Illinois State Medical Society

Recommendations for Deterring Improper Use of Opioids

A report to the

Illinois House Task Force on the Heroin Crisis

and the

Illinois General Assembly

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I. Overview

The prescription of opioids by a physician begins with the obligation to respond to the medical needs of a patient. Prescription opioids can be an important tool for physicians who are tasked with treating complaints of severe suffering that can result from any number of ailments. Patients may suffer pain as a result of invasive medical procedures, which cause severe, temporary discomfort, but offer a chance for an improved quality of life. Prescription opioids are also used to treat pain at the end of life, providing relief to suffering from chronic illnesses such as end-stage emphysema and heart failure.[1]

The physician members of the Illinois State Medical Society (ISMS) recognize that the ethical obligations that arise in treating patients with pain do not stand alone. The misuse of prescription opioids may quickly turn the marvels of advancements in medicine and pharmacology into the nightmare of addiction, which may also cause patients to seek out illegal drugs, like heroin. In its policy paper on prescription drug abuse, the American College of Physicians emphasized that the "challenge for physicians and public policymakers is how to deter prescription drug abuse while maintaining patient access to appropriate treatment."[2] ISMS policy also recognizes the balance between the treatment of pain and the regulation of prescription opioids. Member physicians of ISMS support the "efficacious use of prescription medication in patients with severe, intractable pain in order to eliminate or reduce pain to tolerable levels." [3] ISMS also encourages physicians to "do all in their power to discourage the use of illegal drugs" in their communities and to join forces to "refuse to assist anyone in obtaining drugs for non-medical use."[4]

Illinois lawmakers, in concert with federal law, have provided a foundation of balanced regulation that has deterred the proliferation of "pill mills" that have plagued other states.[5] Per capita utilization rates in Illinois for Schedule II drugs are lower than a majority of other states.[6] Lawmakers in Illinois have also taken a proactive approach to combat prescription drug abuse with the implementation of the Illinois Prescription Monitoring Program (PMP). Started in April 2000, the PMP is a database that allows prescribers to view a patient's prescription drug history, as

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[1] Jane C. Ballantyne, *Managing Pain with and without Opioids in the Primary Care Setting, CDC's Primary Care and Public Health Initiative*, Oct. 24, 2012, http://supportprop.org/news/SupportPROP_ManagingPain_508.pdf.

[2] Neil Kirschner et al, *Prescription Drug Abuse: A Policy Position Paper from the American College of Physicians*, Annals of Internal Medicine, http://annals.org/article.aspx?articleid=1788221.

[3] Illinois State Medical Society Policy, HOD 1997; Last BOT Review 2013.

[4] Illinois State Medical Society Policy, HOD 1992; Last BOT Review 2006.

[5] See Centers for Disease Control and Prevention, *Opioid Painkiller Prescribing Infographic*, http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html#map. Eight states have enacted legislation to regulate "pain management clinics." See Office for State, Tribal, Local and Territorial Support Centers for Disease Control and Prevention, *Menu of Pain Management Clinic Regulation*, 1, http://www.cdc.gov/phlp/docs/menu-pmcr.pdf.

[6] IMS Health Inc., *Oxycodone Utilization by State, A State Comparison: Annual Prescriptions per Capita 2013 Oxycodone (All Forms)*, 2014.

reported by dispensers in Illinois and 25 other states.[7] As a unit within the Illinois Department of Human Services, the Illinois PMP has been able to reduce the number of individuals who "doctor shop" by 66% since 2008.[8]

Illinois has not been immune from the rise in heroin-related deaths that has occurred across the United States. The House Task Force on the Heroin Crisis was swiftly convened in the wake of this significant rise of heroin-related fatalities and first-time usage that has affected all parts of Illinois. Since then, the Task Force has launched a coordinated effort to examine ways to address this crisis, in part by holding hearings to seek input from law enforcement officials, public health organizations, and the families of the victims of heroin abuse. During these hearings, the Task Force has heard testimony on how prescription opioids have been identified as one "gateway" to heroin use.

ISMS concurs with public health experts that prescription opioids "are powerful drugs and should be used for serious pain."[9] This policy paper is offered to the House Task Force on the Heroin Crisis as a summary of ongoing ISMS efforts to ensure that prescription opioids are used by Illinois patients for beneficial medical purposes, as well as outlining the issues and complications faced by prescribers who must treat pain. This paper contains several recommendations for policy changes to avoid improper use of opioids. By examining the experiences of other states and the successful programs here in Illinois, legislative changes can be implemented to address the goals of the Task Force "without negatively affecting clinical decision-making and legitimate treatment" of pain.[10]

The following is a summary of the policy initiatives outlined in Part VI of this document:

Education Efforts for Prescribers and Patients

- The ever-advancing science of medicine requires that physicians and all prescribers have access to the most up-to-date clinical guidelines for the treatment of pain, which have evolved since the initial introduction of opioids like hydrocodone into the U.S. drug market. ISMS has already embarked upon an aggressive campaign to educate its member physicians on the most up-to-date treatment guidelines, presented through accredited continuing medical education programs.
- ISMS encourages other medical advocacy groups to make similar efforts, and to also join ISMS in monitoring the body of medical study to provide relevant, up-to-date, and scientifically sound information to medical professionals who prescribe.
- ISMS policy supports and encourages the education of physicians regarding current evidence-based therapeutic use of cannabinoids. A recent study indicates that prescription overdose deaths are lower in states that have authorized medical cannabis.

[7] HJR 97, adopted both houses May 30, 2014.
[8] Office of Management and Budget, *State of Illinois - State Budget Fiscal Year 2015*, at 123, http://www2.illinois.gov/gov/budget/Documents/Budget%20Book/FY%202015%20Budget%20Book/FY%202015%20Illinois%20Operating%20Budget%20Book.pdf.
[9] Jane C. Ballantyne, *Managing Pain with and without Opioids in the Primary Care Setting, CDC's Primary Care and Public Health Initiative*, Oct. 24, 2012, http://supportprop.org/news/SupportPROP_ManagingPain_508.pdf.
[10] See National Conference of Insurance Legislators, *Best Practices to Address Opioid Abuse, Misuse & Diversion*, Nov. 24, 2013, at 2, http://www.ncoil.org/HomePage/2013/2007964d.pdf.

Improvements to the Illinois PMP

Prescription Monitoring Programs (PMPs) are data clearinghouses containing information about a patient's prescription history. ISMS recommends the following changes to improve the usefulness and effectiveness of the Illinois PMP:

- Require pharmacies to enter prescription data within 24 hours of dispensing, so the PMP is an accurate and effective clinical tool for prescribers.
- Allow prescribers to designate qualified employees to view PMP information.
- Expand participation in the PMP by automatically enrolling prescribers in the PMP when the prescriber obtains or renews their controlled substance license.
- Increase efforts to utilize federal funding to integrate PMP data into electronic health records and expand the only emergency room pilot program in Illinois to other hospitals and physician practices.
- Establish a funding mechanism for the Illinois PMP to finance improvements to its electronic infrastructure.
- Require unsolicited reports to be sent to prescribers when a person has been identified as having three or more unique prescribers or four or more unique pharmacies within the course of a continuous 30-day period. Current law only requires such reports to be generated when there are six or more unique prescribers or six or more unique pharmacies.
- Improve the current PMP website to include information for prescribers on opioids, including links to accredited continuing medical education, public health information, and treatment guidelines to ensure that prescribers receive the most relevant and current information on the prescription of opioids.
- Formalize the appointment and qualifications of the Illinois PMP Advisory Committee, which currently does not have a statutorily defined number of members or representation of all prescribers.
- Expand the Illinois PMP Advisory Committee to include a peer review subcommittee of prescribers to provide a more detailed review of PMP information to send out specific clinical information to prescribers and dispensers.
- Require the PMP to periodically send out information to enrollees about prescribing and opportunities for accredited continuing education opportunities.
- Ensure the confidentiality of information stored on the Illinois PMP.

Urge Creation of a Missouri PMP

- Missouri is the only state without a PMP. The Illinois PMP will be an incomplete resource for prescribers, especially those in the Metro East area, without prescription data from Missouri.
- Without including PMP data from Missouri, it is possible that Illinois patients can see multiple prescribers across the river and illegally obtained opioids from Missouri may come into Illinois for sale or distribution.

Increasing Availability of Naloxone

Naloxone is a prescription drug that is an opiate antagonist, meaning it can reverse the effects of an opioid overdose. While several local jurisdictions in Illinois have made initial efforts to distribute naloxone to first responders and Illinois law now provides some immunity to those

who administer and prescribe naloxone, the following changes should be implemented in Illinois:

- Coordinate efforts to obtain naloxone and train first responders to administer this life-saving drug in order to maximize the buying power of federal and other funding dollars.
- Improve current immunity provisions or "Good Samaritan" laws for friends, family, and first responders who administer naloxone and also the medical professionals who prescribe and dispense naloxone.
- Consider efforts to expand the availability of naloxone to friends and family members through prescriptions, or utilize standing orders to make naloxone available in pharmacies.

Coordinate Proper Disposal of Prescription Drugs to Prevent Diversion

- Recent federal rules have greatly expanded options for drug disposal, which will ultimately help prevent diversion of these drugs for misuse. Many of those who have obtained opioids without a prescription have acquired them from a family member or friend. Disposal options may decrease the opportunity for diversion.
- Illinois needs to coordinate an existing grant program that reimburses law enforcement for drug disposal and capitalize on federal drug take-back events.
- Public education campaigns on drug disposal must connect the dangers of prescription drugs in the home with the potential for misuse or diversion.

Insurance Coverage for Multidisciplinary Pain Programs and Residential Treatment and Coverage Parity for Substance Abuse Treatment

- Multidisciplinary pain programs address chronic pain by engaging a team of physicians from several different medical specialties, such as neurology and anesthesiology, in concert with allied health professionals, such as dieticians, occupational therapists, psychologists, and physical therapists. These programs have been shown to be effective in treating chronic pain without relying on pharmaceutical interventions. Illinois must ensure there is adequate coverage for evidence-based multidisciplinary pain programs to promote options for pain treatment beyond opioids.
- For those who already suffer from substance abuse issues, coverage for appropriate health benefits, such as psychiatric and pharmacologic care, is essential. Illinois must ensure patients have access to residential treatment and other inpatient treatment options without restrictive prior authorization requirements that prevent them from accessing necessary care. Illinois should continue to guarantee that there is coverage parity for substance abuse treatment to ensure that addiction is treated equally with other medical conditions.

