



FINAL REPORT

Opioid Epidemic Evaluation Study Committee

October 16 and 17, 2017

APPROVED

MEMBERS:

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Senator Thomas A. Greene
Senator Kevin Kinney

Representative David E. Heaton,
Co-chairperson
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Legislative Services Agency

AUTHORIZATION AND APPOINTMENT

The Legislative Council authorized two meeting days for the Opioid Epidemic Evaluation Study Committee. The meetings were held on Monday, October 16 and Tuesday, October 17, 2017.

The Opioid Epidemic Evaluation Study Committee was established by the Legislative Council and charged to “comprehensively evaluate the state’s response to the opioid epidemic in the state, including a review of the protocols and practices relating to the prescribing of opioid medications and the treatment options available including medication-assisted treatment. The committee shall receive input from agencies and entities including but not limited to representatives of the professional licensing boards for professionals authorized to prescribe controlled substances, representatives of public safety and public health, representatives of the medical community and health insurance payers, and consumers and representatives of consumers. The committee shall submit a report, including findings and recommendations, to the Governor and the General Assembly by November 15, 2017.”



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I. Executive Summary

A. Charge of the Opioid Epidemic Evaluation Study Committee

The Opioid Epidemic Evaluation Study Committee was established by the Legislative Council and charged to “comprehensively evaluate the state’s response to the opioid epidemic in the state, including a review of the protocols and practices relating to the prescribing of opioid medications and the treatment options available including medication-assisted treatment. The committee shall receive input from agencies and entities including but not limited to representatives of the professional licensing boards for professionals authorized to prescribe controlled substances, representatives of public safety and public health, representatives of the medical community and health insurance payers, and consumers and representatives of consumers. The committee shall submit a report, including findings and recommendations, to the Governor and the General Assembly by November 15, 2017.”

B. Meetings Approved

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C. October 16, 2017, Meeting

1. Meeting Overview

On the first meeting day, the Opioid Epidemic Evaluation Study Committee organized and elected Temporary Co-chairpersons Senator Dan Dawson and Representative David E. Heaton as Permanent Co-chairpersons. The committee approved the proposed rules as distributed. The primary focus of the meeting was to receive information from national and state perspectives, as well as the perspectives of health provider licensing boards and associations, treatment professionals, and managed care organizations. Presentations were provided by representatives of the National Conference of State Legislatures, the University of Iowa Injury Prevention Research Center, the Iowa Board of Nursing, the Iowa Board of Medicine, the Iowa Dental Board, the Iowa Board of Pharmacy, Mercy Turning Point Treatment Center, the Area Substance Abuse Council, United Community Services Healthcare, Prelude Behavioral Services, Anthem Insurance Companies, Inc., UnitedHealthcare, AmeriHealth Caritas Iowa, Inc., the Iowa Physical Therapy Association, and the Iowa Chiropractic Society. The committee also received public comment.

2. National Conference of State Legislatures (NCSL)

a. Overview of State Policies

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 the four pillars of prevention, intervention, treatment, and recovery.



(1) Prevention

Prevention activities in the states include the various approaches to Prescription Drug Monitoring Programs (PDMPs) or Prescription Monitoring Programs (PMPs) as well as other prevention efforts including prescription limits and the use of the 2016 Centers for Disease Control and Prevention of the United States Department of Health and Human Services (CDC) voluntary guidelines for prescribing opioids for chronic pain, excluding active cancer treatment, palliative care, and end-of-life care.

(2) Intervention or Rescue

Intervention or rescue activities include syringe services or needle exchange programs, access to opioid reversal drugs such as naloxone and Narcan, and Good Samaritan laws.

(3) Treatment

Treatment activities in the states focus on Medication Assisted Treatment (MAT). Hurdles to treatment include lack of coverage by all payers and limitations on treatment including fail-first policies, variations in Medicaid fee-for-service payment and lack of coverage for residential treatment, variations in what constitutes comparable coverage, and coordination of the vast numbers of stakeholders involved including consumers, treatment providers, insurers, and state and federal officials.

(4) Road to Recovery Through Treatment

Recovery activities include the use of screening tools by primary care providers and therapists to determine the need for treatment. There is limited access to treatment, including a shortage of detox and treatment beds, as well as a lack of providers in both urban and rural settings. Legislative policies may be used to increase the range of providers authorized to prescribe MAT medications. There is a growing need for sober living and long-term recovery resources as more people work through treatment to the recovery stage.

b. Policy Intersection with Many Sectors

Ms. Hanson provided contact information for other NCSL staff who cover the areas of criminal justice and human services since the opioid epidemic necessitates many policy sectors collaboratively addressing the issue. NCSL is also available to discuss technical assistance options.

c. Key Questions to Ask When Developing Policy

Ms. Hanson suggested key questions to ask in developing policy:

- (1)** What does the data show in Iowa, what are the biggest issues for Iowa, and where do gaps exist? Ask state agencies for data to determine the



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best approach. National survey data is also available through the CDC, the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services.

- (2) What recent action has been taken by the state and what are the federal funding opportunities?
- (3) What new strategies may be needed and are appropriate for Iowa?
- (4) What agencies and stakeholders need to be at the table?

3. The University of Iowa Injury Prevention Research Center (IPRC)

a. Overview

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 is housed in the University of Iowa College of Public Health and has been funded by the CDC as one of 10 such centers in the United States since 1991 to conduct outreach, research, and training relating to the prevention of violence and injuries. One area of IPRC's expertise is prescription opioid overdose.

b. Stakeholder Council — Recommendations

The IPRC received funding from the 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 38-member council met and identified five priorities and actionable program and policy steps. The recommendations of the council included training physicians in pain management and opioid prescribing in medical school; educating practitioners to recognize patients at high risk for opioid misuse and overdose; reducing barriers to using the Iowa PMP; strengthening surveillance; and ensuring Medicaid and other health plan coverage of MAT and behavioral therapy.

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

a. 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 including 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 (ARNP) rules concerning standards of practice for controlled substances; and establishing a program to assist nurses with impairments.

b. 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.

c. 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.

d. 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 Proposal (RFP) to update the PMP, proposed rules to allow for partial filling of prescriptions for Schedule II controlled substances under the Federal Comprehensive Addiction and Recovery Act (CARA), the board's operation of a medication disposal program, and education and outreach efforts.

5. Treatment Providers

a. 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 provided a listing of recommendations relating to 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,



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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.

b. 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 MAT, which allows the brain sufficient time to heal over a longer treatment period, resulting in successful recovery. ASAC uses Vivitrol in the injection form, but there are concerns with reimbursement in the future as health care coverage for Vivitrol changes from a pharmacy benefit to a medical benefit. 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.

c. 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. OTPs are accredited by a 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. OTPs require a great deal of structure and cost approximately \$1 million to establish. UCS is hoping to leverage its OTP license to establish medication units in remote areas using telehealth to prescribe. Medication units cost approximately \$24,000 to establish and allow licensed practitioners or community pharmacists to dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis. There is uncertainty about how third-party payers will bill the OTP for medications provided through a medication unit, and the communities in which medication units are established will have to be educated about stigma and opioid addiction.

d. Prelude Behavioral Services (PBS)

Mr. Ron Berg, Director and Chief Executive Officer, Prelude Behavioral Services, described PBS as providing 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. PBS serves all 99 counties, and both urban and rural areas. PBS has 99 beds for residential treatment and halfway services, with an average waiting period of 9.5 days for admission to treatment. PBS is beginning to provide MAT services and is completing a



community needs assessment to participate in the SAMHSA State Targeted Response grant received by DPH 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.

6. Managed Care Organizations (MCOs)

a. Anthem Insurance Companies, Inc. (Anthem)

- (1)** Mr. Eric Bailly, Business Solutions Director, Anthem Insurance Companies, Inc., spoke about Anthem's efforts at the national level to address the opioid epidemic. Anthem made a 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. Anthem's comprehensive strategy includes addressing the areas of prevention, treatment and recovery, and deterrence.
- (2)** Prevention efforts include promoting coordination of care and ensuring appropriate medication access by placing limitations on or requiring prior authorization for certain opioid prescriptions; covering MAT; introducing a pharmacy home program; and utilizing a controlled substance use monitoring program. Iowa does not allow for point-of-sale edits, but Anthem uses this approach in other markets.
- (3)** Treatment and recovery efforts include minimizing the risks and enabling earlier identification of misuse and abuse by providing care management support; improving MAT access in rural areas through primary care provider recruitment; providing peer support recovery services; expanding care and treatment options through telehealth; and increasing provider and vendor collaboration. Anthem is also providing access to evidence-based online consumer tools and offering coverage for nonpharmacologic approaches to pain management including physical therapy, osteopathic manipulation, pain management programs, and cognitive behavioral therapy. Anthem has established collaborative relationships with treatment providers including the Betty Ford Center and Bright Heart Health, which is helping Anthem to reach rural areas through the use of telehealth.
- (4)** Deterrence efforts include leveraging data mining and analytic capabilities by reviewing high volume pharmacies; partnering with law enforcement to monitor claims for potential fraudulent or abusive behavior; monitoring potential doctor shopping, investigating "pill mills,"



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and providing provider education. Anthem sends cautionary letters to prescribers who are falling outside the norm of established prescribing practices and also notifies prescribers if they are prescribing drugs that have potential negative interactions.

b. UnitedHealthcare (UHC)

- (1) Dr. KellyAnn Light-McGroary, Chief Medical Officer, UnitedHealthcare, said that for the next two years, UHC's goal 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. UHC's comprehensive strategy includes addressing the areas of prevention, treatment, recovery, and harm reduction.
- (2) The objectives of the prevention strategy are to increase understanding of the epidemic among staff, customers, providers, and members and to improve prescriber adherence to the CDC guidelines. UHC is reviewing member opioid use on the PMP, compiling prescriber outlier reports, and following up with primary care providers and behavioral health providers.
- (3) The objectives of the treatment strategy include increasing MAT capacity, increasing the number of members who receive MAT, and supporting individuals seeking treatment on their journey to recovery. There are many opportunities for integration of physical and behavioral health care to address the medical, behavioral, and social needs of the whole person. UHC is also expanding its MAT network and reducing barriers to use of MAT.
- (4) The objectives of the recovery strategy are to utilize person-centered and evidence-based approaches to recovery and to reduce social barriers that impede recovery, health, and well-being. UHC is using interdisciplinary care teams to work around barriers such as transportation, housing, and employment to ensure that those in recovery are successful.
- (5) The objectives of harm reduction are to reduce overdose deaths and to increase the safe use, storage, and disposal of opioid prescriptions.

c. AmeriHealth Caritas Iowa, Inc. (AmeriHealth)

- (1) Dr. Victoria Sharp, Chief Medical Officer, AmeriHealth Caritas Iowa, Inc., spoke about integrative models for chronic pain management and addiction treatment. 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.
- (2) In the area of proactive initiatives to prevent opioid misuse, 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. Specifically, AmeriHealth tracks narcotic prescriptions to pregnant members, provides outreach, and engages these women in high-risk pregnancy care management; and works with substance abuse treatment centers throughout the state to identify places that can accommodate pregnant members and women with infants throughout treatment.

- (3) In the area of treatment options and challenges in Iowa, the limited access to treatment has made it difficult for AmeriHealth's Medicaid members to get the treatment they need. MAT is valuable during the immediate withdrawal process as well as during ongoing treatment, and has a 70 percent success rate, but there is a lack of MAT resources. While AmeriHealth Medicaid members have access to Vivitrol in the daily oral form, the injectable form is preferred for compliance. For Medicaid members, the injectable form of Vivitrol can only be administered in a physician's office, which is costly and time intensive for physicians, thereby limiting access to injectable Vivitrol for Medicaid members.
- (4) In the area of use of overdose reversal drugs, while DPH and the Board of Pharmacy have made overdose reversal drugs such as naloxone available without a prescription, Iowa Medicaid members are not able to participate due to regulatory limitations.
- (5) 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.

7. Iowa Physical Therapy Association (IPTA)

Mr. Matt Bravard, Iowa Physical Therapy Association, described the "#ChoosePT" campaign that the IPTA launched following the release of the 2016 CDC guidelines which included recommendations for safer alternatives for management of acute and chronic pain. Since then, IPTA has been involved in other efforts to increase public awareness, to provide patient education regarding options to address and avoid pain,



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and to educate the public. Physical therapy is an evidence-based, high-quality approach to treating pain. Third-party payers generally impose limitations on the number of weeks 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.

8. Iowa Chiropractic Society

Dr. Wes Nyberg, President, Iowa Chiropractic Society, noted that chiropractic care offers an alternative approach to pain management, without the use of prescribed medications. Instead, chiropractic care addresses neuro-musculoskeletal conditions through adjustment. Chiropractic is a drug-free, noninvasive, and cost-effective alternative to opioid drugs for pain management. Third-party payers do sometimes restrict patient access to chiropractic care by requiring prior authorization from a medical doctor, reducing the number of visits, or decreasing overall reimbursement.

9. Public Comment

- a. 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. 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.
- b. 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.



D. October 17, 2017, Meeting

1. Meeting Overview

On the second meeting day, the focus of the committee was law enforcement and public safety, harm reduction, medical education, private health care coverage, and the activities of the DPH. Presentations were provided by representatives of the Department of Justice; the Iowa Harm Reduction Coalition; the Bureau of HIV, STD, and Hepatitis of the Department of Public Health; the Department of Public Safety; the University of Iowa Carver College of Medicine; Des Moines University College of Osteopathic Medicine; the Cedar Rapids Police Department/Eastern Iowa Heroin Coalition; Wellmark Blue Cross and Blue Shield; and the DPH. The study committee also received public comment and discussed next steps.

2. 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.

3. 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



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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 a 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 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.

4. Department of Public Safety (DPS)

Mr. Paul Feddersen, 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. 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 and the need for practitioners to check the PMP and 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).

5. Medical School Curricula

a. 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 described the new Horizons Curriculum that covers the preclinical years through residency and fellowship, as well as community engagement, and stresses innovation, integration, and individualization. The curriculum involves three different perspectives: the mechanisms of health and disease; medicine and society; and clinical and professional skills. The college also started a pain management task force this year and actively collaborates with the colleges of public health, pharmacy, and



dentistry, the University of Iowa Public Policy Center, and the IPRC. The college of dentistry has done groundbreaking work on acute pain control without using narcotics, and the Iowa City VA Health Care System has a very effective system for tracking opioid prescriptions.

b. Des Moines University College of Osteopathic Medicine (DMU)

Dr. Bret Ripley, Interim Dean, College of Osteopathic Medicine and Chairperson of Family Medicine, DMU, said that students at DMU receive an interprofessional education so that clinicians and other professionals learn how to work together. In pharmacology, 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 learning. 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. In the clinic, students use the Diagnosis, Intractability, Risk and Efficacy (DIRE) Score as one tool to determine the appropriate means of pain management.

6. 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. Activities of the Eastern Iowa Heroin Initiative include community action organizational efforts, first responder training, investigative case development to target sources of supply for federal prosecution, town hall meetings, public awareness campaigns, and work with substance abuse and health care providers. Originally, Officer Fear was only responsible for covering four counties (Linn, Johnson, Black Hawk, and Dubuque) because those four counties represented half of the state submissions to the state crime lab of heroin seized in Iowa. However, the epidemic has exploded and now he covers the whole state. Officer Fear provided a perspective from working in the field and described the path for many that starts with the legitimate use of a prescribed opioid for pain following an injury, and leads to the use of heroin and other illegal opioids. He said that in the 1970s and 1980s, heroin was about 4 to 8 percent pure, but today heroin off the street is 92 to 95 percent pure. He described the increase in availability of more potent synthetic analogs of heroin including fentanyl, and carfentanil, and warned that many drugs on the street, including marijuana, are being laced with these more potent analogs. Officer Fear asked the committee to help to increase the use of the PMP by providers; supported the enactment of a Good Samaritan law to protect the victims of overdose; suggested that addiction recovery medications, including methadone, Suboxone, and Vivitrol, be covered by insurance; asked the committee to address the availability and affordability of naloxone in the nasal spray form which is more user-friendly than the less expensive syringe and vial



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form; suggested there should be access to treatment resources statewide; and suggested that penalties for dealing fentanyl, carfentanil, and other such drugs should be increased as a disincentive to distribute them.

