

Is Your Organization Compliant? The Washington PMP and Opioid Prescribing Rules

2018 Health Care Compliance Association Conference

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Outline

- Overview of the Opioid Epidemic
- Overview of House Bill 1427 and PMP enhancements
- New Comprehensive Opioid Prescribing Rules
- PMP Overview
- PMP Enhancements under HB 1427
- Q&A

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Overview of the Opioid Epidemic

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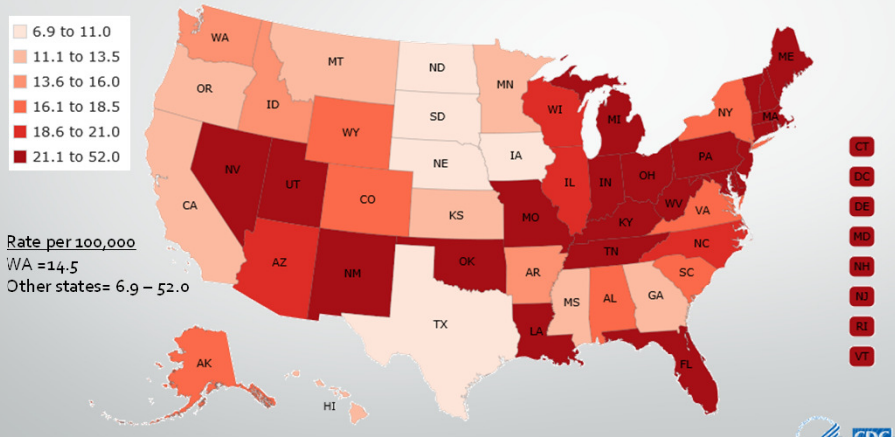
Age-adjusted Rates of Drug Overdose Deaths by State, US 2016



Source: SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

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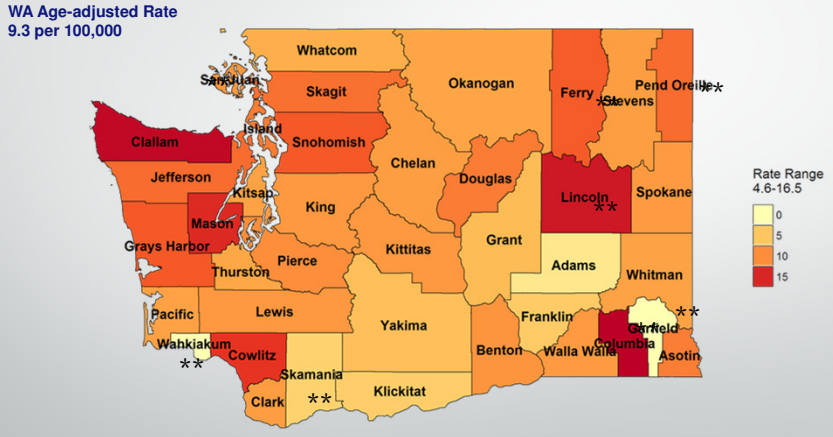
Opioid Overdose Death Rates*
County of Residence, 2012–2016



Source: DOH Death Certificates
* Includes all intent of drug-related deaths with the additional ICD-10 codes of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6
** Rates are unstable due to a low number of deaths in that county.

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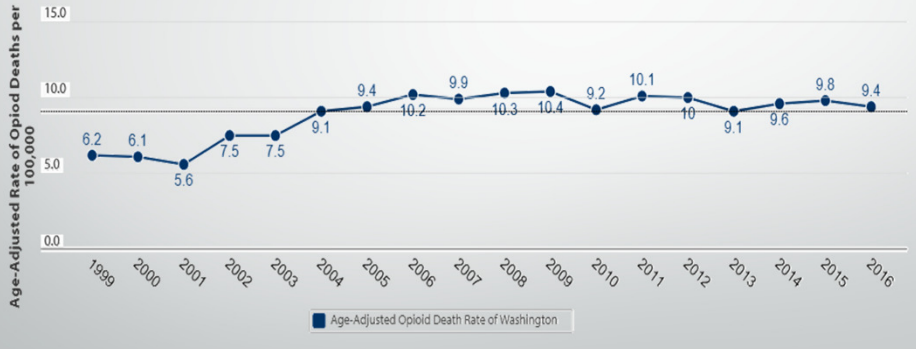
Rate of opioid-related overdose deaths in Washington State, 1999–2016