Opposition to Policies that Will Interfere with the Doctor-Patient Relationship

While ISMS has developed a comprehensive legislative approach to opioid abuse in Illinois, there are several policy changes that we oppose on the basis that they interfere with the practice of medicine and the provision of patient care. ISMS opposes the following legislative changes:

- Mandated continuing education requirements.
- Requirements directing prescribers to check the PMP prior to issuing a prescription.
- Mandates for continuous monitoring of those patients who have been prescribed opioids.

- Limitations on the prescribing of opioids, such as limiting the number of pills or the length or duration of a prescription, or requiring return visits for refills.
- Required screening of patients prior to receiving a prescription opioid, such as drug screenings or behavioral screenings.
- Specific regulation of pain management clinics or of any practice that is primarily devoted to treatment of pain.

II. Education and Training of Physicians to Prescribe

A. Medical School

The education and training of prescribers are essential to instituting safe and effective opioid therapy. For physicians, this education begins in medical school, where pharmacology, including the treatment of pain, is an integrated component of medical education.[11] Accredited medical schools are required to include pharmacologic study as part of their overall course of study.[12] This instruction serves as the foundation for the completion of the United States Medical Licensing Exam (USMLE), which is a three-step test that must be completed in order to become a licensed physician.[13] During Step One, students are tested on general principles and major organ systems, including the central nervous system and the use of drugs for the treatment of nervous system disorders, such as anesthetics, analgesics, as well as substance abuse treatment.[14] Step Two advances into applying medical knowledge to actual patient care, testing the understanding of the mechanisms of disease, establishing a diagnosis, and the ability to apply the principles of management for patients with chronic and acute conditions.[15] Disorders tested in Step Two include many different types of pain, such as neck pain, myofascial pain, low back pain, and end-of-life pain management.[16] Finally, Step Three, a two-day, 16-hour exam, further tests a medical school graduate on their diagnosis skills, with testing based on examples from patients who have "previously diagnosed, frequently occurring chronic illnesses and behavioral/emotional problems."[17]

B. Continuing Medical Education

After medical residency, during which a physician is able to learn under the supervision of senior physicians, and fellowships in specific medical fields, continuing medical education (CME) for physicians is critical because of changes and advancements in medicine. Many of the procedures and technologies used daily by physicians were not developed, approved, or in wide use when those physicians were in medical school.

One example relevant to treatment of pain is the transversus adominis plane (TAP) block, a procedure which involves inserting anesthesia into layers of the abdominal muscle following an

[11] American Medical Association, *Issue Brief: Pharmacology Education of Physicians*, 2011.
[12] Id.
[13] United States Medical Licensing Exam, http://www.usmle.org/.
[14] United States Medical Licensing Exam, *Step One Content Outlines*, http://www.usmle.org/step-1/.
[15] United States Medical Licensing Exam, *Step Two Content Description*, ht http://www.usmle.org/step-2-ck/ .
[16] United States Medical Licensing Exam, *Step Two Content Outlines*, http://www.usmle.org/step-2-ck/.
[17] United States Medical Licensing Exam, *Step Three Content Description*, http://www.usmle.org/step-3/.

abdominal surgery in order to counteract pain after an operation.[18] While this procedure was initially described in 1993, it was only documented in medical journals starting in 2001.[19] More recent studies, which examine the use of the TAP block for different abdominal surgeries, such as C-sections and hernia repair, have demonstrated that the TAP block "reduces the requirement of postoperative opioid use" and "provides more effective pain relief."[20] Even an anesthesiologist who might have been trained to perform this procedure during their residency would have to receive further training on more recent TAP block innovations, such as using ultrasound to ensure that the anesthesia is injected in the correct abdominal muscle layer.[21]

In Illinois, physicians must complete 150 CME hours for each three-year licensure period.[22] The specific content or subject area of those CME hours has never been specified by Illinois law. This is an important recognition by Illinois lawmakers of the complexity of medical care, the fast-paced evolution of science and technology, and the diversity of physician practice areas. While a busy emergency room physician may prescribe medication to a number of patients in a 12-hour shift, a pathologist diagnosing colon cancer from a tiny sample of polyp may never interact with anyone beside his or her own staff. Thus, mandated CME involving prescriptions would serve no purpose for a pathologist who never prescribes to a patient.

But even CME mandates that might be related to a physician's daily practice are a dangerous precedent for the future of medicine in Illinois. Legislating CME content may lead to an onslaught of specific topical mandates which may replace the specialized training provided by accredited institutions and medical specialty licensing boards. After passing a written examination to be board-certified in one of the 24 different specialty boards organized under the American Board of Medical Specialties (ABMS), physicians must maintain their certification by participating in a professional development program called the ABMS program for Maintenance of Certification (MOC).[23] The MOC program for Emergency Medicine, for example, requires physicians to pass four Lifelong Learning and Self-Assessment (LLSA) tests in years 1-5 of their certification and four LLSA tests in years 6-10 of their certification.[24] The MOC program

[18] Michael T. Wiisanen, *Transversus Abdominis Plane Block*, Medscape, Nov. 1, 2013, http://emedicine.medscape.com/article/2000944-overview#aw2aab6b2b1aa.
[19] Muhammed Rafay Sameem Siddiqui et al, *A Meta-analysis of the Clinical Effectiveness of Transversus Abdominis Plane Block*, J. OF CLINICAL ANESTHESIA, Feb. 2011;23(1):7-14, 12.
[20] Id. at 13.
[21] Callesen T. Aveline et al, *Comparison Between Ultrasound-guided Transversus Abdomins Plan and Conventional Ilioinguinal/Iliohypogastric Nerve Block for Day-case Open Inguinal Hernia Repair*, BRITISH J. OF ANAESTHESIA, 106(3):380-6(2011), http://bja.oxfordjournals.org/content/106/3/380.long.
[22] See 225 ILCS 60/20. Other prescribers must also complete continuing education hours to maintain their licensure in Illinois. See 225 ILCS 25/16.1 (Dentists must complete 48 hours per three year licensure period); 68 Ill. Adm. Code 1320.80(a)(1)(Optometrists must complete 30 hours per two year licensure period); 68 Ill. Adm. Code 1360.70(a)(1) (Podiatrists must complete 100 hours per two year licensure period); 225 ILCS 65/65-60 (Advanced Practice Nurses must complete 50 hours every two year licensure period).
[23] American Board of Medical Specialties, *Steps Toward Initial Certification and MOC,* http://www.abms.org/board-certification/steps-toward-initial-certification-and-moc/.
[24] American Board of Emergency Medicine, *Meeting MOC Requirements*, https://www.abem.org/public/general-information/who-is-abem-certified-/meeting-moc-requirements.

culminates in an examination that must be completed by a physician every 10 years to maintain their board certification in that specific field.[25]

Mandates also may become redundant, turning into a "pro forma" requirement rather than being useful, professional development. One example of this phenomenon occurred in Rhode Island, where mandated CME every two years for blood borne pathogens enacted following the AIDS epidemic became "repetitive" and "irrelevant" to some specialties.[26] This mandate eventually had to be broadened to include other options for physicians, including bioterrorism, medical ethics, and palliative care.[27] Medical professionals who study CME have noted that it is "unclear how much CME is the 'right amount' to change behavior."[28] In the meantime, organizations have focused their efforts on making CME more effective in terms of encouraging active participation and self-assessment of CME needs by physicians.[29]

C. Clinical Practice Guidelines

Through CME, board certification, and other means of self-study, physicians are able to keep up-to-date with clinical practice guidelines, which set forth the course and manner of medical treatment. These clinical practice guidelines, including opioid therapy, evolve and change with the implementation of further research and study. When transformed into legislative mandates, however, these guidelines that ensure effective, consistent, and appropriate treatment become "inflexible, static."[30]

The field of pain management also provides examples on the danger of codifying practice guidelines into legislation. Medical studies on the use of prescription opioids have evolved from a time when physicians were criticized for "under treating" pain to the development of prescription opioids like hydrocodone and oxycodone, and studies that proclaimed the opioids' ability to treat non-cancer pain.[31] In the midst of the current high rates of opioid-related overdoses, many have pointed to a seminal study performed in 1986 which "opened the door to more liberal prescribing of opioids."[32] This study not only identified opioids as providing effective pain relief, but that they also posed a minimal risk for addiction.[33] Physicians, policy

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[25] See, e.g., The American Board of Anesthesiology, Examinations and Certifications, http://www.theaba.org/Home/examinations_certifications.

[26] Carolyne Krupa, *Hot-button Issues Drive State CME Mandates,* AMERICAN MEDICAL NEWS, Feb. 13, 2012, http://www.amednews.com/article/20120213/profession/302139947/2/.

[27] Id.

[28] Stephen H. Miller et al, *Continuing Medical Education, Professional Development, and Requirements for Medical Licensure: A White Paper of the Conjoint Committee on Continuing Medical Education*, J. OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS, 28(2):95-98, 2008, at 96.

[29] Id.

[30] Peter D. Jacobson, *Transforming Clinical Practices Guidelines Into Legislative Mandates*, JAMA, Jan. 9/16, 2008 – Vol. 299, at 209.

[31] See Stephen S. Hall, *How Much Does It Hurt?*, NEW YORK MAGAZINE, June 8, 2014, http://nymag.com/health/bestdoctors/2014/zohydro-2014-6/index1.html#.

[32] Kristina Fiore, *AAN Warns Against Opioids in Chronic Noncancer Pain*, MEDPAGE TODAY, Sep. 29, 2014, http://www.medpagetoday.com/PainManagement/PainManagement/47871.

[33] See Stephen S. Hall, *How Much Does It Hurt?*, NEW YORK MAGAZINE, June 8, 2014, http://nymag.com/health/bestdoctors/2014/zohydro-2014-6/index1.html#.

makers, and public health organizations now struggle to address the fall-out from the liberal prescribing of opioids which were once treated with healthy skepticism, then embraced, and are now maligned. This scenario demonstrates that solidifying practice guidelines on *any* medical subject is dangerous because it makes medical concepts static, when they need to evolve based on comprehensive, peer-reviewed studies.

