

# Rural Pennsylvania

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**PUBLIC HEARING**  
**The Center for Rural Pennsylvania**  
**Access to the Prescription Drug Monitoring Program Database**

Wednesday, September 25, 2019  
Keystone Building – Atrium, PUC Hearing Room 5  
Harrisburg, PA

**AGENDA**

- 9:00 AM Welcome and Opening Comments  
*Senator Gene Yaw*, Chairman, The Center for Rural Pennsylvania
- 9:10 AM *Dr. Thomas Farley*, Director, Philadelphia County Health Department  
*Ms. Melissa Lyon*, Director, Erie County Health Department  
*Ms. Barbara Kovacs*, Director, York City Health Department
- 9:40 AM *Ms. Meghna Patel*, Deputy Secretary of Health Innovation and  
*Mr. Jared Shinabery*, Director, Prescription Drug Monitoring Program,  
Pennsylvania Department of Health  
*Ms. Laken Ethun*, Project Director, Program Evaluation and Research Unit,  
University of Pittsburgh School of Pharmacy  
*Mr. Michael Krafick*, Certified Recovery Specialist,  
Armstrong-Indiana-Clarion Drug and Alcohol Commission
- 10:10 AM Closing Remarks and Adjournment

## Center for Rural Pennsylvania Public Hearing

### Testimony of Dr. Thomas Farley, MD MPH, Health Commissioner, City of Philadelphia

September 25, 2019

I am Dr. Thomas Farley, Health Commissioner for the City of Philadelphia. Chairmen Yaw and members of the committee, thank you for allowing me to testify today to address the opioid crisis and our access to data to address it.

Philadelphia has been hit particularly hard by the national crisis of opioid use, addiction, and overdose. More than 2,300 people have died of a drug overdose in the last two years, giving Philadelphia the highest overdose mortality rate by far of any large city in the nation. While several factors are contributing to this crisis, over-prescribing of pharmaceutical opioids like Oxycontin, Vicodin, and Percocet are a major cause of the problem.

Although we should all be concerned about diversion of opioids from the legal to the illegal market, the primary source for pharmaceutical opioids in Philadelphia today is a legal prescription from a licensed health care provider. In a survey that we conducted, 75% of people taking opioids obtained them from this route. If we are going to reduce the over-use of opioids, then, we must focus on reducing prescribing by licensed physicians, nurse-practitioners, and physicians' assistants.

My department – the Philadelphia Department of Public Health – has taken many steps to persuade health care providers to reduce their opioid prescribing.

- We have mailed simplified prescribing guidelines to over 20,000 physicians in the metropolitan Philadelphia area.
- We have sent staff into the offices of more than 1,300 medical practices to deliver very direct messages about reducing prescribing.
- We have developed and distributed additional guidelines, including:
  - Guidelines of how to safely discontinue opioid use – through gradual tapering - for patients who are physically dependent on them
  - Guidelines for dentists
  - Guidelines for use of opioids after surgery
- We have developed and run a media campaign on television and social media warning consumers about the risks of opioids.

Pennsylvania's Prescription Drug Monitoring Program could serve as a crucial tool to reduce over-prescribing. Currently, the PDMP is extremely useful for doctors to identify patients who have received prescriptions of opioids from other physicians. That involves use of the data one patient at a time. But if the opioid prescribing data in the PDMP is aggregated to the physician level, it could be used in many other ways to address this problem.

Our analysis of de-identified PDMP data shows that prescribing of opioids by health care providers in Philadelphia is extremely skewed. 1% of prescribers write nearly 25% of prescriptions. The next 10% of prescribers write nearly 50% of prescriptions. And more than half of prescribers write virtually no opioid prescriptions at all. Therefore, our outreach and education to prescribers should be targeted rather than “one size fits all”.

The aggregate data on physician opioid prescribing patterns could be used to:

- Target our education to high-volume prescribers to persuade them to write fewer prescriptions;
- Shape those educational messages according to the medical specialties and prescribing practices of these high-volume prescribers; and
- Evaluate the effect of these steps by measuring changes in providers’ prescribing patterns.

Unfortunately, we have been told that the law as currently written does not allow us access to the prescribing data in the PDMP for these purposes. These limits prevent us from having a strong response to a public health crisis of enormous magnitude. We could save more lives with changes to the PDMP law that allow us to see the names of prescribers.

A second source of information that could greatly help our response to the opioid crisis is data about people who overdose on opioids and survive. Research shows that people who have had at least one overdose are more likely to have another. If a person who has had an overdose is seen in an emergency department, there is an opportunity to help prevent a repeat overdose by linking them to treatment for drug addiction. Near real-time data is needed to drive rapid, coordinated community response to increases in opioid overdoses. That data is most effective when identifying information is provided to both state and local health officials, because local officials have the local resources to provide survivors various support services. Unfortunately, timely, actionable nonfatal overdose data is not available to local public health officials in Pennsylvania.

Finally, we believe we can better combat the opioid crisis by having mortality review teams study information about people who suffer from fatal overdoses. Mortality review teams are multiagency, multidisciplinary groups that examine the circumstances surrounding deaths in their jurisdictions in detail. These review teams uncover the who, what, when, where, and how of deaths, and characterize any missed opportunities to prevent those fatalities. This information can then be used to change systems and operations in ways to prevent future fatalities. We have recently created an overdose mortality review team in Philadelphia, and this group is developing recommendations to reduce overdose deaths there. Other counties could establish similar mortality review teams, based on the areas of greatest need, in their individual communities. However, just as with the PDMP data, our mortality review team is significantly limited by legal barriers to sharing critical information about the decedents with team members.