To reach our target of 9.0 would mean 30 fewer opiod overdose deaths a year



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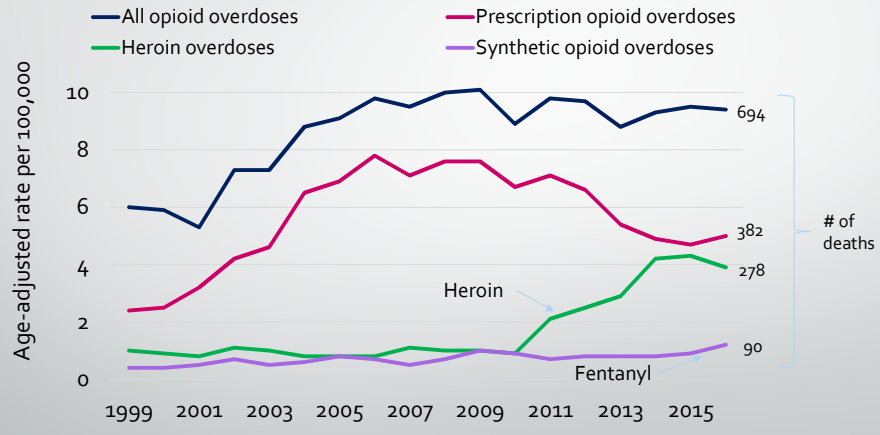
Source: DOH Death Certificates

Rate of opioid-related overdose deaths by type of opioid, WA 2000–2016



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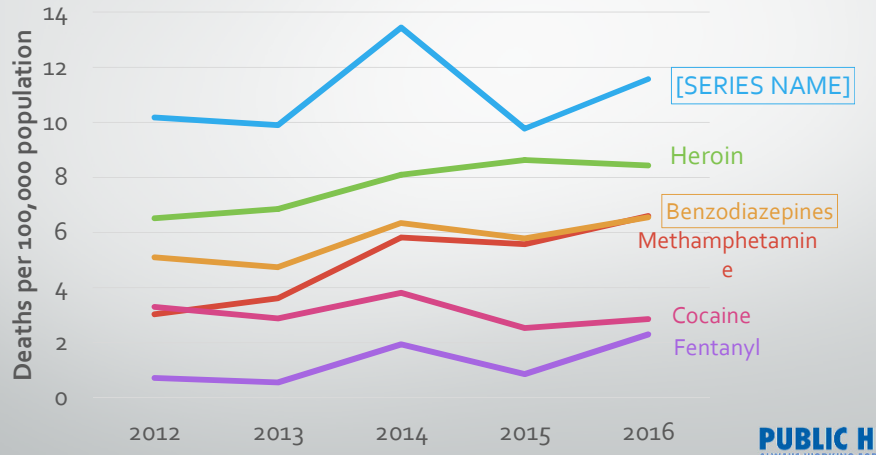
Source: DOH Death Certificates (Note: prescription opioid overdoses exclude synthetic opioid overdoses)

Drug Overdose Death Rates for Selected Drugs, NM, 2012-2016



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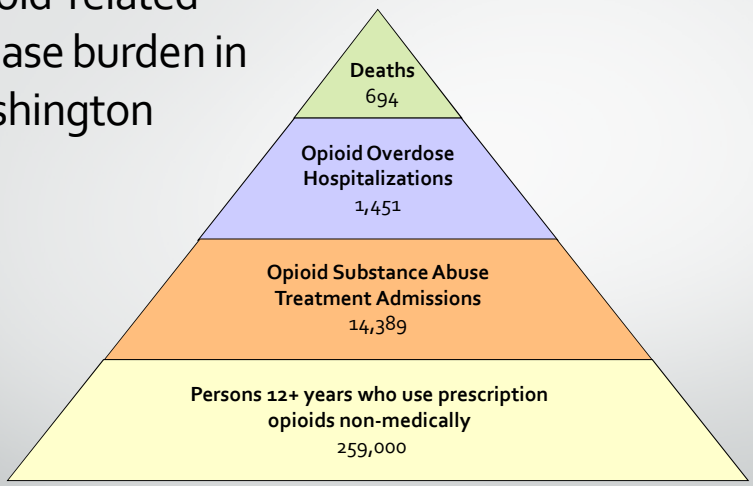
Drug categories are not mutually exclusive; fentanyl includes fentanyl analogues
Rates are age adjusted to the US 2000 standard population
Source: Bureau of Vital Records and Health Statistics death data; UNM/GPS population estimates

