THE FAILURE OF THE PRESCRIPTION DRUG MONITORING PROGRAM AND ITS UNINTENDED AND INTENDED CONSEQUENCES

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DISCLOSURE

I have no relevant financial relationships to disclose.

DISCLAIMER

- All opinions expressed in this presentation are solely mine and do not necessarily reflect the positions of any business or organization with which I am affiliated.
- It is a sad commentary on our society that I have to make this disclaimer.

Drug Category	ICD-10 Code	Drugs
Heroin	T40.1	Heroin
Natural and semi-synthetic opioid analgesics (aka "other opioids")	T40.2	Morphine, Oxycodone, Hydrocodone, Hydromorphone
Methadone	T40.3	Methadone
Synthetic opioid analgesics, excluding methadone (aka "Other synthetic narcotics")	T40.4	Fentanyl, Meperidine
Cocaine	T40.5	Cocaine
Other or unspecified narcotic	T40.6	

First a brief review. These are some of the ICD-10 codes for narcotics both legal and illegal.

The drugs in the red box are all prescription medications, except for fentanyl starting in 2013.

IT'S FOR THE HEALTH AND SAFETY OF THE PEOPLE.

This is the phrase that we constantly hear from legislators.

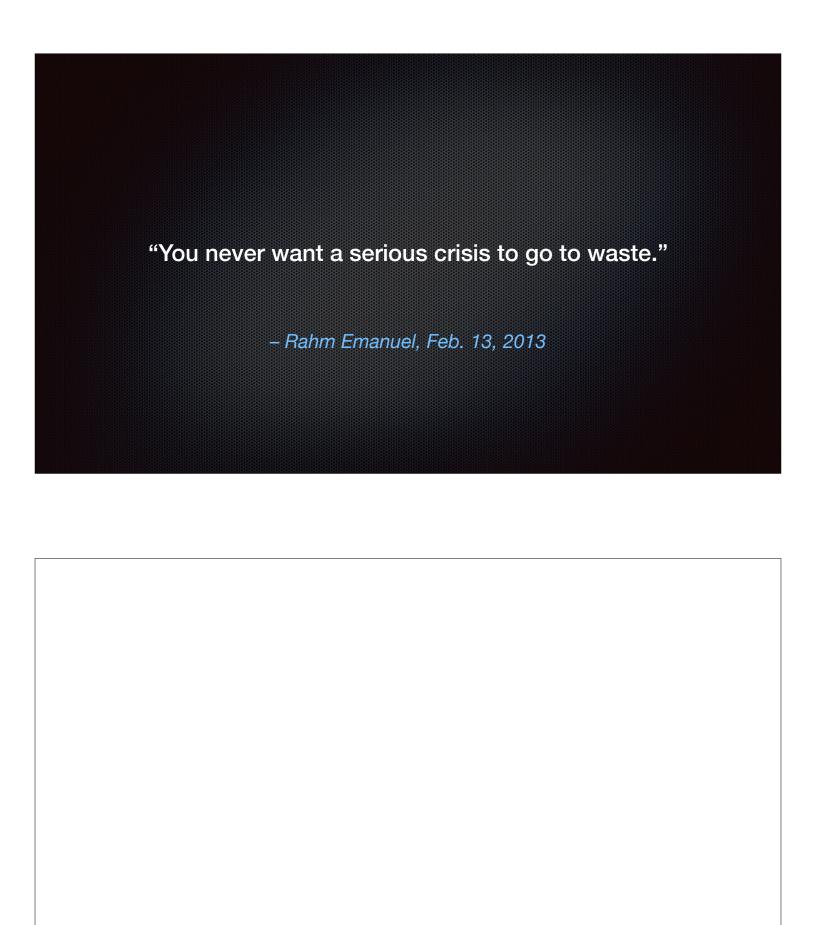
You can pass any law for health and safety. Look what they did during the pandemic.

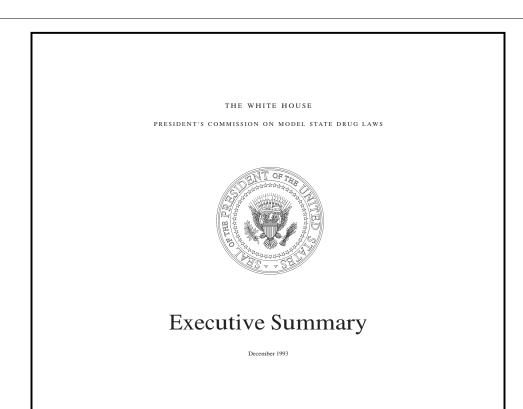
Gov. Parson's State of Emergency Executive Order used the Revised Statutes of Missouri (RSMo) definition of "Disasters" — disasters which may result from terrorism, including bioterrorism, or from fire, wind, flood, earthquake, or other natural or man-made causes. This is meant to cover attacks like anthrax which can kill thousands quickly or a New Madrid earthquake, not a virus.

FAILURE IS INHERENT IN FREEDOM

You can not have freedom unless you also have the ability to fail. 100% security is the same as having no freedom. This is also known as slavery. Some people make bad choices. The government can not stop that. You can not legislate morality. Paraphrasing an old saying, "The road to tyranny is paved with good intensions." Replace good intensions with health and safety laws. "The road to tyranny is paved with health and safety laws."

Here is a quote that sums up what the government is attempting.





This is how it got started. The President's Commission on Model State Drug Laws was released in December 1993.

It had 5 volumes with a total of 40 sections. This was a massive document hundreds of pages long. This was released 11 months after Pres. Bill Clinton was inaugurated. Due you think it was written in 11 months or was it already written waiting for the "crisis?"



This was 1 of the 40 sections.

Highlights of the Model Prescription Accountability Act

ASSUMPTIONS AND REMEDIAL GOALS

- Recognizes that the diversion and abuse of prescription drugs is a serious public health concern, involving an estimated 8.5 million people 12 years or older in nonmedical use of controlled sedatives, tranquilizers, stimulants, or analgesics.
- Simultaneously acknowledges that controlled substances are essential to the effective care of patients suffering a variety of medical conditions, and that access to these drugs for legitimate purposes must be preserved.
- Improves the state's ability to stop illegal diversion of prescription drugs in an efficient and cost effective manner, without impeding the appropriate prescribing of pain-killing and other prescription drugs or compromising patients' interests in confidentiality.
- compromising patients' interests in contidentiality.

 Provides assistance to many thousands of individuals who are addicted to prescription drugs and who presently are receiving no professional attention by using the electronic monitoring system to identify such persons and refer to treatment. The benefits to those individuals, and the resulting social and economic benefits to society, will far outweigh the costs of detection and treatment.

PROCEDURES AND REMEDIES

- Creates a process for the collection, analysis and use
 of essential information on the prescribers, dispensers
 and recipients of controlled substances in order to
 prevent the harm to patients and the public that
 ensues from such drug diversion and abuse.
- Employs an electronic network for rapid and reliable transmission of data from dispensing pharmacies to a central data repository.

- Acknowledges that the value of information in preventing drug diversion depends on its being rapidly and readily available to authorized personnel under appropriate circumstances.
- appropriate circumstances. Requires the designated state agency to use its administrative procedures to determine which substances are being misseed and abused, and are therefore subject to monitoring. This approach increases the likelihood that the list of monitored controlled substances will be kept up to date, since it is less cumbersome to administratively identify newly misseed or abused substances than to pass another law every time a Schedule II-V controlled substance starts to be missued or abused in the state; and provides greater governmental flexibility for each state to respond to its particular prescription drug abuse problems. Minimizes the financial impace on pharmacies by
- Minimizes the financial impact on pharmacies by developing an electronic network that is compatible with (and supportable by) other electronic pharmacy communications equipment and systems already in use.
- Appoints a broadly representative Prescription Accountability and Patient Care Improvement Board to oversee the data collection process and make preliminary determinations as to the ultimate disposition of cases involving questionable drug prescribing, disposing on them.
- pensing or use.

 Provides for the establishment of general criteria to determine which cases will be brought to the attention of the Board. These criteria are to be programmed into the electronic monitoring system to automatically detect cases in which "an identified commoles substance has been dispensed for period controlled substance has been dispensed for period ished normor or sandards." Requires that the standards for exception and referral be consistent with

CRIMES CODE A-15

PRESIDENT	S	COMMISSION	ON	MODEL	STATE	DRUG	LA

well established and respected guidelines and research in the field.

- Facilitates the sharing of case information among relevant state agencies and between state and federal officials. This reflects the intent to encourage state/federal cooperation and coordination.
- state/recent cooperation and coordination. Imposes coding requirements, stringent limitations on access to the data, and other safeguards on sensitive patient information to protect neonificentially of the physician-patient encounter. Establishes a process for consultation with state medical and other health professional societies or their representatives, recognized patient advocay groups, and individuals knowledgeable regarding privacy protection issues.

-16 CRIMES CODE

These are the 2 pages of highlights. The following 13 pages are from the highlights.

ASSUMPTIONS AND REMEDIAL GOALS

Recognizes that the diversion and abuse of prescription drugs is a serious public health concern, involving an estimated 8.5 million people 12 years or older in nonmedical use of controlled sedatives, tranquilizers, stimulants, or analgesics.

This is a correct statement.

Simultaneously acknowledges that controlled substances are essential to the effective care of patients suffering a variety of medical conditions, and that access to these drugs for legitimate purposes must be preserved.

That statement is true, but this is the opposite of what actually happened. Access to these drugs has been severely reduced.

Improves the state's ability to stop illegal diversion of prescription drugs in an efficient and cost effective manner, without impeding the appropriate prescribing of pain-killing and other prescription drugs or compromising patients' interests in confidentiality.

This is a completely false statement.

Provides assistance to many thousands of individuals who are addicted to prescription drugs and who presently are receiving no professional attention by using the electronic monitoring system to identify such persons and refer to treatment. The benefits to those individuals, and the resulting social and economic benefits to society, will far outweigh the costs of detection and treatment.

Another completely false statement.

PROCEDURES AND REMEDIES

Creates a process for the collection, analysis and use of essential information on the prescribers, dispensers and recipients of controlled substances in order to prevent the harm to patients and the public that ensues from such drug diversion and abuse.

This is not correct.

Requires the designated state agency to use its administrative procedures to determine which substances are being misused and abused, and are therefore subject to monitoring. This approach increases the likelihood that the list of monitored controlled substances will be kept up to date,

since it is less cumbersome to administratively identify newly misused or abused substances than to pass another law every time a Schedule II-IV controlled substance starts to be misused or abused in the state; and provides greater governmental flexibility for each state to respond to its particular prescription drug abuse problems.

This is incorrect. It provides greater governmental control over physicians and patients.

Appoints a broadly representative Prescription Accountability and Patient Care Improvement Board to oversee the data collection process and make preliminary determinations as to the ultimate disposition of cases involving questionable drug prescribing, dispensing or use.

This is a nice idea, but it never happened.

Provides for the establishment of general criteria to determine which cases will be brought to the attention of the Board. These criteria are to be programmed into the electronic monitoring system to automatically detect cases in which "an identified controlled substance has been dispensed for a period of time or in a quantity or manner outside the established norms or standards." Requires that the standards for exception and referral be consistent with well established and respected guidelines and research in the field.

There is very little good research in the pain medicine field.