Philadelphia is again on track to have another 1,100 overdose deaths in 2019. We cannot continue to allow barriers to information-sharing hamper our efforts to prevent future deaths. It is critical to amend the law to allow local health departments to protect our residents from this crisis. Specifically, we recommend changes to:

- Allow access to data on prescribing in the PDMP by local health departments

- Allow use of the data to target education to high-volume prescribers and evaluate the effect of that education
- Allow for the reporting of nonfatal overdoses to help those at greatest risk of a fatal overdose
- Allow for local mortality review teams to conduct comprehensive reviews among vulnerable populations to understand the factors that contributed to deaths and prevent future deaths.

Thank you for the opportunity to testify. I am happy to answer your questions and I look forward to continuing to work with you to fight the current opioid epidemic.



# ERIE COUNTY DEPARTMENT OF HEALTH



**Public Health**  
Prevent. Promote. Protect.

**Melissa C. Lyon, MPH**  
**Director**

**Kathy Dahlkemper**  
**County Executive**

September 25, 2019

Chairman Yaw and members of the committee,

I am Melissa Lyon, Director of the Erie County Health Department. Thank you for inviting me to testify today regarding access to the Prescription Drug Monitoring Program (PDMP) and ways we can further work to combat the opioid crisis.

The prescribing of opioids quadrupled in this country between 1999 and 2010.

In 2016, eight out of every ten people in Erie was given a legal opioid prescription (or 80 Opioid Prescriptions per 100 persons)

Between 2015 and 2017, there was a 92% increase in the number of drug-related overdose deaths in Erie County

In 2017, Erie County suffered 43 overdose deaths per 100,000 people, nearly double the national average of 22 deaths per 100,000.

There is also a tremendous economic cost to the opioid crisis. In 2016 alone, Pennsylvania spent over \$53.77 billion dollars in fatalities, health care spending, addiction treatment, criminal justice and lost productivity.

Pennsylvania's Prescription Drug Monitoring Program is one of the most promising tools available to address prescription drug misuse, abuse and diversion. PDMP data can reveal:

- Prescribing rates that may be consistently higher or lower for controlled substances
- Providers who prescribe controlled substances in large or excessive quantities
- Pharmacies that dispense controlled substances in large or excessive quantities
- Individuals prescribed dangerous combinations of drugs
- Individuals who may be addicted and receiving multiple prescriptions for commonly misused drugs from multiple providers and/or pharmacies
- Geographic locations of patients receiving dangerous amounts, combinations or are engaged in doctor/pharmacy shopping

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Because of the role of prescription opioids play in opioid use disorder and overdoses, it is critical we focus on reducing prescribing by licensed physicians, nurse-practitioners, and physicians' assistants.

However, because I do not have access to the PDMP, I do not know how many prescribers are prescribing opioids in Erie County. If there is an unusually high prescriber, or pill mill, or if a particular area has high overdose or fatality rate.

While other states are expanding their use PDMP data, some state health departments are struggling to translate the data at the local level into community public health initiatives. To fully address the prescription drug epidemic, allow for the utilization of new tools and approaches. Local health departments are well positioned to employ PDMP data to serve both a public health and public safety objective.

Local health departments need access to the resources to be able to make these critical assessments and the ability to reach critical assessments and the ability to reach out to those in my community to counter this epidemic.

There is NO cost to the state for this. It does not require additional bureaucracy, the purchase of software or programs, payments to contractors or any other financial expenditure. It simply requires allowing localities to utilize existing data.

The substantial burden of the current opioid epidemic has resulted in a disparity between the need for substance abuse treatment and the current capacity of the health care delivery system to meet that need. In 2017, over 47,600 people died of opioid-related drug overdoses in the United States. That same year, an estimated 11.4 million people aged 12 and older misused opioids, including 11.1 million misusers of prescription pain relievers and 886,000 heroin users. The majority of individuals in need of treatment do not receive it. In 2016, one-fifth (21.1%) of those with any opioid use disorder received specialty substance abuse treatment, including 38 percent of those with heroin use disorder and nearly 20 percent of those with prescription pain reliever use disorders.

In Pennsylvania, between Jan 01, 2018 - Aug 10, 2019, there were 15,987 emergency room visits for opioid overdoses. In 2017, Pennsylvania experienced more than 5,400 drug-related overdose deaths. However, fatal drug overdoses are just the tip of the iceberg. In 2003, an analysis estimated that there are twenty nonfatal opioid-related overdoses for every fatal overdose.

Emergency room and emergency response units are responding to significant increases in non-fatal drug overdoses and those who experience a drug overdose are significantly more likely to experience another. Thus it is critical we are able to offer targeted services to those in our communities that suffer a nonfatal drug overdose. Unfortunately, this kind of actionable data on nonfatal overdoses is not currently

available to local public health officials in Pennsylvania, greatly hindering our ability to prevent the next overdose death.

Geography is essential to accurately evaluating and understanding any discrepancy between need and capacity. It is important to consider that county size and population are not necessarily indicators of substance abuse treatment need. Counties are not equivalent in geographic area, shape, and population size and therefore comparisons on treatment needs strictly across the county level may not be appropriate.

Simply increasing capacity for treatment may not effectively increase availability (or decrease opioid-related overdoses) if prevention efforts are not tailored to the areas they are designed to serve. While current efforts have made some inroads, they do not allow for local health departments to address the overflow of prescription opioids, assess nonfatal overdoses or analyze the growing number of deaths within each community. Other factors, such as substance use treatment financing, also affect opioid addiction treatment availability

Rural areas may not have the same volume of need for substance use disorder treatment as urban areas, yet they may possess additional barriers to care that make accessibility to treatment challenging. For example, patients traveling long distances to receive treatment may face obstacles related to transportation or infrastructure that make continuity of treatment difficult.

