiate lower costs for the Hepatitis C drug so more people can be treated within the limited funds available.

## XI. Department of Public Safety (DPS)

Mr. Paul Fedderson, Assistant Director, and Mr. Lee Leighter, Special Agent, Division of Narcotics Enforcement, DPS, provided a law enforcement perspective and described a three-pronged approach of treatment, prevention, and enforcement to address the opioid crisis. They described the necessity of law enforcement to have access to real-time prescription information and data through the state's prescription drug monitoring program to aid in the enforcement efforts involving legal and illicit drugs. Mr. Leighter works on diversion of prescription drugs in the Omaha area. His work is funded by the Drug Enforcement Administration Diversion Control Program (DCP) fee fund. Because Mr. Leighter works in diversion, his perspective is one of viewing doctors and other professionals as being a source of supply on the legal pharmaceutical side. He described multiple instances of his diversion work in the field. Mr. Leighter suggested improvements to the PMP such as including the morphine milligram equivalent (MME) or morphine equivalent dose (MED) of a drug prescribed to a patient to ensure the patient's safety; including the use of Narcan by a patient in the PMP; emphasized the need for practitioners to check the PMP; suggested that there is a need for additional Board of Pharmacy investigators and that these investigators be given primary jurisdiction rather than only jurisdiction for enforcing Iowa Code chapter 155A (Pharmacy); and noted that any Good Samaritan law must be worded carefully to provide protections for those who are seeking medical care but have not committed a crime while still allowing law enforcement to track the source of distribution of the opioids.

## XII. Medical School Curricula

**University of Iowa Carver College of Medicine.** Dr. Christopher Buresh, Department of Emergency Medicine, University of Iowa Carver College of Medicine, provided a perspective on educating the physicians of the future to address the opioid epidemic. He told the committee when he graduated from medical school in 2001, doctors were encouraged to do more about pain and to prescribe opioids because they were thought to be safe and nonaddictive and people were suffering. Dr. Buresh

provided an overview of the Carver College of Medicine's Horizons Curriculum. The curriculum involves three different perspectives: the mechanisms of health and disease; medicine in society; and clinical and professional skills. The college updates the curriculum every year and this year the curriculum includes "Drug Abuse in America" which addresses the American opiate crisis taught by Dr. Patricia Quinlisk, screening tools for substance use disorder, and drug testing. The curriculum will incorporate Screening, Brief Intervention, and Referral for Treatment (SBIRT) which is a way of screening patients to understand how substance use is affecting their life, understand if it is an addiction, and then help them to access treatment.

**Des Moines University College of Osteopathic Medicine (DMU).** Dr. Bret Ripley, Interim Dean, College of Osteopathic Medicine and Chairperson of Family Medicine, DMU, provided an overview of DMU's curriculum. Students at DMU receive an interprofessional education so that clinicians and other professionals learn how to work together. As in all medical schools, DMU students learn about opioids, appropriate use, appropriate screening, and the use of different medications for diverse types of pain. In behavioral medicine and psychiatry, students learn about addiction and addiction treatment as an integral part of their curriculum. In the third and fourth year, medical students are paired with physicians who provide diverse viewpoints on pain management and opioid use, illustrating the many ways to relieve pain in patients. Students use the Diagnosis, Intractability, Risk and Efficacy (DIRE) Score as one tool to determine the appropriate means of pain management.

**Committee Discussion.** The committee discussed giving preference to Iowans in admissions to Iowa medical schools and retaining doctors once they complete their education.

The Board of Medicine has already taken steps to educate doctors who were not trained in an Iowa medical school by requiring two hours of continuing medical education every five years about pain management. There are many opportunities to learn and the vast majority of doctors are taking the initiative to be educated.

Dr. Ripley cautioned that there are people with real, noncancerous, excruciating pain who are not able to function without opioids, and that outside of addiction, opioids are quite safe. All drugs, even over-the-counter nonsteroidal antiinflammatory drugs (NSAIDS) like Aleve, have side effects that may cause harm to the heart, kidneys, or other organs. He stated that some insurance groups are currently trying to restrict the prescribing of opioids, and wanted the committee to be aware of this as they deliberate.