7. Wellmark Blue Cross and Blue Shield (Wellmark)

Mr. Matt Hosford, Vice President and Chief Pharmacy Officer, Wellmark, discussed a national report published by the national Blue Cross and Blue Shield Association analyzing medical claims from their commercially insured members diagnosed with opioid abuse disorder, and a report that provided 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. Wellmark has a drug utilization program to identify patterns of misuse or abuse, such as the use of multiple pharmacies, prescribers, or other factors indicative of drug-seeking behavior, and based on the results, engages behavioral health staff to link consumers to appropriate treatment. Wellmark does not place limits on counseling or treatment programs that are providing care or evidence-based treatments and result in quality outcomes for members. MAT is a covered benefit, and Wellmark promotes the use of methadone and buprenorphine when it makes sense as part of a treatment program. However, Wellmark does not currently cover Vivitrol because an independent committee evaluated the drug and found no evidence that it is better than the existing treatments.

8. Iowa Department of Public Health

Dr. Patricia Quinlisk, State Medical Director and Epidemiologist; Mr. Kevin Gabbert, ATR/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, reviewed the Iowa opioids report card, and described various grants that DPH has received to address the opioid epidemic. The presenters clarified that while Iowa is a very low opioid overdose prevalence state, the rate of increase in overdoses is high. Prevention is very effective and DPH wants to be proactive rather than reactive. Even though the state as a whole might be considered to have reached a plateau in the prescribing of opioids, a 2017 CDC report demonstrates that approximately one-third of the counties in Iowa still show an increase in opioid prescribing. The presenters provided a list of possible next steps and highlighted the concern of unavailability and lack of data, including real-time data, which makes it difficult to respond quickly or plan accordingly.

9. Public Comment

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.

10. 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. 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:

- a. 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.
- b. 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.
- c. 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.
- d. 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.
- e. 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.



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- f. 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.
- g. 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.
- h. 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.
- i. Health care coverage for and reimbursement of medications, treatment services, and nonpharmacological pain management options are often inconsistent or insufficient.
- j. At least 38 states have Good Samaritan and Overdose Immunity laws. Iowa is one of the only remaining states without such a law.

II. October 16, 2017, Meeting

A. Meeting Overview

On the first meeting day, the Opioid Epidemic Evaluation Study Committee organized and elected Temporary Co-chairpersons Senator Dan Dawson and Representative David E. Heaton as Permanent Co-chairpersons. The committee approved the proposed rules as distributed. The primary focus of the meeting was to receive information from national and state perspectives, as well as the perspectives of health provider licensing boards and associations, treatment professionals, and managed care organizations. Presentations were provided by representatives of the National Conference of State Legislatures, the University of Iowa Injury Prevention Research Center, the Iowa Board of Nursing, the Iowa Board of Medicine, the Iowa Dental Board, the Iowa Board of Pharmacy, Mercy Turning Point Treatment Center, the Area Substance Abuse Council, United Community Services Healthcare, Prelude Behavioral Services, Anthem Insurance Companies, Inc., UnitedHealthcare, AmeriHealth Caritas Iowa, Inc., the Iowa Physical Therapy Association, and the Iowa Chiropractic Society. The committee also received public comment.



B. National Conference of State Legislatures (NCSL)

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 the four pillars of prevention, intervention, treatment, and recovery.

1. Four Pillars to Address the Opioid Epidemic

a. Prevention

(1) Prescription Drug Monitoring Program (PDMP)

All but one state currently has a PDMP (also referred to as a Prescription Monitoring Program or PMP). PDMPs are a best practice in averting the dispensing of multiple prescriptions and in preventing “doctor shopping” for additional prescriptions. PDMPs are a tool to inform providers, protect patients, and maintain access to opioids for those who need them. Variations in uses of PDMPs in the states include: requiring or authorizing prescribers to register to use the PDMP, allowing delegates to check and input data for prescribers, allowing prescribers and delegates to check the site for new or renewal prescriptions, providing real-time data submission, requiring management of data for accuracy, integrating access through electronic medical records, and providing for interstate data sharing.

(2) Other Prevention Efforts

(a) Prescription Limits

State prescription limits include first time prescription quantity limits based on length of treatment or days, a pill count, a morphine milligram equivalent (MME), or the lowest effective dose without a set amount.

(b) Guidelines and Training

In 2016, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services (CDC) issued voluntary guidelines for prescribing opioids for chronic pain, excluding active cancer treatment, palliative care and end-of-life care. Some states direct or authorize provider boards or departments of public health to set prescribing limits or provide training and education for providers.

b. Intervention or Rescue

(1) Syringe Services or Needle Exchange Programs

This approach can be used as a contact point to intervene and steer people to treatment in addition to helping to avoid the spread and cost of communicable diseases and infections like HIV and Hepatitis C. These programs are most often run through state health departments.



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(2) Access to Naloxone and Narcan

All 50 states now provide access to these opioid reversal drugs that are non-narcotic products and typically do not have any serious side effects. Laws allow access to this treatment by emergency responders and laypersons, and through third-party prescriptions and standing orders.

(3) Good Samaritan Laws

Forty states and the District of Columbia have Good Samaritan laws that provide immunity from civil, criminal, or professional liability to a person calling 911 to seek help for a drug overdose and for the person experiencing the overdose. These laws may not provide immunity from all criminal charges.

c. Treatment

(1) Medication Assisted Treatment (MAT)

Only 10 percent of persons with a substance use disorder receive treatment of any kind, including the gold standard, MAT. MAT is the use of federal Food and Drug Administration (FDA)-approved medications in combination with evidence-based behavioral therapies to provide a whole-person approach to treating substance use disorders. There are currently only three FDA-approved medications used with behavioral therapies for MAT that are proven to reduce illicit drug use, misuse, overdose risk, and fatalities. Research demonstrates that substance use disorder is a chronic brain disease which may require long-term treatment similar to other diseases such as cardiovascular disease or diabetes. Behavioral health changes happen in conjunction with counseling, peer support, family support, and social supports, although there is a stigma in some circles of using a substitute medication versus abstinence. People may relapse, so there is no “one and done” approach. Successful treatment reduces other health care costs, criminal activity, withdrawal symptoms, and cravings. Successful treatment improves economic, social, and personal productivity, adherence to therapy, and overall quality of life.

(2) Hurdles to Treatment

Hurdles to treatment include lack of coverage of all types of treatments by all payers and limitations including fail first policies, variations in Medicaid fee-for-service payment and lack of Medicaid coverage for residential treatment since it is an optional service (21 states have no residential treatment), variations in what constitutes comparable coverage, and coordination of the vast numbers of stakeholders involved including consumers, treatment providers, insurers, and state and federal officials.

d. Road to Recovery Through Treatment

(1) Screening



Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a simple, inexpensive, cost-effective screening performed most often in primary care offices or by therapists.

(2) **Limited Access**

Treatment includes initial detox and treatment through the recovery stage. There is a shortage of detox and treatment beds and a lack of providers in both urban and rural settings, creating a bottleneck in making referrals to treatment. Legislative policies may be used to increase the range of providers authorized to prescribe MAT medications. Following detox, there is a growing need for sober living and long-term recovery resources as more people work through treatment and reach the recovery stage. Massachusetts is addressing this issue by ensuring parity and coverage as required by state and federal law.

2. **Policy Intersection with Many Sectors**

Ms. Hanson provided contact information for other NCSL staff who cover the areas of criminal justice and human services, since the opioid epidemic necessitates many policy sectors collaboratively addressing the issue. NCSL is also available to discuss technical assistance options. Ms. Hanson provided the committee with the newest publication on state prescribing policies, an overview of state policy actions, and a list of other resource links. Some states have adopted pain clinic regulations, provide for health insurance coverage of alternative pain management by both public and private payers, have public education campaigns about proper medication use and disposal, provide for medication take-back programs, and have directives to prescribe or use non-opioid products first including abuse-deterrent formulations which are less likely to be abused. The Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services (SAMHSA) data demonstrates that the largest source of referral to treatment is the individual himself or herself, followed closely by the criminal justice system. With regard to the child welfare impact, 2015 data demonstrates that the United States has the highest number of children in foster care since 2008, largely related to parental substance misuse, which is a cost to state budgets. State strategies to address this problem include plans of safe care for children of parents with substance misuse and specialty courts for parents needing treatment.

3. **Key Questions to Ask When Developing Policy:**

- a. What does the data show in Iowa, what are the biggest issues for Iowa, and where do gaps exist? Ask state agencies for data to determine the best approach. National survey data is also available through the CDC, the National Institutes of Health (NIH) and SAMHSA.
- b. What recent action has been taken by the state and what are the federal funding opportunities?



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- c. What new strategies may be needed and are appropriate for Iowa?
- d. What agencies and stakeholders need to be at the table?

4. Committee Discussion

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 PDMP; and the need to provide a compassionate, individualized approach rather than a one-size-fits-all approach to pain management.

C. The University of Iowa Injury Prevention Research Center (IPRC)

1. Overview

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 is housed in the University of Iowa College of Public Health and has been funded by the CDC as one of 10 such centers in the United States since 1991 to conduct outreach, research, and training relating to the prevention of violence and injuries. One area of IPRC's expertise is prescription opioid overdose.

2. Stakeholder Council

a. Development of the Council

The IPRC received funding from the 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 evidenced-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.

b. Stakeholder Council Meeting

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. Those involved were asked to identify five priorities and to suggest next actionable program or policy steps.

c. Recommendations from the Council

- (1) Train Physicians in Pain Management and Opioid Prescribing in Medical School



This recommendation is to provide evidence-based physician training in pain management and opioid prescribing at the point of medical education, and to develop a presentation for current licensed professionals that will provide a historical perspective with up-to-date epidemiological data focusing on evidence-based solutions to alter the course of the epidemic. Physicians are currently required to complete two hours of continuing education in chronic pain management every five years.

(2) Educate Practitioners to Recognize Patients at High Risk for Opioid Misuse and Overdose

This recommendation is to educate physicians, nurses, pharmacists, and other practitioners to ensure a strong knowledge base in recognizing patients at high risk for opioid abuse and addiction.

Currently, the Iowa Board of Medicine utilizes a “reasonable and responsible” approach to pain management. A physician routinely assesses patients for pain, utilizes the expertise of other health care practitioners, thoroughly documents the assessment and plan of care, conducts ongoing monitoring of patient drug use, and minimizes risk through pain management agreements. A physician who utilizes this approach is unlikely to face disciplinary action.

(3) Reduce Barriers to Using the Iowa PMP

This recommendation is that the PMP be made an accurate and effective clinical tool for all prescribers. Stakeholders need to work together to identify and enact measures that eliminate barriers that prevent Iowa’s PMP from achieving maximum use and effectiveness. Barriers include factors such as that the use of the PMP by prescribers in Iowa is not mandatory; pain agreements between a patient and health practitioner are encouraged but not required; prescribers may issue multiple simultaneous opioid prescriptions to the same patient; although refills are not allowed for these prescriptions, a prescriber may issue up to a 90-day supply at one time to a patient; and data for the PMP is recorded on a weekly basis rather than in real-time. Upgrades to make the PMP more user-friendly and effective are pending. Physicians and pharmacists may now identify delegates to access the PMP on their behalf. Other professionals, such as law enforcement, could be authorized to request PMP data.

(4) Strengthen Surveillance

This recommendation is to strengthen the state’s capacity to conduct opioid drug overdose surveillance and prescription opioid monitoring among multiple organizations and agencies. Current Iowa surveillance efforts include the Cedar Rapids Police Department/Eastern Iowa Heroin Initiative data collection from hospitals in Linn County, the Iowa Poison



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Control Center tracking of calls to the center, the Iowa Consortium for Substance Abuse Research and Evaluation tracking trends from 2010 to 2015 on opioid treatment admissions in Iowa, and death certificate data. There is no real-time data currently available for surveillance in Iowa. There is a need to integrate the sharing of information among organizations.

(5) Ensure that Medicaid and Other Health Plans Adequately Cover MAT and Behavioral Therapy

This recommendation is to ensure that Medicaid and other state health programs adequately cover all FDA-approved MAT medications (methadone, buprenorphine, and naltrexone) and evidence-based behavioral interventions, and to encourage or require commercial health plans to provide similar coverage.

In Iowa there are currently approximately 50 eligible buprenorphine providers. A 2016 SAMHSA rule increased the provider-to-patient ratio for provision of MAT from one provider to 100 patients to one provider to 275 patients. There are limited in-patient facilities for treating opioid addiction. Public and private insurers are not required to cover MAT. The Department of Public Health (DPH) received approximately \$5 million over a two-year period for opioid addiction treatment through the federal 21st Century Cares Act.

3. Additional Resources

The IPRC has additional resources available for the committee including the Johns Hopkins Bloomberg School of Public Health report on an evidence-based approach to the opioid epidemic; a state-level IPRC report that provides an overview of opioid deaths in the state and the quantity of these drugs being prescribed in the state, as well as recommendations from the stakeholder meeting; and an inventory of policies and programs that the state has in place around eight topic areas which can be used to determine where Iowa stands in addressing the opioid epidemic with respect to current policies and programs.

4. Evaluation of the PDMP

As a related project, the IPRC evaluated the state PDMP and found that prescribing practices did change after its implementation. The IPRC used health insurance claims data to evaluate the program because currently researchers do not have access to the state PDMP data as researchers do in other states. The IPRC used death certificate data to track prescription opioid deaths, but there is no good mechanism for tracking nonfatal prescription opioid and other opioid-involved outcomes like abuse and addiction. States like Ohio that have taken a comprehensive approach with their PDMP are seeing reductions in opioid overdose deaths.



5. 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-the-counter 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.

D. Iowa Board of Nursing, Iowa Board of Medicine, and Iowa Dental Board

1. 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.

a. Board Activities

The board has worked with the DPH to disseminate the “Safe Prescribing of Opioids for Pain, and Reduction of Opioid Misuse” E-Blast series; will launch a new website on November 1, 2017, dedicated to opioid prescribing and resources available; is currently updating the Advanced Registered Nurse Practitioner (ARNP) rules concerning standards of practice for controlled substances that will be submitted to the board for approval in January 2018; and has established a program to assist nurses with impairments. Ms. Weinberg provided a copy of the National Council of State Boards of Nursing Opioid Toolkit and a copy of the Iowa Nurse Assistance Program brochure.

b. Future Activities — Proposed Rules

The proposed rules do not mandate use of the PMP, but state only that nurses should utilize the PMP. Ms. Weinberg clarified that the existing rules, adopted in the 1980s, only include one paragraph that specifies the parameters of prescription authority, but do not provide specific guidelines. The proposed rules include standards of practice for controlled substances, not just opioids. While the rules are not exactly the same as those adopted by the Board of Medicine, they are based on the same principles. The rules address taking a health history and personal and family substance abuse risk assessment; documenting in the



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patient's health record one or more recognized indications for the use of a controlled substance; encouraging an ARNP to review the patient's information on the PMP and to use a treatment agreement when prescribing one or more controlled substances to a patient; requiring an ARNP to provide ongoing education to a patient throughout the course of treatment including regarding the risks of using a controlled substance; requiring an ARNP to maintain an active federal Drug Enforcement Administration (DEA) and an Iowa Uniform Controlled Substances Act (CSA) registration; and prohibiting an ARNP from prescribing a controlled substance to himself or herself or a family member.