Mortality review teams allow localities to examine and understand the circumstances surrounding fatal drug overdoses and identify interventions designed to prevent future deaths. These teams can summarize the findings from the reviews local deaths and make recommendations about how to utilize those findings to inform prevention strategies and programming. They can also be used to highlight some of the prevention activities accomplished locally and at the state level throughout the year. Thus it is critical to recognize the importance of evidence-based prevention strategies and the value of effective death reviews to inform those strategies.

The Pennsylvania Department of Health website specifically states that County and Municipal Health Departments receive state funding for “services are aimed at improving the respective community's public health via the provision of direct health services, health education and community health leadership and control. Emphasis is placed on primary and secondary preventive health services. The overall goal of these programs is to reduce morbidity and mortality among the local service population and to promote healthy lifestyles.” Despite that mission statement, local health departments are being actively prevented from using existing tools that should be at their disposal.

Data is showing a decline in drug overdose deaths since 2017 and continues to trend downward in Erie County. However, just this year, 2019, Erie County, reported 34 preventable overdose deaths- this is still too many. There is more work to be done. Pennsylvania must continue to focus on saving lives

through harm reduction and evidence-based prevention strategies, expanding treatment access and getting patients into treatment. It is therefore critical to provide local health departments with the data we need to design, implement and evaluate our response efforts, allow for the reporting of non-fatal drug overdose events to state and local health departments and analyze any opportunities to prevent future deaths.

Thank you for the opportunity to testify and I look forward to continuing to work with you to fight the current opioid epidemic.



## Introduction and Context

Chairman Yaw and members of the committee, I am Barbara Kovacs, Director of the York City Bureau of Health. Thank you for inviting me to testify today regarding access to the **Prescription Drug Monitoring Program (PDMP)** and ways we can further work together to combat the opioid crisis.

In 2017:

- 5,456 Pennsylvanians died of a drug-related overdose, 85 percent of which were the result of an opioid overdose. The high availability and corresponding demand leading to the misuse of illicit and prescription opioids is a crisis without geographic, demographic, or socioeconomic boundaries in Pennsylvania,
- Pennsylvania had the second highest number of heroin seizures of any state in the nation. York County had 1,294 heroin seizures – the fourth highest number of any county in the state – this staggering number of heroin seizures indicates high levels of opioids are available throughout the Commonwealth, including in rural counties,
- Pennsylvania ranked 13th in the nation for highest rate of overdose deaths, and this month Governor Wolf renewed the state of emergency surrounding the opioid crisis for the seventh time,
- Increased fentanyl availability and misuse contributed to a 65 percent overall increase in drug-related overdose deaths in Pennsylvania between 2015 and 2017. In 2018, opioids were found in 95 percent of all drug overdoses in York,
- Along with other states with high numbers of opioid fatalities, the heroin threat to Pennsylvania has largely transitioned into a Fentanyl threat. Heroin has been made markedly more dangerous by the unprecedented proliferation of clandestinely produced fentanyl and fentanyl-related substances.

The opioid epidemic is one that touches urban and rural communities alike:

- From 1999 through 2003, drug overdose death rates were higher in urban counties than in rural counties. Rates were similar from 2004 through 2006, then higher in rural counties from 2007 through 2015,
- Between 2015 and 2017, there was an 82% increase in the number of drug-related overdose deaths in York county,
- For both urban and rural counties, the rate of drug overdose deaths was highest among people between the ages of 25 and 44.

Opioid overdoses in the United States are a full-fledged public health and public safety crisis, with astronomical overdose death rates, detrimental social consequences, increased health- and safety-related risk, and high economic costs.

## PDMP in its present form

Pennsylvania's **Prescription Drug Monitoring Program** is an excellent tool to help protect both patients and providers. The PDMP helps prescribers identify patients who "doctor-shop", limiting the potential to harm patients. Such requests often indicate an individual with concerning use patterns who may benefit

from substance use disorder treatment. It also protects patients by identifying dangerous combinations of medications that may have unknowingly been prescribed by multiple providers.

### **PDMP Opportunities**

Beyond the established benefits to the individual patient and prescriber, the **PDMP** can serve as a key resource to groups outside of the individual patient/provider relationship. Since our **PDMP** collects comprehensive dispensing data, it is the ideal tool to help identify prescribers at risk of over-prescribing or prescribing inappropriately. It can help local government agencies monitor prescribing practices and identify unusual prescribing patterns, identify ‘pill mills,’ and can inform community-based prevention strategies. The **Centers for Disease Control and Prevention (CDC)** itself has recommended that PDMPs focus resources on “prescribers who clearly deviate from accepted medical practice in terms of prescription painkiller dosage, numbers of prescriptions for controlled substances, and proportion of doctor shoppers among their patients.”

Possible indicators of problematic prescribing detectable in **PDMP** data might include:

- Opioid prescriptions and/or doses in excess of accepted norms for their particular specialty,
- Prescribing dangerous combinations of medications or “drug cocktails”,
- Multiple patients in their practice who meet the criteria for doctor shopping or prescribing for multiple out-of-state or geographically distant patients, and
- Data on deaths, overdoses and other adverse health outcomes associated with prescription drug abuse among an individual prescriber’s patients would also serve as indicators.

Just as patterns of prescribing can indicate concerns, dispensing patterns also can identify potential problems. Signals of possible problematic dispensing by pharmacists and physicians include:

- High proportions of cash payments for prescriptions dispensed, particularly for prescriptions that duplicate those covered by Medicaid
- Filling prescriptions that noticeably appear forged and filling duplicate or excessive prescriptions without seeking confirmation from prescribers.