In response to a recent CDC statement that there is insufficient evidence to determine the long-term benefits of prescription painkillers, Dr. Ripley noted that evidence is great when evidence exists, and the statement that there is insufficient evidence that longterm opioid use for chronic pain is beneficial is correct, but there is also not sufficient evidence that such use is not beneficial to the patients. A physician needs to understand what is causing the pain, and address it appropriately. Patients have to be evaluated on an ongoing basis and this is what all medical societies advocate. All medicines have side effects and it is not an "either/or" situation. If opioids or other medicines are not helping they should not be prescribed. Dr. Buresh agreed that there are certain types of pain that do not require opioids and a nonprescription medication will work if the patient's kidney and liver will tolerate them. There is some evidence of the downside of long-term narcotic use. One study shows that the longer a person takes pain medication, the higher their risk of dying sooner compared to the population that is not on pain medication, and that to attain the same pain relief the person has to continue to increase the dosage. Doctors do their best to educate patients. In a paper one student submitted, the student pointed out that society does a great job of educating people addicted to alcohol about the harmful effects, that it is going to hurt their liver and cause all kinds of problems with their marriage, job, etc. and it will eventually kill them. But, society does not do a great job of telling people when they have been on prescription

opioids for too long. This is largely because there are not a lot of treatment alternatives. Dr. Buresh noted that he does have a conversation with everyone he treats with opioids about their alternatives for pain management, but the conversation almost always turns contentious and heated. Part of the issue is that even if a person admits they have an opioid problem, there is almost nowhere to send them for treatment, such as MAT. The CDC guidance is important to keep in mind, but it is difficult to enforce when other treatment options are not available.

## XIII. Cedar Rapids Law Enforcement and the Eastern Iowa Heroin Initiative

Officer Al Fear, Cedar Rapids Police Department and Coordinator, Eastern Iowa Heroin Initiative, discussed his experiences traveling the state to educate the community about the heroin epidemic. The Eastern Iowa Heroin Initiative is funded by a federal grant through the High Intensity Drug Trafficking Areas program and has a three-pronged approach: prevention, treatment, and enforcement and prosecution. Officer Fear originally was only responsible for covering four counties as those four counties represented half of the state submissions to the state crime lab of heroin seized in Iowa. Unfortunately, in the past two years the epidemic has exploded and now he covers the whole state. Officer Fear provided statistics on national overdose deaths and noted that while the biggest drug threat in 2007 was cocaine, in 2016, it was heroin. Ohio is ground zero for the heroin epidemic, the epidemic has made its way up the east coast, and the eye of the storm is currently in Chicago and moving westward across the United States. Officer Fear provided the example in Linn County where there were 26 opioid deaths and 874 hospital admissions for opioid dependency, however there are only 84 beds for inpatient treatment in Iowa. Officer Fear told the committee from what he has seen on the street, opioid addiction usually starts from an injury after which a person is legitimately prescribed opioid painkillers. Over a period of time, the person runs out of the prescription but addiction has set in and the person begins to go through withdrawal symptoms. To stop the withdrawal symptoms, the person transitions to heroin use. Officer Fear provided recommendations to the committee related to prescriber responsibility through increasing the use of the PMP by prescribers; establishing a Good Samaritan Law; including methadone, Suboxone, and Vivitrol on the list of medications covered by insurance; increasing treatment resources statewide for addiction; and increasing penalties for drug dealers. Officer Fear opined that the reason physicians may not use the PMP is that the system is cumbersome, but moving forward the PMP will be more user friendly and linked to electronic records. Officer Fear noted that Narcan is only a means to stabilize a person and that based upon the drug, a person may require multiple injections of Narcan to be revived. He provided the example of an officer in Ohio arresting individuals who were attempting to hide heroin. The officer was wearing gloves, as required, when he made the arrest. However, when he returned to the station, another officer saw white powder on the officer's uniform and brushed it off without realizing that it was heroin laced with fentanyl dust. That officer overdosed as a result of brushing the dust off and required four administrations of Narcan to be revived.