D. ISMS Education Efforts

To promote the most up-to-date CME and relevant clinical guidelines, ISMS has already embarked on a campaign to educate physicians on how to achieve the safe and appropriate use of prescription opioids while improving patient care. Some of these efforts include a dedicated physician resource page on opioids, which is available to both members and non-member physicians and prescribers on the ISMS website.[34] The resource page promotes and compiles a multitude of existing guidelines for the treatment of pain and the prescription of opioids from groups like the American Medical Association, American Academy of Family Physicians, and the Federation of State Medical Boards. It also contains the most up-to-date public health information from the federal Centers for Disease Control and Prevention (CDC).

The ISMS opioid resource page is also a clearinghouse for opioid education, and includes a significant amount of accredited continuing medical education (CME). Included in the ISMS CME resources is a free CME module sponsored by the Providers' Clinical Support System for Opioid Therapies, which is collaboration of several national groups, including the American Medical Association, American Dental Association, and the American Academy of Addiction Psychiatry, all dedicated to the safe and effective use of opioid medication.[35] The American Medical Association also has a 12-part CME program on pain management, which covers specific pain topics such as pediatric pain management, pain for older adults, cancer pain and barriers to pain management in certain populations.[36]

ISMS and ISMIE Mutual Insurance Company are also marketing a CME program on prescribing opioids, which is designed for physicians, as well as physician assistants and advanced practice nurses.[37] This course focuses on extended release/long-acting opioids and prescriber responsibilities under the FDA-approved Risk Evaluation and Mitigations Strategies (REMS) for such products. This program sets forth the best practices to initiate opioid therapy, modify doses, and discontinue use of opioids. In addition, the ISMS/ISMIE CME program demonstrates how prescribers can employ methods to counsel patients and caregivers about the safe use of opioids, including proper storage and disposal. ISMIE Mutual policyholders who complete the course are eligible to earn a 1% discount on their annual premium.

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[34] See Illinois State Medical Society, *Opioids: Resources to Combat Misuse, Abuse and Overdose, https://www.isms.org/opioids/.*

[35] Providers' Clinical Support System for Opioid Therapies, http://www.pcss-o.org/.

[36] American Medical Association, *Pain Management CME Series*, http://www.ama-assn.org/ama/pub/physician-resources/pain-management.page.

[37] ISMIE Mutual Insurance Company, *Extended-Release/Long-Acting Opioid Risk Evaluation and Mitigation Strategy: Achieving Safe Use While Improving Patient Care*, https://www.isms.org/Resources/For_Physicians/Medication/Opioid_Use_brochure/.

III. Statistics on Opioid Prescriptions in Illinois

Recent data demonstrates that Illinois prescribers, when compared to their peers in other states, have prescribed fewer opioids, such as oxycodone. A study of prescription drug use by IMS Health Inc. found that Illinois ranked 50th out of the 50 states, plus Puerto Rico and District of Columbia, for oxycodone utilization.[38] Of the total oxycodone prescriptions issued in 2013, Illinois had a per capita use of only .05, ranking 50th in the United States, including Puerto Rico and the District of Columbia.[39] By contrast, Tennessee had over six times as much utilization of oxycodone per capita, ranking at third in the nation with a .31 utilization rate per capita.[40] Oxycodone prescriptions actually decreased four percent in Illinois from 2012 through 2013.[41] For all Schedule II controlled substance utilization in 2013, Illinois was ranked 48th in per capita usage.[42]

IV. Recent Federal Rule Changes

On the federal level, the Drug Enforcement Agency (DEA) has authored two important rule changes to combat the misuse of prescription opioids. First, Hydrocodone Combination Products (HCPs) will now be classified as Schedule II drugs.[43] HCPs are painkilling medications that combine hydrocodone, already a Schedule II drug on its own, with another substance, such as acetaminophen.[44] The rule change was spearheaded by a recommendation of the Department of Health and Human Services (HHS). HHS concluded that (1) individuals are taking HCPs in amounts sufficient to create a hazard to their health; (2) there is significant diversion of HCPs; and (3) individuals are taking HCPs on their own initiative rather than on the basis of medical advice from a practitioner.[45]

As a result of this rule change, HCPs are now subject to the federal requirements that apply to all Schedule II drugs, such as registration with the DEA for parties who handle HCPs, security requirements for storage, a prohibition on refills that applies to all Schedule II drugs, and a limit of a 90-day supply of Schedule II drugs.[46] The Illinois Controlled Substances Act mirrors the federal Act. Illinois law specifies that Illinois prescribers may issue three sequential 30-day prescriptions for the same Schedule II drug, up to a 90-day supply.[47] Before authorizing a 90-day prescription of Schedule II drugs, two conditions must be met.[48] First, each separate prescription must be issued

[38] IMS Health Inc., *Oxycodone Utilization by State, A State Comparison: Annual Prescriptions per Capita 2013 Oxycodone (All Forms)*, 2014.
[39] Id.
[40] Id.
[41] IMS Health Inc., *Growth in Oxycodone Utilization by State, Percent Changed in Filled Prescriptions, 2013 v. 2012, Oxycodone (All Forms)*, 2014.
[42] IMS Health Inc., *C-II Controlled Substance Utilization by State*, 2014.
[43] Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II, 79 Fed. Reg. 49,661 (Aug. 22,2014) (to be codified at 21 C.F.R. pt 1308). This rule change is effective Oct. 6, 2014.
[44] Id. at 49,665. Vicodin is an example of a HCP that combines Hydrocodone and acetaminophen.
[45] Id. at 49,663.
[46] See Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products From Schedule III to Schedule II, 79 Fed. Reg. 11,037, 11,044 (proposed Feb., 27, 2014). See also 21 C.F.R.§ 1306.12 (2014) (prohibition on refills on Schedule II drugs).
[47] 720 ILCS 570/312(a-5).
[48] Id.

for a legitimate medical purpose by an individual physician acting in the usual course of professional practice.[49] Second, the physician must also provide written instructions on each prescription indicating the earliest date on which a pharmacy may fill that prescription.[50]

The other recent federal rule change implements the Secure and Responsible Drug Disposal Act of 2010 to expand options for the disposal of prescription drugs by patients.[51] Before the passage of the legislation, the only option for patients to lawfully dispose of prescription drugs was to destroy the drugs themselves either by flushing or discarding the drugs in the trash; turn drugs in to local law enforcement; or return unused drugs at events hosted by the DEA. The new rules expand disposal options to include dedicated take-back sites at retail pharmacies and other registered locations, as well as promoting "mail-back" options.[52] Results from a 2012 national survey performed by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicate that approximately 70% of those who had misused prescription pain relievers had either stolen or received these pain relievers from a friend or relative.[53] In this same study, 19.7% reported receiving those pain relievers from one doctor and 1.8% received them from more than one doctor.[54]

V. Issues with Pain Treatment

A. Treating Pain

By itself, the treatment of pain is complex, as subjective complaints of pain from a patient may not have a readily apparent clinical cause. Pain also has a distinct psychological aspect, as the Food and Drug Administration has reported that "upwards of 40% of patients who take part in clinical trials report pain relief when given a sugar pill."[55] Further complicating a physician's role in the treatment of pain is predicting when a patient may have the propensity to become addicted to prescription opioids or even detecting when a patient has crossed into substance abuse.

When it comes to the prescription of opioids, physicians may use many different guidelines to determine both the efficacy of the potential pain treatment, a patient's long-term options, and whether risk factors are present for opioid abuse.[56] While many guidelines recommend using patient questionnaires to detect a history of depression, anxiety, post-traumatic stress, or a

[49] 720 ILCS 570/312(a-5)(1).
[50] 720 ILCS 570/312(a-5)(2).
[51] Act of Oct. 12, 2010, Pub. L. No. 111-273, (124 Stat.) 2858 . See also Disposal of Controlled Substances, 79 Fed. Reg. 53520 (Sep. 9 2014) (to be codified at 21 CFR pts 1300, 1301, 1304, 1305, 1307, and 1317). This rule change is effective Oct. 9, 2014.
[52] Id. at 53,521.
[53] Substance Abuse and Mental Health Services Administration. *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, Sept. 2013, http://archive.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#ch2.16.
[54] Id.
[55] Stephen S. Hall, *How Much Does It Hurt?*, New York Magazine, June 8, 2014, http://nymag.com/health/bestdoctors/2014/zohydro-2014-6/index1.html#.
[56] Jane C. Ballyntyne, *Managing Pain with and without Opioid's in the Primary Care Setting, CDC's Primary Care and Public Health Initiative*, Oct. 24, 2012, http://supportprop.org/news/SupportPROP_ManagingPain_508.pdf.

family history of substance abuse, receiving accurate information from patients is often difficult as there is a reluctance to disclose these histories.[57]

B. Diversion of Properly Prescribed Opioids

Beyond the control of physicians is when properly prescribed opioids are diverted from their intended use by the patient for their own, non-medical use, given by the patient to another person, or taken from a patient by a family member, friend, or other person for a non-medical use. These behaviors are commonly described as diversion, which is defined by the federal Uniform Controlled Substances Act as the "transfer of a controlled substance from a lawful to an unlawful channel of distribution or use."[58]

Diversion sources for those who use opioids for non-medical use are varied. In a national survey of high school seniors who had used opioids for non-medical purposes, 63.2% of respondents replied that they had obtained the opioid from a source other than a previous prescription.[59] 14.4% reported the source of the opioids as only a previous prescription, while 22.5% obtained the opioid from a previous prescription and another source. The sources of diversion queried in this study were: purchase on the internet (1.4%), taken from a friend or relative without asking (22.2%), given by a friend or relative (55%), bought from a friend or relative (37.9%), bought from a drug dealer (19.4%), or other (9.5%).