Identification of problematic prescribing or dispensing is one of the first steps in addressing addiction issues in the medical setting. It is also imperative to educate prescribers on the appropriate uses and doses of controlled substances as well as the risks of high dosing or diversion to nonmedical uses. We must also make the ability to treat opioid use disorder a routine part of medical care, with expectations that all practices have adequate capacity to provide effective treatment or referral. Treatment should be available for patients with opioid use disorder and at risk for overdose, starting with those who survive a drug overdose.

### **PDMP and Overdose Fatality Reviews**

It is crucial to recognize the importance of evidence-based prevention strategies and the value of effective Overdose Fatality Review to inform those strategies. Through these local fatality review processes, deaths among Pennsylvanians can be better understood and interventions designed to prevent future deaths can be identified. This involves analyzing mortality data to determine the most common causes of death and contributing factors. Using frequencies of death by cause and manner, it can be determined which deaths are considered preventable and to identify factors that contributed to

the deaths that can be used to inform prevention efforts both locally and statewide. Such analysis requires giving local, multi-disciplinary teams the ability to freely discuss the circumstances of a person's death, including prescribing history from the PDMP, in order to gain a better understanding of any shortfalls or gaps in the community's systems and resources. The ultimate goals of an Overdose Fatality Review are to prevent future deaths, decrease morbidity, and improve the general health and wellbeing of the population being reviewed. The information in the PDMP is a critical element to such reviews.

### **Final Thoughts**

The Center for Rural Pennsylvania Public Health Infrastructure for Rural Pennsylvania July 2005 Report highlights that PA counties and municipalities with local health departments have stronger information delivery systems, and thus often make more progress in combatting issues of public health than counties or cities without local health departments. It states that "one of the essential functions of a public health department is to 'inform educate and empower people about health issues,'." It would follow that local governments with limited infrastructure would be less able to "provide health information to enable individuals and groups to make informed decisions about healthy living and lifestyle choices and sponsor educational programs to develop knowledge, skills, and behavior needed to improve individual and community health"

We must stop preventing local health departments from employing the information and resources available to combat this deadly crisis. I know that in York there are people and groups we are not currently engaging because we do not have the necessary information to identify them. Local public health agencies can partner with the PDMP to help apply appropriate techniques to ensure and improve data quality. Local Mortality Review analyses can be used to identify the causes of individual's deaths, identify preventable factors, engage stakeholders in the region, and reduce the number of preventable deaths. Expanding the use of PDMP data to local health departments will maximize its utilization and impact, helping us reach those at greatest risk for dying in our community.

Unfortunately, at this time local health departments are limited in our ability to make use of the important data gathered through the PDMP. Full utilization of Pennsylvania's **Prescription Drug Monitoring Program** could maximize our effectiveness in combatting this crisis. Expanding the appropriate utilization of the PDMP is an essential next step in responding to the opioid crisis.

Thank you for the opportunity to testify and I look forward to continuing to work with you to fight the current opioid epidemic.

Testimony of Meghna Patel, Deputy Secretary for Health Innovation, Pennsylvania Department of Health  
Informational Hearing about Pennsylvania PDMP  
The Center for Rural Pennsylvania

Good Morning Chairman Senator Yaw, Vice Chairman Representative Everett and the members of the Center for Rural Pennsylvania Committee.

Thank you for giving me an opportunity to testify about Pennsylvania's Prescription Drug Monitoring Program (PDMP), a critical program for addressing the opioid epidemic. I am Meghna Patel, Deputy Secretary for Health Innovation, at the Pennsylvania Department of Health where I oversee the Pennsylvania PDMP. With me in this hearing, I have Jared Shinabery, Director of the PDMP Office, at the Pennsylvania Department of Health.

I joined the Department of Health in March of 2016 to launch the PDMP system and make it accessible to prescribers and dispensers as early as possible. My team and I have not only focused on implementing the PDMP system successfully but expanded our efforts to fatal and non-fatal drug-related surveillance, education and prevention activities as well as patient advocacy. In my testimony today, I will provide an update of Pennsylvania's PDMP since it was transferred from the Office of Attorney General, and its efforts to share data with prescribers and dispensers to improve clinical decision making and with federal, state, and local partners to drive law enforcement, investigative, and public health programs. At the end of this testimony, I would also like to share some recommendations inspired by states that have optimized their own PDMPs in innovative ways with an emphasis on patient safety.

## **Background**

Pennsylvania has had a PDMP since 1973, which was operated and maintained by the Office of Attorney General for law enforcement and investigation purposes and collected Schedule II controlled substances prescription dispensation data until June of 2016. It was then transitioned to the Department of Health in accordance to the Achieving Better Care by Monitoring All Prescriptions (ABC-MAP) Program Act of 2014. The ABC-MAP Program is most commonly referred to as the Pennsylvania PDMP for the ease of understanding amongst health care providers nationwide. The PDMP started collecting Schedule II – V controlled substance prescription dispensations records from over 3,200 licensed pharmacies starting on June 24, 2016. Today, the PDMP collects approximately 1.7 million dispensation records of controlled substances schedule II – V per month.

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The PDMP system was launched on August 25, 2016, granting access to critical prescription information to licensed prescribers, dispensers and their delegates for the first time in Pennsylvania. PDMP data is also shared with other agencies and groups as authorized by the law for public health, investigative, and law enforcement purposes. Additional authorized users include the Office of Attorney General on behalf of law enforcement agencies, Department of State Licensing Board for licensure investigations, U.S. Drug Enforcement Agency (DEA) for the administrative licensure investigations, out-of-state licensing boards for their licensure investigations, Department of Drug and Alcohol Program staff that administer the Methadone Death and Incident Review (MDAIR), county coroners and medical examiners, Department of Human Services' medical assistance and CHIP programs, and Department of Aging's PACE and PACENET programs. Through Governor Wolf's Statewide Disaster and Emergency declaration in January 2018, to aggressively combat the heroin and opioid epidemic, the PDMP was permitted to collaborate with other state agencies and provide PDMP access to the Professional Health Monitoring Program in the Department of State, the Workers' Compensation Claims Program in the Department of Labor and Industry, and the Special Funds program in the Pennsylvania Insurance Department. Today, more than 110,000 licensed prescribers, dispensers and their delegates have registered with the PDMP. On average, the users perform more than 1.6 million patient searches each month. Pennsylvania's PDMP is also sharing data with 22 states, Washington D.C. and the federal Military Health System through an interstate data sharing hub. This allows practitioners in Pennsylvania to search across state lines for their patients, who may be traveling outside of Pennsylvania to see other prescribers or pick up prescriptions and vice-versa.