## XIV. Wellmark Blue Cross and Blue Shield (Wellmark)

Mr. Matt Hosford, Vice President and Chief Pharmacy Officer, Wellmark, oversees all pharmacy as well as the relationship with CVS Health which is Wellmark's Pharmacy Benefits Manager (PBM) in Iowa. Mr. Hosford discussed two recent reports. One report was published by the national Blue Cross and Blue Shield Association and analyzes medical claims from commercially insured members diagnosed with opioid abuse disorder from 2010 through 2016. The other report provides an interpretation of similar data for Wellmark's commercially insured population in Iowa. Mr. Hosford discussed what Wellmark covers and why, and some of their programs focusing on opioid overuse, misuse, and abuse. He told the committee that across Wellmark's commercially insured population, about 17.3 percent of

Iowa members filled at least one opioid prescription compared to 21.4 percent nationally in 2015. Mr. Hosford provided the committee with an overview of Welmark's policies to ensure that those in pain have access to medications. Wellmark is incorporating national initiatives including the 2016 CDC guidelines for prescribing opioids for acute pain and the prescribing guidelines recently released by the American College of Emergency Physicians into their guidelines for appropriate prescribing of opioids. He described Wellmark's drug utilization program that monitors all utilization from a claims perspective to identify patterns of misuse or abuse, such as the use of multiple pharmacies, prescribers, or other factors indicative of drug-seeking behavior, and engaging behavioral health staff to link consumers to appropriate treatment. Mr. Hosford said Wellmark does not place limits on counseling or treatment programs that are providing quality care or evidence-based treatments that have quality outcomes for members. However, there is a lack of available treatment in both Iowa and South Dakota. MAT is a covered benefit, and Wellmark promotes the use of methadone and buprenenorphine when it makes sense as part of a treatment plan, but Vivitrol is not covered. In response to a committee question of whether Wellmark would work with the State of Iowa as an employer to address the opioid crisis by covering substance use treatment and mental health treatment, Mr. Hosford stated that it would be a great place to start to design a benefit as a model for the state.

## XV. Iowa Department of Public Health

**Overview.** Dr. Patricia Quinlisk, State Medical Director and Epidemiologist; Mr. Kevin Gabbert, ART/MAT-PDOA Project Director, Bureau of Substance Abuse; and Ms. Deborah Thompson, Policy Advisor and Legislative Liaison, DPH, described the work of DPH in addressing the opioid epidemic and reviewed the State of Iowa opioids report card. Part of the duties of DPH include being designated the State Opioid Treatment Authority (SOTA) and providing oversight for the OTPs regulated by SAMHSA.

Mr. Gabbert reviewed how Iowa compares with other states on specific policies regarding the addressing of the opioid epidemic. He provided an overview of opioid-related grants that DPH is currently administering to address the opioid epidemic. He provided a list of possible next steps for the state to take including requiring the use of the PMP by prescribers; requiring the uploading of pharmacy data within 24 hours, instead of weekly, to the PMP; implementing a seven-day limit on opioid prescriptions; amending the drug paraphernalia law to allow for, and authorizing DPH to develop, an SSP; establishing a Good Samaritan law; allocating dedicated funds for naloxone to replace the grant funding that will eventually be depleted; requiring training on CDC guidelines for all prescribers; and collaborating on data collection.

**Committee Discussion.** In response to a question regarding a document showing the number of prescriptions per 100 people in some of the bordering counties that exceed a ratio of 1:1, Mr. Gabbert opined that the reasons for this might be that the counties that have fewer prescriptions per 100 people, might have had more education of providers and prescribers, or that those areas are aware that opioid prescribing is a big issue. The document data demonstrates actual prescriptions dispensed in Iowa, but the residency of the person to whom the prescription was dispensed may not be available information.

With respect to the capacity of local public health departments to provide assistance, it was noted that each local public health department completes a community health needs assessment and the issues of mental health and substance abuse have been among the top 10 issues consistently identified by local health departments in these assessments. Even though local public health staffs are small, they are ready and willing to help and will collaborate with others within their communities. Dr. Quinlisk was requested, in her role as the State Medical Director, to consider developing recommendations in collaboration with law enforcement and others to present jointly to the Governor, and to work with local boards of health to make the opioid epidemic a priority. Dr. Quinlisk responded that a lot can be

done through collaborations with local public health and with private practices, that the state needs a comprehensive approach for substance use disorders, not just to address opioids, and that there should be alternatives for those struggling, not just criminal charges.