When unused prescription opioids remain in the home, they represent a source of potential diversion that can lead to non-medical use. A study conducted the Utah Department of Health revealed that 71% of adult respondents who had leftover medication from a prescription kept the leftover medication.[60] Simply "keeping" this medication, instead of properly disposing of it, represents a potential source of diversion that is within our own homes. Recently, U.S. Attorney General Eric Holder cited a study showing that "close to four in 10 teens who misused prescription drugs obtained them from family medicine cabinets."[61]

Diversion of opioids is not isolated to the medicine cabinets of our patients. Diversion can also occur at medical facilities, such as hospitals and long-term care facilities. Patients, their visitors, and even the health care workers employed by these types of facilities are all potential sources of diversion of prescription opioids. [62] These drugs are often accumulated in large quantities in hospitals and long-term care facilities to treat the pain of patient populations.[63] The

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[57] Physicians for Responsible Prescribing, *Cautious, Evidence-Based Opioid Prescribing, Physicians for Responsible Opioid Prescribing*, http://www.supportprop.org/educational/PROP_OpioidPrescribing.pdf.
[58] Uniform Controlled Substances Act, Sec. 309(a) (1994), http://www.uniformlaws.org/shared/docs/controlled%20substances/UCSA_final%20_94%20with%2095amends.pdf.
[59] Sean Esteban McCabe, Brady T. West & Carol J. Boyd, *Leftover Prescription Opioids and Nonmedical Use Amount High School Seniors: A Multi-Cohort National Study*, J. OF ADOLESCENT HEALTH, Vol. 52, Issue 4, Apr. 2013 , http://jahonline.org/article/S1054-139X(12)00350-3/fulltext.
[60] Centers for Disease Control and Prevention, *Adult Use of Prescription Opioid Pain Medications – Utah, 2008*, Morbidity and Mortality Weekly Report, Feb. 19, 2010, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5906a1.htm.
[61] Devlin Barrett, *U.S. to Allow Pharmacies to Take Back Unused Prescription Drugs*, WALL STREET JOURNAL, Sept. 8, 2014.
[62] Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple Victim Crime: Patterns of Diversion Scope, Consequences, Detection and Prevention*, MAYO CLINIC PROCEEDINGS, July 2012, at 674, http://www.mayoclinicproceedings.org/article/S0025-6196(12)00484-3/pdf.
[63] Id.

issues associated with the management of large inventories,[64] coupled with the fact that facilities like hospitals "are generally open 24-hours per day, with "foot traffic [that is] is generally not routinely monitored for unlawful purposes"[65] provides "ample opportunity for drug diversion."[66]

Many hospitals have turned toward technology to aid efforts in preventing diversion that may be due to a lack of a sufficient inventory management or the misplacement of drugs by hospital staff.[67] Following a large increase in prescription drug diversion at medical facilities in Minnesota, the Mayo Clinic published its own comprehensive recommendations regarding how facilities can implement systems to prevent diversion by patients, visitors, and employees.[68] Its recommendations were driven by the Clinic's own internal experiences with diversion.[69] The Mayo Clinic recommends that all health care facilities should be proactive about diversion of prescription drugs by instituting systems that prevent the diversion of controlled substances and "promptly identify diversion and intervene when it is occurring."[70]

C. Other Prescribers

Illinois physicians are not alone in balancing the need to treat pain with the threat of opioid addiction and diversion. In addition to physicians, other professionals, such as dentists, optometrists, podiatrists, and veterinarians are all able to prescribe medication, including opioids.[71] Midlevel practitioners, such as advanced practice nurses (APNs) and physician assistants (PAs), may also be authorized to prescribe medication.

In Illinois, PAs work under a written supervision agreement with a physician, which may authorize the delegation of prescriptive authority to the PA for Schedule II through V controlled substances.[72] PAs in hospitals, hospital affiliates, or ambulatory surgical treatment centers (ASTCs) may provide services without a written supervision agreement.[73] In order to provide services without the written supervision agreement, the physician assistant must possess clinical

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[64] Laura Landro, *Hospitals Address a Drug Problem*, WALL STREET JOURNAL, Feb. 23, 2014, http://online.wsj.com/news/articles/SB10001424052702304104504579377283066012564.

[65] 79 Fed. Reg. 53520, 53523. In its most recent rulemaking, the DEA ultimately decided with only allowing drug take-back receptacles at hospitals with on on-site pharmacy to help prevent diversion.

[66] Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple Victim Crime: Patterns of Diversion Scope, Consequences, Detection and Prevention*, MAYO CLINIC PROCEEDINGS, July 2012, at 674, http://www.mayoclinicproceedings.org/article/S0025-6196(12)00484-3/pdf.

[67] Laura Landro, *Hospitals Address a Drug Problem*, Wall Street Journal, Feb. 23, 2014, http://online.wsj.com/news/articles/SB10001424052702304104504579377283066012564.

[68] Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple Victim Crime: Patterns of Diversion Scope, Consequences, Detection and Prevention*, MAYO CLINIC PROCEEDINGS, July 2012, 674-82, 674, http://www.mayoclinicproceedings.org/article/S0025-6196(12)00484-3/pdf.
See also Tara Bannow, *Minnesota Hospitals Teaming up Against Theft of Drugs*, Star Tribune, May 31, 2011, http://www.startribune.com/local/122911273.html.

[69] Keith H. Berge et al, *Diversion of Drugs within Health Care Facilities, a Multiple Victim Crime: Patterns of Diversion Scope, Consequences, Detection and Prevention*, MAYO CLINIC PROCEEDINGS, July 2012, at 674, http://www.mayoclinicproceedings.org/article/S0025-6196(12)00484-3/pdf.

[70] Id.

[71] See 225 ILCS 25/17 (dentists); 225 ILCS 80/15.1 (optometrists); 225 ILCS 100/5 (podiatrists); 225 ILCS 115/3 (veterinarians).

[72] 225 ILCS 95/7.5 (prescriptive authority for physician assistants not practicing in a hospital setting).

[73] 225 ILCS 95/7.7(a).

privileges recommended by the hospital medical staff and granted by the hospital.[74] For ASTCs, these clinical privileges must be recommended by the consulting medical staff committee and granted by the ASTC.[75] APNs may be able to prescribe through a written collaborative agreement with a physician or podiatrist.[76] Similar to PAs, APNs providing services at a hospital, hospital affiliate, or ASTC may be granted "clinical privileges" through the facility's medical staff.[77]

The scope and extent of collaborative agreements for APNs who do not work in a hospital or an ASTC have become less restrictive in recent years.[78] APNs are no longer required to meet in person with a physician to provide "collaboration and consultation."[79] The delegation of prescriptive authority is contained within that collaborative agreement.[80] Specific restrictions for the delegation of the authority to prescribe Schedule II drugs by an APN include the requirement that any Schedule II prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician.[81] The APN must also discuss with delegating physician the condition of any patients for whom a controlled substance is prescribed on a monthly basis.[82]

While a majority of studies regarding the non-medical use of opioids have been focused on physicians, particularly physicians practicing in emergency departments, more recent studies have examined other prescribers, such as dentists who have been noted to prescribe a "sizeable minority" of all opioid prescriptions.[83] A recent study focused on patients of dental clinics revealed that non-medical use of opioids was common in the population; this may be related to the high percentage of concurrent substance abuse issues of patients who utilize free dental clinics.[84]

All prescribers of opioids should be aware of the benefits these products bring to patients, as well as the potential for abuse and diversion. Educational efforts, such as the CME program developed by ISMS and ISMIE Mutual, are tailored to all practitioners with prescriptive authority. ISMS is committed to providing the most relevant and updated information regarding the prescribing of opioids, the appropriate treatment options for pain, and detecting the signs of prescription drug abuse to the universe of prescribers in Illinois.

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[74] Id.
[75] Id.
[76] See 225 ILCS 65/65-40 (prescriptive authority for advanced practice nurses).
[77] 225 ILCS 65/65-45.
[78] See P.A. 97-358, eff. Aug. 12, 2011.
[79] See 225 ILCS 60/54.5. See also P.A. 97-358, eff. Aug. 12, 2011 (changing the monthly "in person" consultation requirement to simply "consult").
[80] See 225 ILCS 65/65-40. See also P.A. 97-358, eff. Aug 12, 2011.
[81] 225 ILCS 65/65-40(d)(1-5).
[82] Id.
[83] Lisham Ashrafioun et al, *Nonmedical use of Pain Medication in Dental Patients*, AMERICAN J. OF DRUG AND ALCOHOL ABUSE, 40(4), 312-16, 312 (2014).
[84] Id. at 314, 315.

D. The Illinois Prescription Monitoring Program

For prescribers in Illinois, the main clearinghouse of information regarding their patients' prescription information is the Illinois Prescription Monitoring Program (PMP).[85] The Illinois PMP program has two main functions: the collection of data from dispensers of Schedule II through V controlled substances and the maintenance of a central repository of that information, which is made available for view by prescribers through a free website.[86]

Dispensers are required to submit specific information to the Illinois PMP, including the patient's name, address, sex, the date the prescription was filled, the payment used by the patient, and details about the prescription itself.[87] This information must be transmitted to the Illinois PMP not more than seven days after the date on which a controlled substance is dispensed.[88] The Illinois PMP updates its data every Friday.[89] Users of the Illinois PMP must log-in to the system and then enter a patient's name manually to view PMP information. The accuracy of this search depends on how the patient's name was entered by a pharmacy or dispenser.[90] For example, if a pharmacy enters a shortened patient name (e.g., Bill instead of William), the prescriber may not be able to locate the information on the PMP.[91]

Illinois has been able to facilitate both the transfer of its PMP data and the receipt of data from other states by joining the National Association of Boards and Pharmacy (NABP) PMP InterConnect.[92] With the data available on the NABP InterConnect, authorized PMP users in Illinois can gain access to data from other participating states through the Illinois PMP portal. Besides Illinois, 25 other states participate in the NABP Interconnect, including Indiana, Wisconsin, and Kentucky.[93] Illinois has also recently improved the PMP as a resource that can prevent "doctor shopping" by authorizing the PMP to issue an unsolicited report to prescribers when a person has been identified as having six or more unique prescribers or six or more unique pharmacies within the course of a continuous 30-day period.[94]