2. 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 when pain measurement was introduced as the fifth vital sign.

a. Board Activities

Since the PMP was launched in 2009, the board has promoted use of the PMP with materials provided at initial licensure and at license renewal. In 2010, the board adopted rules relating to interventional procedures, such as injections, for pain management. Since 2011, the board has distributed over 6,000 copies of a nationally-recognized resource book that also provides additional training on appropriate pain management. In 2011, the board adopted rules requiring physicians, with a focus on primary care providers, to complete two hours of training every five years on appropriate prescribing in each of two areas: chronic pain management and end-of-life care. The board sponsored legislation in 2013 and in 2015, introduced in the Iowa Senate, that would require a physician to check the PMP if writing a new or renewal prescription for a new patient when the prescriber suspected drug abuse or diversion. In proposing rules in 2015 for telemedicine, the board required an appropriate relationship to exist between the patient and the prescriber and defined what constitutes an appropriate relationship. The board works closely with the Federation of State Medical Boards, utilizes national resources that address opioid prescribing, and often adopts rules that embody parts of the national model policies.

b. Complaints and Disciplinary Actions

Mr. Bowden provided a summary of the approximately 200 opioid-related complaints relating to appropriate prescribing and pain management that the board has dealt with since 2011. He included the disciplinary cases that are public information in the packet of information provided to the committee. In general, the physicians involved in disciplinary actions are in smaller, rural, solo practices and are isolated; these physicians are not recklessly prescribing, but often know their patients too well, are overly trusting of and want to help the patient, and find it difficult to deny a prescription. The physicians whose actions rise to the level of a complaint or a disciplinary action are simply not following the rules that require



regular evaluation of the efficacy of the medicines being prescribed, random screening to make sure the levels of medication are appropriate, contracting with patients to require dispensing from a single pharmacy, and having other protocols in place to help address noncompliant patients. Today, approximately 17 percent of the cases the board is investigating relate to prescribing for pain management. The board relies on multiple sources, including patients, family members, other practitioners, law enforcement, county attorneys, and U.S. district attorneys when they are investigating reports relating to licensees. Generally, the physicians practicing in Iowa who are over 50 years of age were trained at a time when there wasn't an emphasis on pain management and the use of opioids. In 1960, the United Nations stated that opiates are a human right that are indispensable for the relief of pain and suffering, and 50 years later society is dealing with the aftermath.

c. Future Activities

The board is reviewing its legislative agenda for the 2018 Legislative Session and is involved in an ongoing review of its rules. The board is supportive of legislation that ensures easy access to the PMP information and timely reporting of the information. 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.

3. Iowa Dental Board

Mr. Phil McCollum, Associate Director, Iowa Dental Board, provided an overview of the board's activities.

a. Board Activities

(1) PMP Utilization

The board is reviewing data available through licensing surveys and complaints, and is encouraging all licensees to participate in a survey being administered by the University of Iowa regarding the PMP. The results of these reviews, as well as the results of the board's internal review of the last three years of disciplinary data concerning opioid prescribing, will be presented to the board at its next meeting in January 2018. Based on the most recent data from the PMP, in 2016, out of the 1,600 practicing dentists in the state, 82 percent are authorized to prescribe controlled substances, 23 percent have registered with the PMP, and only 4 percent have actually used the PMP and submitted a query. Because of this, the board is trying to educate licensees by collaborating with DPH and the University of Iowa to disseminate educational materials regarding strategies for assessing risk, prescribing and misuse prevention practices, patient education, coordination of care, and referral to treatment when indicated. Dentists would probably utilize



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the PMP more often if it were easier to access and integrated into their practice without being burdensome.

(2) Pain Management Techniques

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.

b. Future Activities

The board recently created an opioid task force to create guidelines as well as drug alternatives for prescribing that are specific to acute pain. The board has also had discussions with the University of Iowa College of Dentistry about hosting a one-day symposium on this topic and developing continuing education programming.

4. Committee Discussion

a. Medical School Curricula and the Use of Alternative Therapies

Mr. Bowden noted that the Board of Medicine does not prescribe the curricula for medical schools in the state, and that many doctors practicing in Iowa were educated outside of the state. Current Board of Medicine rules address the treatment of acute and chronic pain, and require physicians to consider other modalities before using pharmacological interventions. The idea of writing a prescription as an initial step in addressing pain is not the expectation. Mr. Bowden has made presentations at the University of Iowa Carver College of Medicine and at the Des Moines University College of Osteopathic Medicine on these rules to increase awareness about what is expected.

b. Accessibility and Affordability of Treatment

Mr. Bowden noted that Iowa falls well below the national average of physicians per 100,000 population, but when considering the most populated 13 counties, the state is nearer the national average. There is only a handful of professionals authorized to prescribe the three FDA-approved MAT medications, so limitations stem from who is authorized by law to prescribe. 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.

E. Iowa Board of Pharmacy

Mr. Andrew Funk, Executive Director, Iowa Board of Pharmacy, said the board is tasked with oversight of the distribution of legal prescription drugs through prescribing, dispensing, manufacturing, wholesaling, and retailing in this state, as well as, since 2009, managing the state PMP. The board has taken proactive steps in educating and training practitioners regarding the PMP, and in 2017, year-to-date, 45 percent of those authorized are using the PMP. Mr. Funk described various issues with the current PMP that limit registration and usage, and noted that the board sent out a survey to the approximately 900 pharmacists-in-charge in the state to determine their use and perceptions of the current PMP. Mr. Funk reported that in 2016, 3 million dosage units of controlled substances were dispensed. Comparatively, annualized year-to-date as of October 1, 2017, there has been a 10 percent reduction in dosages dispensed. Additionally, for Schedule II, III, and IV controlled substances, the number of dosages dispensed per prescription has decreased throughout the year.

1. Issues with the Current PMP — Request for Proposal

a. Registration and Renewal Processes and Password Changes

The board has issued a request for proposal (RFP) to address various shortcomings of the current PMP. Currently, the registration and renewal processes are handled on paper and the information is manually entered. The vendor selected through the RFP will provide for online enrollment, renewal, and the importing of existing information from the old into the new program. User agents, which currently may be as many as six per prescriber, will be able to register online. Password resets, which are currently provided over the phone, will also be available through an online process.

b. Reporting to the PMP Weekly or Daily

Iowa is one of only three states that require reporting to the PMP every seven days rather than daily. Based on the board survey, with a 33 percent response rate, 50 percent of those responding confirmed their reports are automatically submitted on their behalf, and 20 percent already report on a daily basis. Those who already report on a daily basis are probably employed by national retailers that have more stringent reporting requirements in another state so report to the Iowa PMP consistent with those more stringent requirements. Ninety-five percent of those responding confirmed that increasing reporting to a daily basis would not



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require them to incur onerous expenses, so the board has been developing additional reporting requirements to include in the rules. The board will review these rules on November 1, 2017.

c. Antiquated Software

The current PMP software is antiquated. Mr. Funk used the analogy that the current system is like operating with an Atari™ when there is Playstation IV™ available. The new RFP would bring the software up to date.

d. Data

The state wants to have access to data that can be easily disseminated and is affordable. The board tried to retrieve data to determine where to place medication takeback receptacles and the current vendor wanted to charge \$5,000 to retrieve the data. In preparing for this meeting, Mr. Funk wanted to get information about the units of hydrocodone dispensed in 2016 and year-to-date in 2017. He was told it would take three days to get the data because the program is so cumbersome.

e. Integration with Electronic Health Records (EHRs)

The integration with EHRs will be more streamlined under the RFP. Integration is available now, but there are costs involved as well as concern that if all potential providers chose to integrate, the current antiquated platform would be overwhelmed. The board has reached out to pharmacies, hospitals, and others in the state to do a pilot project on EHR integration and has identified four pharmacies to be involved. The pilot project, funded by board registration fees that have already been set aside, will continue until the new program is up and running so the board can determine the effect of integration on the utilization rate of the PMP, how many requests integration will generate, and who will pay for the ongoing integration. In some states initial and ongoing integration is paid for by those who administer the program. Based on the board's current registration fees and incomes, sufficient funds are not currently available to pay for the initial and ongoing integration.

f. New Software

The estimated deadline for the new software to be in place and functioning is April 1, 2018. The RFP responses are due November 3, 2017, and vendor demonstrations will take place on November 13, 2017. As part of the PMP, the board is considering requiring prescribers to report dispensings or self-administrations to the PMP. The board would also prefer that the PMP have the capacity to disseminate proactive reports for notifications to providers. With this function in place, if a patient meets certain criteria, such as milligram morphine equivalents levels, or a number of prescribers or pharmacies visited, the PMP would generate a letter to the individual practitioner notifying them that checking the PMP is in the individual's best interest, but not requiring the provider to do so. The board would also favor expanding reporting to include Schedule V, as well as the existing Schedule II through IV, controlled substances. Some of the Schedule



V controlled substances that are familiar are Lyrica, codeine-containing cough suppressant, promethazine with codeine, and Lomotil, which is chemically similar to Demerol. There is a significant black market for these products, and when used above the recommended dosages there is potential for abuse.

2. **Partial Filling of Prescriptions — Federal Comprehensive Addiction and Recovery Act (CARA)**

The board has noticed administrative rules to implement the provision in CARA that allows the partial filling of a prescription for Schedule II controlled substances at the request of a prescriber or patient. Under this provision, for example, if a prescription is written for a total of 30 dosage units, the prescriber may write the prescription to initially dispense fewer than the total, allowing the patient to return to fill the remainder of the 30 dosage units under the same prescription within 30 days. This provision permits the prescriber to offer the proper length of time for pain management while still restricting the dosage units dispensed. While these rules are already noticed, until they are final, the board has announced that no board action will be taken against a prescriber who writes a partial-fill prescription based on the CARA provision.

3. **Medication Disposal Program**

The board operates a medication disposal program. Since 2016, a new vendor has worked with the Governor's Office of Drug Control Policy to place a medication disposal receptacle in each of the 99 counties within a pharmacy or law enforcement location. In the future, the board hopes to engage larger pharmacy retailers in the program.

4. **Education and Outreach**

The board hired a pharmacist at the beginning of 2017 who is dedicated to traveling the state to educate pharmacists and explain the current PMP as well as proposed changes to the PMP.

5. **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 EHRs, 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



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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.

F. Treatment Providers

1. Mercy Turning Point Treatment Center (MTP)

Ms. Malissa Sprenger, Coordinator, Mercy Turning Point Treatment Center, located at Mercy Medical Center in Dubuque, noted that she has been a clinician for 23 years and because of the opioid epidemic over the past two years she has witnessed the most intense human suffering she has ever witnessed, including standing by as a mother buried her only child and as a family buried two children on the same day.

a. Message of Concern and Hope

From the perspective of the Mercy national network as a whole, the number of those affected in Iowa by the opioid epidemic is significantly lower when compared with the number of those affected in other states, but the suffering is the same. The opioid epidemic is a global threat, is a crisis for the nation, and is plaguing Dubuque and eastern Iowa. Ms. Sprenger brought a message of concern and hope. Federal experts state that the eye of the storm in Ohio is coming our way, and the brunt of it will hit Dubuque in about five years. Her message is one of concern because very recently in Omaha there was a large fentanyl drug bust with enough product to kill 5 million people. So, the threat is now coming from both directions. Her message is one of hope because Dubuque has established an opioid response team to combat the crisis in their area. Last April, Dubuque had seven opioid-related deaths in one week. But, now with the opioid response team, MAT services are available for patients and these patients are demonstrating a positive therapeutic response by managing their cravings, managing withdrawal, being able to secure employment, and maintaining interpersonal relationships and functioning lives, and they are experiencing decreased criminal activity and drug use.

b. Local Activities

MTP has also been training local law enforcement, and the Dubuque Mercy Health Foundation has pledged approximately \$20,000 to cover the cost of naloxone rescue kits. To date, MTP has trained and disseminated Narcan to almost 600 individuals which has saved at least 10 lives in the community. Law enforcement also carries Narcan for their own well-being in case they have an exposure to fentanyl. MTP representatives talk with prescribers about appropriate prescribing, with the goal of having 100 percent of over 500 prescribers registered and using



the PMP, and are working with practitioners to redefine how to talk about pain at the bedside in nonpharmacological ways.

c. Recommendations

Ms. Sprenger noted that Iowa has very effective leadership compared with some other states and the state is actively working to obtain the federal funds available to address the opioid epidemic. She suggested that altering the course of opioid addiction must include people-centered imperatives that encompass prevention, intervention, treatment, and recovery, and included the following recommendations in her presentation:

(1) Good Samaritan Law — Access to Reversal Drugs — Permanent Take-Back and Disposal Programs

- (a)** Support increased access to life-saving opioid overdose reversal drugs through laws that encourage the prescription, training and use of naloxone, the timely seeking of emergency medical assistance, and advancement of important protections for those administering naloxone, such as Good Samaritan laws and standing orders. MTP supports the enactment of a Good Samaritan law because the law saves lives and Iowa is one of the only remaining states without such a law.
- (b)** Increase the number of and access to permanent prescription take-back programs and drop-off sites, including addressing regulatory barriers and easy-to-access disposal options such as drug deactivation systems.

(2) Public Health-based Interventions and Specialty Courts

Invest in and support public health-based interventions as well as the use of specialty courts, such as mental health and drug courts, and stabilization centers as a means of directing persons into appropriate levels of care.

(3) Private Insurance and Medicaid Coverage — Report on Coverage and Payment Policies — Coverage of Alternative Approaches to Pain Management

- (a)** Maintain health care coverage for vulnerable populations, including immediate coverage for Medicaid and private insurance-eligible offenders when released from incarceration, and including coverage of naltrexone for addicted offenders.
- (b)** Align payment systems to support delivery system innovations targeted at high-need individuals such as through federal Section 1115 Medicaid waivers that allow for expanded substance use disorder services and improved care coordination.
- (c)** Request that the Department of Human Services (DHS) and the Iowa Insurance Division compile a report specifying the coverage



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and payment policies for diagnosis and treatment of substance use disorders of third-party payers including insurance companies and managed care organizations.

- (d) Provide meaningful insurance coverage for MAT by limiting prior authorization requirements, allowing clinical decisions on medication dosage and length of treatment, and enforcing parity regulations.
- (e) Expand coverage for non-drug, alternative approaches to pain management such as physical therapy and cognitive behavioral therapy as well as complementary approaches like acupuncture and chiropractic care.

(4) PMP — Prescribing

Require participation of physicians, pharmacists, and eligible prescribers in the state PMP, enable interstate exchange of prescription information, assure provider adherence to CDC guidelines for prescribing opioids for pain, and limit opioid prescriptions to a seven-day supply.

(5) Education and Training of Professionals — Patient Satisfaction Surveys

- (a) Advance responsible, evidence-based opioid prescribing and counseling through pain management education, safe prescribing training, and addiction training for all prescribers and dispensers in medical school and on an ongoing basis throughout their professional careers.
- (b) Study the effects of the revised patient satisfaction survey pain management questions and accreditation standards and their implications on opioid prescribing.

(6) Treatment Capacity — Long-term Treatment Facility — Workforce

- (a) Ensure adequate funding for FDA-approved medications for the treatment of opioid use disorder and treatment access. Currently, prior authorization is required for some of these medications and it is resulting in deadly delays.
- (b) Create a public long-term treatment facility for patients with complex, multi-occurring conditions, including substance use disorder, mental illness, and physical complications. When these individuals are in the hospital, they have access to physicians who are not available in community-based settings. If patients return to the community too soon, they remain symptomatic, and continue to spiral downward. These patients end up in jail or deceased. Patients cannot wait for weeks to be provided treatment.
- (c) Continue to build capacity so the state is prepared when the opioid emergency reaches Iowa, or so that the state can avert an emergency.



- (d) Expand the pipeline of the behavioral health workforce with particular emphasis on increasing professional expertise in addiction prevention, treatment, and rehabilitation.

(7) Whole-person Care — Barriers to Treatment and Recovery — Stigma

- (a) Support a whole-person approach to meet the full range of an individual's physical, behavioral, and social supports and ensure resources and coordinated, comprehensive solutions across local, state, and federal levels of government.
- (b) Support funding for community care teams, crisis intervention teams, and high-utilizer programs which include critical wrap-around services.
- (c) Allow the full spectrum of providers from physicians to peer-to-peer support specialists to work in collaborative, team-based environments, and enable them to practice at the highest level of their education, training, and licensure.
- (d) Recognize the importance of and support informal, peer supports by expanding education, increasing inclusivity, and providing financial supports.
- (e) Broaden community awareness, engagement, and education across all stakeholders to break down barriers and reduce stigma.