Facilitates the sharing of case information among relevant state agencies and between state and federal officials. This reflects the intent to encourage state/federal cooperation and coordination.

This is their goal. 100% control of prescribing pain medicine. Thanks to the 2021 Missouri legislature, they are within a few years of achieving their goal.

Imposes coding requirements, stringent limitations on access to the data, and other safeguards on sensitive patient information to protect the confidentiality of the physician-patient encounter. Establishes a process for consultation with state medical and other health professional societies or their representatives, recognized patient advocacy groups, and individuals knowledgeable regarding privacy protection issues.

This never happened. The system does not protect privacy.

LEGISLATIVE FINDINGS

According to the National Institute on Drug Abuse (NIDA) sponsored Drug Abuse Research Survey of drug treatment facilities around the country, approximately 10% of the patients' principal drugs of abuse were drugs that may be prescribed.

This is not a correct statement.

It is the policy of this state that any retail monitoring system, in order not to impede the appropriate prescribing and use of prescription drugs, must not be unduly burdensome to prescribing physicians and must fully protect the legitimate confidentiality concerns of patients.

That is not a correct statement. The result was the exact opposite.



This is the result of the President's Commission.

HISTORY

Formed in 1993, NAMSDL began as a result of the President's Commission on Model State Drug Laws. This congressionally established commission was charged with creating a model code of laws to help states effectively address alcohol and other types of drug abuse. It is a non-profit organization.

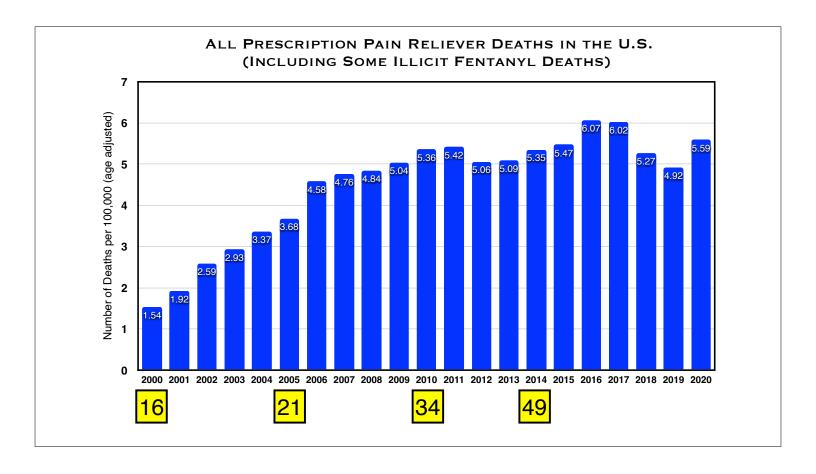
NAMSDL is the National Alliance for Model State Drug Laws.

MISSION STATEMENT

NAMSDL empowers states by identifying and creating the most comprehensive, integrative and effective model laws, policies and protocols in the areas of drug and alcohol prevention, intervention, treatment, recovery support, overdose abatement and criminal justice.

PRESCRIPTION OPIOID DEATH RATE AND STATE PARTICIPATION IN PDMP 2000 to 2020

Now let's look at the results of all of this government intervention.

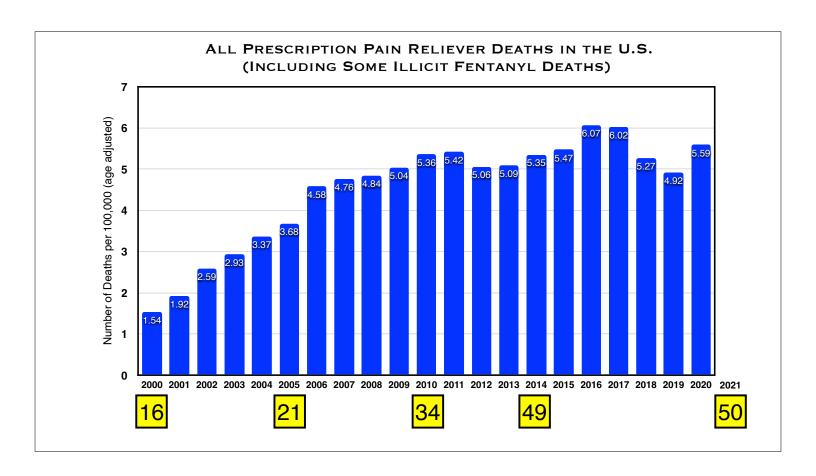


This graph shows the increase in the per capita death rate due to prescription opioids.

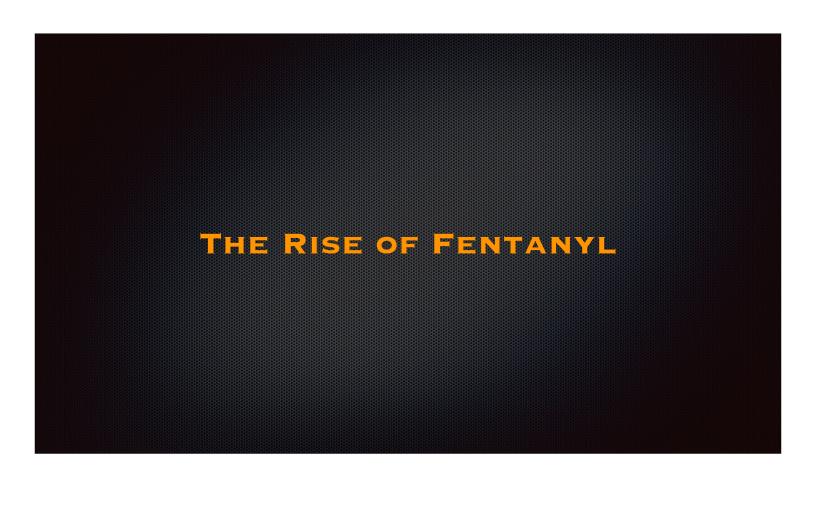
In 2000, there were 16 states with operational PDMPs.

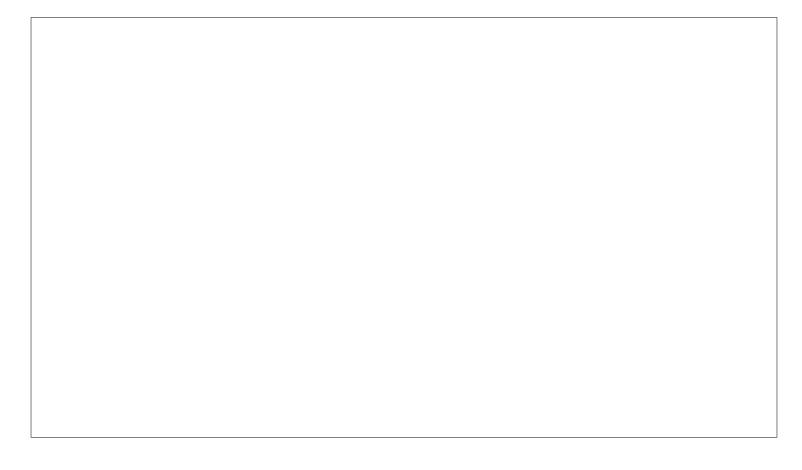
That number increased to 21 by 2005 and to 34 by 2010.

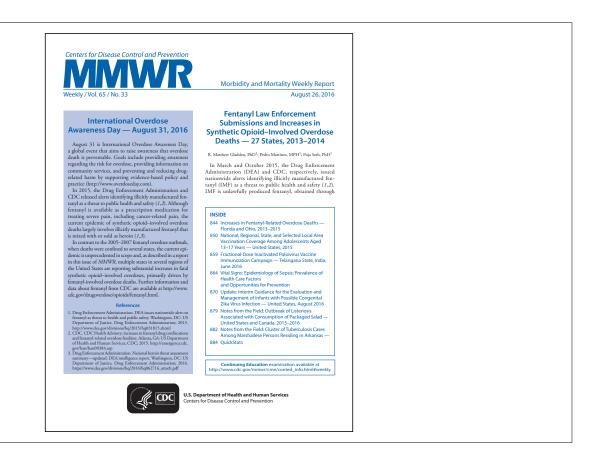
By 2014, there were 49. All of the states participated except Missouri. If the PDMPs were designed to prevent prescription opioid deaths, then the programs are an abject failure, yet the government continues the program and expands it. Why?



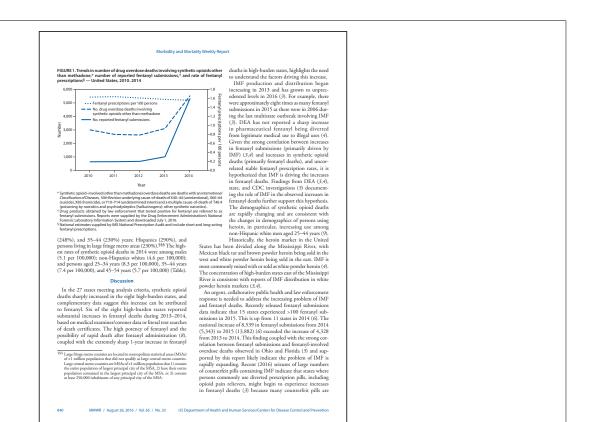
In 2021, Missouri passed the PDMP legislation making it the final state to fall. The network is now complete.



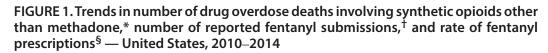


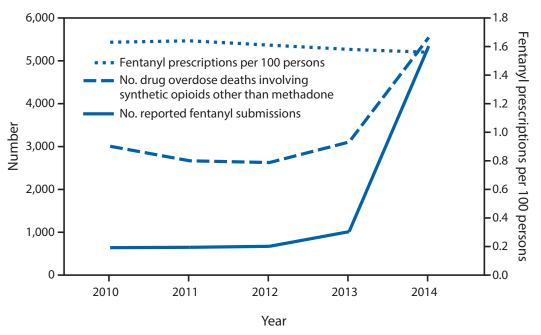


This is the CDC Morbidity and Mortality Weekly Report from August 26, 2016.



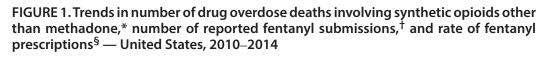
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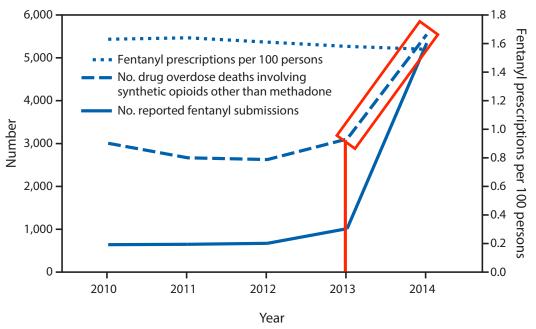




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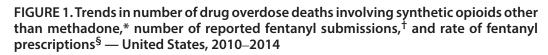
This is the graph at the top to the page.





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In 2013, fentanyl deaths started to show a significant increase.