### **Clinical Tool**

As a clinical tool, the PDMP gives prescribers and dispensers the information they need to facilitate more effective and safer prescribing, dispensing and treatment for patients. The PDMP helps prescribers and dispensers identify when patients are seeing multiple prescribers and dispensers in a short-time, when patients are receiving dangerous combinations of opioid and benzodiazepines, when patients are receiving a daily dose of 90 morphine milligram equivalent or more of opioids, or when patients are paying cash for prescriptions even though they have insurance coverage. As an enhancement, we launched a feature in October 2018 that provides notifications to health care practitioners in three situations: when a patient is seeing 3 or more prescribers and going to 3 or more pharmacies in a 3-month timeframe, when a patient is receiving a dosage of 90 morphine milligram equivalent or more of

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opioids, or when there are concurrent opioid and benzodiazepine prescriptions. These notifications are made available at the top of the patient's report and practitioners can access a listing of all their notifications in the PDMP system. The thresholds for alert notifications were established based on the Centers for Disease Control and Prevention (CDC) and Pennsylvania Prescribing Guidelines. The PDMP has communicated and educated clinicians that the notifications and the prescribing guidelines are intended to help them improve patient outcomes and to supplement, but not replace the individual practitioner's clinical judgement.

To make prescriber education a priority, PDMP Office developed a Prescriber Education Workgroup in November of 2016. This workgroup consists of addiction specialists, health care practitioners, representatives from Single County Authorities, and experts from the Department of Health and the Department of Drug and Alcohol Programs. Through this workgroup, we identified several key priority education topics for prescribers in Pennsylvania, and ultimately developed a series of prescriber education materials called "Evidence-Based Prescribing: Tools you can use to fight the opioid epidemic." There are seven educational modules available online and health care providers can also receive face-to-face educational sessions for free. Health care practitioners can earn continuing medical education (CME) credits for each of the seven modules, and five of the modules can be used to meet the Act 124 of 2016 opioid education requirements. These modules focus on the importance of using the PDMP, effectively using data from the PDMP to make clinical decisions and optimize pain management, opioid prescribing and tapering guidelines for opioid dependent patients, referral to treatment for patients with substance use disorder, approaches to addressing substance use disorder with patients that were identified through PDMP, and how to conduct a warm-hand off to a treatment program or center. Since March of 2017, the PDMP has educated more than 6,000 health care providers to date.

Another enhancement that our prescribers and dispensers requested right after the launch of the PDMP system was to integrate the system within their clinical workflows. Without integration, users must navigate to the PDMP web portal, log-in to the system, and enter the patient's name and date of birth in order to get to a patient report. I am very glad to share that Pennsylvania has made tremendous progress in ensuring that the PDMP is available to prescribers from within their electronic health records (EHR) systems and to the pharmacists from within their pharmacy management systems. These users can access a patient's PDMP report in seconds with a single click. Since September 2017, my team has ensured that more than 46,000 health care providers can obtain PDMP reports for their patients

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seamlessly without disrupting their clinical workflows. This allows providers to spend more face time with patients, and less time on the computer.

### **Law Enforcement and Investigative Tool**

The PDMP is also a critical tool for law enforcement and licensure investigations. As required in Act 191 of 2014, the PDMP office provides data on aberrant prescribers to the Department of State Licensing Board. This report is also sent to the Office of Attorney General in response to grand jury subpoenas. In 2018, the Office of Attorney General reported that by using PDMP as an investigative tool, they made 72% more diversion-related arrests that involved health care professionals. The opioid crisis has been a challenge for both public health and public safety agencies. Pennsylvania's PDMP remains committed to assisting our law enforcement partners with prevention, treatment referral and intervention efforts.

### **Public Health Tool**

The PDMP is also an effective public health tool. The PDMP office understands the importance of sharing de-identified data and statistics in support of public health research that informs health policy decisions. With the approval of the ABC-MAP Board, the PDMP developed a policy and protocol of de-identified data sharing to governmental and non-governmental agencies. We have successfully shared de-identified, record level data with Philadelphia Department of Public Health and Allegheny County Health Department so that they can identify prescribing patterns and evaluate and design prevention and intervention strategies in their jurisdictions. Additionally, we have also created an Interactive Data Report which is hosted on the Pennsylvania PDMP website. This data dashboard provides the public with statewide and county-level data on controlled substances dispensations and drug-related overdose measures. Much of this data is also available on the Pennsylvania Opioid Data Dashboard under Open data PA. Researchers, reporters, academic institutions, and county coalitions can use this data to measure and monitor their prevention, intervention and treatment efforts.

### **Progress**

It is important to note that the Pennsylvania PDMP system is just one piece of the many strategies that we have developed in our efforts to promote safe and effective prescribing. Opioid prescribing has decreased by 26% from the time we launched the PDMP system in August 2016 to December 2018. For

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comparison, the national trend for opioid prescribing decreased by 19% from 2006 to 2017 according to the CDC. The total number of patients in Pennsylvania who went to 5 or more prescribers and 5 or more pharmacies in a 3-month timeframe have decreased by 92%. The total number of patients who are prescribed a high dosage of opioids<sup>1</sup> per CDC and Pennsylvania prescribing guidelines, has decreased by 36%.