(8) Communication — Data

- (a) Enhance prevention through communication, transparency, and accountability among all stakeholders.
- (b) Invest in innovative technology that advances interstate data-sharing and real-time, actionable, data accessible to providers and care managers, and strengthens utilization and connectivity to PMPs.
- (c) Aggregate utilization data by county, based on the number of people treated, services provided, costs incurred, and payments made.

2. Area Substance Abuse Council (ASAC)

Ms. Barb Gay, Executive Director, ASAC, said that ASAC is located in Cedar Rapids and serves five counties. ASAC is a comprehensive agency, providing prevention, treatment, and recovery services but only provides MAT in the Linn County location. Among treatment providers across the state, there is a high level of collaboration and communication.

a. ASAC Activities

ASAC uses a collaborative approach with all sectors and tools because treatment alone is not the answer to success. ASAC has focused on physician recruitment and is collaborating with the local Federally Qualified Health Center (FQHC) and



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Abbe Center for Community Mental Health, an outpatient treatment center in Cedar Rapids. ASAC is focusing on residential patients with MAT and also provides services on an outpatient basis. ASAC serves approximately 3,000 patients, annually, but serves only 40 in MAT, annually. ASAC began MAT because of the increase in both prescription drug and heroin abuse. MAT patients remain in treatment longer than is the practice for other types of treatment. This longer, more comprehensive treatment allows the brain sufficient time to heal so that more patients are successful in maintaining recovery and staying in aftercare. The average age of a patient in the program is 32 years of age and there are slightly more women than men in their treatment programs. About two-thirds of the patients are heroin users and the remaining patients are opioid users or opioid and heroin users. ASAC is doing a lot of community education around MAT because of the varying perceptions of law enforcement, hospitals, and the community regarding opioids and overdoses. For example, in comparing data, in 2015, law enforcement reported 60 overdose calls involving heroin, but hospitals reported over 300 admissions involving heroin or opioids.

b. Vivitrol Reimbursement, Prescribers, Funding

ASAC utilizes Vivitrol in its treatment program, and has concerns about access to the drug going forward. Coverage is changing from a pharmacy benefit to a medical benefit because the Medicaid Pharmaceutical and Therapeutics Committee (P & T Committee) wanted the drug to be provided in a more controlled treatment environment and subject to prior authorization. Currently, the ASAC provider writes the prescription and it is dispensed and billed by a local pharmacy as a pharmacy benefit. Going forward as a medical benefit, ASAC, not the local pharmacy, will have to purchase, store, and have the drug available when the patient needs it. The drug costs about \$1,400 per monthly injection and its shelf-life is about 18 months. It is unclear to date how the medical benefit will be compensated. For small providers like ASAC, the issue is how to pay for the drug in advance, especially if ASAC wants to expand their programming to other counties. Even though the treatment drugs used are patient-specific, the positive aspects of Vivitrol are that it is non-habit forming and there is no oral non-compliance because it is injected only once a month.

ASAC has three prescribers of MAT medications and is considering telehealth and partnering with hospitals to recruit more providers. Some providers have concerns with taking on these patients due to the stigma attached to treatment.

Going forward, funding is needed for medications as well as for treatment and follow-up care with peer and other supports. The evidence indicates that MAT is successful. Linn County has a State Innovation Model Initiative grant which they have used to develop a shared database to link patients to a variety of support services.



3. 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 has a family practice clinic on the premises and provides services in Beavertdale, Ankeny, and Knoxville. UCS currently has 872 MAT patients that come from all socioeconomic groups and from zip codes across the state. UCS is one of only a few organizations in the state certified as an Opioid Treatment Program (OTP) providing MAT services to individuals diagnosed with an opioid treatment disorder. OTPs are accredited by a SAMHSA-approved accrediting body. Unlike a prescriber in a private practice who does not generally have the resources available to provide a successful MAT program, federal law requires patients who receive treatment through an OTP to receive medical, counseling, vocational, educational, and other assessment and treatment services, in addition to prescribed medications. OTPs require a great deal of structure and provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and the spread of infectious disease, as well as provide diversion control and the counseling and behavioral therapy necessary to get to the root cause of the addiction. There is a need to educate providers, caregivers, and the whole system against the stigma and preconceived notions about MAT being only a means to substitute one drug for another. The medications used in MAT relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body.

One benefit of an OTP is that under the SAMHSA rules, OTPs may establish medication units in remote areas under the OTP license and use telehealth to prescribe. Medication units are facilities established as part of, but geographically separate from, an OTP from which licensed practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis. The caveat is that medication units cannot provide for assessment and therapy as part of the medication unit. So UCS is going to establish medication units within treatment centers in various locations to increase access to MAT. There are current plans to establish medication units in Ankeny and Knoxville, and UCS is also discussing plans with providers located in Ottumwa, and in southwest Iowa in Creston, Atlantic, and Clarinda. Providers can establish these medication units for about \$24,000 compared with the cost of an OTP which is approximately \$1 million. There is uncertainty about how third-party payers will bill the OTP for the medications provided through a medication unit, and the communities in which medication units are established will have to be educated about stigma and opioid addiction.

4. Committee Discussion

a. 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



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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.

b. 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.

c. 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.

d. 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.

G. Prelude Behavioral Services (PBS)

1. Mr. Ron Berg, Director and Chief Executive Officer, Prelude Behavioral Services, said that PBS provides 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. PBS serves all 99 counties, and both urban and rural areas. PBS has 99 beds for residential treatment and halfway services, with an average waiting period of 9.5 days for admission to treatment. PBS is just starting on the learning curve relative to MAT. As an initial step, to participate in the SAMHSA State Targeted Response grant received by DPH, PBS is working on completion of a community needs assessment. Some of the findings from interviews and data collected through the community needs assessment process from partners in Cedar, Iowa, Johnson, and Washington counties include: Iowa City police have been able to make an impact in Johnson County on the supply of heroin; Narcan seems to be more readily available to urban than to rural law enforcement; there is concern for elderly citizens in rural areas from both the standpoint of their use of opiates in isolation and the potential for accidental overdose, as well as from the standpoint that these elderly citizens are vulnerable to robbery and theft from unknown individuals or friends and family; while only 8 percent of PBS patients are being treated for an opioid substance use disorder, the numbers of deaths from opioids relative to the number of patients using those substances is disproportionate; and roughly an even percentage of the patients seen at PBS for use of opioids, and heroin specifically, are from urban and rural counties.

MAT services are not as easily accessible in Iowa City as they are in Des Moines where PBS works with Primary Health Care, a community health center, to provide these services. Accessibility needs to be expanded to this evidence-based practice.

To make substance use disorder treatment viable and sustainable in the state, once the spotlight shifts from the opioid epidemic and grants are depleted, there needs to be a solid business model, especially for rural areas, to maintain adequate substance use disorder treatment resources. Methamphetamine is still a problem in the state, but the spotlight has just temporarily shifted to opioids. Reimbursement rates must be sufficient to support efforts to expand MAT, specifically addressing the case management activities with this patient population.

Response to the opioid crisis, as with any other substance abuse crisis, is hampered by the stigma still associated with drug and alcohol abuse. In the community needs assessment process there was an underlying tone that either the physicians, treatment agencies, or law enforcement need to do something different. All stakeholders have a role in improving collaboration to address the epidemic.

2. Committee Discussion

a. Proper Use of Pain Medications



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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.

b. 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.

H. Managed Care Organizations (MCOs)

1. Anthem Insurance Companies, Inc. (Anthem)

a. Overview

Mr. Eric Bailly, Business Solutions Director, Anthem Insurance Companies, Inc., spoke about Anthem's efforts at the national level to address the opioid epidemic. There has been a significant increase in opioid deaths with no sign of slowing, and the rate of babies born with Neonatal Abstinence Syndrome between 2000 and 2012 has increased five-fold. Based on CDC data, there was a 7 percent increase in drug overdose deaths between January of 2016 and January of 2017 in Iowa. Eighty-seven percent of these 324 deaths are attributable to natural or synthetic opioids.

b. Anthem's Activities

(1) Goals

Anthem made a 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.

(2) Comprehensive Strategy

Anthem's comprehensive strategy includes addressing the areas of prevention, treatment and recovery, and deterrence.

(a) Prevention

In the area of prevention, Anthem is promoting coordination of care and ensuring appropriate medication access by limiting initial prescriptions for short-acting opioids; requiring prior authorization for all long-acting opioids; covering MAT for members; introducing a pharmacy home program; and utilizing a controlled substance use monitoring program. While Iowa law does not allow for point-of-sale edits, in other markets Anthem has instituted point-of-sale edits that limit opioid prescriptions to a seven-day supply for a new



patient. Point-of-sale edits only apply to new starts and do not apply to prescriptions for chronic conditions or for long-term prescriptions. Notably, however, even without the point-of-sale edits in Iowa, there has been an 11 percent reduction in opioid prescriptions. For long-acting prescriptions, there is a prior authorization requirement in place for new starts to demonstrate that other drugs have been used first. In Maryland, this policy has resulted in a reduction of 22 percent in opioid prescriptions, resulting in thousands of fewer pills in medicine cabinets.

(b) Treatment and Recovery

In the area of treatment and recovery, Anthem is minimizing the risks and enabling earlier identification of opioid misuse and abuse by providing patient care management support; improving MAT access in rural areas through primary care provider recruitment; providing peer support recovery services; expanding care and treatment options through telehealth; and increasing provider and vendor collaboration. Anthem is also providing access to evidence-based online consumer tools such as mobile apps, decision-support tools and support groups; and offering a variety of coverage options for non-pharmacologic approaches to pain management including physical therapy, osteopathic manipulation, pain management programs, and cognitive behavioral therapy. Anthem has established collaborative relationships with treatment providers including the Betty Ford Center, which, while well-steeped in the 12-step philosophy, has now added MAT to its array of services, and Bright Heart Health which is helping Anthem to reach rural areas through the use of telehealth.

(c) Deterrence

In the area of deterrence, Anthem is leveraging data mining and analytic capabilities by reviewing high volume pharmacies; partnering with law enforcement to monitor claims for potential fraudulent or abusive behavior; monitoring potential doctor shopping, investigating “pill mills,” and providing provider education. Anthem sends cautionary letters to prescribers who are falling outside the norm of established prescribing practices and also notifies prescribers if they are prescribing drugs that have potential negative interactions.

2. UnitedHealthcare (UHC)

a. Overview

Dr. KellyAnn Light-McGroary, Chief Medical Officer, UnitedHealthcare, said that as a cardiologist and a hospice physician she has had a lot of experience with those living with and dying in pain. Even though the opioid epidemic is not limited to one



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population, the Medicaid population is more at risk than any other and the number of babies born to women on Medicaid with substance use disorders is higher.

b. UHC Activities

(1) Goals

For the next two years, the goal of UHC is to use a multipronged approach to reach at least 75 percent compliance, if not higher, with the CDC opioid prescribing guidelines for providers; increase participation in MAT programs for those patients needing MAT by 50 percent; and increase staff, customer, provider, and member education in attacking the problem.

(2) Comprehensive Strategy

UnitedHealthcare's comprehensive strategy includes addressing the areas of prevention, treatment, recovery, and harm reduction.

(a) Prevention

The objectives of the prevention strategy are to increase understanding of the epidemic among staff, customers, providers, and members and to improve prescriber adherence to CDC guidelines. UHC is reviewing member opioid use on the PMP, compiling prescriber outlier reports, and following up with primary care providers and behavioral health providers.

(b) Treatment

The objectives of the treatment strategy include increasing MAT capacity, increasing the number of members who receive MAT, and supporting individuals seeking treatment on their journey to recovery. There are many opportunities for integration of physical and behavioral health care to address the medical, behavioral, and social needs of the whole person. UHC is also expanding its MAT network and reducing barriers to use of MAT.

(c) Recovery

The objectives of the recovery strategy are to utilize person-centered and evidence-based approaches to recovery and to reduce social barriers that impede recovery, health, and well-being. UHC is using interdisciplinary care teams that include behavioral health, maternal and child health, pharmacy, case managers, community health workers, housing providers, social services providers and others to work around barriers such as transportation, housing, and employment to ensure that those in recovery are successful.

(d) Harm Reduction

The objectives of harm reduction are to reduce overdose deaths and to increase the safe use, storage, and disposal of opioid



prescriptions. Harm reduction efforts are driven by local community needs and collaborations.

3. AmeriHealth Caritas Iowa, Inc. (AmeriHealth)

a. Overview

Dr. Victoria Sharp, Chief Medical Officer, AmeriHealth Caritas Iowa, Inc., spoke about integrative models for chronic pain management and addiction treatment. She focused on the Medicaid population which she characterized as a very vulnerable population with complex psychosocial issues.

b. AmeriHealth Activities

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.

(1) Preventing Opioid Misuse

Chronic pain is a multifactorial problem and requires a multifaceted approach. AmeriHealth has processes to identify at-risk members; monitors for overprescribing and reaches out to providers to discuss cases; offers provider education to ensure providers are aware of nonopioid pain management options available to patients such as physical therapy, occupational therapy, and chiropractic services; uses pharmacist telephonic outreach to address overutilization; has a pharmacy lock-in program that requires a member to use only one pharmacy; includes member education in its newsletter; and uses a holistic approach to integrating care management by merging behavioral health support with physical treatment of chronic pain as well as for addiction. Because opioid use can result in poor outcomes for a pregnant woman and her baby after birth, AmeriHealth currently tracks narcotic prescriptions to pregnant members, provides outreach, and engages these women in high-risk pregnancy care management. AmeriHealth works closely with substance abuse treatment centers throughout the state to identify places that can accommodate pregnant members and women with infants throughout treatment. Unfortunately, there are few options in Iowa. The PMP in Iowa is not mandated and is cumbersome and time consuming. MCOs do not have access to the PMP currently and there is a time delay of seven days to upload information.

(2) Treatment

With regard to treatment options and challenges in Iowa, the limited access to treatment has made it difficult for AmeriHealth's Medicaid members to get the treatment they need. MAT is valuable during the immediate withdrawal process as well as during ongoing treatment, but there is a lack of MAT resources. Treatment success rates are as low as



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10 percent without MAT and as high as 70 percent with MAT. AmeriHealth contracts with 100 percent of the available providers of MAT, but Iowa only has about 50 prescribers of the FDA-approved medications for MAT across the state. AmeriHealth Medicaid members have access to Vivitrol in the daily oral form. The injectable form is preferred for compliance. For Medicaid members, the only way to have access to Vivitrol in the injectable form is for a physician to administer it in the physician's office. This is costly and time-intensive for physicians, thereby limiting access to injectable Vivitrol for Medicaid members.

(3) Use of Overdose Reversal Drugs

The DPH and the Board of Pharmacy have made overdose reversal drugs such as naloxone available without a prescription and administration of naloxone has been demonstrated to reduce deaths. However, Iowa Medicaid members are not able to participate due to regulatory limitations.

c. Recommendations

- (1)** Increase access to Vivitrol and MAT by working with DHS to explore options for delivering the injectable version of the drug.
- (2)** Work with DHS to allow Medicaid members to participate in the standing order program to ensure access to naloxone. This may also require additional funding.
- (3)** Continue to develop a multifaceted approach by involving providers, members, families, law enforcement, and others to provide a more accessible, efficient, and productive addiction treatment environment.
- (4)** Expand the available education resources for prescribers and other practitioners on evidence-based pain management treatment and substance use disorders.

4. 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.

I. Iowa Physical Therapy Association

1. Overview

Mr. Matt Bravard, Iowa Physical Therapy Association, said that following the release of the 2016 CDC guidelines with recommendations for safer alternatives for management of pain, the American Physical Therapist Association acted quickly and launched the “#ChoosePT” campaign to educate the public in methods of physical therapy to address chronic pain and acute pain. Since then, there have been efforts to increase public awareness, to provide patient education regarding alternative ways to address and avoid pain, and to educate the public. Physical therapy is an evidence-based high-quality approach to treating pain.