#Rx Summit www.NationalRxDrugAbuseSummit.org

Opioid-related disease burden in Washington



1. Opioids involved in an overdose death listed as underlying cause of death. Washington State death certificate data, 2016.
2. Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS), 2016.
3. Treatment and Assessment Report Generation Tool, 2015.
4. National Survey on Drug Use and Health, 2013-2014.

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Overview of House Bill 1427

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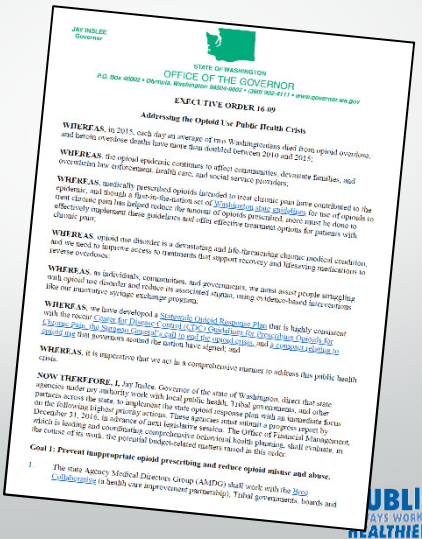
Executive Order 16-09

Key goals from the Order:

- Safer prescribing practices
- Expanding use of non-opioid alternatives
- Expanded access to medication-assisted treatment
- Increased use of the PMP



JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR

EXECUTIVE ORDER 16-09

Addressing the Opioid Use Public Health Crisis

WHEREAS, in 2015, each day an average of two Washingtonians died from opioid overdose, and heroin overdose deaths have more than doubled between 2010 and 2015;

WHEREAS, the opioid epidemic continues to affect communities, devastate families, and overwhelm law enforcement, health care, and social service providers;

WHEREAS, medically prescribed opioids intended to treat chronic pain have contributed to the epidemic, and though a first-to-the-nation set of Washington state guidelines for use of opioids to treat chronic pain has helped reduce the amount of opioids prescribed, more must be done to effectively implement these guidelines and offer effective treatment options for patients with chronic pain;

WHEREAS, opioid use disorder is a devastating and life-threatening chronic medical condition, and we need to improve access to treatments that support recovery and lifesaving medications to reverse overdoses;

WHEREAS, as individuals, communities, and governments, we must assist people struggling with opioid use disorder and reduce its associated stigma, using evidence-based interventions like our innovative syringe exchange programs;

WHEREAS, we have developed a Statewide Opioid Response Plan that is highly consistent with the recent Centers for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, the Surgeon General's Call to Action Opioid Crisis, and a compact pledging to combat the first generation around the nation have signed; and

WHEREAS, it is imperative that we act in a comprehensive manner to address this public health crisis.

NOW THEREFORE, I, Jay Inslee, Governor of the state of Washington, direct that state agencies under my authority work with local public health, Tribal governments, and other partners across the state, to implement the state opioid response plan with an immediate focus on the following highest priority actions. These agencies must submit a progress report by December 31, 2016, in advance of next legislative session. The Office of Financial Management (OFM) is leading and coordinating comprehensive policy/fiscal/health planning, shall evaluate, in the course of its work, the potential budget-related matters raised in this order.

Goal 1: Prevent inappropriate opioid prescribing and reduce opioid misuse and abuse.