With regard to the limited number of approximately 58 physicians authorized to treat opioid dependency with buprenorphine in the state, Mr. Gabbert clarified that the state actually has 109 such physicians potentially available. The lower number is the number of physicians listed on the SAMHSA physician locator for this service, and the number is lower than those potentially available because the remainder have opted not to be listed. Those opting out do not want to be in charge of providing the variety of services including drug testing, treatment, and diversion that come into play for MAT and do not want people lining up outside their practices wanting buprenorphine or Saboxone. The number of those providers authorized and signed up since 2015 has increased from 31 to 58, and one benefit of the federal 21st Century Cures Act and the federal Comprehensive Addiction and Recovery Act (CARA), is that nurse practitioners and physician assistants, after training, are able to administer buprenorphine, as well. In regard to methadone services, UCS is working on opening medication units in some of the treatment programs in areas that do not have adequate funding for an OTP. The southern part of the state is still limited in access to MAT services. Telehealth is a possibility, but there are issues with insurance coverage and whether the provider using telehealth is required to be located physically in Iowa.

In response to a question regarding providing adequate resources to address alcohol and substance use disorders in the state by asking for an increase of at least one percent or maybe two percent across-the-board price increase for alcohol in the state, DPH representatives said they would take this idea back to the department for consideration.

## XVI. Public Comment

The committee received public comment in person and through submission in writing. The public comments submitted in writing will be posted on the committee's webpage.

Dr. Janie Hendricks, Past President, Polk County Medical Society, speaking as a patient advocate, cautioned that there should not be a one-size-fits-all approach from insurance companies regarding pain management, the prescribing of medications, and the treatment of opioid abuse. Dr. Hendricks stated physicians should have the latitude to determine the best course of treatment for their patients, because doctors, not insurance companies know their patients and how to treat their pain. Dr. Hendricks said it is the role of the primary care physician to provide long-term monitoring of a patient to evaluate ongoing use of opioids to address pain.

Ms. Deborah Thompson, policy advisor and legislative liaison for DPH, spoke in her capacity as an individual to provide the story of her husband, Joe Thompson, who died of an accidental overdose in September 2016, leaving her and their one-year-old son, Lincoln, behind. Joe had a good childhood and was successful throughout his lifetime; he had a strong, supportive, and loving family; they had a successful marriage; and she had a stable income and good health insurance coverage. However, Joe was overprescribed opioids after a serious car accident in 2004, and this started them on a 13-year journey through the disease to which he ultimately succumbed. Ms. Thompson described Joe's treatment history, noted that the abstinence approach did not work for Joe and his opioid addiction, and cautioned that not all treatment facilities are equipped to provide treatment for opioid addiction. Ms. Thompson said there is a stigma associated with opioid addiction both from society toward the person with the addiction and on the part of the person with the addiction who feels they do not belong in the addiction community. Opioid addiction is a disease like any other that needs to be addressed

and overcome. Ms. Thompson shared their story because she wanted the committee members to ask questions and to continue to use her as a resource. She noted that she is proud of her colleagues at DPH and is sure the state can address the opioid epidemic using good public health prevention strategies.

Ms. Lori Peter, Dubuque, an RN in Iowa for over 22 years, spoke to the committee on behalf of I Hate Heroin, a nonprofit organization started by a friend who lost two of her boys in one night to heroin. Ms. Peter also lost her son, Kelly Peter, because of the opioid epidemic. Her son and his friends began their path to addiction by taking the leftover opioids from their parents' medicine cabinets, including hers, and the cycle continued for seven years. He went through treatment voluntarily two times and once after being committed, but at that point MAT was not available. She cautioned that while insurance companies say MAT is a covered service, there is a prior authorization process that has to be completed before it is covered, and MAT is not widely available. Ms. Peter recommended that physicians be required to check the PMP because it saves lives.