While Illinois was a leader in developing its PMP in 2000 and has continued to improve the PMP by connecting our data with surrounding states, the Illinois PMP program still has major shortfalls that limit its effectiveness as a tool to deter and prevent prescription opioid abuse. The data on the Illinois PMP is delayed by a week because of the current statutory seven day reporting mandate. With once-a-week reporting, it is possible for a patient to visit several prescribers to obtain prescriptions before any information is reported to the PMP. It is also unclear whether non-resident dispensers, and mail-order pharmacies, are required to report

[85] See P.A. 91-0576, eff. Apr. 1, 2000. Prior to the implementation of the PMP, prescribers were required to use triplicate prescription forms.
[86] 720 ILCS 570/316 (requirements for the information to be transmitted by dispensers); 720 ILCS 570/317 (requirements for the central repository of information transmitted by dispensers).
[87] See 720 ILCS 570/316(a)(1)(A-K); 77 Ill. Adm. Code 2080.100.
[88] See 720 ILCS 570/316(a)(2).
[89] Illinois Prescription Monitoring Program, *Frequently Asked Questions*, https://www.ilpmp.org/QandA.php.
[90] Id.
[91] Id.
[92] National Association of Boards of Pharmacy, *PMP InterConnect*, http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect.
[93] Id.
[94] See 720 ILCS 570/314.5. See also P.A. 97-334, eff. Jan. 1, 2012.

information to the PMP, which may prevent it from becoming a "substantial body of accurate information."[95] Medical cannabis dispensing organizations are not required to report dispensing information to the Illinois PMP.[96]

The use of the Illinois PMP is limited to the medical prescriber, meaning that the PMP cannot be checked by a prescriber's staff.[97] Other states like New York, Alabama, and Massachusetts allow this practice, which may reduce overall time demands on practicing physicians, as experts in the treatment of pain acknowledge that the effective and safe management of prescription opioids is "time consuming and resource heavy."[98]

Illinois has made strides to promote electronic health records supported by health information exchanges with the Illinois Health Information Exchange and Technology Act.[99] However, most medical records, including the PMP data, still remain in "silos," requiring physicians to check several sources of information for vital patient information, if they even exist in an electronic format at all. Thus, the processes required to check the PMP may deter its full use and integration because the PMP is not a part of clinical workflows.[100] In short, because the PMP requires a manual query by the prescriber, separate and apart from a patient's EHR, it takes additional time away from patients and other responsibilities of physicians. Because the Illinois PMP requires a manual query of the patient's name, there remain concerns that it may not yield accurate prescription information if dispensers have entered a patient's information under a slightly different name, or if there are any other order entry discrepancies.

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[95] See National Conference of Insurance Legislators, *Best Practices to Address Opioid Abuse, Misuse & Diversion*, Nov. 24, 2013, at 2, http://www.ncoil.org/HomePage/2013/2007964d.pdf.

[96] See 720 ILCS 570/316.

[97] See 77 Ill. Adm. Code 2080.210(a). See also Illinois Prescription Monitoring Program, Frequently Asked Questions, https://www.ilpmp.org/QandA.php.

[98] See N.Y. PUB. HEALTH LAW § 3343-a(2)(b) (McKinney 2014).; ALA. CODE 1975 § 20-2-213 (authorizing a physician to designate two employees to view the prescription monitoring database); and MASS. GEN. LAWS ANN. ch. 94c § 24A9c)(West 2014). See also Jane C. Ballantyne, MD, *Managing Pain with and without Opioid's in the Primary Care Setting, CDC's Primary Care and Public Health Initiative*, Oct. 24, 2012, http://supportprop.org/news/SupportPROP_ManagingPain_508.pdf.

[99] See 20 ILCS 3860. See also Illinois Health Information Exchange, http://www2.illinois.gov/gov/HIE/Pages/default.aspx.

[100] See National Governor's Association, *Reducing Prescription Drug Abuse: Lessons Learned from an NGA Policy Academy*, http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1402ReducingPrescriptionDrugAbuse-Paper.pdf. See also The MI-RE Corporation, *Enhancing Access to Prescription Drug Monitoring Programs Using Health Information Technology: Workgroup Recommendations*, Aug. 17, 2012, at 7, http://www.healthit.gov/sites/default/files/pdmp_work_group_recommendations-1.pdf.

VI. ISMS Recommendations to the Task Force

A. Education Efforts for Prescribers and Patients

Professional Organizations Promoting Education and Updated Clinical Guidelines

The education of prescribers is essential to keep pace with the evolving field of medicine, which has included important advances in the science of pain management. Professional organizations like ISMS play a key role in providing this sort of education and can do so effectively because of its staff and expertise in providing educational materials and keeping pace with treatment guidelines. Illinois needs to encourage this type public-private collaboration to help promote the education and training of all prescribers. This approach has achieved success on the federal level. The Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a three-year grant to the Providers' Clinical Support System for Opioid Therapies (PCSS-O).[101] The PCSS-O is a consortium of professional medical associations, including the American Medical Association and the American Academy of Addiction Psychiatry.[102] Through the expertise and resources of its member organizations, the PCSS-O is able to maintain a comprehensive website, which not only contains new and archived webinars, training modules, and other information regarding the prescription of opioids, but also has a mentorship program and ability to connect medical professionals with a colleague regarding their questions on opioid prescribing.[103]

Supporting Education of Physicians about Medical Cannabis

Joining a growing number of states, in 2013 Illinois passed the Compassionate Use of Medical Cannabis Pilot Program Act.[104] During the legislative debates for this Act, the sponsors of this landmark legislation emphasized how medical cannabis does not have the addictive properties of other prescription drugs, thus avoiding the danger of misuse leading to overdose deaths.[105] These statements have found additional support in a recent study published in *JAMA Internal Medicine*, which indicates that in states where a medical marijuana law was implemented, there was a 25% lower rate of prescription painkiller overdose.[106]

ISMS has passed a resolution that establishes our policy to support and encourage the education of physicians regarding current, evidence-based therapeutic use of cannabinoids.[107] The Medical Cannabis Pilot Program Act is still being implemented in Illinois, and it may take some time to

[101] Providers' Clinical Support System for Opioid Therapies, http://www.pcss-o.org/about.
[102] Id.
[103] Providers' Clinical Support System for Opioid Therapies, *Ask a Colleague,* http://www.pcss-o.org/ask-colleague.
[104] 410 ILCS 130, P.A. 98-122, eff, Jan. 1, 2014.
[105] See Comments of Senator Bill Haine on the Debate of HB 1, May 17, 2013. ("... it is a substance which is more benign than, for example, powerful prescription drugs, such as OxyContin, Vicodin, and the rest. The scourge of these drugs is well known. This is not true of the medical use of marijuana.") See also comments of House Sponsor Representative Lou Lang on the Debate of HB 1, Apr. 17, 2013, ("It's [medical cannabis] not addictive like those other narcotics." In response to a question about FDA approved drugs, "The FDA approved all of those narcotics that Rep. Fine referred to, and each and every one of them is addictive . . . [and] has led to, in this country, having more deaths by drug overdose than by traffic accident in the last three years.").
[106] See also Sandra Young, *Medical Marijuana Laws May Reduce Painkiller Overdoses*, CNN, Aug. 26, 2014, http://www.cnn.com/2014/08/25/health/medical-marijuana-overdose-deaths/.
[107] Illinois State Medical Society Policy (HOD 2006; BOT 2006-OCT; Last BOT Review 2011).

evaluate whether the sale of medical cannabis in Illinois has a similar effect on the number of overdose deaths that was documented in the recent *JAMA* study. As the State develops and rolls out the pilot program, ISMS has issued guidelines for our member physicians so that they can stay informed of a physician's role and obligations within the pilot program.

B. Improvements to the Illinois PMP

24-Hour Reporting of PMP Information

There are several ways that the PMP can be improved to enhance its usefulness as a clinical tool for prescribers. The data that is housed in the PMP can be improved by requiring that dispensers report prescription information to the PMP within 24 hours so that prescription information on the PMP is closer to a "real-time" basis. Again, when a prescriber views Illinois PMP data, it may be incomplete, as the PMP is only updated on Friday of each week, receiving data only once a week from pharmacies.[108] Other states, however, have a more aggressive reporting schedule. Oklahoma law first required that all dispensers must transmit data to the Oklahoma PMP within 24 hours.[109] Starting January 1, 2012, all information must be transmitted to the Oklahoma PMP on a "real-time log," which, according to the Oklahoma PMP's website, is within five minutes of being dispensed to a customer.[110]

Automatic Enrollment in the PMP

One way to increase the exposure of the PMP as a beneficial clinical tool for prescribers without imposing a restrictive mandate for all prescribers or health care professionals is to automatically enroll prescribers in the PMP when they either obtain or renew their controlled substance license. The Illinois Department of Financial and Professional Regulation (IDFPR), the department that issues controlled substance licenses, is already required to provide license information to the PMP.[111] Making this change would allow for the PMP to expand its target, provide relevant communications to an audience of health care professionals who prescribe opioids, and facilitate the enrollment and use of this important clinical tool.