1. The state Agency Medical Directors Group (AMDG) shall work with the Hero Collaborative (a health care improvement partnership), Tribal governments, boards and

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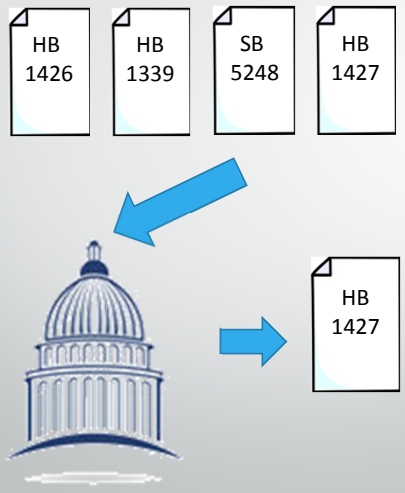
Legislative Process



ESHB 1427 Key components:

- Expands B/C prescribing rules--
  - Acute, subacute, peri-operative pain
  - Update chronic pain rules
- Authorizes health officer and other gov't access to PMP data.
- Authorizes facility/group access to PMP data.
- Authorizes hospital CQIPs to use PMP data.
- Authorizes prescriber feedback reports.

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2011 – B/C Chronic Pain Rules

- In 2010, HB 2876 directed:
  - Dental Quality Assurance Commission (DQAC)
  - Medical Quality Assurance Commission (MQAC)
  - Nursing Care Quality Assurance Commission (NCQAC)
  - Board of Osteopathic Medicine and Surgery (BOMS)
  - Podiatric Medical Board (PMB)

  to adopt chronic non-cancer pain rules by June 30, 2011.
- Specifically excluded both acute and palliative care.

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2011 – B/C Chronic Pain Rules (cont.)

- Rules included dosage limits for pain management consultation and any exceptions, education and training requirements, and other practice standards.
- Required consultation with Agency Medical Directors Group (AMDG), DOH, UW and professional associations.

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New Comprehensive Opioid Prescribing Rules

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2017 – Expanded B/C Pain Rules

- Boards and Commissions must adopt general opioid prescribing rules under HB 1427.
- Provides for possible exemptions based on education, training, prescribing level, patient panel, and practice environment.
- Must consider revised AMDG and CDC guidelines.
- May consult with professional associations, DOH, and the UW.
- Must adopt rules by January 1, 2019.
- DOH convened a task force of representatives from each board/commission

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2017 Opioid Rules – Highlights

- Acute pain (0-6 weeks)
  - Patient evaluation and record; treatment plan.
  - 7 day prescribing limit without documentation in patient record.
- Perioperative pain
  - Treatment plan.
  - 14-day prescribing limit without documentation in patient record.

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2017 Opioid Rules – Highlights (cont.)

- Subacute pain (6-12 weeks)
  - Patient evaluation and record; treatment plan.
  - 14 day prescribing limit without documentation in patient record.
  - Additional screening, biological testing, and consultation requirements.
  - Consideration of pharmacologic or non-pharmacologic alternatives.
  - Acknowledgement that patient is transitioning to a period of increased risk for opioid addiction.

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2017 Opioid Rules – Highlights (cont.)

For chronic non-cancer pain (greater than 12 weeks), most requirements were unchanged.

- History, evaluation, and treatment plan.
- Written provider/patient agreement with periodic review.
- Consultation agreement remains when patient prescription exceeds 120 mg/day MED.
- Consultation exemptions for patients and prescribers.
- Education/experience requirements to be a pain management specialist.
- Tapering requirements. NEW!
- High-dose patients with new prescribers. NEW!

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2017 Opioid Rules – Highlights (cont.)

- Continuing Education—minimum 1 hour in first full CE cycle on opioid prescribing best practices.
- Alternative treatments—must consider pharmacologic and non-pharmacologic alternatives, rather than defaulting to opioids.
- Patient notification—discuss and document:
  - Risk of opioids
  - Safe and secure storage of opioid prescriptions.
  - Appropriate disposal of unused opioids.

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2017 Opioid Rules – Highlights (cont.)

- Co-prescribing:
  - With benzodiazepines or sedative hypnotics.
  - With buprenorphine, naltrexone, etc.
  - With naloxone.
- Special populations:
  - Patients under age of 25.
  - Pregnant women.
  - Aging populations.
  - Acute care for chronic pain patients.