## XVII. Member Conclusions, Key Themes, and Next Steps

The members discussed the breadth of information provided over the two meeting days and all agreed that everyone has in some way been touched, personally or professionally, by the opioid epidemic because it affects everyday people in all walks of life and is getting worse in Iowa. Rather than having the committee make specific findings and recommendations as specified in the charge of the committee, the co-chairpersons resolved to take a hard look at the recommendations made by the presenters and members of the public, and to work together on legislation that would be effective in putting the state in a better position. Committee members provided suggestions for moving forward with legislative action in the 2018 Legislative Session to address the opioid epidemic, based on the presentations and public comments received. Some of the conclusions of the members and key themes are summarized as follows:

1. Any pain management policy needs to provide for appropriate access to opioids for those who have chronic pain. There is a need for an individualized rather than a one-size-fits-all approach to pain management. Patients and health care professionals should be educated about alternatives to opioids for pain management including over-the-counter medications, physical therapy, cognitive behavioral therapy, chiropractic care, and acupuncture.
2. One commonality in the majority of the presentations was the importance of an effective, user-friendly PMP. Access to the PMP by various entities, including law enforcement and researchers, was suggested as a means of improving the state response to the opioid epidemic.
3. The issues of stigma and public awareness need to be addressed to ensure that those who need help come forward because opioid addiction is a disease and those with an addiction come from all walks of life. There is a need to educate the public, including youth even at very early ages, about the harm caused by the use and misuse of opioids, including prescription opioids.
4. Various state agencies are looking at the opioid epidemic from their individual perspective, but all need to come together to address common concerns and develop policy they can all support to propose and enact legislation.
5. Over the past year, people have been working collaboratively and the legislature should develop a fair bill that considers the many different perspectives, policy sectors, and options including the PMP; prevention, treatment, and recovery for, among others, pregnant women and babies born dependent, newly released inmates, and the chronically mentally ill with a

dual diagnosis of substance use disorder; law enforcement; and the collection and sharing of data.

6. A whole-person, team approach is needed to address substance use disorders and addiction, including physicians, behavioral therapists, pharmacists, psychologists, those who address social supports, and informal peer supports. There is always a need for more specialists, including those with expertise in addiction prevention, treatment, and rehabilitation. Specifically, there is a need for more affordable and accessible substance use disorder treatment, including MAT. One obstacle is that only a limited number of professionals are authorized to prescribe the FDA-approved medications for MAT.
7. There is a need for accurate, real-time data that is collected and shared in a manner that enhances the communication, transparency, and collaboration needed to appropriately plan for and respond to the opioid epidemic.
8. The increased incidence of HCV and HIV is a separate epidemic, related to and exacerbated by the opioid epidemic. Current state Hepatitis C treatment policies prioritize treatment for those in the later stages of the disease. If those in the earlier stages with ongoing transmission were treated, it would slow the spread of HCV by averting the number of new infections. Syringe services programs are utilized in other states to address the HCV and HIV epidemic.
9. Health care coverage for and reimbursement of medications, treatment services, and nonpharmacological pain management options are often inconsistent or insufficient.
10. At least 38 states have Good Samaritan and Overdose Immunity laws. Iowa is one of the only remaining states without such a law.

## XVIII. Materials Filed with the Legislative Services Agency

The following materials listed were distributed at or in connection with the committee's two meetings and are on file with the Legislative Services Agency. The materials may be accessed from the "Additional Information" link on the committee's Internet web page: www.legis.iowa.gov/committees/committee?ga=87&session=1&groupID=29687

1. **National Conference of State Legislatures (NCSL):**
   - Overview of State Policy Actions About the Opioid Epidemic (NCSL, October 16, 2017)
   - Prescribing Policies: States Confront Opioid Overdose Epidemic (NCSL, August 2017)
   - The Opioid Epidemic and Federal Efforts to Address It: Frequently Asked Questions (Congressional Research Service, October 18, 2017)
   - Opioid and Health Indicators Iowa (amfAR 2017)
2. **The University of Iowa Injury Prevention Research Center (IPRC):**
   - Policy and Program Recommendations to Reduce Opioid Overdose and Deaths in Iowa (IPRC October 16, 2017)
   - The Prescription Opioid Crisis: Policy and Program Recommendations to Reduce Opioid Overdose and Deaths in Iowa (IPRC August 1, 2017)
3. **Iowa Board of Medicine:**
   - Iowa Board of Medicine Presentation and Compilation of Materials, October 16, 2017
4. **Iowa Board of Nursing:**