2. 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.

J. Iowa Chiropractic Society

1. Overview

Dr. Wes Nyberg, 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 opioid drugs for pain management.

2. 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.



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K. Public Comment

1. Dr. Janie Hendricks

Dr. Janie Hendricks, Past President, Polk County Medical Society, stated that she was providing comments as an advocate for patients. She cautioned that there seems to be a one-size-fits-all approach from insurance companies regarding pain management, the treatment of opioid abuse, and the prescribing of medications. Physicians are trained to take care of patients, and one tool available to treat pain is opioids. A Schedule II narcotic requires a written prescription and cannot be refilled without a new prescription. Some insurers are now limiting an initial prescription to a 5 to 10 day supply and then requiring prior authorization for a subsequent prescription. Some insurers are also requiring the signing of a pain contract or the completion of a survey prior to prescribing an opioid. These one-size-fits-all limitations do not always work. For example, if a person has a knee replacement and then returns shortly thereafter for the second knee replacement before an initial pain medication prescription has run its course, it can take 48 hours, at a minimum, to receive prior authorization for a subsequent prescription. It takes physician and staff time, and increases costs to address the situation with a one-size-fits-all solution. Doctors know better than insurance companies how to treat pain because doctors, not insurance companies, know their patients and have relationships with them. It does not make sense to require a patient in a rural area struggling with chronic pain to be subject to prior authorization or for an 80-year-old with chronic pain to fill out a survey before they can get their medication. The PMP has been effective, but allowing for more real-time updating would be an improvement. With regard to the CDC guidelines and using over-the-counter medications first, Dr. Hendricks stated that it should be left up to the physician to decide and that narcotics should be available if needed. She also noted that it is the role of the primary care physician to provide long-term monitoring of a patient so that if opioids are prescribed to address acute pain, once the initial acute pain has subsided, the primary care physician can evaluate the patient if the patient still feels in need of opioids to address pain. There could be some other underlying issue if a patient is having ongoing pain, and sometimes cognitive behavioral therapy is helpful for those who perceive they still have pain or crave the feeling they get from the narcotics.

2. Ms. Deborah Thompson

Ms. Thompson thanked the committee for their leadership and stated that today would have been her 7th wedding anniversary. Her husband, Joe Thompson, passed away from an accidental heroin overdose in September 2016, and left her and a one-year-old son, Lincoln, behind. Ms. Thompson is a policy advisor and legislative liaison for the DPH, and while she and Joe were working through what would be his last addiction cycle, she was simultaneously working on the Narcan and naloxone legislation in her professional role. She had been part of or listened to the opioid policy discussions and reflected on how Joe would have or could have been impacted by some of these ideas. She also reflected on the rhetoric from other states, much of which is rife with



stereotypes, assumptions, misperceptions and lack of understanding or compassion. She hoped Iowa would not follow suit. Ms. Thompson offered an anecdote to tell those policymakers not present at the meeting in case they were persuaded by the rhetoric: Joe's story. Joe was educated at Grand View University for nursing and came from a strong Iowa family. He had a very good childhood. He made it to the state wrestling tournament twice, and was very successful in high school. He received the Ironman award for going to every single wrestling practice during his high school career all four years. He had supportive, loving parents even through the final days and they continue to help raise Lincoln. They had a very strong marriage, she had a very stable state income, and they were overjoyed when Lincoln was born. Joe was overprescribed opioids after a serious car accident in 2004 by a doctor who, in his own words, wanted to treat Joe's pain with a firehose rather than a garden hose. This started them on a 13-year journey through the disease to which he ultimately succumbed. The doctor from Joe's childhood did not intend for Joe's addiction to start in his office. Joe and his doctor had a close relationship and Joe probably did manipulate this relationship at times after the disease took hold. There is a stigma, not just from the outside, but from those inside looking out, too. They made the decision to wean Joe off of the Saboxone that had kept him alive for 2.5 years through treatment at UCS. They were talked into care at a reputable place in Des Moines that promoted abstinence. She reflected that the reputable place might be good with alcohol addiction, but they were not good with opioid addiction. Joe could not be admitted until he detoxed from the Saboxone because they equated it with being on heroin. While trying to get Joe into this treatment facility, he became sicker, and then finally they found him deceased. Ms. Thompson implored the members to listen to what Mr. Polich said about education of providers. The place Joe went to, not UCS, is not ready for opioid treatment but they are accepting patients anyway. All the days of Joe's life, even the worst ones, were worth living. Those legislator colleagues who were skeptical about the use of naloxone should know it did save Joe's life twice. Although Joe ultimately did pass away, he was able to see his son walk for the first time, talk for the first time, and he attended Lincoln's first birthday party where he saw many of his friends and family for the last time. Joe was kind, was part of his community in Indianola, and also part of his recovery community. Every time Joe heard someone in his recovery community had died, he traveled to those funerals with members of his recovery community from UCS so their loved ones would know their loved one was still loved even if they had lost connections through the addiction. Three hundred people showed up to Joe's funeral — he was very loved. Ms. Thompson shared their story because she wanted the committee members to ask questions. She noted that she has always been a resource and she did not want committee members to avoid asking her now because they knew this story. She stated that she owed it to Joe to tell his story and help people understand how to help. It is a very hard and complex disease. But living in it is really hard. She said she knows it is a disease because Joe would never have chosen to leave her and Lincoln. Joe loved the life he had with them. She noted that she is proud of her colleagues at DPH and is sure the state can address the opioid epidemic



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using good public health prevention strategies. She said the committee members would hear more from DPH on Tuesday, and asked the committee members to please continue to support the efforts of DPH and be a leader on this issue.

In response to a question, Ms. Thompson stated that Joe was able to obtain the drugs to feed his addiction first by doctor shopping. He was also employed at UPS and benefitted from the pill mills that were unregulated in Florida. He figured out which packages had drugs in them and how to get them out. Luckily, he was never caught because it would have been an awful legal battle. Joe does not have a police record. Additionally, he would meet people. He was in treatment several times. It was not an everyday thing, an every month thing, or an every year thing. That is why it is called a cycle of addiction. Sometimes Joe would meet people at treatment. There were times he went to nursing homes to find drugs. He was very honest with his wife, they had a good relationship, and she wanted to help him get better. The first time he quit, he quit cold turkey. The second time he realized what was happening and he checked himself into UCS. That worked well for 2.5 years. MAT was so new. As they were trying to get him into Powell Chemical Dependency Center in Des Moines, she was at a MAT training for work, listening to the statistics and talk of dopamine levels. She called Powell to ask how they were going to deal with dopamine levels, but they did not have any answers. Joe really wanted to be done with all of it. There is a stigma. Joe struggled to think of it as a disease. He knew he had a disease, but to deal with it you have to go to a not-so-nice place on a regular basis and you cannot help but feel you do not belong there. The answer was that he had a disease and he could not just be done with it. They abandoned Powell and were trying to go to Mercy Medical Center for treatment. They had to enroll and had gone to a couple of classes but then it did not work out. Members commented on the courage it took for Ms. Thompson to share her story, how difficult it is to watch a mate deal with an addiction, and the fact that there are so many who have been touched by this issue.

III. October 17, 2017, Meeting

A. Meeting Overview

On the second meeting day, the focus of the committee was enforcement and public safety, harm reduction, medical education, private health care coverage, and activities of the Department of Public Health. Presentations were provided by representatives of the Department of Justice, the Iowa Harm Reduction Coalition, the Bureau of HIV, STD, and Hepatitis of the Department of Public Health, the Department of Public Safety, the University of Iowa Carver College of Medicine, Des Moines University College of Osteopathic Medicine, the Cedar Rapids Police Department/Eastern Iowa Heroin Coalition, Wellmark Blue Cross and Blue Shield, and the Department of Public Health. The study committee also received public comment and discussed next steps.



B. Department of Justice

1. Overview

Mr. Nathan Blake, Deputy Attorney General for Policy, Department of Justice, discussed opioid use and enforcement in Iowa. This office has been involved in this issue for some time, mostly on the enforcement side. They represent the state and state agencies, but also handle criminal enforcement at the national level. Much of what they do is through consumer protection and they are currently involved in an active investigation of the pharmaceutical industry.

2. Data

Mr. Blake presented data showing the large increase in national opioid deaths and the number of opioid prescriptions dispensed. In Iowa, data from the DPH demonstrates that from 2005 to 2016, opioid treatment admissions increased from 608 to 2,274, opioid overdose deaths increased from 28 to 67, and opioid-related deaths increased from 59 to 146. Mr. Blake noted that there is not good data available to know about all those addicted who are not seeking treatment or have not died.

3. Investigations

Mr. Blake reviewed the multistate opioid investigation that was publicly announced in June 2017 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. Pharmaceutical companies are using as evidence for the claim that opioids have a low risk of addiction, a one-paragraph letter sent to the editor of a large newspaper from a doctor who said he had not observed much addiction in his own practice. In 1996, pain as the fifth vital sign was introduced, which Mr. Blake characterized as an insidious plan developed by the pharmaceutical companies to increase the sale of opioids. Other city, county, and state lawsuits are also pending. Iowa is actually a leader in the multistate action and the state is actively cooperating with other states for the multistate action. However, the state is also developing research for a strong state case, because it is unclear whether the multistate investigation or filing an individual lawsuit is a quicker way to get to resolution. This is a national issue, not a partisan issue, so finding a solution should include all parties.

Regarding the pharmaceutical industry, Mr. Blake noted that, while it would be helpful if the industry that benefited from the increased prescribing of opioids and is benefiting from the use of opioids in treatment would come to the table and discuss their role in financing treatment efforts, it has been his experience with large-scale investigations that if the opposing party is not receiving some relief or something in return from the state, they probably will not be inclined to proactively fund treatment.



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4. Options for Addressing the Opioid Epidemic

Without advocating for any one option, Mr. Blake listed potential options for the State to address the epidemic.

a. Prescription Limits

Some states limit initial opioid prescriptions for acute pain to a certain number of days. Eighteen states have a seven-day limit. There are exceptions for cancer, hospice and palliative care, and chronic pain. Another approach is to limit the length of the validity of an opiate prescription ranging from three days to one year with most being 30, 90, or 180 days. Under federal law, prescribers are allowed to issue multiple prescriptions of different Schedule II substances at once, but 37 states prohibit this practice.

b. PDMP Requirements

Twenty-six states mandate prescriber participation in PDMPs. PDMPs also can provide access and data-sharing across state lines and with law enforcement which is helpful in addressing the epidemic. In 36 states, pharmacists must check a person's ID before dispensing prescriptions of controlled substances.

c. Availability of Opioid Antagonists

In 2016, Iowa began to allow opioid reversal drugs to be dispensed to certain persons including first responders. In Iowa, the Attorney General negotiated an agreement with Amphastar Pharmaceuticals to provide a \$6 rebate per dose of naloxone for public entities which will be administered through the Governor's Office of Drug Control Policy.

d. Good Samaritan Laws

Thirty-eight states have Good Samaritan and Overdose Immunity laws that provide immunity from arrest or prosecution when someone calls 911 for assistance.

e. Other Options

Other state legislative activities include syringe services programs which are explicitly authorized in 19 states, prescription drug take-back programs, mandated provider training on addiction risks, and MAT funding.

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

1. Overview

Ms. Sarah Ziegenhorn, Executive Director and Co-founder, and Mr. Jonathan Birdsall, Legislative Advocacy Director, IHRC, brought one specific proposal to the committee: the establishment of a syringe services program. The IHRC was founded in 2016 as a 501(c)(3) nonprofit organization made up of community members, students, and those impacted by drug use. The mission of the IHRC is to reduce the harms associated with drug use and promote health equity through compassionate, nonjudgmental community services, education, and advocacy. Harm reduction is a set of practical strategies and



ideas aimed at reducing the negative consequences associated with drug use, and requires that interventions and policies reflect specific individual and community needs.

2. Syringe Services Programs (SSPs)

a. Background

Ms. Ziegenhorn said that while formerly referred to as needle exchange programs, today these programs are referred to as SSPs because they have evolved to include other services. IHRC is highlighting SSPs because, in addition to opioid use, addiction, and overdosing in the state, there is an increase in infectious disease that can happen to people when they are using opioids. One question IHRC is asked is whether people in Iowa who use drugs use needles. The opioid crisis has been portrayed as a prescription opioid problem. However, the tide is shifting, and it is no longer the case that people are initially becoming addicted to pain pills from the doctor. Last month, for the first time since 2015, heroin replaced all opioids as the initial opioid that people use. So, it is no longer only prescription opioids that people start with, it is heroin, and people use needles to inject heroin.

Data from DPH on needle usage of people admitted to treatment in Iowa for opioids between 2012 and 2016 demonstrates a 58 percent increase in individuals using needles to inject opioids rather than a pill. This equates to about 1,200 people in 2016, which is a fairly high percentage of those who are admitted to treatment.

b. Scott County, Indiana

Mr. Birdsall spoke about the test case of Scott County, Indiana, a rural community of 24,000 people. Between 2004 and 2014, Scott County only had five cases of diagnosed HIV. Then the opioid crisis started, people began using injection opioids, and between November 2014 and August 2015 there were 181 positive diagnoses of HIV in the county. On March 26, 2015, Indiana Governor Michael Pence declared the HIV epidemic a public health emergency and said he was putting the lives of the people of Indiana first by issuing an executive order legalizing a syringe exchange program. In April 2015, the syringe exchange program began operation. In September and October 2016, not a single person tested positive for HIV. There is a very tragic human side of an HIV diagnosis. Lifetime treatment costs for one person with HIV are \$380,000 to the state Medicaid program. The New England Journal of Medicine did a story on the circumstances that led to a massive outbreak in Scott County. There were many markers to indicate how the epidemic grew and how it could occur in other parts of the country. When an increase in injection drug use is observed, there is also an increased risk of sharing needles and transmission of diseases like HIV and Hepatitis C which are transmitted by blood. There is also a separate issue with those who use the same needles, repeatedly, infecting themselves with deadly and costly bacterial infections. An acute rapid rise in Hepatitis C in a community is



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a positive predictor of how a community might subsequently have an HIV outbreak. It is the canary in the coal mine.

c. Hepatitis C and HIV

Mr. Randy Mayer, Bureau Chief, Bureau of HIV, STD, and Hepatitis, DPH, provided information regarding Hepatitis C in Iowa. 2016 was the first year DPH was able to compile a comprehensive profile of Hepatitis C in the state by redirecting funding from another source. Nationally in 2012, the number of Hepatitis C-related deaths surpassed the number of deaths from all other infectious conditions combined. An estimate of the number of Iowans diagnosed with Hepatitis C Virus (HCV) in 2016, as reported to DPH, was about 24,000. Approximately 15,500 of these had evidence of confirmatory test results and approximately 8,000 of these had antibody-only test results. The CDC estimates that 45 to 85 percent of people with HCV are undiagnosed, so DPH estimates that there are 39,000 to 149,000 Iowans with HCV.

d. Diagnoses of HCV — Age Distribution

In 2000, there were 754 reported cases of HCV. In 2016, there were over 2,200 reported cases, making it the third-highest reportable disease in the state. About 60 percent of those infected with HCV are “Baby Boomers.” When the data is broken down by age, there is a bimodal distribution of people with HCV. Those in the 46 to 70-year-old age range at the time they are diagnosed were infected many years ago in the 1960s and 1970s. They are at risk for complications, but there is little ongoing transmission. HCV is an increasing but separate epidemic related to opioids. In Iowa, the age distribution of the second group ranges from 15 to 39 years of age. Those in the second age grouping diagnosed with HCV have ongoing transmission. In 2000, there were approximately 50 people in this age group diagnosed with HCV. In 2016, there were almost 700 cases, or a 1,100 percent increase since 2000. This indicates an epidemic of people sharing needles for injection drug use.