Allow Designees to view PMP information

To facilitate usage of the Illinois PMP, the viewers of the PMP information should be expanded to include the designees of a prescriber. Expanding the scope of who may view PMP data is not unprecedented. New York, for example, allows for both prescribing and non-prescribing medical professionals to access its PMP, as well as administrative staff acting as designees.[112] To qualify as a designee under New York law the designee must be employed by the same professional practice or must be under contract with such practice.[113] To ensure that the designee is aware how to use the PMP, the practitioner is required to take reasonable steps to

[108] 720 ILCS 570/316(a)(2).
[109] See OKLA. STAT. tit. 63 § 2-309C (2014).
[110] See id. See also Oklahoma Prescription Monitoring Program, http://www.ok.gov/obndd/Prescription_Monitoring_Program/.
[111] See 720 ILCS 570/317(b)(2)(Requiring IDFPR to provide the Illinois PMP with electronic access to the license information of a prescriber or dispenser).
[112] See New York Prescription Monitoring Program, *PMP Registry Frequently Asked Questions*, http://www.health.ny.gov/professionals/narcotic/prescription_monitoring/docs/pmp_registry_faq.pdf
[113] N.Y. PUB. HEALTH LAW § 3343-a(2)(b)(i) (McKinney 2014).

ensure that the designee is "sufficiently competent" in the use of the registry. [114] The prescriber is ultimately responsible for any breach of confidentiality by the designee and remains responsible for ensuring that access to the registry by the designee is limited to authorized purposes and occurs in a manner that protects the confidentiality of the information obtained from the registry[115] In addition, all viewers of the PMP information in New York must register for an account.[116]

PMP Funding

An increase in the transmissions or data to the PMP will likely require an improvement in PMP technology and data reception.[117] This highlights concerns that the Illinois PMP does not have a dedicated funding stream. According to PMP staff, over half of its annual budget is obtained through grants awarded by the federal government or private foundations. While grants may be available for certain PMP projects and innovations, they may not represent a consistent source of funding to support long term operations.[118] New York is an example of a state that has instituted stable funding of its PMP through fees assessed against health insurers in that state.[119] With this funding source, New York was able to hire the staff necessary to fulfill several of the statutory mandates which were implemented to improve its PMP.[120]

Increase Frequency of Unsolicited Reports to Prescribers

The Illinois PMP only sends reports to prescribers warning them about patients who potentially are "doctor shopping" for prescription medication when the patient has six or more unique prescribers or six or more unique pharmacies in a single 30-day period. Reducing that number to three or more unique prescribers or pharmacies is one way to provide an additional level of detection to assist prescribers in making more informed clinical decisions.[121]

Using the PMP as a Resource for Prescribers

The Illinois PMP website should be utilized as a clearinghouse of the most current information on pain treatment, public health information, and continuing professional education for all prescribers. Besides putting this information on the Illinois PMP website, prescribers, who are currently required to provide their work email address when they register for an account with the Illinois PMP, can also be reached via email for periodic updates.

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[114] N.Y. PUB. HEALTH LAW § 3343-a(2)(b)(ii) (McKinney 2014).
[115] N.Y. PUB. HEALTH LAW § 3343-a(2)(b)(iii) (McKinney 2014).
[116] New York Prescription Monitoring Program, *PMP Registry Frequently Asked Questions*, http://www.health.ny.gov/professionals/narcotic/prescription_monitoring/docs/pmp_registry_faq.pdf.
[117] PDMP Center for Excellence, *Mandating PDMP participation by Medical Providers: Current Status and Experience in Selected States*, Feb. 2014, http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf.
[118] See National Conference of Insurance Legislators, *Best Practices to Address Opioid Abuse, Misuse & Diversion*, Nov. 24, 2013, at 4, available at http://www.ncoil.org/HomePage/2013/2007964d.pdf.
[119] Prescription Monitoring Program Center of Excellence , *Mandating PDMP Participation by Medical Providers: Current Status and Experience in Selected States*, Feb. 2014, http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf
[120] Id.
[121] Prescription Monitoring Program Center of Excellence, *Best Practices for Prescription Monitoring Programs*, Apr. 2012, at 1, http://www.pdmpexcellence.org/sites/all/pdfs/COE_BriefingOnBestPractices_final_april_2012.pdf.

Improving the PMP Advisory Committee

The Illinois PMP is currently guided by an "advisory committee," which is tasked with assisting the Department of Human Services in implementing the Illinois PMP program.[122] The advisory committee should also be empowered and improved to provide the necessary support for the Illinois PMP. While current law mandates that "prescribers and dispensers" comprise the Committee, it does not outline any required qualifications or background for these members, or even the specific number of members that make up the committee. While formal requirements for an advisory committee are not always necessary to ensure its success, developing more standard requirements for the make-up and duties of the Illinois PMP Advisory Committee will ensure that it keeps pace with the ever-changing face of medicine. Some of these duties should include advising the PMP on the content of the PMP website, as well as developing the communications to be sent to the enrollees of the PMP.

Peer Review Subcommittee

Another way the current Illinois PMP Advisory Committee can be improved is by creating a designated subcommittee composed of prescribers who will review PMP information to identify prescribers to receive information on recent clinical guidelines and continuing education on the prescription of opioids. While current law already authorizes the PMP to send unsolicited communications to specific prescribers, communications developed by actual peers to a target audience can potentially be more effective than other, more passive and general communications.

Ensure the Confidentiality of PMP Information

The confidentiality of information contained in the Illinois PMP is specifically governed by the Illinois Controlled Substances Act.[123] This information about patients, prescribers, and dispensers must continue to be protected. The meetings of the PMP Advisory Committee or any subcommittees should be conducted in accordance with the mandate of the Illinois Controlled Substances Act to protect patient, prescriber, and dispenser information. Specifically, these meetings should be held under the provisions of the Open Meetings Act which allow for "closed meetings" in specific circumstances.[124]

Increasing "Pilot Programs" to Integrate PMP Data in Electronic Health Records

Integrating the prescription data in the Illinois PMP with a patient's electronic health record (EHR) or with health information exchanges (HIEs) will provide a more efficient and accurate way for prescribers and dispensers to utilize this prescription information.[125] Such a pilot project in Illinois should focus on integrating information in the Illinois PMP within a patient's EHR. This would ultimately eliminate the need for the prescriber to check two different sources

[122] 720 ILCS 570/320(a). The Secretary of the Department of Human Services or his designee is authorized to both make appointments to the Committee and to designate the number of members.
[123] See 720 ILCS 570/318.
[124] See 5 ILCS 120/2(c)(1)-(32) (listing the situations when a meeting of a public body can be closed to the public).
[125] Prescription Drug Monitoring Program Center of Excellence, *Best Practices for Prescription Drug Monitoring Programs, Federation of State Medical Boards, 2014 Annual Meeting Presentation*, Apr. 25, 2014, http://pdmpexcellence.org/sites/all/pdfs/PDMP_COE_presentation_FSMB_2014_04_25.pdf.

of information before deciding to issue or not issue a prescription. It would also eliminate the need for the prescriber to manually enter a patient's name, which can result in errors and missed information.

Preliminary efforts at pilot programs that focus on integrating the Illinois PMP with specific EHR systems at Illinois hospitals have been funded by the federal government through grants from the Substance Abuse & Mental Health Services Administration (SAMHSA).[126] While grant documents indicate that the Illinois PMP has attempted to reach out to several hospital affiliates to gain support for more widespread efforts for interoperability with those systems, thus far the only pilot program in effect has been conducted in the emergency department of Anderson Hospital, located in Maryville, Illinois.

Even with this small pilot program, which integrated Illinois PMP data as a PDF message to emergency room prescribers, results showed that "[a]utomating the query from within the [patient's] EHR was easier and faster, resulting in increased usage and satisfaction by providers."[127] Illinois needs to increase these efforts to integrate PMP data in more emergency rooms and EHR systems throughout this State in order to keep up with more expansive pilot programs in other states.[128]

Improving the Illinois PMP Website

A cost effective way to reach prescribers and dispensers in their daily practice is to expand the PMP website to become a resource for prescribers. The website should contain links to the following information: the most recent clinical guidelines developed by health care organizations on the prescription of opioids; accredited continuing education related to prescribing, tools developed by health care professionals that may be used to assess patients or help assure compliance with prescriptions; and the regular communications with all prescribers regarding updates from the Food and Drug Administration, Centers for Disease Control and Prevention, or other government or private organizations which are relevant to prescribing. While the current PMP staff is small and their current duties are significant, the members of the PMP Advisory Committee could suggest and review content to be posted on the website, making the PMP website more of a resource library for prescribers and dispensers.

C. Urge Creation of a Missouri PMP

The Illinois PMP integration into Anderson Hospital, located in the Metro East area, highlights a severe limitation for the Illinois PMP that may be beyond the power of Illinois lawmakers—the failure of Missouri to establish a PMP which shares its data through the National Association of Boards of Pharmacy PMP InterConnect. Without a Missouri PMP, even if an emergency room physician in Anderson Hospital is able to quickly and easily view PMP data through the patient's EHR, that patient could be receiving multiple prescriptions across the river in Missouri. In addition, it has been documented that those who wish to illegally obtain

[126] Department of Health and Human Services Grant Tracking Document, http://pphf.hhs.gov/programs/1070.
[127] Jinhee Lee & Jennifer Frazier, *Connecting for Impact: Federal Efforts to Integrate Health IT and PDMPs to Improve Patient Care* http://www.pdmpassist.org/pdf/PPTs/National2013/27-3-A_B%20Frazier_Lee.pdf.
[128] See id.

prescriptions opioids recognize that Missouri is a place where they can do so more easily than those states without a PMP.[129] Prescription information from ExpressScripts indicates that residents of the eight states bordering Missouri travel into Missouri to fill their prescriptions more often than residents in Missouri travel to other states to fill their prescriptions.[130] ISMS is committed to joining Illinois lawmakers to urge Missouri to create a PMP in order to improve the effectiveness of the Illinois PMP, as well as stopping illegally obtained prescriptions from coming into Illinois.

D. Coordinate Proper Disposal to Prevent Diversion

Proper disposal of unused medication is one way to avoid diversion of prescription medicines. To prevent properly prescribed medications from being diverted, Illinois needs to build upon recent federal law changes regarding prescription drug disposal efforts and current grant programs in Illinois to develop a coordinated drug disposal program that connects the dangers of prescription drug misuse with a failure to properly dispose of unused medication.

On the federal level, Attorney General Eric Holder recently announced new regulations implementing the Secure and Responsible Drug Disposal Act of 2010.[131] These regulations, which took effect on October 9, 2014, expand disposal of unused, unwanted, and expired medications beyond only surrender to law enforcement, DEA sponsored collection efforts, or discarding drugs in the toilet or trash.[132] Added to the options for disposal are designated "collectors," which include manufacturers, distributors, retail pharmacies, and hospitals with on-site pharmacies. These collectors, which must have a current DEA license to handle Schedule II drugs and register with the DEA, are authorized to conduct a drug mail-back program or have a public disposal bin to accept unused prescription drugs.[133] As of February Feb. 2, 2015, there are only seven registered public controlled substance disposal locations within a 50 mile radius of Chicago, four within a 50 mile radius of Springfield, and two within a 50 mile radius of Mount Vernon.[134] While the federal Controlled Substances Act explicitly prohibits any regulations developed by the Attorney General from requiring any entity to establish or operate a disposal program, increasing disposal options in Illinois would provide an additional opportunity to keep unused prescription drugs from becoming a source of experimentation or unauthorized use.[135]

Current drug disposal efforts in Illinois reveal the need for these new federal regulations that expand disposal options. The Illinois Environmental Protection Agency (IEPA) maintains a page on its website with information on how citizens can safely dispose of prescription drugs

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[129] Alan Schwarz, *Missouri Alone in Resisting Prescription Drug Database*, N.Y. TIMES, July 20, 2014, http://www.nytimes.com/2014/07/21/us/missouri-alone-in-resisting-prescription-drug-database.html?_r=0.