In September 2016, the PDMP office was able to secure a CDC grant which allows us to conduct enhanced opioid and heroin related fatal and non-fatal overdose surveillance. We collect data on drug-related overdoses from 98 percent of Emergency Departments in Pennsylvania and are in the process of onboarding the rest of the Emergency Departments. This data is collected in a de-identified and near real-time manner for syndromic surveillance purposes at the Department of Health. Drug-related overdose classifiers and thresholds have been developed to alert public health and public safety agencies if there are clusters of overdoses identified in a particular region. These alerts are called “EpiCenter Alerts”, which are sent out to the Unified Opioid Emergency Command Center for distribution, which may then trigger a need for an intervention or rapid response. The PDMP also collaborates with 50 county coroners and medical examiners to collect drug-related overdose death data and to collect additional risk factor data. After in-depth analysis with the CDC, this data can help drive public policy and health policy decisions. We aim to partner with all 67 county coroners and medical examiners by the end of this year to have a comprehensive and detailed view of drug-related overdose deaths in Pennsylvania. We will leverage this partnership and identify training opportunities for them that can help increase specificity of drugs and completeness of death certificates in Pennsylvania.

In the past 3 years since the inception of the PDMP, our team has consistently encountered complaints from patients who have abruptly lost access to their providers due to variety of factors, such as patient dismissal, provider arrest or licensure revocation, retirement, or relocation of practice. These patients are not necessarily diagnosed with substance use disorder or opioid use disorder, but rather are opioid dependent and need consistent and reliable care from providers trained to treat pain safely and effectively. In order to help guide Pennsylvanians that face such issues, the PDMP created the Patient Advocacy Program. This program serves as a centralized response team to coordinate health care

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<sup>1</sup> High dosage of opioids is defined as an average daily dose of opioid medications with morphine milligram equivalent of greater than 90.



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resources for opioid-dependent patients in need. The Patient Advocacy Program collaborates with other federal and state agencies to ensure that high-risk patients are helped and placed under the care of a health care provider.

The PDMP also continues to focus on innovative education and outreach strategies to promote the Naloxone Standing Order and Good Samaritan laws. An education curriculum was developed for First Responders, such as members from EMS, Fire and Police departments, to reduce stigma and encourage the adoption of best practices for Naloxone administration. The education program is expected to begin early 2020.

Recently, the PDMP Office was awarded the CDC Overdose Data to Action grant that will provide \$8.4 million per year for up to three years. The purpose of the Overdose Data to Action grant is to support the relationship between surveillance and prevention efforts. This is done by improving the collection of comprehensive and timely data on fatal and non-fatal overdoses and using that data to drive prevention programs. Accordingly, the PDMP Office is using a significant portion of this funding to collaborate with county and municipal health departments by sharing data to drive local prevention activities. For example, prescriber data from the PDMP can be used by local health departments for targeted, personalized prescriber education. The PDMP fully recognizes the benefit of sharing PDMP data and has always been open and willing to share data within the confines of the law for the benefit of public health.

### **Potential Enhancements/Recommendations**

The Pennsylvania PDMP team received several opportunities to collaborate with other state administrators to meet, discuss challenges and learn from each other's experiences. To optimize PDMP as an effective clinical, public health and public safety tool, we would need to think outside of the traditional standards of data collection and data sharing. First, it would be helpful to health care practitioners if they knew whether their patient recently had a non-fatal drug-related overdose event reported in an Emergency Department before they further prescribe or dispense controlled substances to that patient. Second, it would also be helpful to health care practitioners if they received notifications when a patient dies from a fatal drug related overdose. Third, the Pennsylvania PDMP could improve its data if there was a standard patient identifier, such as a government ID, collected or validated at the

Testimony of Meghna Patel, Deputy Secretary for Health Innovation, Pennsylvania Department of Health  
Informational Hearing about Pennsylvania PDMP  
The Center for Rural Pennsylvania

point of dispensation. Fourth, we should evaluate the impact of state and federal privacy laws pertaining to the patients who are in medication assisted treatment programs. In many instances, prescribers are not aware that their patients are undergoing substance use treatment and unknowingly prescribe opioids, which can overlap with other treatment medication and be dangerous or fatal to those patients. Fifth, PDMP should have the ability to proactively reach out to at-risk chronic pain or substance use disorder (SUD) patients who have lost access to their health care provider. Finally, medical directors should be lawfully permitted to review PDMP records as part of peer review and clinical supervision of their prescribers to monitor any instances of inappropriate prescribing of controlled substances, and for post-mortem reviews to determine which controlled substances had been prescribed when there was an overdose death.

### **Concluding Remarks**

The Pennsylvania PDMP is committed to continue to share data for public health good, and I believe that the PDMP has been proven to be an effective tool for prescribers and dispensers in Pennsylvania, as well as for others working in public health and public safety. However, the PDMP can become a more robust clinical tool if we continue to innovate, look at the lessons learned from other states and listen to feedback from the PDMP user community on opportunities for improvement. Thank you for giving me an opportunity to share this update about the Pennsylvania PDMP and illustrate its important role in saving the lives of Pennsylvanians.