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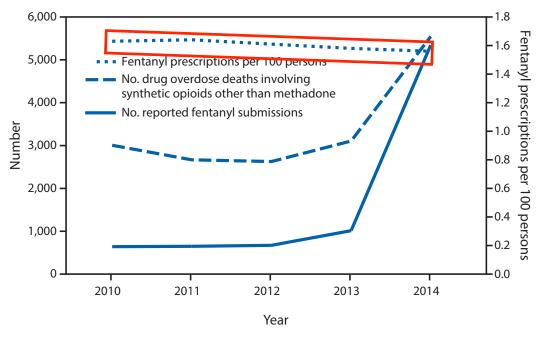
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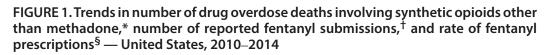
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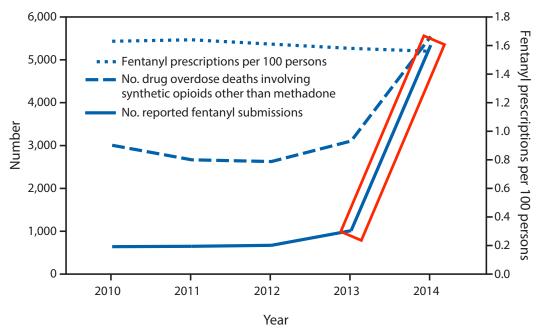
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IMF prod



But the fentanyl prescriptions decreased slightly from 2010 to 2014.





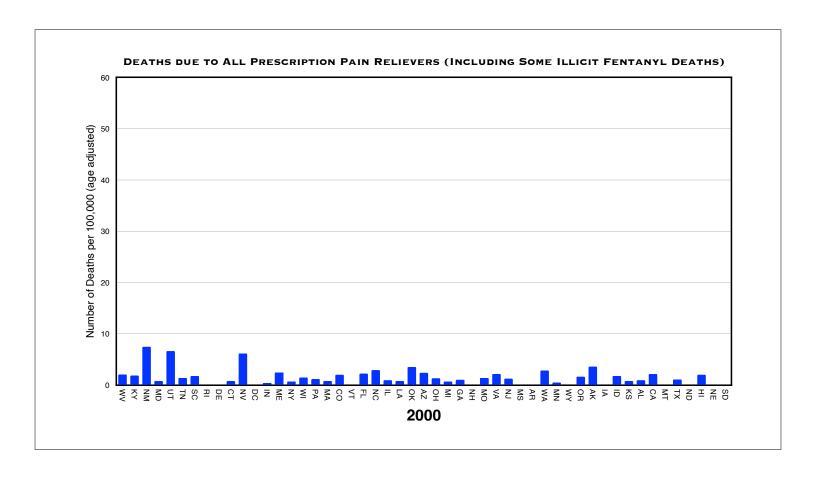
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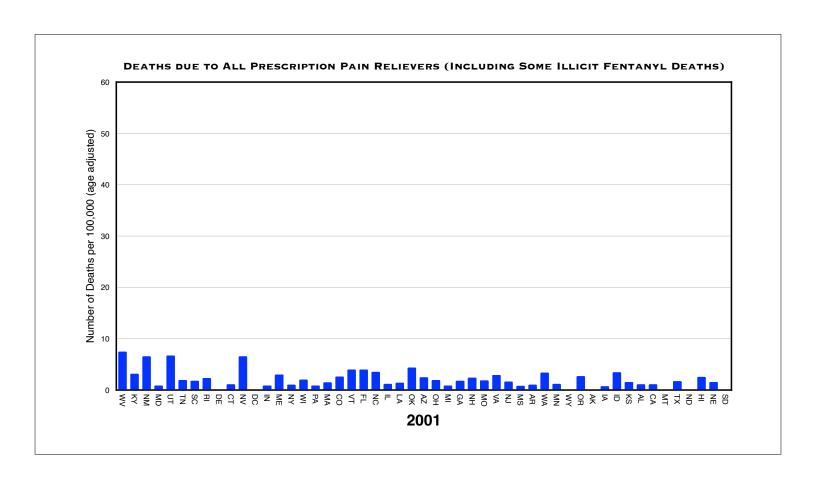
The solid blue line is the number of reported fentanyl submissions which are reports of drug products obtained by law enforcement and submitted for testing. This increased from about 1,000 to over 5,000 in one year.

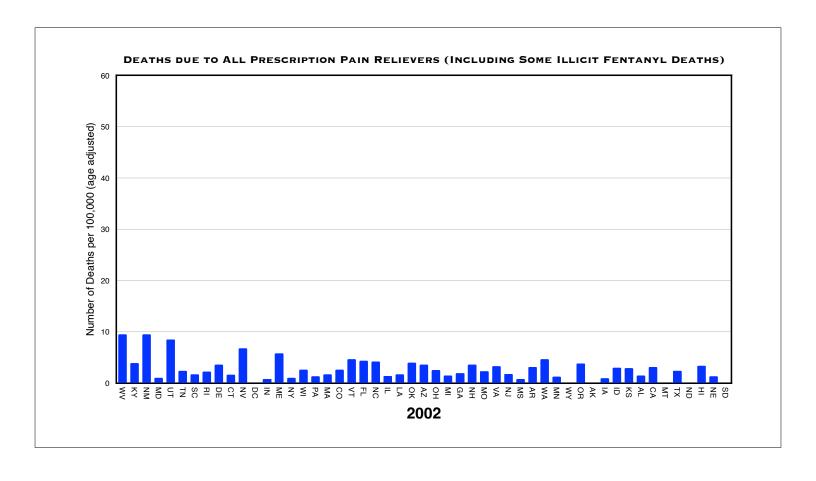
ILLICIT FENTANYL

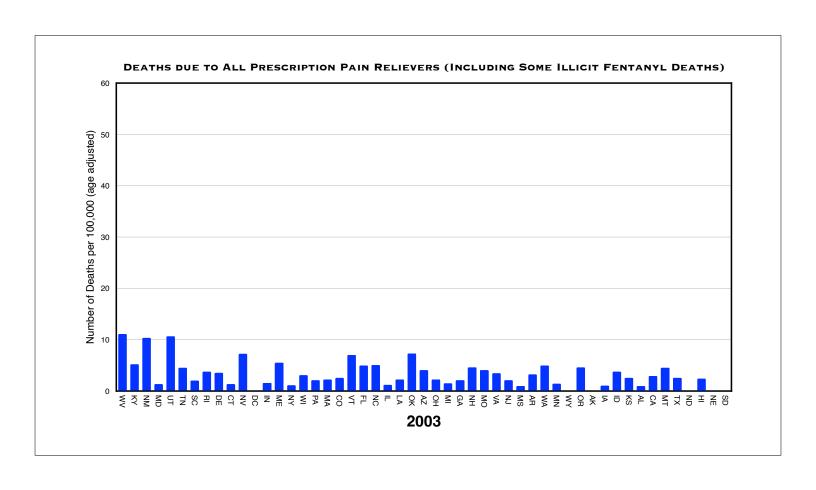
- Fentanyl has been the main problem since 2013.
- Illicit fentanyl is manufactured in China and Mexico in pill form and smuggled into the U.S.
- Because it is in pill form it is very easy to transport.
- Before 2013, virtually all of the deaths in the T40.4 category were due to prescription fentanyl patches.

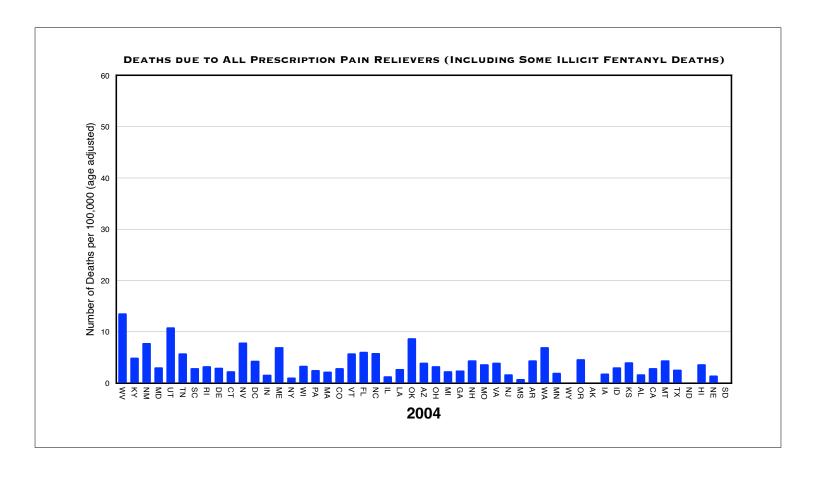
The following pages show the increase in per capita deaths due to all prescription opioids from 2000 to 2020.