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2017 Opioid Rules – Highlights (cont.)

- Required PMP checks are a "floor" and each board/commission may enact stricter standards.
- Required PMP registration if you prescribe opioids.
- Required use of PMP:
  - Second opioid refill for acute and perioperative care.
  - Between acute→subacute and subacute→chronic.
  - For all acute opioid and sedative hypnotic prescriptions where PMP data are integrated into the electronic health record.

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2017 Opioid Rules – Highlights (cont.)

- Required PMP check for patients on chronic opioids (continued):
  - At least quarterly for high-risk patients.
  - At least semiannually for moderate-risk patients.
  - At least annually for low-risk patients.
  - Any aberrant behavior.
  - During episodic acute or perioperative care.

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Next Steps

- May/June – boards/commissions will approve draft rules for public comment period.
- July – draft rules (CR-102) will be filed with Office of the Code Reviser; public comment period begins.
- August – boards/commissions will conduct formal rules hearings to consider comments/testimony.
- September – final rules (CR-103) adopted are filed with Office of the Code Reviser.
- October/November – final rules effective.
- September to December – education and outreach.

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PMP Overview

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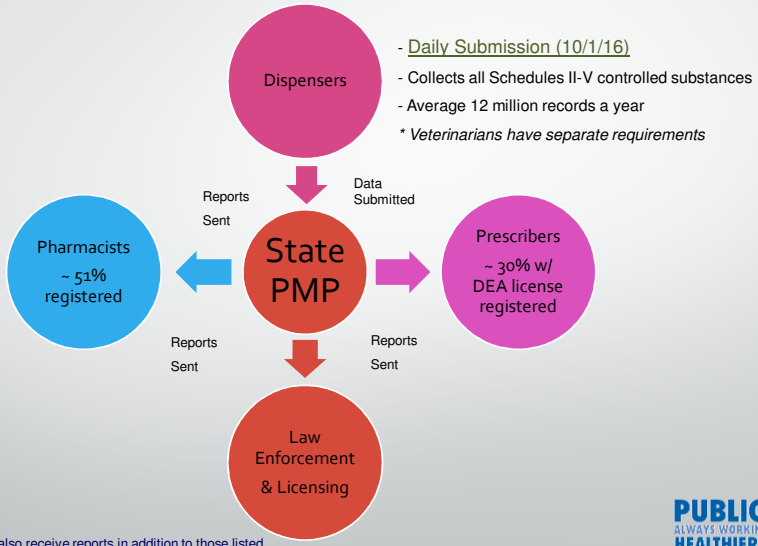
PMP Data Collection and Access



*Other groups may also receive reports in addition to those listed.

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Prescriptions Dispensed 2012 – 2016

Generic Name	2012 Rx	2013 Rx	2014 Rx	2015 Rx	2016 Rx
HYDROCODONE (all)	3,043,357	2,928,052	2,855,227	2,521,688	2,371,802
OXYCODONE (all)	1,816,171	1,827,750	1,889,380	1,952,720	1,937,349
TRAMADOL HCL	----	----	308,803	730,446	718,261
ZOLPIDEM TARTRATE	898,620	838,636	790,571	761,159	712,360
DEXTROAMPHETAMINE/ AMPHETAMINE	466,702	323,013	579,927	626,923	701,795
LORAZEPAM	632,757	634,566	643,922	640,505	623,551
ALPRAZOLAM	644,377	641,634	644,930	625,209	609,594
CLONAZEPAM	519,642	521,425	527,935	520,615	502,644
METHYLPHENIDATE HCL	397,021	410,821	422,664	420,891	443,262
MORPHINE SULFATE	327,191	330,399	336,190	362,408	351,167
Total Rx Dispensed CS reported to PMP	**11,509,488**	**11,434,877**	**11,771,216**	**11,992,986**	**11,798,943**