Testimony to Public Hearing called by Senator Yaw – Center for Rural Health  
September 25, 2019  
University of Pittsburgh  
School of Pharmacy: PERU  
Janice Pringle, PhD, Director

Testimony provided by:  
Laken Ethun, MPH  
Project Director  
Program Evaluation and Research Unit  
University of Pittsburgh School of Pharmacy

Thank you Senator Yaw for inviting PERU to be part of this important testimony. PERU is located within the University of Pittsburgh's School of Pharmacy and has been working closely with various state Departments (DOH, DHS, DDAP), the Pennsylvania Commission on Crime and Delinquency (PCCD), and other state entities to implement a number of initiatives aimed at reducing overdoses across the Commonwealth. PERU has also been providing technical assistance and support to a variety of initiatives led by various state departments, county entities (such as the Single County Authorities), Managed Care Organizations (MCO's), and private healthcare organizations and systems, which are all aimed at improving the health, wellness and recovery for persons who suffer from or are at risk for developing a substance use disorder. All in all, we have approximately 34 such initiatives including a pivotal program, the Pennsylvania Overdose Reduction Technical Assistance Center (or TAC).

With funding graciously provided by PCCD, the TAC provides support to 41 counties across the Commonwealth for the purpose of reducing overdose deaths. TAC assists these counties in developing coalitions that include stakeholders from both the public health and public safety sectors such as District Attorneys, Single County Authorities, physicians, SUD treatment providers, law enforcement, EMS first responders, faith-based leaders, and others that may have contact with individuals with substance use/opioid use disorder. These coalitions have successfully developed and implemented over 150 evidence-based initiatives using a large amount of local data and a systematic implementation framework proprietary to PERU to guide their work. Many of you may have heard of our website: [OverdosefreePA.org](http://OverdosefreePA.org), which has been nationally recognized for its work in standardizing overdose death data and presenting community-based public health/public safety data so it can be used to determine what interventions in what areas could best reduce overdose deaths in a given community or county. Preliminary evaluations indicate that counties which have worked with us for at least 6 months have reduced their overdose rates by 20 – 30%.

PERU has been involved with the Governor's Initiative to develop and implement a more state-of-the-art PDMP since its inception. We provided DOH with research regarding how other state PDMP's were developed and sustained and from this made recommendations regarding optimal qualities of the Pennsylvania PDMP. We also worked along with our colleagues at the University's Graduate School of Public Health (GSPH) to develop the curricula that DOH used to support the PDMPs roll out. DOH did an excellent job of rolling out what was essentially a completely new PDMP based upon many of the recommended features of other state PDMP's. As part of this work, we have become very familiar with the state's PDMP.

We have also become familiar with PDMP data, having been graciously provided these data from the DEA as we worked through data sharing agreements with the DOH. The TAC has analyzed aggregate

level data for patient numbers, number of pills, and number of physicians prescribing for the purpose of identifying general trends for each of these domains at the county level. In these analyses we have worked carefully with DOH to ensure that none of the data aggregates or analyses could ever divulge the identity of patients or prescribers. We have primarily conveyed these analyses through data presentations as part of our data driven strategic planning process conducted with each county coalition. The counties have used this information to determine the extent of their environmental exposure to prescription opioids, the potential need for provider education and interventions, and areas within the county where interventions such as drug take-back programs and naloxone distribution programs would potentially be most impactful.

Thus, the communities in which we work have learned that the PDMP data can be very useful to guiding their initiatives aimed at reducing opioid use disorder and overdose deaths. They are very interested in learning more about their PDMP data and would like to receive even more detailed PDMP information (but that we either do not currently have or do not feel appropriate for us to share).

- First, they would like to have more information regarding prescribing of benzodiazepines, as currently the data we receive from the DEA does not provide information regarding the prescribing of this sedative. This is important because the toxicology associated with many overdose deaths across the Commonwealth include a combination of benzodiazepines and opioids. Sometimes decedents are acquiring the benzodiazepines illicitly, but there is evidence that they may also be acquiring this drug via legitimate prescriptions via prescribers who do not fully understand their patient's exposure to illicit opioids or medications used to treat opioid use disorder.
- The counties would like there to be a more aggressive way that prescribers who are prescribing a variety of addictive or risky drugs at clinically problematic levels be more quickly identified and investigated. Some of these prescribers do not intend to prescribe unsafely, but lack the information regarding how to manage their patients' pain more safely or how to determine via patient interviews what other drugs they may be taking either via bonafide prescriptions or illicitly. Moreover, they feel that health systems often know which of their providers fall into this category, but because the health systems (large and small) lack the knowledge and support necessary to help the providers change their prescribing practices and safely taper patients, they often choose to do little to nothing to intervene with the providers.
- The counties also would like to more aggressively identify which pharmacies may be filling prescriptions that should be questioned or not filled. The PDMP data can be used to demonstrate the need for collaborations with local pharmacies to develop programs that provide the training and support necessary to change pharmacy fill practices to ones that provide greater patient safety. PDMP data can also be used by the counties to determine the best locations for drug take-back programs. PDMP data could also be used to influence greater distribution of naloxone within pharmacies since unfortunately, despite the Standing Order provided by Dr. Levine, many pharmacies across the Commonwealth are not distributing naloxone as expected.
- As we discovered in our examination of evaluation efforts associated with PDMP's in other states, the institution of PDMP programs such as Pennsylvania's can sometimes result in a net increase in opioid prescribing as providers using the PDMP become more at ease with prescribing pain medication for persons who truly need the medications to manage significant and catastrophic pain. The counties would like to be able to have a way of

determining which physicians may be prescribing pain medication in this appropriate manner versus those who may be prescribing pain medications at unsafe and clinically unnecessary levels.

- Some pharmacies in Pennsylvania are beginning to implement programs such as Screening, Brief Intervention and Referral to Treatment (SBIRT). This evidence-based program identifies patients who are at risk for substance (including alcohol) misuse and provide to them appropriate interventions aimed at reducing their risk (i.e., facilitated access to specialty substance use disorder treatment). Counties would like to have PDMP data to determine which healthcare settings (primary care or pharmacies) might best implement SBIRT programs first.