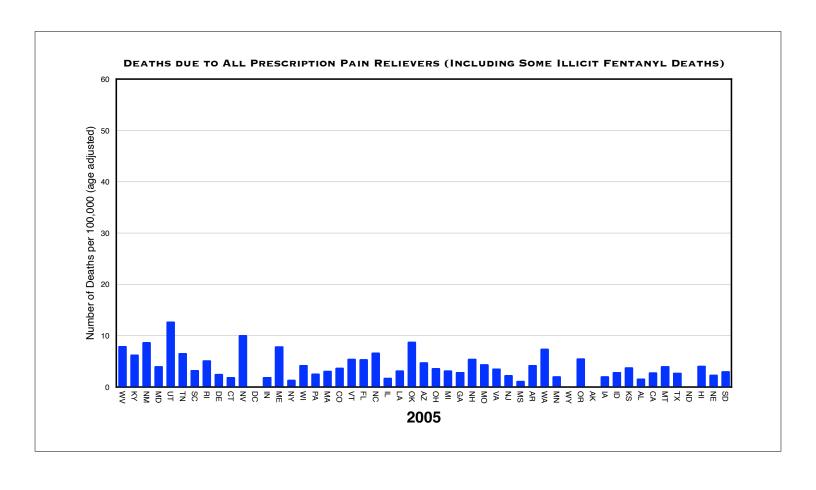


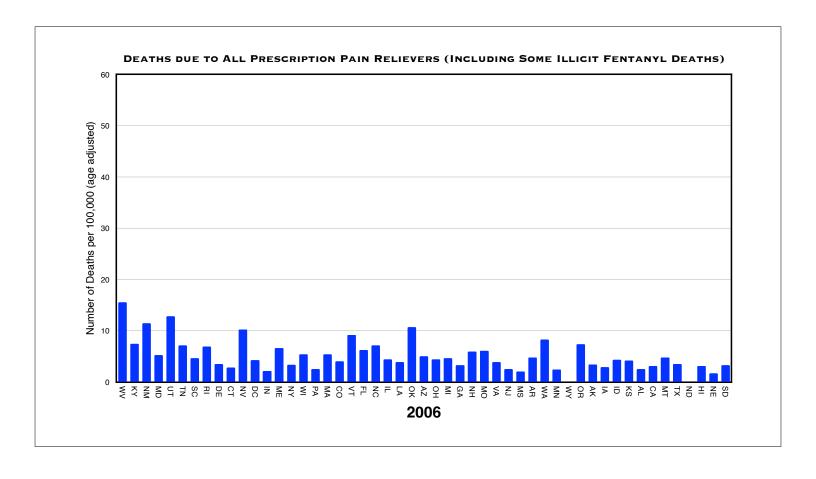


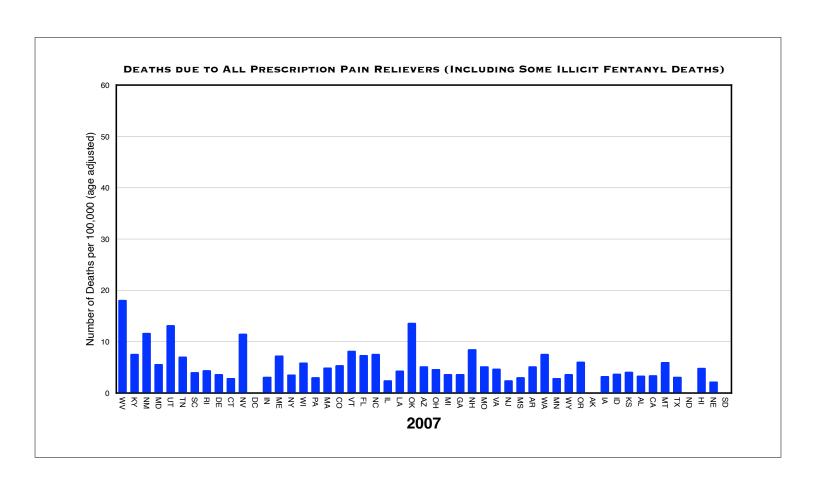


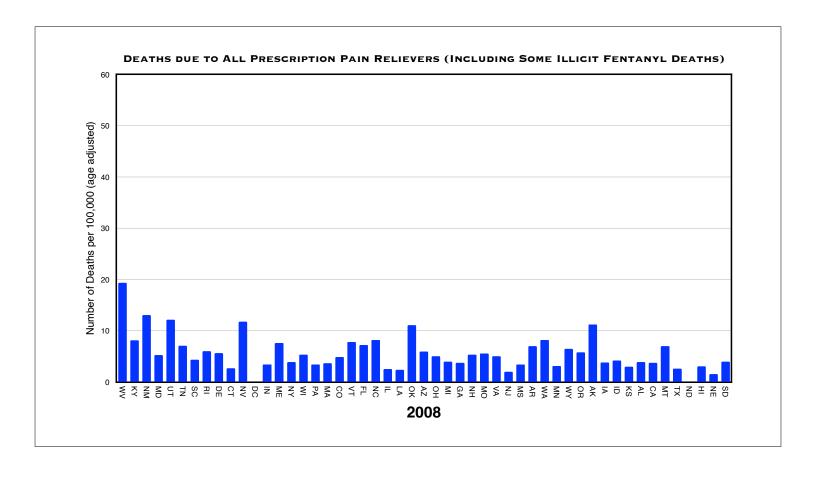


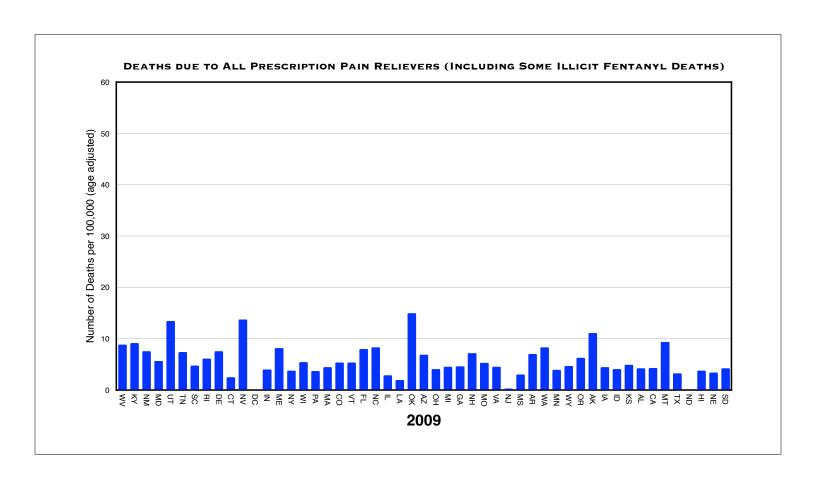


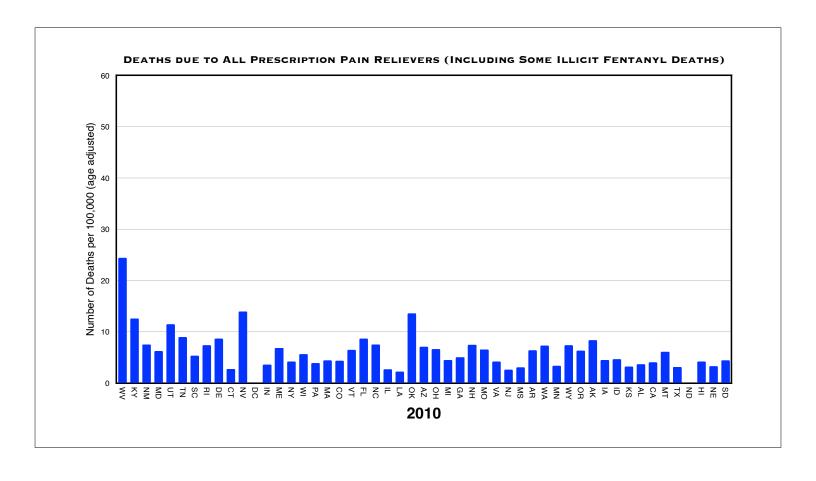


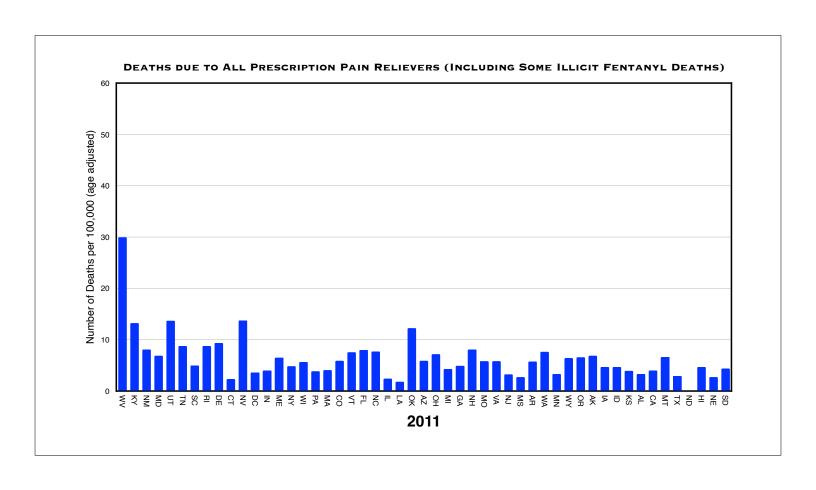


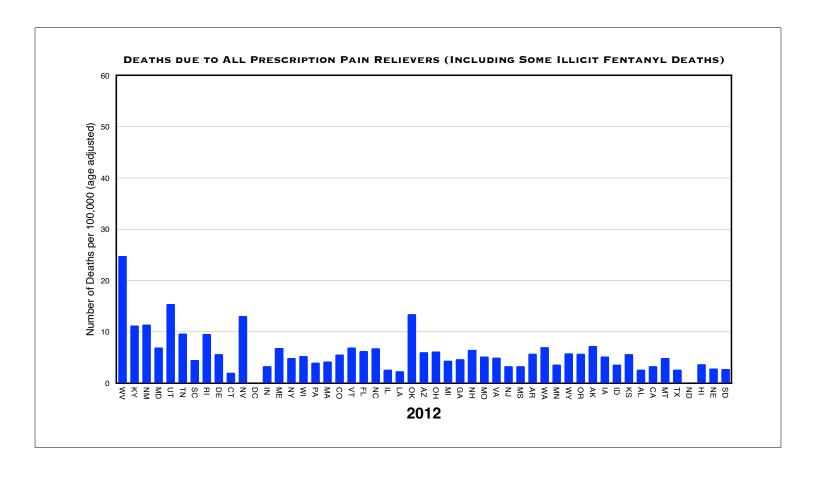


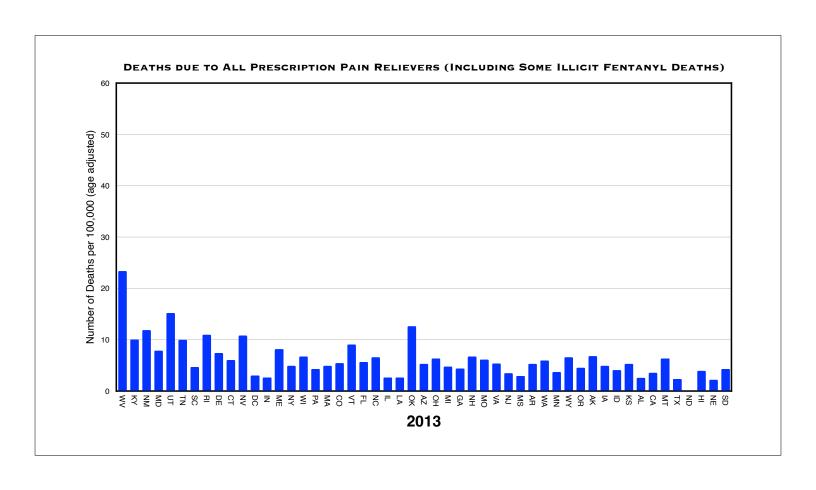


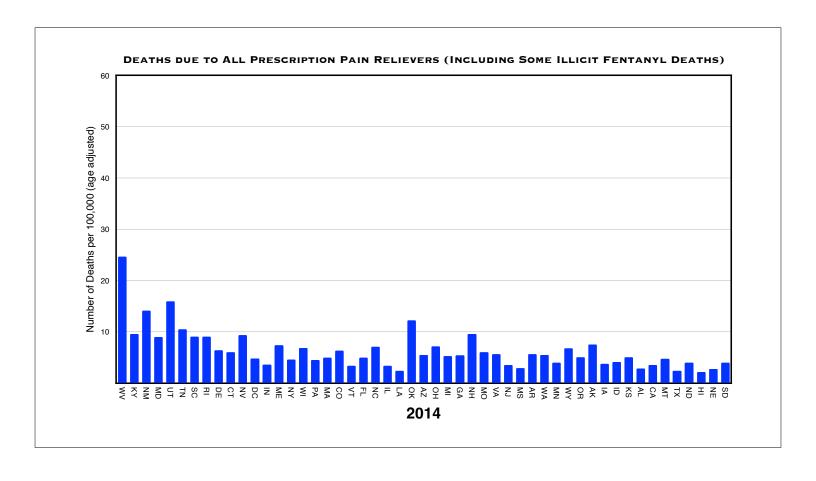


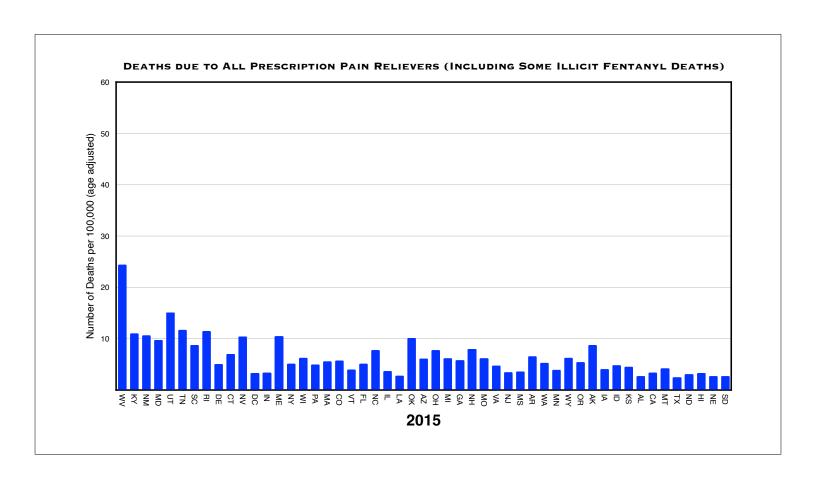


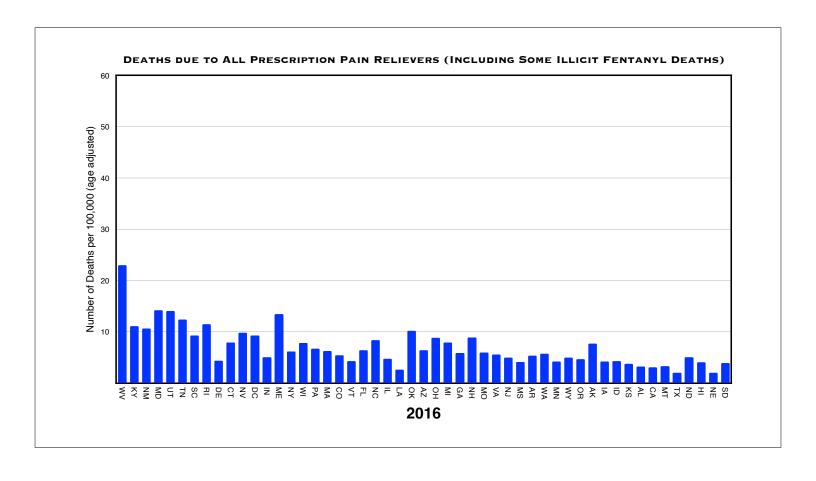