e. Demographics

HCV testing is done in stages. First, a person has an antibody test. The second test is a viral test to confirm the infection. About 15 percent of those with a positive antibody test can clear, or get rid of the disease, without treatment. The demographics of those with HCV in Iowa reflect, more than any other disease, the demographic make-up of the general population of Iowa, meaning that there is not a disproportionate diagnosis within a minority population, but instead 88 percent of those diagnosed are white. Additionally, there is almost an even distribution in the number of those diagnosed between men and women.

f. Urban vs. Rural

With regard to the distribution of those with HCV between urban and rural areas, the distribution of the “Baby Boomers” is more heavily concentrated in the urban areas while the distribution of those 15 to 39 years of age is more heavily concentrated in the rural and south-central parts of the state.



g. Coinfection with HIV and HCV

About 11 percent of Iowans living with HIV also have been diagnosed with HCV. HCV treatment medications were added to the Iowa AIDS Drug Assistance Program (ADAP) formulary in 2014. ADAP funds cannot be used for those who only have been diagnosed with HCV, but can be used to pay for treatment of HCV for those co-infected with HIV and denied treatment by Medicaid.

h. National Elimination Strategy

The National Academies of Sciences, Engineering, and Medicine released a National Elimination Strategy (NES) in 2017 to address viral hepatitis. Mr. Mayer was a member of the committee that developed the NES. Under the NES, the goal for all states is to reduce the incidence of HCV by 90 percent by 2030. If only those with fibrosis scores of F-3 and F-4 who have been infected for a long time (20 to 30 years), are starting to show symptoms, and are treated in these later stages, it will only reduce the number of liver deaths. This approach, however, will do nothing to 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 the reimbursement limitations under the Medicaid program and the Department of Corrections were removed, thereby providing treatment for all those infected, including those with fibrosis scores of F-1 and F-2, 280,000 new infections could be averted. Strategies recommended by the NES include expanding access to syringe exchange programs in combination with opioid treatment in accessible venues; having the CDC work with the state to identify venues for expanded HCV testing and HBV vaccinations with SSPs potentially providing these venues; and having public and private health plans remove restrictions on HCV treatment that are not medically indicated and instead treat all patients. The nation is very early in this epidemic in terms of curing it. There are about 3.5 million people chronically HCV-infected in the United States and only about 9 percent have been cured as of 2014.

i. Funding for SSPs

Under the Consolidated Appropriations Act of 2016, funds from the United States Department of Health and Human Services, including from SAMHSA, the Health Resources and Services Administration (HRSA), and the CDC, may be used to support SSPs, with the exception that these funds cannot be used to purchase needles or syringes. However, to be able to use these funds, the eligible government entity must submit a determination of need to the CDC to provide evidence that the jurisdiction is experiencing, or is at risk for significant increases in, hepatitis infection or an HIV outbreak due to injection drug use. DPH is currently preparing a determination of need to submit to the CDC for review. Other funding options for SSPs include CDC HIV prevention funds and HRSA Ryan White Part B supplemental funds which allow for the purchase of supplies and staff time related to syringe exchange programs, excluding needles or syringes. The Bureau of HIV, STD, and Hepatitis receives state general fund



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appropriations for HIV and STD programming including the ADAP and this funding could be prioritized, after using it for ADAP, for use in SSPs. The Bureau currently supports 10 agencies across the state that are providing HCV testing.

j. State Readiness in Addressing Hepatitis

A CDC report was released earlier this year gauging state readiness in addressing the hepatitis epidemic. Based on the five elements of laws assessed, Iowa's rating is "less comprehensive" which is 4th lowest on a five point scale.

k. Contextualizing the Data

Ms. Zeigenhorn noted that it can be difficult to contextualize all of the data and apply it to real Iowans to see how it is affecting them directly. Ms. Zeigenhorn told the story of Allison, whom she met about 11 months ago when Allison was pregnant with her son. Allison had back surgery years before, and after the surgery, she was prescribed morphine and eventually became dependent. Allison had a history of childhood abuse, adverse childhood experiences (ACEs), sexual assaults, and her brain was primed for addiction. Allison began crushing the pills and injecting them so her body would not go through daily withdrawals and still experience pain relief. In Iowa, a person can technically go to a pharmacy and buy syringes, but pharmacists have discretion to sell syringes without a prescription. So, in reality, a known injection drug user cannot just walk into a pharmacy in Waterloo and buy syringes. Since Allison could not buy syringes, she instead began to share needles with those in her community. She became pregnant and went to Iowa City for care, got off the opioids and other substances, had a remarkably healthy baby, and they are both healthy now. However, during her pregnancy it was determined that she has Hepatitis C from the needle sharing. Allison accepted that her Hepatitis C is a consequence of sharing needles, but what she finds unacceptable is the consequences to her baby and she wants to keep her baby safe and healthy at all costs. As a breast-feeding mom, she is, with some likelihood, transmitting the virus to her baby. Allison, who is eligible for the Medicaid program, is interested in receiving treatment. However, she was denied treatment because Medicaid requires that to be eligible for treatment for Hepatitis C, a person must have a cirrhosis score of F-3 or F-4. This means Allison would have to have liver failure, severe liver disease, or liver cancer and be in a stage where she required a liver transplant to be eligible. The drugs for Hepatitis C are expensive, about \$100,000 per treatment course, and Medicaid is struggling to pay for this for the 30,000 to 150,000 people in the state who need it. But for Allison, this denial of treatment is really a sentence to sickness for her and her child for the foreseeable future.

In order to prevent cases like Allison's, 36 other states offer syringe exchange programs. Of these, 19 had to modify their existing drug paraphernalia law, just as Iowa will need to do. In the past four years, there has been a sea change as states have adopted these programs. In those four years, 16 states with



Republican governors or legislatures passed bills to implement statewide exchanges and they did it because they were facing crises similar to Iowa's crisis.

I. Examples of State SSPs

(1) Wisconsin

Wisconsin has one of the oldest SSPs which started in 1994. The AIDS Resource Center of Wisconsin runs the program, operates in 10 different cities, and also supplies county health departments to try to reach people across the state. Wisconsin has had a reduction in viral transmissions. In 1995, there were 250 HIV infections among the community of people who inject drugs. In 2015, there were only two HIV infections in the same community, even though the state was going through the same opioid epidemic as all other states. SSPs also connect people to drug treatment. In Wisconsin from July 2016 to July 2017, about 47,000 people participated in the SSP statewide, and there were over 8,000 referrals to drug treatment. This reflects the national trend and findings from other states that people who use drugs are often marginalized and encounter numerous barriers when seeking drug treatment. SSPs act as a gateway to treatment by helping people connect to resources and navigate the complex application process to get into drug treatment. Participants in needle exchange programs are five times more likely to enter drug treatment programs than people who have never participated in a program.

(2) North Carolina

North Carolina has 22 syringe exchange locations serving 35 out of its 100 counties. The North Carolina Harm Reduction Coalition supplies these locations which include drug treatment centers, county public health departments, and community-based organizations. H972, the syringe exchange program bill, was enacted in July 2016, but prohibits the use of state funds to purchase syringes and other injection supplies. State funds can still be used for all other expenses, including personnel, health care costs, HIV and Hepatitis C testing, naloxone, wound care, treatment and social services referrals. However, organizations have to secure funding for syringes and injection supplies through other sources such as private grants. Local governments may also fund injection supplies. One reason North Carolina established a program was that the law enforcement community backed the program to keep officers and the public safe. One in three officers in their career will be stuck by a needle and run the risk of contracting HIV or Hepatitis C.

m. SSP Options for Iowa

There are many options for Iowa to administer an SSP. Some models include fixed site exchanges, home delivery or peer-based exchanges, mobile, street, or vehicle-based exchanges and integrated syringe exchanges.



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(1) Florida

In Florida, the bill legalizing syringe exchange was signed into law in March 2016. The program operates one syringe exchange site in Miami-Dade County. One of the reasons Florida enacted the law was because a study found that over a 12-month period at one Florida hospital, Medicaid was charged over \$18 million for injection drug user infections that could have been prevented by a syringe exchange program.

(2) Illinois

The Illinois program that has been in existence since the early 1990s uses a participation card and paraphernalia code system. The IHRC is often asked if they are trying to legalize drugs and all drug paraphernalia by starting an SSP, so states with these programs often use a card and a unique identifying number that identifies the person as a participant in a public health program and demonstrates that the person is taking steps to improve their health and the health of their community. This is an important step in moving on the path toward treatment and recovery.

n. Suggested Legislation for Iowa

With regard to drafting legislation to establish an SSP in Iowa and to address the drug paraphernalia limitation, Mr. Mayer suggested that, at a minimum, the legislation should amend the drug paraphernalia law as included in the materials presented to the committee, but should also authorize DPH to establish an SSP and to adopt rules to establish the parameters of the program. Ms. Ziegenhorn noted that most states have left the specifics of the SSP to the administering department or entity to develop by rule, and this is preferred because states that have been more prescriptive now have programs that are too limited and are experiencing difficulties in lowering their infection rates.

o. Other Services and Benefits of IHRC

The IHRC also connects people to wrap-around services such as risk reduction kits, syringe cleanup, HIV/HCV rapid testing, naloxone kits, linkages to health and social services, referrals to addiction treatment, fentanyl test strips, and enrollment in housing programs. The program is currently being developed in Des Moines, Cedar Rapids, and Iowa City. For injection drug users, accessing health care is often difficult. For example, IHRC staff recently administered an HCV test to an individual who has been an injection drug user for years. He tested positive. He had never had an HIV or HCV test, had no social record, and had been living outside for many years. Now, with the test and its results, the IHRC can connect him to health care and a continuum of social supports. The benefit of these services is not only connecting a person to HCV testing and treatment, but to other supports including housing. The IHRC believes this is a model that can be easily duplicated in other communities around the state, not necessarily as an individual, stand-alone organization, but as a key part of FQHCs and local public health



departments, which is the same as the successful model used in North Carolina. SSPs are a benefit to public safety and law enforcement. The IHRC has had many phone calls from nurses who report that construction workers and trash collectors are getting stuck with needles and asking what they should do.

p. Moving Forward

This is a complex issue and will require a comprehensive set of legislative reforms. While a number of strategies to tackle the crisis will require significant financial investment, syringe exchange requires no funding from the state and can result in significant cost reductions to the state Medicaid budget.

3. Committee Discussion

With regard to limitations on payment for treatment, Mr. Mayer clarified that there are no regulations prohibiting treatment to anyone. However, the Medicaid program and the Department of Corrections have prioritized treatment to those most ill due to limitations in funding. DPH has no dedicated funding to treat those infected with Hepatitis C. If a person is dually infected with both HIV and HCV, the department may use Ryan White Part B Funds for treatment. The dilemma is that in treating only the most ill, those recently infected are not being treated. Treatment is really most effective with younger people who need fewer weeks of treatment. The best way to address the limitation is for the Medicaid program and the Department of Corrections to negotiate lower costs for the Hepatitis C drug so more people can be treated within the limited funds available.

With regard to the effectiveness of the drug used to treat Hepatitis C, Mr. Mayer noted that the cure rate is almost 100 percent with very few failures. For people who have been infected for a long time, the treatment can cure Hepatitis C, but it cannot remove the risk of liver cancer. So the sooner a person is treated, the greater the opportunity to eliminate that risk. Members commented that it seemed that treatment priorities were backward when treatment is not provided until someone is very sick. Mr. Mayer mentioned that states with a higher number of Hepatitis C cases are also seeing increases in cases of perinatal transmission to infants. Perinatal transmission has a low probability, but as the number of cases of infected women with high viral loads increases, there is a higher probability of transmission.

With regard to law enforcement officers being covered by insurance for treatment following a work-related exposure, Mr. Mayer responded that whether or not they are covered depends on their health plan. He noted that the majority of insurance plans do cover Hepatitis C treatment. Ms. Zeigenhorn added that if a person is diagnosed with Hepatitis C in Iowa, they will most likely receive treatment at the University of Iowa Hospitals and Clinics (UIHC) from a specialist. About 60 percent of people who are referred to the liver clinic at UIHC are Medicaid-eligible, so the vast majority do not have private insurance. Mr. Mayer and Ms. Zeigenhorn also said that even though the cost of the drug regimen for Hepatitis C treatment is decreasing, treatment usually



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requires not just one drug but a cocktail of drugs, and there are also costs associated with clinic visits, physician visits, and testing, among other costs.

D. Department of Public Safety (DPS)

1. Overview

Mr. Paul Feddersen, 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.

2. Drug Enforcement Administration (DEA) Diversion Control Program

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. The DCP is designed to reduce the supply of dangerous controlled substance pharmaceuticals available for abuse by maintaining the integrity of the closed system of distribution for controlled substances. The fee fund consists of moneys collected as fees from the registrants who handle, dispense, or prescribe controlled substances including doctors, pharmacists, and others and is separate from the enforcement side funding that is approved at the federal level each year. The Iowa Division of Criminal Investigation (DCI) laboratory receives the majority of submissions of drugs seized by law enforcement in Iowa. Based on DCI laboratory statistics, during 2015, the DCI lab recorded a 67 percent increase in the number of submissions of heroin, fentanyl, and a combination of heroin and fentanyl. Today the DCI lab is receiving submissions of heroin and many drug analogs laced with fentanyl, or fentanyl only. Mr. Leighter clarified that he is usually only involved with a person seeking treatment if they are court-ordered to treatment. However, if he is approached about treatment, he will help to engage social services to find the person help. Since he is involved in diversion and the supply side, his main goal is to find the importer and the packaging store that brought the drugs into Iowa.

3. A Perspective from the Field

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.

In one case, a doctor in a rural community, serving a city of 3,500 and a county of 16,000, is in the 95th percentile, nationwide, for issuing opiates. This doctor is also issuing methadone to opioid addicts and is not licensed to do so. The investigation includes a team of representatives of the Medicaid fraud control unit, the United States Department of Health and Human Services, Office of the Inspector General, and state pharmacy and medical boards, and is far reaching. When Mr. Leighter does undercover work, the typical scenario is that a client fills a prescription and the prescriber is paid with taxpayer dollars and then the client sells to the undercover



officer for anywhere from 50 cents to \$1.50 on the milligram. This is all profit for the person selling and the tax dollars being wasted are substantial.

In another case, a doctor has a seemingly legitimate medical practice during the day and at night sells prescription opioids for cash at a bar. The doctor demands that his staff see 75 patients a day whether the doctor is present or not. The clinic has no other licensed professional, and the doctor travels to exotic locations one or two times per month and has his staff issue prescriptions while he is gone. The doctor also bills both private and public insurance for office visits while he is overseas.

In another case, an anesthesiologist, who was at the top of his class in medical school, has overdosed twice himself and has been in treatment. The doctor works in a pain clinic and issues prescriptions to addicts and is an addict himself, as is his wife.

There are cases where nurses and other professionals divert opioids from the practices by which they are employed. In one case, 37 people were potentially poisoned because a nurse, feeding her habit, was stealing Dilaudid from vials and replacing it with an unknown substance and putting it back into inventory. The paramedics and EMTs and others who then used these vials were unwittingly deploying the vials on patients. These vials did not provide any pain medication, but were also potentially poisoning patients with whatever substance was in the vials. In other cases, a police officer working in an evidence room, and firefighters and paramedics, all with access to opioids, were diverting and overdosing.

Recently in Council Bluffs, there were actually nine young people involved, but only six were reported in the news, who all overdosed in one evening on one batch of "pink," an analog of fentanyl, which is not even scheduled yet. The cook for this "pink" is a scientist shipping it in from Montreal, who adds a sugar to the mix giving it a unique signature. Some fentanyl analogs are so potent that six grains is enough to be lethal when absorbed through the skin.

The overdose deaths are hard to comprehend. A culture change should happen in law enforcement because these are not victimless crimes. One 10-year-old boy overdosed because he was told to cut a corner off of his grandma's fentanyl patch and put it in his energy drink. He only made it 10 steps to the couch where his grandfather found him deceased. There was a series of overdoses in Carter Lake from a fentanyl analog that was traced back to China. Law enforcement was able to identify the source and start the process to extradite the distributor from China.