- Iowa Board of Nursing Summary of Initiatives (October 16, 2017)
- Iowa Nurse Assistance Program brochure
- Opioid Toolkit (National Council of State Boards of Nursing)

5. **Mercy Turning Point Treatment Center:**
   - Reducing Opioid Harm: Promoting People-Centered Care (Trinity Health)
   - Mercy — Dubuque Opioid Response Team Opioid Epidemic Public Policy Recommendations (Drafted by Mercy Opioid Response Team Public Policy Workgroup)
6. **UCS Healthcare:**
   - Presentation for Opioid Epidemic Evaluation Study Committee (October 16, 2017)
7. **Area Substance Abuse Council:**
   - Opioids and Heroin (Erin Foster, Advanced Prevention Specialist)
   - Linn County Coordinated Opioid Response Chart
8. **Prelude Behavioral Services:**
   - Opioid Epidemic Evaluation Study Committee Presentation (October 16, 2017)
9. **Anthem Insurance Companies, Inc.:**
   - Strategies for Prevention and Treatment
10. **UnitedHealthcare:**
    - Medicaid and the Opioid Epidemic: Collaboration, Partnership, and Innovation (October 2017)
    - Medicaid and the Opioid Epidemic Collaboration, Partnership and Innovation Are Essential (2017)
11. **Iowa Physical Therapy Association:**
    - Physical Therapy: A Safe Alternative to Opioids for Pain Management
12. **Iowa Chiropractic Society:**
    - Chiropractic: A Safer Strategy than Opioids
13. **Iowa Department of Justice:**
    - Opioid Use and Enforcement in Iowa
14. **Iowa Harm Reduction Coalition:**
    - Proposed Drug Paraphernalia Bill language to protect law enforcement and prevent disease, syringe exchange programs materials, and syringe exchange program studies bibliography
    - IHRC Supplemental Materials links
    - Background Literature on Syringe Services Programs, Supplement to Presentation (Sarah Ziegenhorn and Jonathan Birdsall, October 17, 2017)
    - Law Enforcement Safety and Infectious Disease Prevention: A Critical Component of the Opioid Crisis (Sarah Ziegenhorn and Jonathan Birdsall)
15. **Bureau of HIV, STD, and Hepatitis — DPH:**
    - Hepatitis C in Iowa (Randy Mayer, MS, MPH Chief, Bureau of HIV, STD, and Hepatitis)

16. **Department of Public Safety:**
    - National Emerging Threats Initiative a National HIDTA Program. PDMPs and Emerging Threats. (John L. Eidie, Public Health and PDMP Project Coordinator, Wednesday, October 4, 2017, Midwest HIDTA-Kansas City, MO)
17. **University of Iowa Carver College of Medicine:**
    - Educating Physicians About the Opioid Epidemic (Chris Buresh, MD, MPH, Professor, Emergency Medicine)
18. **Des Moines University College of Osteopathic Medicine:**
    - DMU Presentation and Diagnosis, Intractability, Risk, and Efficacy (DIRE) score survey tool (Dr. Bret Ripley, Des Moines University)
    - First, Do No Harm. Marshaling Clinician Leadership to Counter the Opioid Epidemic (National Academy of Medicine 2017)
19. **The Eastern Iowa Heroin Initiative:**
    - Opioid Pain Killers and the Heroin Epidemic (The Eastern Iowa Heroin Initiative, Officer Al Fear)
    - Online Drug Profile for Jeremy Hrabak
20. **Wellmark:**
    - America's Opioid Epidemic and its Effects on the Nation's Commercially-Insured Population (Blue Cross and Blue Shield Association, The Health of America Report, June 29, 2017)
    - News Release: Wellmark Data Reinforces Gap in Treatment for Opioid Addiction (July 19, 2017)
21. **Iowa Department of Public Health:**
    - Addressing Opioid Use in Iowa: How Do We Measure Up?
    - Opioid Use in Iowa: An Update
    - Iowa's Prescription Monitoring Program (PMP)
22. **Iowa Pharmacy Association:**
    - Written Recommendations Submitted October 27, 2017
23. **Representative Chuck Isenhart:**
    - Written Recommendations Submitted November 17, 2017