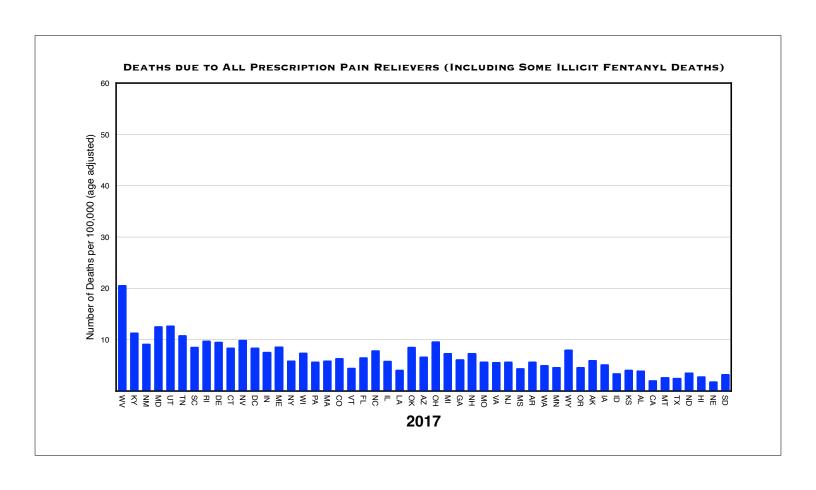


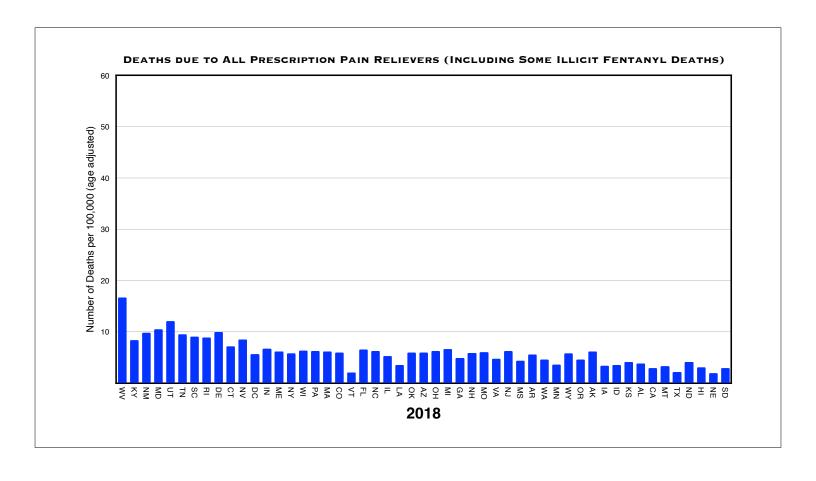


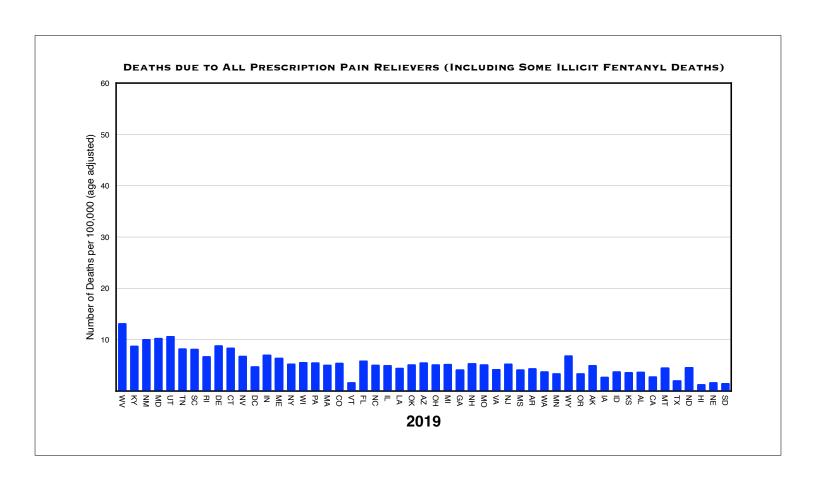


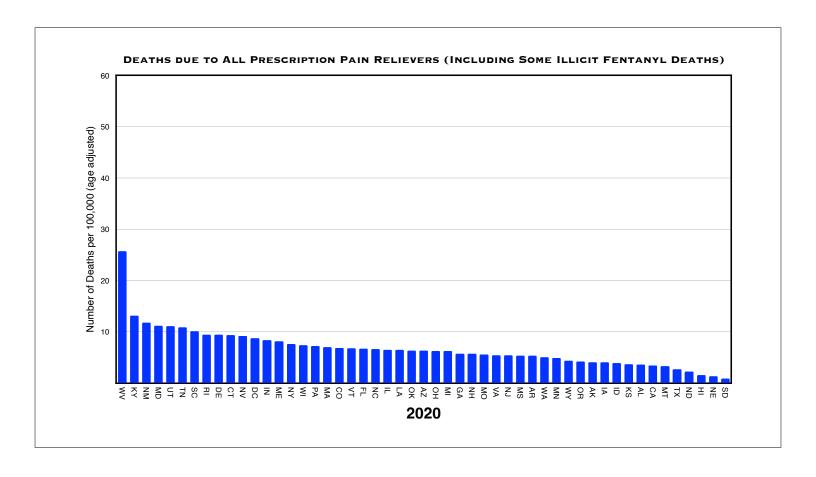




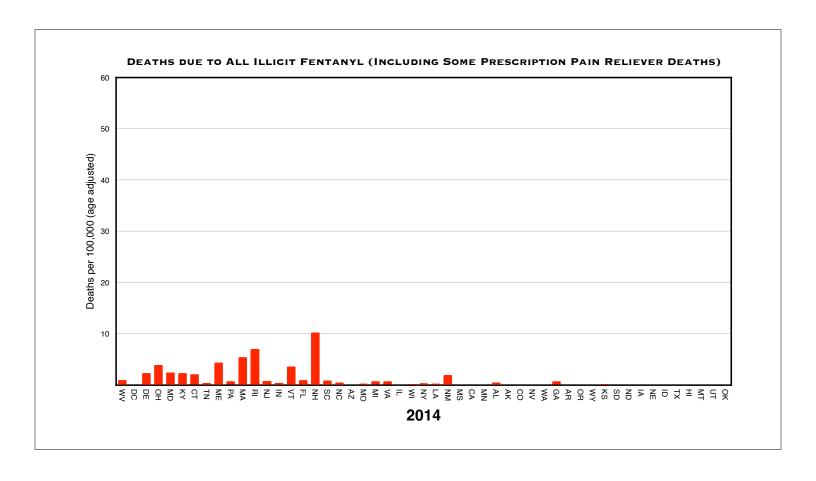


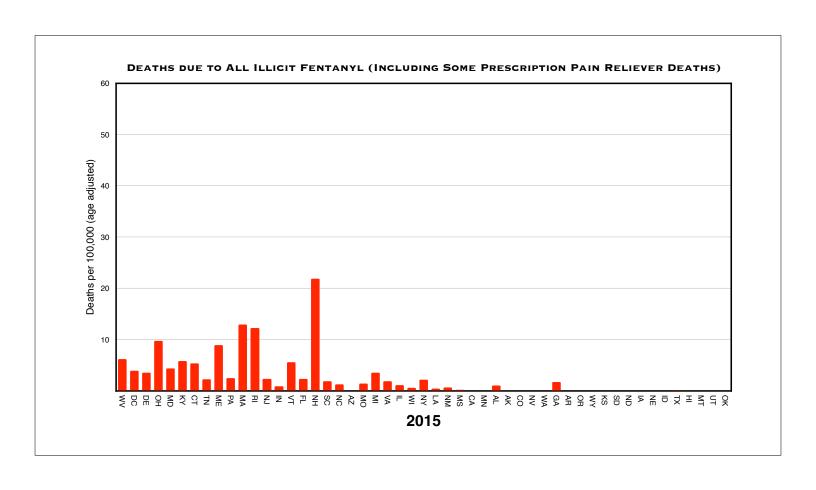


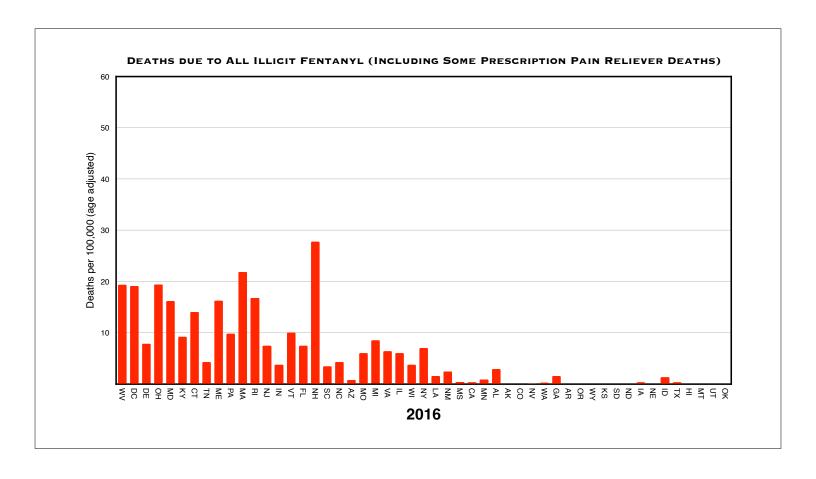


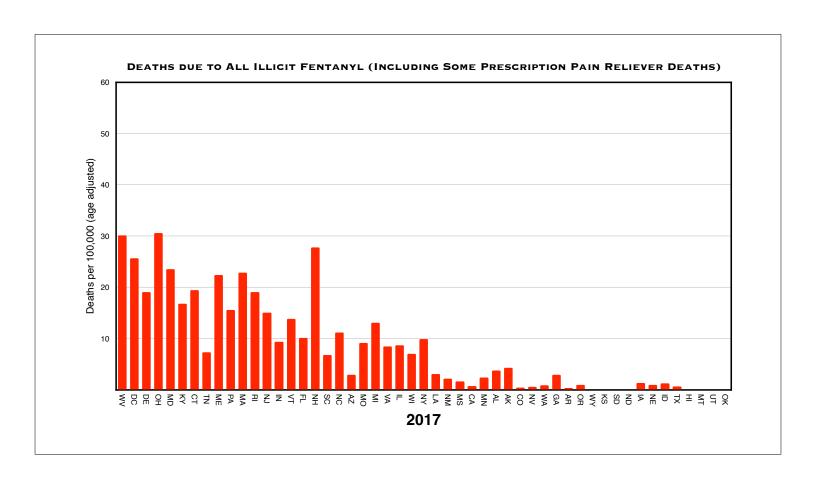


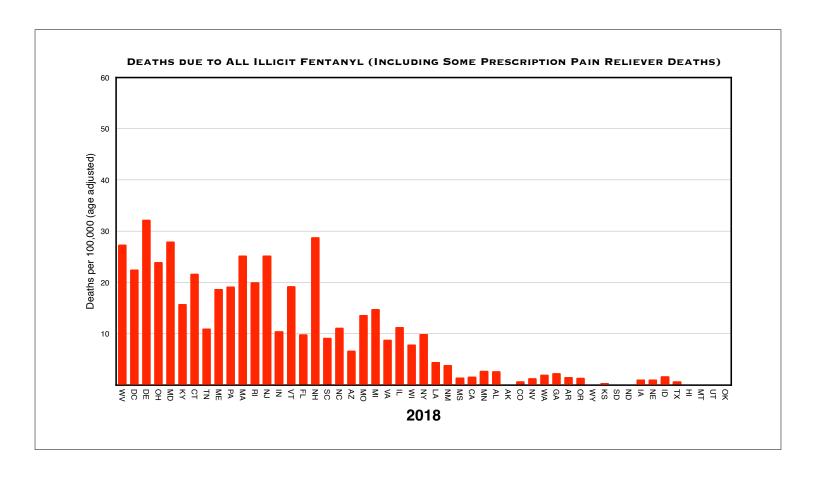
The following pages show the increase in all illicit fentanyl deaths from 2014 to 2020. The Y-axis is the same on the following graphs as it was on the previous graphs.