In working narcotics exclusively since 1999, Mr. Leighter has learned there is a whole industry behind this, both illicit and legal, and it is costing a lot of money and a lot of lives. Anecdotally, the Omaha Fire Department uses Narcan as many as 5 to 10 times during a shift. Every time Narcan is used, it is billed, so those statistics are available through private and public insurance providers.

4. Recommendations

a. PMP



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The PMP is good, but could be improved. Nebraska just implemented its PMP on January 1, 2017, and Mr. Leighter described it as “a train wreck.” Missouri just approved a PMP so it is not in place yet. So in the southwest corner of Iowa, it is easy for someone to go to three pharmacies in three states in one day and obtain a lot of drugs because there is no interstate communication. Specifically for the PMP, Mr. Leighter suggested that the PMP include the Morphine Milligram Equivalent (MME) or Morphine Equivalent Dose (MED) of the drugs prescribed to a patient to ensure patient safety; include the use of Narcan by a patient; and allow vetted officers to have real-time access to the PMP.

Mr. Leighter suggested that at least for Schedule II narcotics, a prescriber should be required to use the PMP. Reviewing the PMP also helps to avoid prescribing a lethal cocktail to a patient. He noted that he has not been involved with any overdoses that have not involved polydrugs.

b. Law Enforcement

A cultural shift in law enforcement has to happen. There are criminal organizations that are specifically targeting pharmacies regionally and this is criminal conspiracy. However, since communication is not taking place, these crimes are being investigated as separate burglaries.

5. Committee Discussion

In response to whether food stamps have ever been involved as a source of payment in a drug buy, Mr. Leighter stated that he has never had food stamps involved.

Regarding oversight of licensees by the Board of Pharmacy, Mr. Leighter responded that the number of state investigators has been reduced from eight to six and the system is overloaded. In addition to needing more investigators, Mr. Leighter suggested that these investigators be given primary jurisdiction rather than only jurisdiction for enforcing Iowa Code chapter 155A (Pharmacy), and be able to carry guns. The agencies investigating licensees are only authorized to suspend licenses, but there are still criminal charges and a criminal process involved.

In response to a question about how law enforcement and harm reduction efforts can work together to develop legislation that the Governor can support, Mr. Feddersen stated that DPS is open to conversation about different topics. Regarding a Good Samaritan law, Mr. Feddersen stated that there was a bill in the past that they had some concerns with. He clarified that people do not go to prison for being arrested for using opioids unless they are also involved in extenuating circumstances and step over the line that constitutes criminal activity such as distribution, robbery, or another crime. The presenters were asked to respond to a hypothetical of two opioid drug users in which one person gives another money to buy opioids, the one person buys but both people use the drugs, the one who did not buy the drugs overdoses, and the other calls 911. The question is whether the person who called 911 is a “distributor” because he bought the drugs. Mr. Feddersen responded that this has happened many times and in those cases it is up to the prosecutor, and common sense plays a role in the prosecutor



making the decision whether the person is continuing criminal activity or is a proven drug trafficker. Mr. Leighter added that when a person is successful in their recovery and is able to function again, being held accountable was important to them. Co-chairperson Dawson offered that he had been involved in the case in Carter Lake in which the fentanyl was traced back to China. Two individuals overdosed in a house, but it was not until months later that law enforcement found multiple packets of fentanyl that one of the individuals had been selling in the community and there was a subsequent enforcement action that linked the two together. So it is important for law enforcement to have an effective Good Samaritan law and the General Assembly needs to find the right language to get through because if law enforcement disregards a low-level supplier, they may also lose the opportunity to track the distribution to its source.

E. Medical School Curricula

1. University of Iowa Carver College of Medicine

a. Overview

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. In 2001 when Dr. Buresh graduated from medical school, 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.

b. Horizons Curriculum

In 2013, the Carver College of Medicine redesigned its curriculum. The Horizons Curriculum covers the preclinical years through residency and fellowship, as well as community engagement, and stresses innovation, integration, and individualization. The curriculum involves three different perspectives: the mechanisms of health and disease; medicine and society; and clinical and professional skills. Relative to opioid use and abuse, the mechanisms of health and disease curriculum addresses the nervous system anatomy, cell biology, the pharmacology of addictive medications, and the pharmacotherapy to treat overdose and addiction. The medicine in society curriculum includes lectures on alcohol and drug use and addiction, specifically opioid addiction and diversion. The college is committed to updating the curriculum every year, so 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. Additionally, 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. In the clinical and professional skills curriculum, students interact with simulated patient experiences relating to acute pain, develop treatment plans, and then have case conferences



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on opioid use and interdisciplinary evaluation and treatment of pain and pain management.

As a way to integrate the preclinical years with the clinical years, the college uses exemplars or conditions that are repeatedly discussed at each level of study. Current exemplars include those related to substance abuse and chronic and acute pain. Several of the clinical clerkships have curricula that focus on pain and pain management and addiction. In the emergency medicine clinic, students write a paper on the ethical conundrum that runs throughout their training. Eighty percent of the writings address substance abuse or chronic pain. The curriculum allows for individualization such as work with the IHRC and the Examined Life Conference in which students can participate in creative writing. At the level of graduate medical education, the recent focus has been on acute and chronic pain treatment, and students have worked on developing screening tools for acute and chronic pain, performing literature reviews, and doing research. During this time, the students are involved in multidisciplinary teams, including pharmacists, pain psychologists, and social workers. These teams help with developing skills for referral to treatment and to other social services to address root causes. The college started a pain management task force this year that is looking at naloxone administration and collecting data about where the most opioids are being prescribed, dosages, how many days of prescriptions are being prescribed, and for which conditions opioids are being prescribed. The college of medicine actively collaborates with the colleges of public health, pharmacy, and dentistry, the University of Iowa Public Policy Center, and the IPRC. The college of dentistry has done groundbreaking work on acute pain control without using narcotics. The Iowa City VA Health Care System has a very effective system for tracking opioid prescriptions.

Outside of the institution, students are involved in community engagement efforts including the IHRC, Johnson and Linn County public health, local EMS, and law enforcement.

2. Des Moines University College of Osteopathic Medicine (DMU)

a. Overview

Dr. Bret Ripley, Interim Dean, College of Osteopathic Medicine and Chairperson of Family Medicine, DMU, noted that a large number of the prescriptions issued for pain are appropriate for people who have severe pain. Opioids are a huge epidemic, but doctors are responding and high levels of prescribing are leveling off. Heroin and illegally imported and distributed synthetic opioids are becoming more available. When Dr. Ripley started in medicine in 1995, there were patients denied pain medication because practitioners did not think their pain was real. When pain was declared the fifth vital sign, it was because things needed to change so that appropriate pain treatment was administered.



b. Curriculum

Students at DMU receive an interprofessional education so that clinicians and other professionals learn how to work together. As in all medical schools, in pharmacology, 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. In the clinic, students use the Diagnosis, Intractability, Risk and Efficacy (DIRE) Score as one tool to determine the appropriate means of pain management.

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 anti-inflammatory 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.

3. Committee Discussion

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.

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

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 long-term 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



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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.

F. Cedar Rapids Law Enforcement and the Eastern Iowa Heroin Initiative

1. Overview

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. Activities of the Eastern Iowa Heroin Initiative include community action organizational efforts, first responder training, investigative case development to target sources of supply for federal prosecution, town hall meetings, public awareness campaigns, and work with substance abuse and health care providers. Originally, Officer Fear was only responsible for covering four counties (Linn, Johnson, Black Hawk, and Dubuque) because 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. Drug poisoning deaths from illicit drugs have exploded and involve fentanyl, carfentanyl, a variety of analgesics of fentanyl, and fentanyl-laced narcotics. However, there are only 84 beds for inpatient treatment in the state and in Linn County alone in 2016 there were 26 opioid deaths and 874 hospital admissions for opioid dependency.

2. Perspective from the Field

From what Officer Fear 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. If the person stops taking the drugs, they are “dope sick” or going through withdrawal symptoms. So the person transitions to heroin which is readily available, cheap, and provides a more potent high. Back in the 1970s and 1980s, heroin was about 4 to 8 percent pure.



Today heroin off the street is 92 to 95 percent pure. Once a person becomes addicted to opioid painkillers, they are not using it to get high, they are using it to avoid the withdrawal symptoms and being sick. The heroin cycle is pretty simple to understand and there are really two outcomes: death or recovery. Going into treatment and recovering is a rarity. The odds of someone going to treatment and having a relapse is 95 percent. In 2015, Officer Fear started seeing a lot of fentanyl in eastern Iowa. At first it was heroin laced with fentanyl, followed by fentanyl being sold as heroin. He has also seen fentanyl patches on college campuses and it is 100 times stronger than morphine and 30 to 50 times stronger than heroin. Carfentanil is an analog of fentanyl and is 10,000 times more potent than morphine and 100 times more potent than fentanyl. The first case of carfentanil in Iowa was seen in Newton. If the ear of Lincoln on a penny is filled with carfentanil, it is enough to be fatal. Fentanyl and carfentanil are transdermal so can go right through the skin. In a comparison of the potency of various opioids, from the least to most potent is morphine, heroin, fentanyl, carfentanil, and something called great death. Great death is a mixture of fentanyl and carfentanil, and is currently on the east coast, but is making its way toward Iowa. Based on Iowa crime lab statistics, the lab is seeing more of a heroin mixture rather than straight heroin. There are many fentanyl analogs currently being used and found, and there are also counterfeit tablets of oxycodone, Xanax, and others that are being laced with fentanyl. Recently, there was a large seizure of about 400 pounds of marijuana in Tennessee and it was laced with fentanyl. In responding to the heroin epidemic, the goals are to prevent people from starting heroin by reducing prescription opioid painkiller abuse; to reduce heroin addiction by ensuring access to MAT; and to reverse heroin overdoses by expanding the use of naloxone. Two years ago the naloxone kit with two nasal spray canisters was \$35; today the cost is \$170. The IHRC is able to provide naloxone in the less expensive syringe and vial form, but the nasal spray canisters that are more user-friendly are increasing in price.

3. Recommendations

a. Prescriber Responsibility

Officer Fear asked the committee to help with increasing the use of the PMP by prescribers as it is vital in reducing the overprescribing of opioids. Officer Fear related the story of Jeremy Hrabak, a State of Iowa employee who worked as a correctional officer at the Oakdale prison. Jeremy injured his shoulder, had surgery, was prescribed hydrocodone, became addicted over a period of time and started to get prescribed painkillers as often as he could. He had very good insurance and was able to get multiple painkillers within a short period of time because the prescribers were not using the PMP. Jeremy committed suicide because he could not deal with his opioid addiction. Before he died, Jeremy lost his wife to divorce and incurred \$50,000 in debt. Jeremy's wife, Janet, spoke at the first town hall meeting Officer Fear held in Cedar Rapids and Officer Fear promised her he would do everything he could to fight for the use of the PMP. Officer Fear said that while the current PMP is not perfect, improvements are



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being made to include real-time data, to make it easily accessible, and to link it to EHRs.

With respect to the pushback from health professionals and others on mandating the PMP, Officer Fear responded that the majority of pharmacists use the PMP and that through education and by making improvements to the PMP, the objections will be minimized and more physicians will use it because it saves lives.

b. Good Samaritan Law

A Good Samaritan law is needed to protect the victims of overdose. The person who is with the victim should not be charged with simple misdemeanor possession of narcotics or paraphernalia if they dial 911 to save the victim. Last year the bill introduced in the Iowa General Assembly failed because of the wording of the bill. The bill should be very simple. If the person responsible for the death is there, they would not be given any kind of immunity. Several states bordering Iowa are using Good Samaritan laws with success.

c. Insurance Coverage of Addiction Recovery Medications

Officer Fear suggested that addiction recovery medications, including methadone, Suboxone, and Vivitrol, be included on the list of medications covered by insurance. Vivitrol is a very good drug that helps with curbing cravings and has an extended release of up to 28 days, but it is very expensive, costing up to \$1,400 per injection. In the state of Illinois, Vivitrol is covered by insurance and is available for a \$5 insurance copayment. These medications are beneficial, but they are not consistently covered by insurance. The cost and availability of naloxone also needs to be addressed. The syringe and vial form of naloxone, even though more inexpensive, is not as user-friendly as the nasal spray form, especially for those who are afraid of needles. There is an atomizer that can be attached to the needle, but the atomizer costs \$20. Officer Fear did note that with the increased prevalence of analogs of various drugs, one administration of naloxone might not be enough to stabilize a person.

d. Increased Treatment Resources Statewide for Addiction

In Dubuque, there are no methadone clinics. Mercy Turning Point is available, but they do not have the capacity needed. There should be access to treatment resources statewide, but currently there are really only three places to detox from opioid withdrawal.

e. Increased Penalties for Drug Dealers

Penalties for dealing fentanyl, carfentanil, and other such drugs should be increased as a disincentive to distribute them.

G. Wellmark Blue Cross and Blue Shield (Wellmark)

1. Overview

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.

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. There is a fine line between balancing access to care to ensure appropriate pain relief with overuse or misuse of opioids.

2. Activities

a. Policies

Ensuring that those in pain have access to medications is Wellmark's top priority. 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. In their guidelines for appropriate prescribing of opioids, Wellmark does distinguish between the prescribing of higher doses of opioids for those dying of cancer from the prescribing of opioids for the general population. Wellmark has also worked with the National Governors Association Road Map for the States recommendations, and is reviewing the national CVS policy that limits the use of immediate-release opioids to a seven-day supply at any given time when a person does not have a history of opioids use (is treatment naive) and the treatment is for an acute condition.

b. Drug Utilization

Wellmark has a 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 engages behavioral health staff to link consumers to appropriate treatment.

c. Coverage for Treatment — No Coverage for Vivitrol

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 buprenorphine when it makes sense as part of a treatment program. Both of these drugs are the gold standard in the treatment protocol and are effective drugs. Wellmark does not cover Vivitrol because an independent committee of practicing physicians and pharmacists from Iowa evaluated the drug evidence and found no evidence that it is better than the existing treatments. Mr. Hosford noted that the maker of Vivitrol has a \$4 million lobbying budget and has been successful in



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incorporating Vivitrol by name into 70 pieces of legislation across 15 states, despite the fact that no evidence exists to support that it is a better or safer alternative than lower-cost treatments. Mr. Hosford added that Wellmark reviews all drugs on at least an annual basis, that since Vivitrol is not a covered benefit it is not covered in any manner including through a plan deductible, and that if new evidence becomes available to support coverage of Vivitrol, Wellmark will reevaluate its policy.

3. Committee Discussion

Wellmark recognizes the opioid crisis and the profound effect it has on communities. Wellmark wants to ensure that evidence-based treatment guidelines are utilized and that quality substance abuse treatment programs are available and covered for members when they provide positive outcomes. In response to a 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.

H. Iowa Department of Public Health

1. Overview

Dr. Patricia Quinlisk, State Medical Director and Epidemiologist; Mr. Kevin Gabbert, ATR/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.

2. State Opioid Report Card

Mr. Gabbert reviewed how Iowa compares with other states on specific policies regarding the addressing of the opioid epidemic:

- a. **#1** The state has a PMP. Iowa has had a PMP since 2009.
- b. **#2** Prescribers are required to use the PMP. Iowa does not require prescribers to use the PMP. About 45 percent of prescribers are registered and fewer are actually utilizing it. Required use of the PMP is proven to result in success. Between 2012 and 2016 in Ohio, use of the PMP resulted in a reduction of 162 million or a 20.4 percent reduction in doses of opioids prescribed.
- c. **#3** There is a 24-hour upload to the PMP from pharmacies. Iowa allows one week for uploading information to the PMP. Utilizing a 24-hour upload by other states has proven to reduce doctor shopping. Ohio experienced a 78.2 percent decrease in the number of individuals who saw multiple prescribers to obtain controlled substances illicitly between 2012 and 2016. DPH was recently awarded a \$400,000 Federal Bureau of Justice Assistance Harold Rogers grant for the purpose of enhancing the PMP and is working with the Iowa Board of Pharmacy and the Governor's Office of Drug Control Policy to improve the PMP.