Update 03/03/2017

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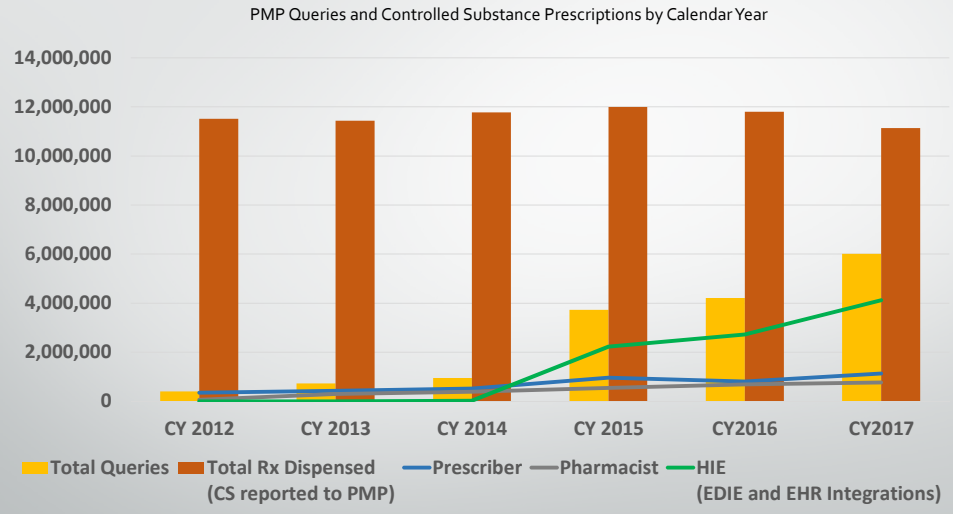
PMP Data and Utilization



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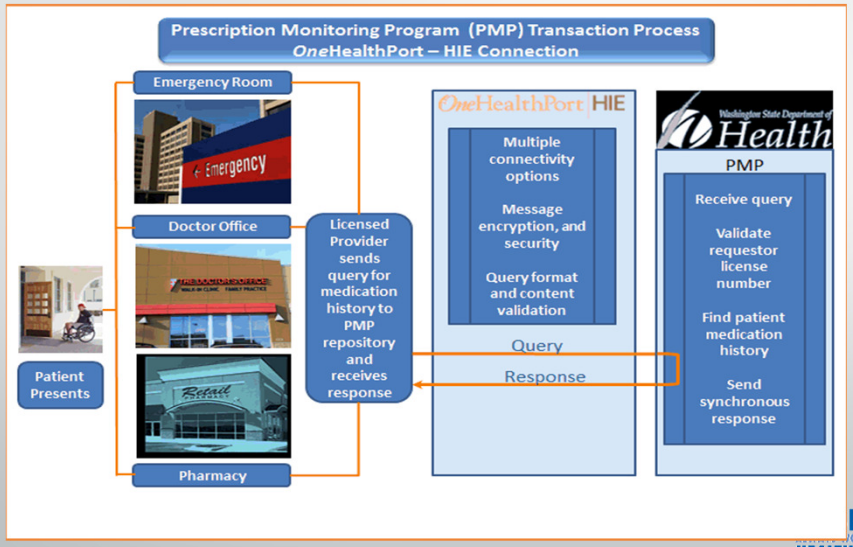
PMP to EMR Connection



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PMP – HIE Status

- EDIE is currently sending requests for PMP data
  - 85 of 92 hospitals live
  - 5 Oregon ED's
- 5 entities actively trading (CMT/EDIE, Valley Med, PTSO, UW, Kadlec)
- 2 health systems actively testing with their EMRs (Kaiser and Providence)
- 115 registrations of intent (meaningful use) to date representing 1,285 site locations

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PMP Enhancements Under HB 1427

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Assessing Overdose…

- Have linked PMP data to death data
  - Look at patterns most associated with deaths
- Would like to also look to do this with hospital overdose data
- Driven by recent high profile license revocations
  - Seattle Pain Center cases
  - Over 40 providers, estimated 12,000 patients
  - Possibly linked to 18 deaths

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Local Health Officer Access

- County LHJ can make overdoses a notifiable condition
- When notified of overdose, the health officer checks PMP to find prescribers for overdose patient
- Three counties funded by CDC to follow up with living patients to refer to treatment with MAT.

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Overdose Notification

- Emergency Department Information Exchange (EDIE) already receives:
  - Discharge information (overdose)
  - PMP information (prescribers)
- With this additional authority they can now send a notification to prescriber listed on the PMP report or to other PCPs they may have on record.