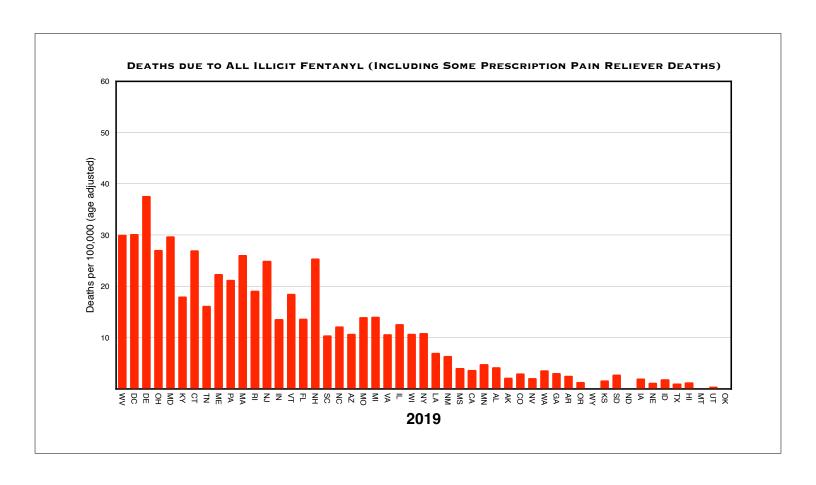


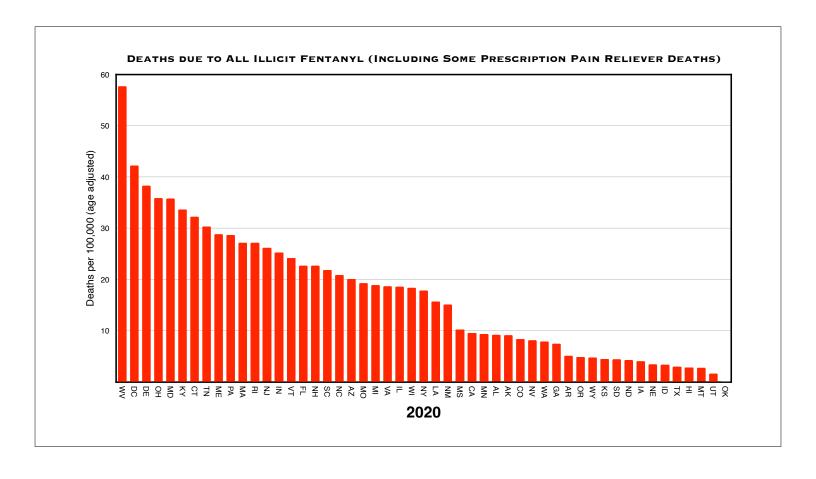




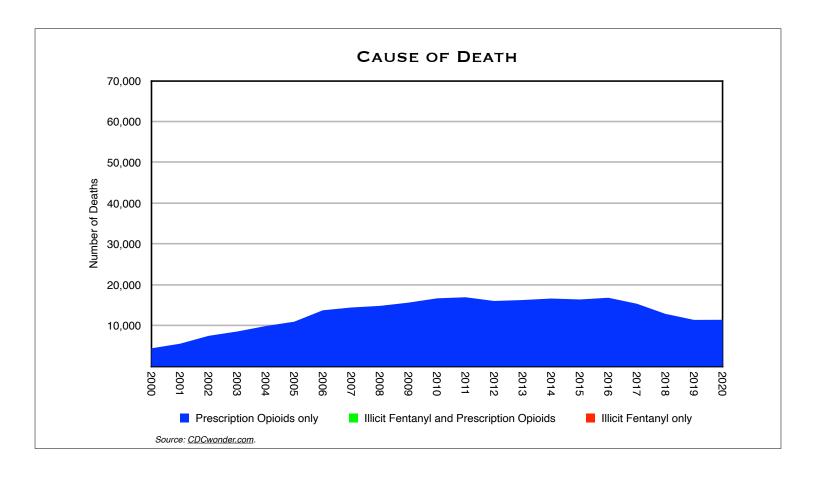




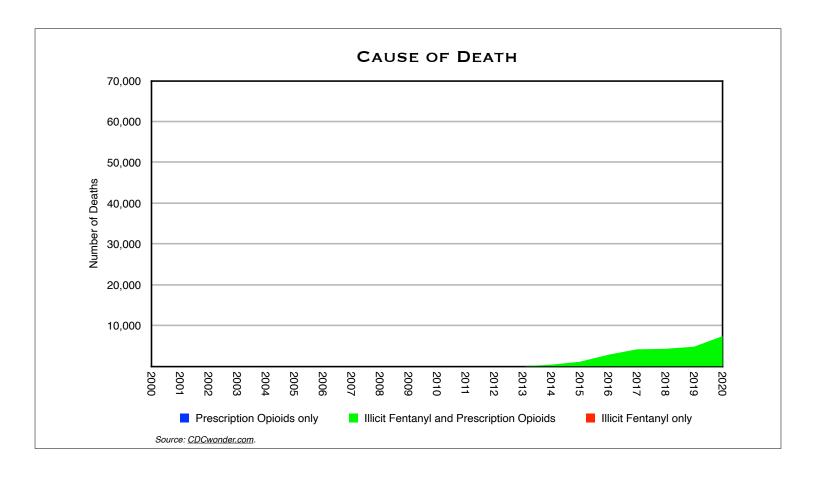




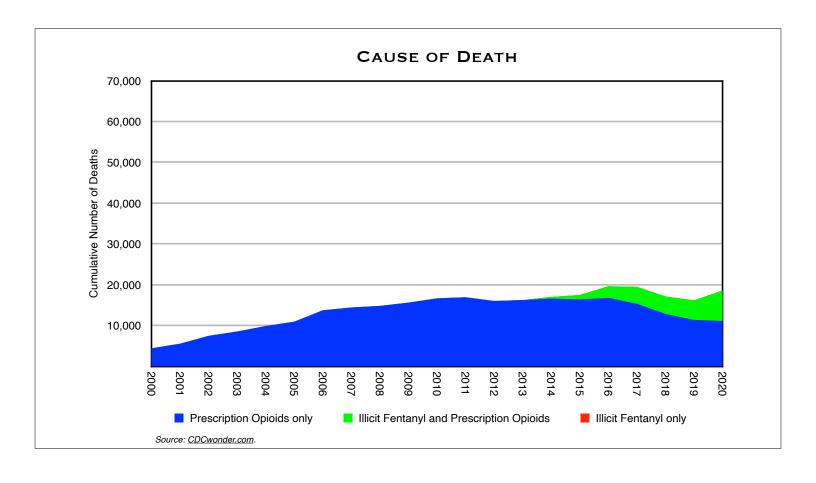
This is now the real opioid problem in the United States.



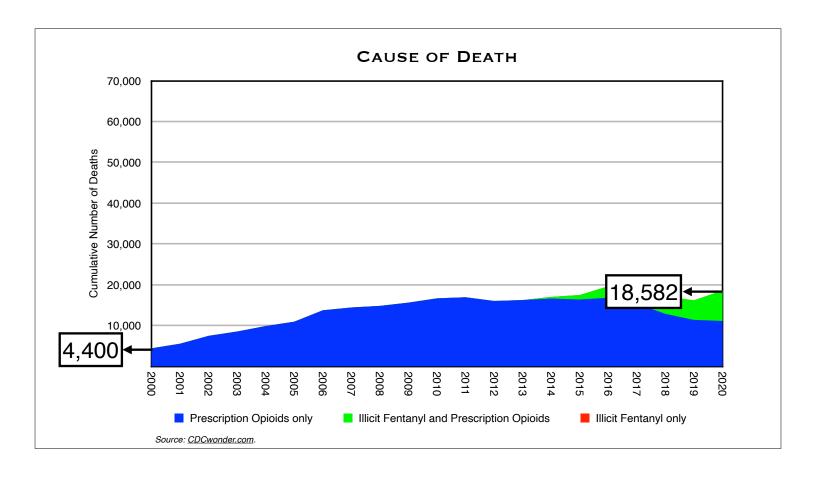
This shows the actual deaths due to prescription opioids only from 2000 to 2020. All of these graphs are from the CDC Wonder, Multiple Cause of Death website. They take the information from death certificates.