- d. **#4** The state utilizes prescription limits for opioids. Iowa does not do this. Ohio implemented an executive order limiting opioid prescriptions to seven days and anticipates a reduction of approximately 109 million doses dispensed as a result of this change. DPH met with the Department of Administrative Services (DAS) and Wellmark to discuss prescription limits. Wellmark indicated they would recommend to prescribers that a seven-day limit of opioids be considered but would not mandate the limit.
- e. **#5** The state has a syringe services program. Iowa does not operate an SSP currently because it is a violation of the drug paraphernalia law (Iowa Code section 124.414). SSPs have been shown to reduce the spread of infectious disease, assist in the referral process for individuals seeking treatment services, and provide an opportunity for individuals to receive support through peer interaction. DPH has worked with other entities such as the IHRC which is positioned to secure funding for the development of an SSP should the current drug paraphernalia law be amended to allow for an SSP.
- f. **#6** The state has a Good Samaritan law. Currently Iowa does not have a Good Samaritan law. Good Samaritan laws provide legal protections for low-level criminal offenses when an individual reaches out for medical assistance due to observing someone experiencing an overdose. These laws can have a positive impact on reducing overdose deaths by removing the fear of legal consequences. There has been some criticism in the past that these laws would allow people carte blanche immunity for the commission of crimes without being subject to consequences. However, Good Samaritan laws only provide immunity for low-level criminal offenses. One of the media campaigns going on in Ohio stated that 89 percent of those experiencing an overdose were found alone. The concern is that unless a person present with another individual who is possibly in possession of illicit substances or under the influence, knows there are legal protections in place, that person will not make the phone call to help the person overdosing. DPH does have funds available if a Good Samaritan law is enacted for a media campaign for outreach to explain how the law works.
- g. **#7 and #8** The state has expanded access to and has dedicated funding for naloxone. Iowa passed a law in 2016 to expand access to naloxone for first responders, EMS, and persons in a position to assist. There is still an issue of the high cost of a naloxone kit which ranges from \$125 to \$150. DPH is reviewing the limitations of their grant funding to determine whether these funds can be used to provide naloxone. In 2016, Dr. Patricia Quinlisk wrote a standing order, making naloxone available at participating pharmacies for individuals without a prescription. She also made her medical license number available to law enforcement organizations wanting to utilize the DAS Master Agreement allowing the purchase of Naloxone at a reduced rate of \$75 for state entities. DPH is currently reviewing an amendment to the DAS Master Agreement to determine if others, such as nonprofits, might also be able to receive the reduced rate.



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- h. **#9** The state has Medicaid coverage for all forms of MAT. Federal sources and some of Iowa's OTPs reported that methadone (as a form of MAT) was not a Medicaid-covered service in Iowa. The exception, UCS Healthcare, reported they were receiving Medicaid funding for methadone, but it was unclear if this was due to UCS having a pharmacy on-site and billing the service as a pharmacy benefit. DPH recently obtained documentation of service coverage and eligibility criteria from DHS and the Iowa Medicaid Enterprise (IME) clarifying that OTPs without a pharmacy are eligible for reimbursement through Medicaid.
- i. **#10** The state requires training on CDC guidelines for managing chronic pain. Although Iowa does require continuing education for prescribers regarding the management of chronic pain, the CDC guidelines released in 2016 have quickly become the standard for prescribing guidelines. The guidelines have benefits and shortcomings, and DPH is reviewing guidance from many sources including from SAMSHA, the Surgeon General of the United States, and the FDA. DPH has been supporting the use of CDC guidelines through various outreach efforts such as media interviews, community presentations, and discussions.

3. Opioid-Related Grant Efforts

DPH is currently administering a number of grants to support its efforts in addressing the opioid epidemic.

a. Substance Abuse Block Grant

In addition to federal funds, DPH receives a substance abuse block grant through a state appropriation. These funds are used to subsidize substance use disorder treatment and MAT.

b. Access to Recovery (ATR) Grant

This is a three-year SAMHSA discretionary grant that focuses on addressing barriers to recovery support services such as transportation, child care, and other services not supported through normal funding sources. DPH is also using ATR to test naloxone and buprenorphine in MAT.

c. MAT-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant

This is a three-year SAMHSA grant that was received in 2015. The grant directs \$1 million per year to DPH to assist the state in broadening treatment services and infrastructure for evidence-based MAT and educating and advocating on MAT-related issues. With the grant, DPH identified the 10 highest need counties in the state, based on opioid prevalence data, and then released an RFP to select four substance use treatment providers in the highest need counties in Iowa. The four awards were made to United Community Services, Inc. in Des Moines, an OTP; Jackson Recovery in Sioux City, an abstinence-based program; the Area Substance Abuse Council (ASAC) in Cedar Rapids, an abstinence-based program; and Mercy Turning Point Treatment Center in Dubuque, a hospital-based program.



To date, at the end of year two, 257 clients had been admitted to treatment. The original goal was 220 clients. Jackson Recovery and ASAC are traditionally abstinence-based providers, but through the grant have demonstrated to abstinence-based providers that MAT does not, as was confusedly thought, allow merely the exchange of one drug for another. The median length of stay for clients was 161 days (which compares to 55 days when MAT is not the treatment model), and the longer a client is engaged in evidence-based treatment, the better the possibility of recovery. The longer engagement speaks to the benefit of the medication, the fact that addiction is about changes in brain chemistry, and that abstinence-based treatment does not address brain chemistry. If a person remains in treatment longer, they are completing treatment with maximum benefits. If a person leaves at 55 days, it suggests that the person wants to leave prematurely. Another goal of the grant is to provide for education and advocacy on MAT issues such as the naloxone standing order. DPH has developed materials on various aspects of MAT, and is involved in presentations, media requests, and other activities. Because there are multiple pathways to recovery and no one-size-fits-all approach, DPH has also tried to develop recovery community organizations as advocates to lead the recovery efforts since there are barriers to DPH doing this. DPH has also helped to educate the professional licensing boards and has helped them to reach out to their members through the creation of E-blasts and brochures. DPH also publishes an opioid update newsletter on a biweekly basis.

d. Residential Treatment for Pregnant and Postpartum Women (PPW) Grant and the State Youth Treatment Implementation (SYT-I) Grant.

(1) The PPW Grant

The purpose of the program developed through this three-year SAMHSA grant is to expand the availability of comprehensive, residential substance abuse treatment, prevention, and recovery support services for pregnant and postpartum women and their minor children, including services for non-residential family members of both the women and children. The Iowa PPW program is implemented at four established residential treatment programs in Cedar Rapids (ASAC), Council Bluffs (Heartland), Des Moines (House of Mercy), and Sioux City (Jackson Recovery, Women and Children's Center). These programs do provide MAT services.

(2) The SYT-I Grant

This three-year SAMHSA grant is being used by DPH to expand and enhance evidence-based treatment and recovery support services for substance use disorders and co-occurring disorders among adolescents (ages 12 to 17) and transitional aged youth (ages 18 to 25) and their families. Outcomes will be achieved by assuring statewide access to evidence-based treatment and recovery support services through establishing an enduring infrastructure capable of serving more adolescents, transitional aged youth and their



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families. DPH is utilizing four substance abuse treatment providers to administer the program and these providers will continue to implement effective treatment, interventions, and treatment standards.

e. Strategic Prevention Framework for Prescription Drugs (SPF-Rx) Grant.

The goal of this five-year SAMHSA grant awarded to DPH is to target the priority issue of prescription drug misuse. The program is designed to raise awareness about the dangers of sharing medications, and to work with the pharmaceutical and medical communities on the risks of overprescribing to young adults, and to raise community awareness and bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and their patients. The grant is also used to promote the use of the PMP.

f. State Targeted Response (STR) Grant

This grant was provided through the 2016 federal 21st Century Cures Act, and amounts were awarded to all states through a formula, based on prevalence data. DPH received the SAMHSA STR grant in May 2017. The two-year grant directs \$2.7 million per year to assist the state in accomplishing the goals of: building an enhanced, statewide infrastructure to address opioid misuse in Iowa; increasing awareness of opioid risks through statewide prevention efforts; and increasing the use of MAT and other evidence-based practices through the regional substance abuse prevention and treatment provider network in 20 of the service areas. The plan is to develop opioid-informed communities throughout the state. Funds will be distributed through the service areas to the substance abuse treatment center in each area. The recipient organization is required to perform a community-wide needs assessment and, based upon the needs of the community as identified in the assessment, develop a comprehensive strategic plan with the assistance of community partners to address the community's needs. The hope is that within two years, MAT will be offered either directly or through telehealth or other providers in each of the areas.

g. Prevention of Opioid Misuse in Women Grant

The goal of this U.S. Department of Health and Human Services Office on Women's Health grant is to address the primary and secondary prevention of prescription and illegal opioid misuse by women across their lifespans. In Iowa, DPH is using SBIRT in nonmedical settings to reach this goal.

h. Bureau of Justice Assistance Harold Rogers Grant

This grant of \$200,000 in each of the next two years was recently awarded to DPH and will be used to enhance the PMP. Iowa's project is a partnership between the DPH Bureau of Substance Abuse, the Iowa Board of Pharmacy, and the Governor's Office of Drug Control Policy. The goals of the project include increasing prescriber registration, increasing access and admission to treatment and recovery support, and implementing multi-system planning and program development.



4. Why the Focus on Opioids in Iowa

Iowa is a very low opioid overdose prevalence state, but the rate of increase in overdoses is high. Between 2005 and 2016, the state went from 28 to 86 opioid overdose deaths (deaths in which the Medical Examiner (ME) report identified that opioids were the direct cause of the death); went from 59 to 180 opioid-related deaths (deaths in which opioids may not have been the direct cause of death, but were present or involved); and went from 608 to 2,274 admissions to substance use disorder treatment. Prevention is very effective and, with the biggest concern being the rate of the increase in overdose deaths, DPH wants to be proactive rather than reactive.

As to reaching a plateau in prescribing as reported by other presenters, while the state as a whole might be considered to have reached a plateau in the prescribing of opioids, a 2017 CDC report demonstrates that approximately one-third of the counties in Iowa still show an increase in opioid prescribing.

5. Possible Next Steps

Mr. Gabbert listed a number of possible next steps for the state.

- a. Requiring the use of the PMP by prescribers.
- b. Requiring the uploading of pharmacy data within 24 hours, instead of weekly, to the PMP.
- c. Implementing a seven-day limit on opioid prescriptions.
- d. Amending the drug paraphernalia law to allow for, and authorizing DPH to develop, a SSP.
- e. Establishing a Good Samaritan law.
- f. Allocating dedicated funds for naloxone to replace the grant funding that will eventually be depleted.
- g. Requiring training on CDC guidelines for all prescribers.
- h. Collaborating on data collection. There is a concern with the lack of data collected and its availability. When there were overdoses in Council Bluffs recently, there was a total of nine, but only six were reported in the news. DPH found out about the overdoses through the media. A variety of sources should be reporting data including hospitals, EMS, law enforcement, treatment centers, and others. DPH will defer to the Board of Pharmacy regarding data collection and sharing being a function of the PMP, but something needs to be done to have better, real-time data so that everyone can respond more quickly and plan accordingly.

6. 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



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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 to help. 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.

I. Public Comment

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 said she also belongs to a club that nobody else wants to belong to as her son,



Kelly Peter, died because of the opioid epidemic. She noted that while four out of five people who become addicted to opioids start with a prescription from their physician, her son did not. Her son and his friends decided to take the leftover opioids from their parents' medicine cabinets, including hers, and that is how it started. The cycle continued for seven years and he desperately wanted help. Her son went through treatment voluntarily two times and one time because he was committed. His longest treatment cycle was 28 days. They had great insurance coverage, but he died on August 29, 2015. At that point, the epidemic in Iowa was just getting started, she had no help, and there was no MAT, which might have saved her son. While insurance companies say MAT is a covered service, there is a prior authorization process that has to be completed before it is covered. If a person fails with this disease, the only option is death. Currently, Dubuque is facing a big problem. Ms. Peter stated that there are not enough treatment beds available. She spoke about one young woman who overdosed, was admitted to the hospital, and ended up in the intensive care unit. The young woman was committed by the court for treatment, but there were no beds available so the judge changed the order and released her. MAT is an amazing option for Dubuque, but availability is not adequate. Dubuque does have a methadone clinic, but insurance does not cover it, so a person must pay in cash. She talked about a couple who went to high school with her and are both addicted to opioids. The husband worked for NASA, but was injured, became addicted, and moved back to Dubuque after they had lost everything they owned. The couple pays \$800/month for methadone. It is cheaper for them to buy heroin and use again. Ms. Peter suggested that changes need to take place including requiring physicians to check the PMP. She shared that as a nurse she did the prior authorizations and checked the PMP for the physicians in the practice in which she was employed. She stated that checking the PMP is very basic and that if a physician finds checking the PMP difficult, she would not want that physician as her doctor. She said that it was insane not to require physicians to use the PMP, and asked that it be required in memory of her son because all it can do is save lives.

J. 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. 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.



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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.



IV. 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):**
 - a. Overview of State Policy Actions About the Opioid Epidemic (NCSL, October 16, 2017)
 - b. Prescribing Policies: States Confront Opioid Overdose Epidemic (NCSL, August 2017)
 - c. The Opioid Epidemic and Federal Efforts to Address It: Frequently Asked Questions (Congressional Research Service, October 18, 2017)
 - d. Opioid and Health Indicators Iowa (amfAR 2017)
2. **The University of Iowa Injury Prevention Research Center (IPRC):**
 - a. Policy and Program Recommendations to Reduce Opioid Overdose and Deaths in Iowa (IPRC October 16, 2017)
 - b. 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:**
 - a. Iowa Board of Nursing Summary of Initiatives (October 16, 2017)
 - b. Iowa Nurse Assistance Program brochure
 - c. Opioid Toolkit (National Council of State Boards of Nursing)
5. **Mercy Turning Point Treatment Center:**
 - a. Reducing Opioid Harm: Promoting People-Centered Care (Trinity Health)
 - b. 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:**
 - a. Opioids and Heroin (Erin Foster, Advanced Prevention Specialist)
 - b. Linn County Coordinated Opioid Response Chart
8. **Prelude Behavioral Services:**

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9. **Anthem Insurance Companies, Inc.:**
Strategies for Prevention and Treatment
10. **UnitedHealthcare:**
 - a. Medicaid and the Opioid Epidemic: Collaboration, Partnership, and Innovation (October 2017)
 - b. 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:**
 - a. Proposed Drug Paraphernalia Bill language to protect law enforcement and prevent disease, syringe exchange programs materials, and syringe exchange program studies bibliography
 - b. IHRC Supplemental Materials links
 - c. Background Literature on Syringe Services Programs, Supplement to Presentation (Sarah Ziegenhorn and Jonathan Birdsall, October 17, 2017)
 - d. 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:**
 - a. DMU Presentation and Diagnosis, Intractability, Risk, and Efficacy (DIRE) score survey tool (Dr. Bret Ripley, Des Moines University)
 - b. First, Do No Harm. Marshaling Clinician Leadership to Counter the Opioid Epidemic (National Academy of Medicine 2017)



19. The Eastern Iowa Heroin Initiative:

- a. Opioid Pain Killers and the Heroin Epidemic (The Eastern Iowa Heroin Initiative, Officer Al Fear)
- b. Online Drug Profile for Jeremy Hrabak

20. Wellmark:

- a. 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)
- b. News Release: Wellmark Data Reinforces Gap in Treatment for Opioid Addiction (July 19, 2017)

21. Iowa Department of Public Health:

- a. Addressing Opioid Use in Iowa: How Do We Measure Up?
- b. Opioid Use in Iowa: An Update
- c. 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