Testimony to Public Hearing called by Senator Yaw – Center for Rural Health
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University of Pittsburgh
School of Pharmacy: PERU
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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, 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.