[130] Id.

[131] Dept. of Justice, *Attorney General Holder Announces New Drug Take-Back Effort to Help Tackle Rising Threat of Prescription Drug Addiction and Opioid Abuse*, Sept. 8, 2014, http://www.justice.gov/opa/pr/2014/September/14-ag-947.html. See also Act of Oct. 12, 2010, Pub. L. No. 111-273, (124 Stat.) 2858.

[132] Disposal of Controlled Substances, 79 Fed. Reg. 53,520 (Sep. 9 2014) (to be codified at 21 CFR pts 1300, 1301, 1304, 1305, 1307, and 1317).

[133] 21 CFR § 1301.51.

[134] Drug Enforcement Administration, Office of Diversion Control, *Drug Disposal Information, Search for an Authorized Collector Location,* https://www.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e3s1.

[135] 21 U.S.C. § 822(g)(2).

and lists sites that accept prescription drugs for drop-off and disposal.[136] Reflecting the limitations of the current federal Controlled Substances Act, these disposal sites are mostly police stations. While the IEPA maintains a dedicated email for questions related specifically to the disposal of medications, there does not appear to be any significant coordination or outreach efforts that link the dangers of prescription medications with possible diversion into the hands of teenagers and others for misuse.[137]

There is a pharmaceutical disposal grant program in Illinois with a dedicated funding stream that is geared toward reimbursing local law enforcement agencies for the costs associated with the disposal of prescription drugs.[138] The Prescription Pill and Drug Disposal Fund was created in 2012. It is supported by fees assessed in certain drug related offenses.[139] Monies deposited in the fund are to be used for grants to be administered by the Illinois Criminal Justice Information Authority (ICJIA) to local law enforcement agencies that collect prescription drugs for incineration.

Despite the fund's positive origins, there do not appear to be any efforts to publicize this program with law enforcement entities or any data on the effectiveness of this program.[140] The enacting legislation requires that ICJIA adopt rules specifying the conditions under which grants will be awarded from the fund and otherwise provide for the implementation and administration of the grant program.[141] It is unclear as to whether those rules have ever been adopted.[142] While ICJIA maintains an extensive listing on its website of its various state and federal grant programs, there is no mention of the Prescription Pill and Drug Disposal Fund on this site.

Budget documents reveal that the Prescription Pill and Drug Disposal Fund has indeed received appropriations. In FY 2013, $200,000 was appropriated into the fund.[143] $150,000 was appropriated for each FY 2014 and FY 2015.[144] As of February 2, 2015, the Illinois Comptroller's fund balance website reveals that the current cash balance of the fund is

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[136] Illinois Environmental Protection Agency, *Medical Disposal – Information for Environmentally Safe Disposal of Pharmaceuticals*, http://www.epa.state.il.us/medication-disposal/.

[137] The email address provided on the IEPA website is EPA.Meds.Mail@Illinois.gov.

[138] See 20 ILCS 3930/9.3 (creating the Prescription Pill and Drug Disposal Fund); P.A. 97-545 (HB 2056 - Osmond/Schmidt); 415 ILCS 5/17.9A (authorizing the collection and transportation of pharmaceuticals from residential sources to incinerators).

[139] See 730 ILCS 5/5-9-1.1-5 (authorizing a $20 assessment for methamphetamine related offices); 730 ILCS 5/5-9-1.1 (authorizing a $25 dollar assessment for drug related offenses). Of the fees collected, 90% is remitted to the Prescription Pill and Drug Disposal Fund and 5% is remitted to the Criminal Justice Information Projects Fund. Id.

[140] See Comments of House Sponsor Representative Osmond, Apr. 11, 2011, which indicate that HB 2056 was developed by classes of Antioch Community High School and Pontiac Township High School as a means to prevent contamination of drinking water by prescription drugs that were not disposed of in a proper manner. See also P2D2 Prescription Pill and Drug Disposal, *History*, http://p2d2program.wordpress.com/about/history/.

[141] See 20 ILCS 3930/9.3.

[142] A review of ICJIA's administrative rules reveals that no new rules were introduced by the agency following the enactment of P.A. 97-545. The 2013 Annual Report of the Joint Committee on Administrative Rules also confirms the ICJIA has had no rulemakings filed within the last three years. See Joint Committee on Administrative Rules, *2013 Annual Report*, at 66, http://ilga.gov/commission/jcar/13AnnualReport.pdf.

[143] Office of Management and Budget, *State of Illinois - State Budget Fiscal Year 2015*, at 232, http://www2.illinois.gov/gov/budget/Documents/Budget%20Book/FY%202015%20Budget%20Book/FY%202015%20Illinois%20Operating%20Budget%20Book.pdf.

[144] Id. See also P. A. 98-0681.

$97,055.53, revealing that there have been transfers out of the fund, presumably to local law enforcement agencies recouping the cost of drug disposal or for the administration of the grant program.[145]

Other states, such as Georgia, have used a multi-tiered approach to drug disposal and have explicitly linked the issue of drug disposal with reducing drug diversion and limiting improper access to prescription drugs. This includes advertising regarding where drop-off sites are located, coordinated collection and disposal days, and use of federal drug disposal resources.[146] With the new opportunities for drug collection and disposal, Illinois needs to capitalize on this change in federal regulations to facilitate the collection of unused prescription drugs, thus preventing another source of diversion of drugs at the home.

E. Increasing Availability of Naloxone

Naloxone, which is also known under the brand name of Narcan, is an opiate antidote which can be administered to a person to reverse the effects of an opioid overdose, whether that overdose is caused by heroin or a prescription opioid.[147] According the Centers for Disease Control and Prevention, naloxone has been credited with 10,000 overdose reversals since 1996, based on 53,000 kits being handed out through distribution centers.[148] Several states have developed programs that train first responders in the use of naloxone and ensure that first aid kits contain this drug for use when encountering a victim of heroin overdose. United States Attorney General Eric Holder has advocated for the use of naloxone by law enforcement officers on both the state and federal levels, including the Drug Enforcement Administration, the ATF, the FBI, and the U.S. Marshalls Service.[149] In remarks at a conference at the Justice Department's Bureau of Justice Assistance, Attorney General Holder recognized the increase in heroin-related deaths and acknowledged that naloxone can be a way that first responders can effectively and quickly respond in the event of heroin overdose.[150]

Coordinated efforts for Naloxone Training and Distribution for First Responders

A coordinated effort to increase naloxone use by first responders in Illinois could provide another way to prevent overdose deaths. New York has recently implemented a project called the Community Overdose Prevention Program, which enables every state and local law-

[145] See State of Illinois Comptroller, Leslie Geissler Munger, *Cash Balance - Prescription Pill and Drug Disposal Fund – 0665*, https://www.wh1.ioc.state.il.us/index.cfm/financial-inquiries/cash-balance/. Cash balances reported on this site will vary depending upon transfers in and out of the fund.

[146] See Georgia Prescription Drug Abuse Initiative, *Safe Storage and Disposal*, http://www.stoprxabuseinga.org/safe-storage-and-secure-disposal.html.

[147] Leo Beletsky et al, *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose*, J. OF URBAN HEALTH, Vol. 84, No. 1, 2006, http://www.ncbi.nlm.nih.gov/pubmed/17146712. See also National Institutes of Health, *Hydrocodone/Oxycodone Overdose*, Medline Plus, Jan. 28, 2013, http://www.nlm.nih.gov/medlineplus/ency/article/007285.htm.

[148] Centers for Disease Control and Prevention, *Community-Based Opioid Overdose Prevention Programs Providing Naloxone*, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm?s_cid=mm6106a1_w.

[149] Department of Justice, *Attorney General Holder Announces Plans for Federal Law Enforcement Personnel to Begin Carrying Naloxone*, July 31, 2014, http://www.justice.gov/opa/pr/2014/July/14-ag-805.html.

[150] Dept. of Justice, *Attorney General Holder Announces Plans for Federal Law Enforcement Personnel to Begin Carrying Naloxone*, July 31, 2014, http://www.justice.gov/opa/pr/2014/July/14-ag-805.html .

enforcement officer in New York to carry naloxone.[151] As described by New York Attorney General Eric Schneiderman, this program will be funded through $5 million of joint federal-state criminal and civil forfeiture money, which will cover both the cost of training and the actual naloxone kits.

Thus far in Illinois, there have been separate, uncoordinated efforts to increase the use of naloxone to police departments, schools, treatment centers, and other groups.[152] Without health insurance, Narcan, the brand name of naloxone, can cost $22.99 per syringe when obtained by an individual from a pharmacy.[153] However, by securing federal funding, like the Community Overdose Prevention Program in New York, and utilizing the cost savings that can be achieved through bulk orders and coordinated education efforts, the use of naloxone can be more uniformly implemented in Illinois municipalities, as well as State Police districts. These efforts should be starting in Illinois soon, as in some areas, like New York and Georgia, the price of naloxone has been reported to be on the rise, spiking by as much as 50% higher than previous prices.[154]

Immunity Legislation

Legislation in Illinois has been enacted to provide some legal protection to persons who administer naloxone to someone who they believe is experiencing a drug overdose, but it is conditional and only limited to immunity from a violation of professional acts, not complete civil or criminal immunity.[155] Specifically, Illinois law now provides that a person who is not licensed to administer naloxone may do so in an emergency if the following two conditions are met: (1) The person administering naloxone has received "patient information" and (2) The person believes in good faith that another person is experiencing a drug overdose.[156] "Patient information" is defined as information "on drug overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antidote dosage and administration; the importance of calling 911; care for the overdose victim after administration of the overdose antidote; and other issues as necessary."[157] Thus, what appears to be immunity for friends and family of overdose victims is really limited to those who have been trained to administer naloxone.