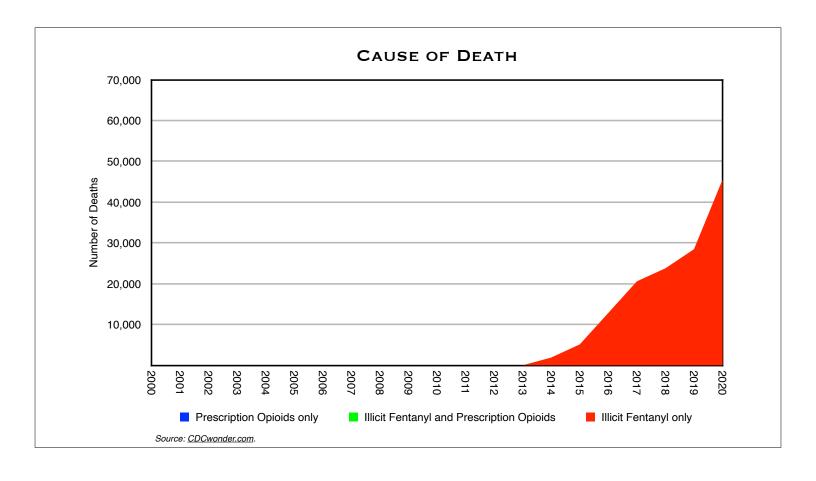
This shows the actual deaths due to both illicit fentanyl and prescription opioids on the death certificate.

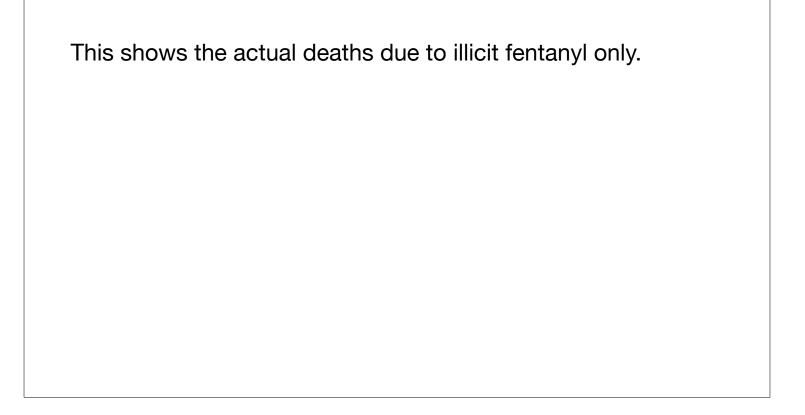


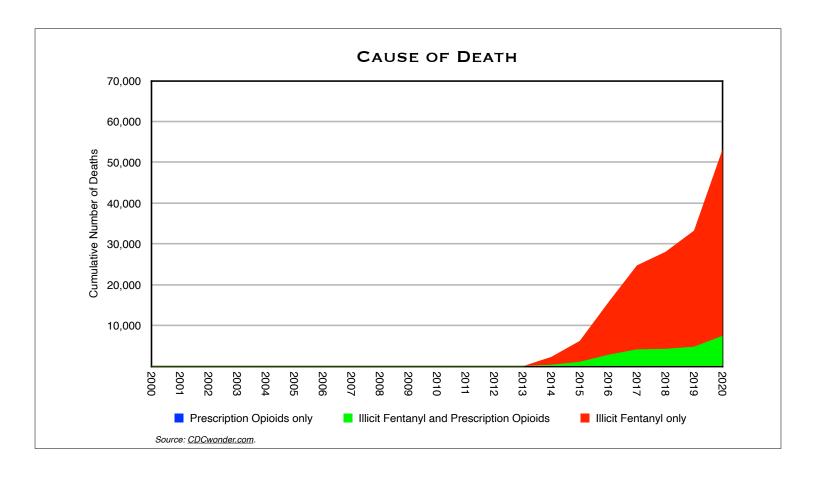
This shows the cumulative deaths due to all prescription opioids. The green area includes illicit fentanyl on the death certificate.



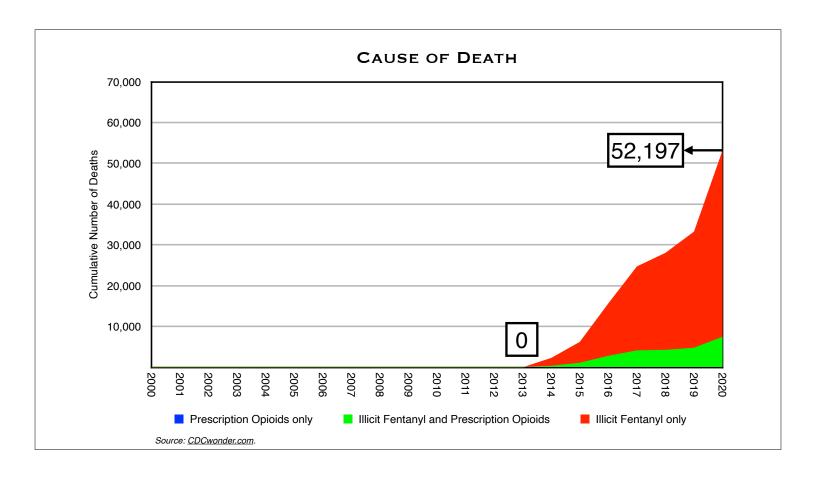
There were only 4,400 prescription opioid deaths in 2000 and we thought that was a lot. By 2016, the prescription opioid deaths had leveled out, but there were still 18,582 deaths in 2020.

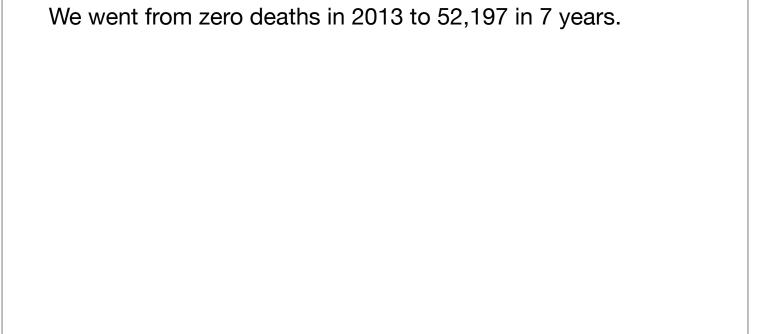






This shows the cumulative deaths due to all illicit fentanyl including when it is taken with prescription opioids.

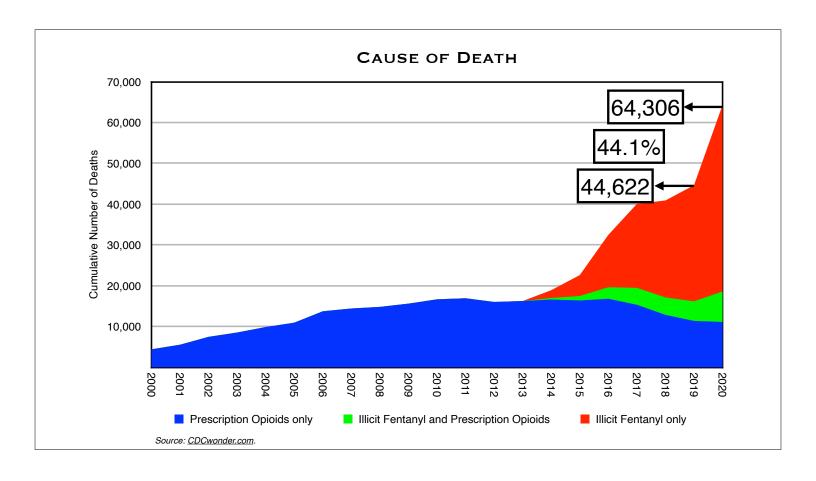




ALL ILLICIT FENTANYL DEATHS

YEAR	DEATHS	Annual Increase
2014	2,128	
2015	5,988	181%
2016	15,646	161%
2017	24,524	57%
2018	27,868	14%
2019	33,255	19%
2020	53,197	60%

These are the raw numbers for all illicit fentanyl deaths and the annual percentage change. It was high in the first two years because the raw numbers were low. In 2020, it took a big jump.

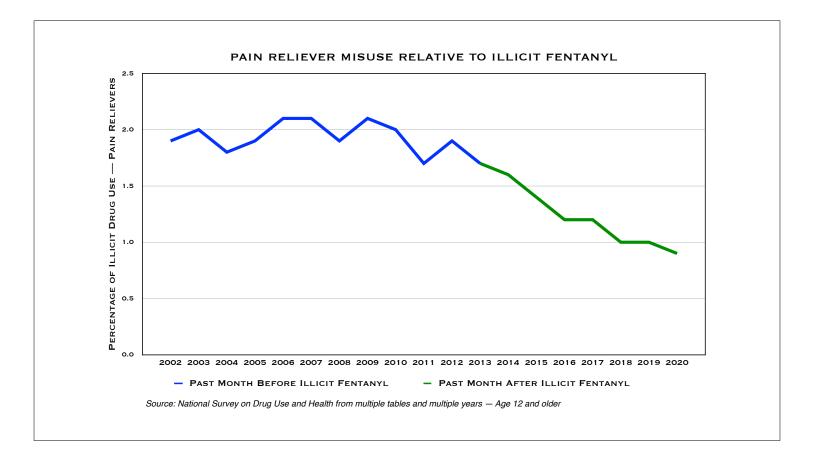


This is a graph of the cumulative number of deaths.

In 2019, the total number of opioid deaths due to prescription opioids and illicit fentanyl was 44,622.

In 2020, the total increased to 64,306 which equals 44.1%. This is the largest raw number and percentage annual increase to date.

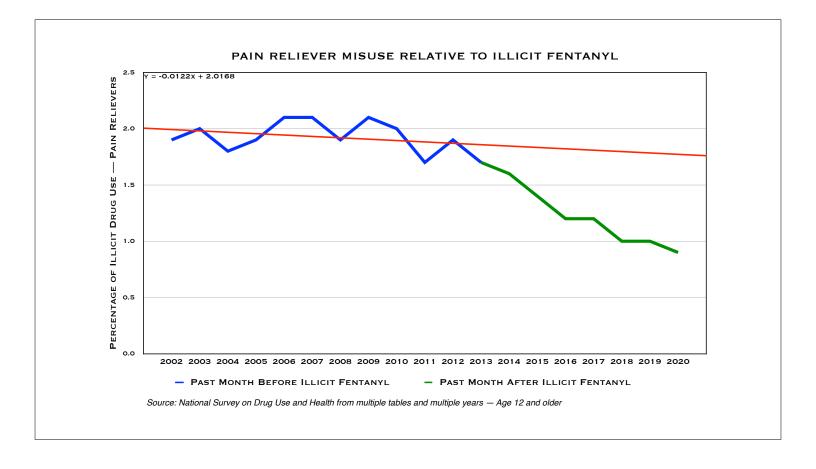
In 2020, there were 40,698 deaths due to motor vehicle accidents. The opioid deaths surpassed the MVA deaths in 2017.