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SAMPLE Letters to Provider

RE: **(PATIENT'S FIRST AND LAST NAME, DOB), FATAL OPIOID OVERDOSE**

Dear PROVIDER **(LAST NAME AND DESIGNATED CREDENTIALS)**,

Your patient, **(PATIENT'S FIRST AND LAST NAME)**, died from an apparent opioid-related overdose at **(HEALTHCARE FACILITY'S NAME)** on **(MONTH/DATE/YEAR)**. Prescription Monitoring Program and Emergency Department Information Exchange data identified you as the patient's primary care provider, and/or as having prescribed a controlled substance to this patient, during the six months before the patient died. We do not know that your prescribing contributed to the death.

We understand that any patient's death is difficult for health care professionals to accept and process. We are providing you this information to support you in offering safe and effective care to patients.

Here are some important tips on managing pain and prescribing opioids:

- ✓ Consider providing overdose education and naloxone to patients on opioids. See www.stopoverdose.org
- ✓ Follow opioid prescribing guidelines at: http://www.agencymeddirectors.wa.gov/, http://www.coperems.org and https://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - ✓ If a patient needs opioids for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest duration. Discuss opioids' risks and benefits with your patient. Patients rarely need more than seven days' supply.
  - ✓ Prescribe opioids for chronic pain only if benefits for both pain and function outweigh risks to the patient.
  - ✓ Avoid co-prescribing opioids, benzodiazepines, or other sedatives. Combining opioids with sedatives, sleeping pills, or alcohol increases the risk of an overdose.
- ✓ Use the Prescription Monitoring Program database to verify if patients are receiving controlled substances from other prescribers. Register for the system at www.doh.wa.gov/pmp.
- ✓ Participate in UW TelePain (https://depts.washington.edu/anesth/care/pain/telepain/) or call the UW Medicine Pain Consult line (1-844-520-PAIN) for help in managing complex pain patients.
- ✓ Learn how to recognize opioid use disorder and offer evidence-based treatment. See the Recovery Helpline – https://www.warecoveryhelpline.org/
- ✓ Consider providing medication-assisted treatment for your patients. See the federal requirements at https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management

If you have any questions about the Prescription Monitoring Program, please contact the Washington State Department of Health at (360-236-XXXX or email).

Dear PROVIDER **(LAST NAME AND DESIGNATED CREDENTIALS)**,

Your patient, **(PATIENT'S FIRST AND LAST NAME)**, was diagnosed with a non-fatal opioid-related overdose at **(HEALTHCARE FACILITY'S NAME)** on **(MONTH/DATE/YEAR)**. Prescription Monitoring Program and Emergency Department Information Exchange data identified you as the patient's primary care provider, and/or as having prescribed a controlled substance to this patient, during the six months before the overdose.

We understand that no health care professional wants any patient to experience an overdose. We are providing you this information to support you in offering safe and effective care to patients.

If you are providing ongoing care to this patient, we encourage you to immediately coordinate care with the patient's other providers, if necessary. We also encourage you to contact the patient to reassess the pain management plan, and to educate the patient about opioids' risks. Patients who experience an opioid-related overdose are at high risk of future overdose, either non-fatal or fatal.

Here are some other important tips on managing pain and prescribing opioids:

- ✓ Follow opioid prescribing guidelines at: http://www.agencymeddirectors.wa.gov/, http://www.coperems.org and https://www.cdc.gov/drugoverdose/prescribing/guideline.html
  - ✓ If a patient needs opioids for for acute pain, prescribe the lowest effective dose of immediate-release opioids for the shortest duration. Discuss opioids' risks and benefits with your patient. Patients rarely need more than seven days' supply.
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  - ✓ Avoid co-prescribing opioids, benzodiazepines, or other sedatives. Combining opioids with sedatives, sleeping pills or alcohol increases the risk of an overdose.
- ✓ Use the Prescription Monitoring Program database to verify if patients are receiving controlled substances from other prescribers. Register for the system at www.doh.wa.gov/pmp.
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Prescriber Feedback Reports