Current law also does not explicitly mention immunity for first responders, who are now administering naloxone in Illinois on a more frequent basis. The Illinois Department of Human

[151] Ken Lovett, *Eric Schneiderman Announces New Program to Equip Cops with Heroin Antidote to Treat Overdose Victims*, N.Y. DAILY NEWS, Apr. 3, 2014, http://www.nydailynews.com/blogs/dailypolitics/eric-schneiderman-announces-new-program-equip-cops-heroin-antidote-treat-overdose-victims-blog-entry-1.1744229.

[152] Georgette Braun and Chris Green, *Heroin Special Report: Counterattacking the Epidemic in Rockford and the Rock River Valley*, ROCKFORD REGISTER STAR, Mar. 22, 2014, http://www.rrstar.com/article/20140322/News/140329828/?Start=6.

[153] Id.

[154] J. David Goodman, *Naloxone, a Drug to Stop Heroin Deaths, Is More Costly, the Police Say*, N.Y. TIMES, Nov. 30, 2014, http://www.nytimes.com/2014/12/01/nyregion/prices-increase-for-antidote-to-heroin-overdoses-used-by-police.html?_r=0.

[155] See P.A. 96-0361, eff. Jan. 1. 2010.

[156] 20 ILCS 301/5-23(d)(2).

[157] 20 ILCS 301/5-23(d)(4).

Services through its Division of Alcoholism and Substance Abuse (DASA) and the DuPage County Health Department have trained over 1,700 DuPage County police officers on how to administer naloxone.[158] While efforts to train first responders continue and trained first responders in Illinois have already started to save lives by administering naloxone, there still is no specific immunity provision for first responders in Illinois law, in contrast to other states.[159]

For those administering naloxone and for physicians, APNs, and PAs who have prescribed naloxone, the immunity is limited. People administering naloxone, such as friends and family members, will not be liable for violations of the Medical Practice Act, any other professional licensing statute, or criminal prosecution for the unauthorized practice of medicine or the possession of naloxone or any other opioid antidote.[160] For prescribers in Illinois, the immunity provision regarding the prescription of naloxone is only limited to immunity from disciplinary action under their professional acts.[161]

Illinois law should be changed to clarify the confusing requirement that a friend or family member must have the required "patient information" before they receive immunity related to the administration of naloxone. Current immunity provisions should be expanded to include all civil and criminal actions and should be expanded to include first responders. Other states have provided models of immunity for prescribers and other persons who assist a person experiencing an overdose.[162] Wisconsin law now extends civil, criminal, and professional immunity to prescribers and pharmacists who deliver opioid antagonists like naloxone.[163] For any person who reasonably believes that another person is undergoing an opioid-related overdose, Wisconsin law also provides that the person shall be immune from civil or criminal liability for any outcomes resulting from the administration of the opioid antagonist.[164]

Increasing Naloxone Availability

While immunity provisions are important to protect prescribers and the friends and family members of overdose victims, these efforts will not achieve significant impact without the availability of naloxone, which is a drug requiring a prescription. Some states, like Utah, have allowed for medical providers to give a prescription for naloxone to a family member, friend, or other person in a position to assist a person who is at increased risk of experiencing an opiate-related drug overdose.[165] Another option to increase the availability of naloxone is through standing orders. In Rhode Island, CVS will offer Narcan without a prescription at its 60

[158] Illinois Department of Human Services, DASA's First Drug Overdose Awareness Event, SMART ALERT, Vol. VIII, Issue II, July 2014, https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/OASA/DASA_Smart_Alerts/SMART_ALERT_Volume_VIII_Issue_II_DASAs_First_Drug_Overdose_Awareness_Event.pdf.

[159] Marie Wilson, *Naperville Police use Heroin Antidote to save 17-year-old*, DAILY HERALD, Jan. 29, 2015, http://www.dailyherald.com/article/20150129/news/150128589/.

[160] 20 ILCS 301/5-23(d)(2).

[161] 20 ILCS 301/5-23(d)(1).

[162] National Alliance for Model State Drug Laws, *Good Samaritan and Naloxone Bill State Report – Carryover 2014 and Special Sessions*, May 22, 2014, http://www.namsdl.org/library/4ECB3174-19B9-E1C5-3119EA3DF725DD85/.

[163] See WISC. STAT. ANN. § 448.037(3) (West 2014) (immunity for physicians); WISC. STAT. ANN. § 450.11(1i)(a) (West 2014) (immunity for pharmacists).

[164] WISC. STAT. ANN. § 450.11(1i)(c)(3)(West 2014).

[165] UTAH CODE ANN. § 26-55-104(2) (West 2014).

pharmacies in that state.[166] The dispensing of the prescription is authorized under a standing order issued by a physician. CVS indicated that it will consider expanding this effort to other states if successful in Rhode Island.

Under current Illinois law, there is no provision that specifically authorizes naloxone prescription under a standing order. Illinois law does include the Public Health Standing Orders Act, which allows for a physician to provide standing orders to provide specific medical services at public health clinics in Illinois.[167]

F. Insurance Coverage for Multidisciplinary Pain Programs and Coverage Parity for Substance Abuse Treatment

With many pain experts and public health organizations recommending limited and closely monitored use of prescription opioids for the treatment of pain, exploring other avenues for addressing the complexity of pain management, especially for chronic pain, are now receiving renewed attention. Multidisciplinary pain programs utilize a variety of different medical specialties, such as neurology and anesthesiology, in concert with allied health professionals, such as dieticians, occupational therapists, psychologists, and physical therapists.[168] The goal of this care is to provide a comprehensive approach to the management of pain that focuses on increasing activity levels, decreasing pain behaviors, and eliminating reliance on opioids.[169]

With a model focused on bundled care from multiple professionals oftentimes performed on an inpatient basis, the costs of evidence-based multidisciplinary pain programs may initially appear to be prohibitive. However, for the management of chronic pain, interdisciplinary treatments produce strong evidence for efficacy and cost-effectiveness.[170] Interdisciplinary pain clinics are part of the model of care adopted by the federal Veterans' Health Administration for the treatment of pain for the veteran population.[171]

High deductibles and out-of-pocket costs may limit a patient's ability to utilize multidisciplinary pain programs when suffering from chronic pain. Illinois law should ensure that patients who require this type of coordinated medical care have access to treatment options beyond opioid therapy. Insurers who currently offer such programs should encourage participation by qualified insureds.

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[166] Linda Borg, *By End of August, CVS will offer Narcan without Prescription to Counter Opiate Overdose*, PROVIDENCE JOURNAL, Aug. 23, 2014, http://www.providencejournal.com/news/health/overdose/20140823-by-end-of-august-cvs-will-offer-narcan-without-prescription-to-counter-opiate-overdoses.ece.

[167] 410 ILCS 125/10.

[168] David A. Williams, *Multi-disciplinary Pain Management: It works. Why isn't it used?*, Apr. 5, 2006, 12-14, http://www.med.umich.edu/painresearch/doc/williams.ppt.

[169] Id. at 12.

[170] Michael E. Schatman, Interdisciplinary Chronic Pain Management International Perspectives, PAIN CLINICAL UPDATES, Vol. XX, Issue 7, Dec. 2012, 1, http://iasp.files.cms-plus.com/Content/ContentFolders/Publications2/PainClinicalUpdates/Archives/PCU_20-7_web.pdf.

[171] See Robert D. Kerns, VHA National Pain Management Strategy Implementation of Stepped Care Model, Oct. 2012, http://www.va.gov/PAINMANAGEMENT/docs/VHANationalPainMangementStrateg.ppt.

For those who unfortunately fall into the cycle of addiction, proper medical care is still essential. ISMS supports the substance abuse treatment parity policy of the American Academy of Addiction Psychiatry (AAAP).[172] This policy calls for insurance coverage levels for substance abuse treatment "on an equal basis with treatment for medical and surgical services." AAAP recommends that the benefits that should be included are coverage for screening, psychiatric assessment, detoxification, pharmacotherapy, and follow-up treatment with psychiatric input.

While Illinois law provides for mental health parity in insurance coverage, inpatient drug treatment services are critical for the comprehensive treatment of addiction.[173] A recently enacted law in Massachusetts has provided a template for the coverage of inpatient care.[174] The law, which garnered bipartisan support, requires insurers to cover 14 days of inpatient care for substance abuse treatment. The law also limits utilization review procedures, which is how insurance companies determine if a procedure ordered by a health care professional is medically necessary, so that these procedures can only be started on the seventh day of treatment. Illinois should also consider this type of coverage to ensure that people in Illinois who suffer from substance abuse are able to access the comprehensive care they need to fight addiction and maintain abstinence from drugs.

VII. Conclusion

ISMS is committed to working with the House Task Force on the Heroin Crisis on legislation focused on the misuse of opioids and the prevention of heroin use in Illinois. ISMS and other medical specialty groups offer their resources and experience with these issues to the Task Force to reduce the extent of this problem. ISMS is committed to expanding current ISMS CME programs to other prescribers to ensure that the prescription of opioids is limited to appropriate patient populations. ISMS also believes that changes to the PMP will reduce the amount of "doctor shopping" that occurs in Illinois, and that a coordinated disposal effort will limit access to the non-medical use of prescription opioids. While prescription drug data indicates that opioids in Illinois have been prescribed on a more limited basis than in other states, this does not prevent the medical community in Illinois from striving to improve current efforts to make our state a positive example for the entire nation.

[172] American Academy of Addiction Psychiatry, *Treatment Parity*, Oct. 2002, http://www.aaap.org/wp-content/uploads/2014/05/treatment-parity-2002.pdf.
[173] See 217 ILCS 5/370c.1, P.A. 97-437, eff. Aug. 18, 2011.
[174] Shira Schoenberg, *Gov. Deval Patrick Signs Substance Abuse Law as National Policy Leaders gather in Boston*, THE REPUBLICAN, Aug. 6, 2014, http://www.masslive.com/politics/index.ssf/2014/08/gov_deval_patrick_signs_substa.html. See also MASS. GEN. LAWS ANN. ch. 175 § 47GG (West 2014) (eff. Oct. 1, 2015).

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