We applaud the DOH for designing and implementing so well a more state-of-the-art, public health focused PDMP. We understand that the law governing this PDMP may ostensibly make the sharing of its data difficult and restricted. Given the pervasive nature of substance use disorder within the state, the PDMP is a powerful tool that can guide the development and implementation of interventions that can lead to improved patient health and safety. The restrictive nature of the state's data sharing process can impede the speed in which these interventions are conceived, rolled out and evaluated. Still, the unfettered sharing of PDMP data could also lead to very significant deleterious outcomes such as poorer patient health outcomes, unmanaged patient pain, inaccurately labeling providers and dispensers as to their intentions with respect to their prescribing and dispensing practices, and even most seriously significant breeches with respect to patient identities. There has to be some middle ground where data can be shared with the counties in a responsible manner so initiatives such as the TAC can best make use of these data to increase the impact of intervention programs aimed at improving the community health within our Commonwealth. We would be happy to be part of a Task Force that could explore best how this middle ground could be defined and implemented.

September 25, 2019

Hello and thank you for the opportunity to speak today at this Public Hearing for Access to the Prescription Drug Monitoring Program Database.

My name is Mike Krafick and I am a Certified Recovery Specialist and the CRS Supervisor with the Armstrong-Indiana-Clarion Drug and Alcohol Commission. I am also a person in long-term recovery, for years I struggled with addiction to heroin and other opioids but this past April I celebrated 11 years of recovery. I started using drugs and alcohol at a very young age, by age 20 I started using heroin after experimenting with a variety of other drugs prior to that. Over the next 7 years I was in and out of treatment facilities and County jails. The first time I went to treatment I was 22 years old and by the time I was 27 I entered treatment for the ninth time. I am an overdose survivor, throughout my addiction to opioids I was hospitalized for overdose 5 different times. During my experience with addiction and recovery I've had plenty of opportunities to experience the stigma of addiction firsthand and that is what I would like to focus my testimony on today, the stigma that people with substance use disorders experience.

When I learned that Pennsylvania was considering expanding access to the Prescription Drug Monitoring Program stigma was the first concern that came to mind. How would this data be used and how would that impact those individuals and families that are dealing with substance use disorders? I believe that there are several positive things that can happen if entities like County Health Departments have access to PDMP data. Data drives good decision making, and having accurate data is very important to the work that these agencies do. I do think County Health Departments having access to prescriber data would be very valuable information, allowing them to see what doctors are prescribing more opioids than others so they could provide education to those physicians. This information would allow Health Departments to do education and outreach with those prescribers which could lead to a reduction in over prescribing of these dangerous and addictive drugs.

The consideration of expanding what medications are logged in the Prescription Drug Monitoring Program to include Naloxone was something that I was much more concerned about because that is where I believe that the stigma around addiction could have a significant negative impact on individuals struggling with opioid use disorders. Naloxone is not a controlled substance and with the Standing Order that was signed by the Secretary of the Department of Health, Rachel Levine Naloxone is essentially an over the counter medication. Increasing access to Naloxone has been one of the major initiatives across the Commonwealth to combat the opioid epidemic. The PDMP has been vital in gaining a better understanding of the amount of opioids that are being prescribed across the state and from all the data that I have seen, it has had a positive impact on reducing the number of prescription opioids that are in our communities. The system has allowed doctors to have the information about what controlled substances their patients are already getting, therefore cutting down on the doctor shopping for opioids. What is the benefit of tracking Naloxone in the PDMP and more importantly in my opinion, what is the harm that could be caused by tracking this life saving medication in the same system used to track addictive and potentially lethal opioids? My main concern about tracking Naloxone administration in the PDMP is that it would be used to label individuals as addicts, adding a red flag into their medical record that this person is a drug addict and how that could impact the care that they receive. Like I said earlier, I have experienced stigma around addiction myself and for me my experience

with being treated for multiple overdoses is the time that I most vividly recall feeling judged, misunderstood, and even mistreated. In the work that I have the opportunity to do at Armstrong-Indiana-Clarion Drug and Alcohol Commission with overdose survivors I know that not a lot has changed in that regard over the past 15 years. I hear stories from overdose survivors about their experiences with hospital staff and first responders and I even get the opportunity to hear comments from some medical personnel and first responders myself. Part of my role with our Warm Handoff Program is working with medical providers to reduce the stigma around substance use disorders and while we have made some progress in that area, there is still a lot of work to be done.

In Middletown, Ohio in 2017 the town's City Council considered implementing a rule that would exclude individuals that have more than 2 overdoses from receiving life saving treatment with Naloxone from EMS. <https://www.usatoday.com/story/news/nation/2017/06/28/ohio-councilman-suggests-three-strikes-law-halt-overdose-rescues/434920001/> This thought process is not unique to Ohio, I hear comments like this from people in my community.

The American Medical Association (AMA) determined that addiction was a disease in 1956, over 60 years ago, but I can say from my experience that substance use disorders are still not treated the same way that other chronic diseases like diabetes, hypertension, and asthma are and I believe stigma is the reason that is the case. My number one concern with making this change is that this stigma that we still see on this issue will prevent overdose survivors from getting the medical care that they need because they would be treated as if they were drug seeking because they have a history of substance use. I'm concerned that will prevent individuals that need assistance from EMS/other first responders from calling 911 for help.

Thank you very much for the opportunity to offer testimony on this very important topic. I know this issue of opioid use disorder impacts a lot of people in our communities and I appreciate the chance to be a part of this hearing today. I would be happy to answer any questions.

Sincerely,

Mike Krafick  
CRS Supervisor  
Armstrong-Indiana-Clarion Drug and Alcohol Commission