- DOH can send providers a report card about their prescribing practices
- Will use NPI to compare prescribing metrics of provider to those of like license type and specialty
- Plan to make the reports available self-service in the PMP portal
- Plan to send the reports out to select providers

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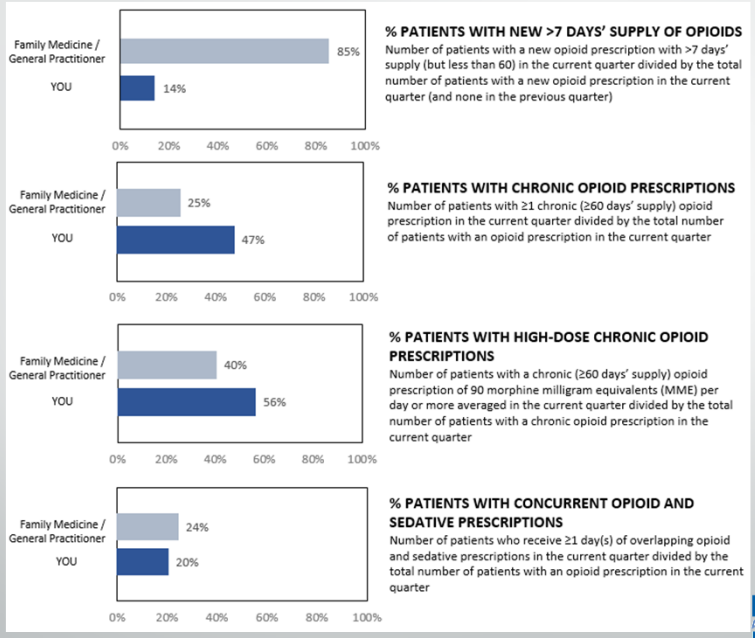

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Facility/Group Prescribing Reports

- Allows chief medical officers to view prescribing metrics of those they supervise
- Use of quality improvement initiatives to drive adoption of prescribing guidelines
- Cannot be used for employment actions
- CMO must provide list of providers (with DEA #'s) to PMP for creation of metric reports
- Required by law to be sent quarterly

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Washington State Department of Health

Health Facility Name
CMO last name, first name
Reporting Period: MM/YYYY–MM/YYYY

Washington State Opioid Prescriber Feedback Report

Prescriber	Has WA PMP access	Prescriber's Specialty	Number of WA Prescribers in Specialty	% NEW PATIENTS WITH >7 DAYS' SUPPLY OF OPIOIDS		% PATIENTS WITH CHRONIC OPIOID PRESCRIPTIONS		% PATIENTS WITH HIGH-DOSE CHRONIC OPIOID PRESCRIPTIONS		% PATIENTS WITH CONCURRENT OPIOID AND SEDATIVE PRESCRIPTIONS	
				Prescriber	Specialty Average	Prescriber	Specialty Average	Prescriber	Specialty Average	Prescriber	Specialty Average
YOU	**yes**	**Internal medicine**	**25,699**	**55%**	**48%**	**30%**	**29%**	**13%**	**32%**	**27%**	**18%**
Last name, first name	no	Psychiatry	19,002	14%	85%	47%	25%	56%	40%	20%	24%
Last name, first name	yes	Pediatrics	15,682	84%	45%	55%	60%	43%	21%	32%	45%
Last name, first name	no	Internal medicine	25,699	56%	48%	10%	29%	22%	32%	2%	18%
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Washington State Department of Health | Prescription Monitoring Program
www.doh.wa.gov/pmp | prescriptionmonitoring@doh.wa.gov

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Washington Hospital Association

- Coordinated Quality Improvement Program (CQIP)
  - Purpose: "to improve the quality of health care services by identifying and preventing health care malpractice"
  - Approved by DOH, confidential (no public disclosure)
- Receive a flat file of records (patients are de-identified)
- Allows the association's program to evaluate prescribing statewide for quality improvement opportunities

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Questions?

www.doh.wa.gov/opioidprescribing

Blake Maresh, MPA, CMBE

Executive Director
Office of Health Professions
Washington Department of Health
360/236-4760 (W)
blake.maresh@doh.wa.gov

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