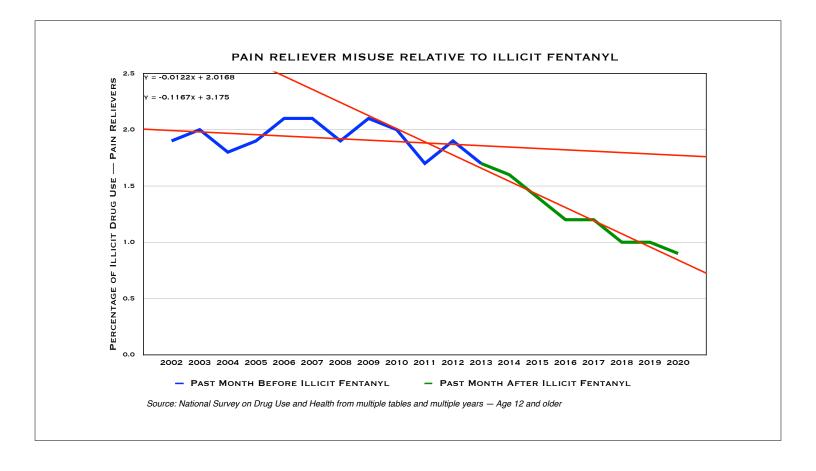
This data is from the National Survey on Drug Use and Health. You will see more about this data in a few slides.

The blue line is the percentage of individuals who misused prescription pain medicine in the past month from 2002 to 2013.

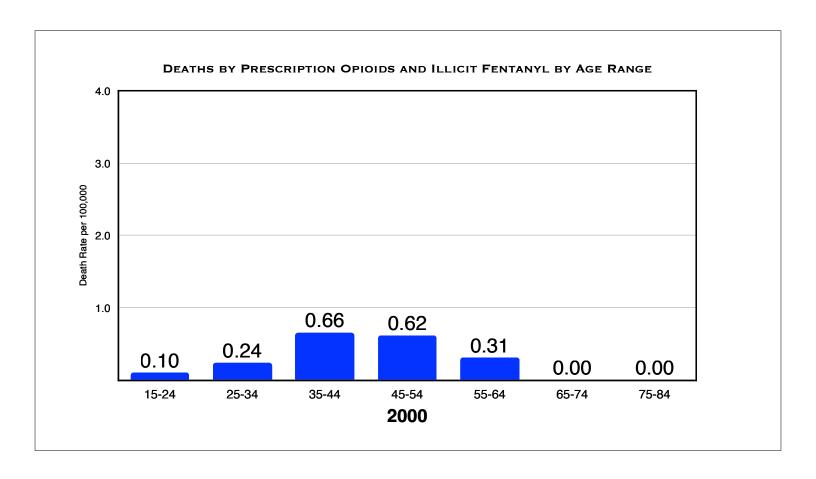
The green line is the percentage of individuals who misused prescription pain medicine in the past month from 2013 to 2020 after illicit fentanyl came on the market.



This is the linear trend line for the blue line from 2002 to 2013. It is almost horizontal which means the percentage of individuals misusing prescription pain medicine from 2002 to 2013 was not increasing or decreasing.

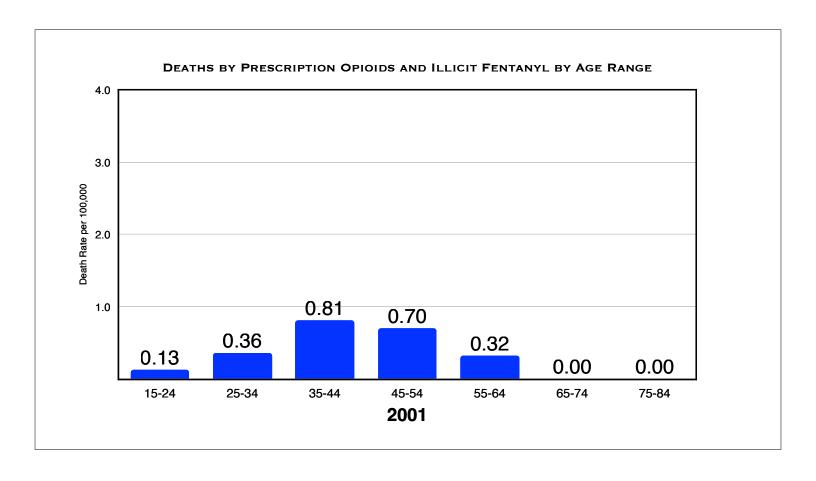


This is the linear trend line for the green line from 2013 to 2020. From 2002 to 2013 the number of states with an operational PDMP increased from 16 to 49 yet the trend line is almost horizontal. After illicit fentanyl, the trend line changed drastically. This shows the decrease in prescription opioid misuse was not due to the PDMPs, but the rise of illicit fentanyl.

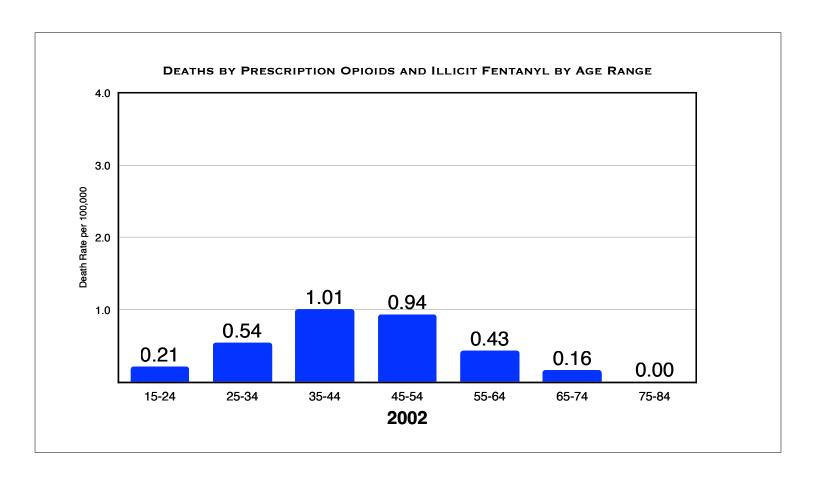


This is a chart of the death rate by age range from 2000 to 2013. In 2000, the largest death rate is in the 35-44 age group.

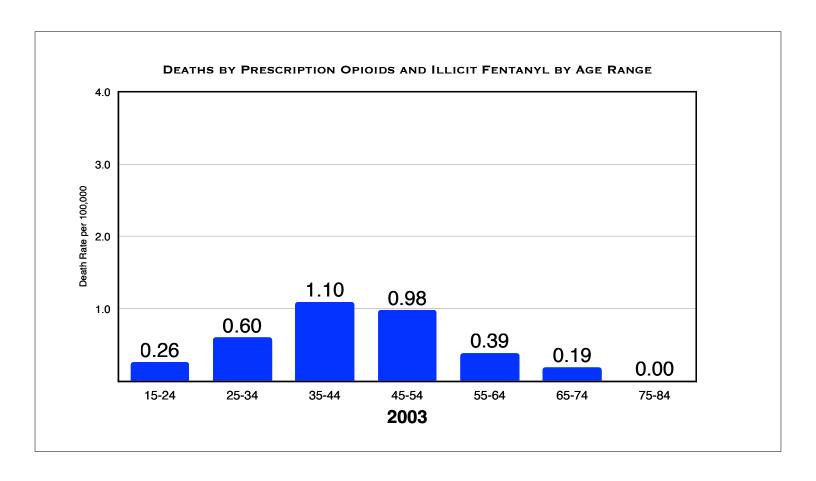
This shows a series of graphs of the age ranges for deaths due to prescription opioids and starting in 2013, illicit fentanyl.

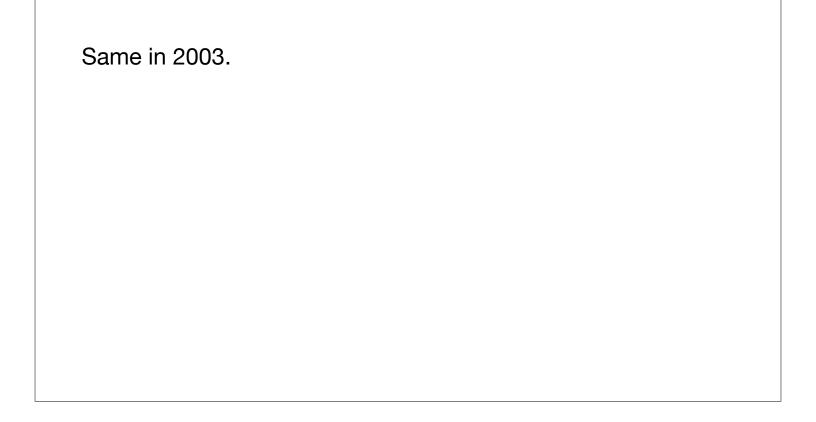


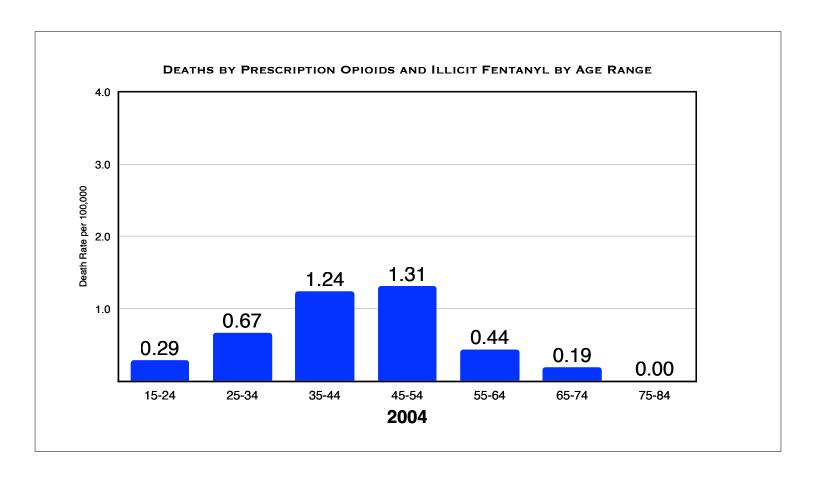
In 2001, the largest death rate was again in the 35-44 age group.



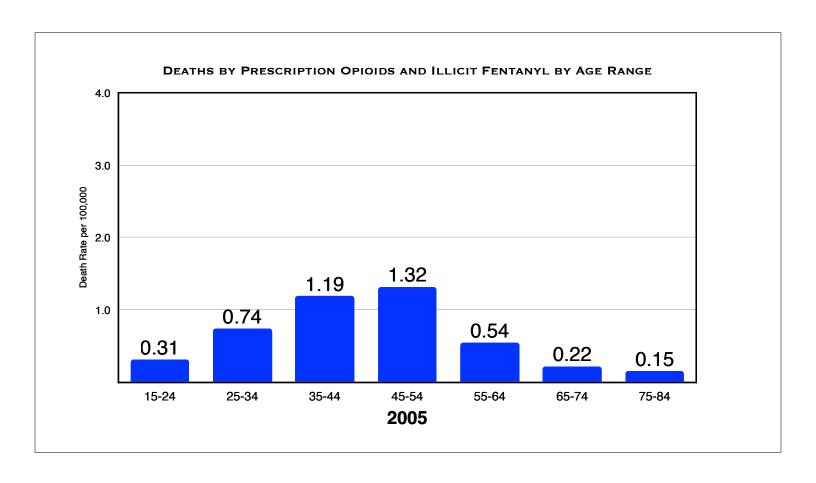




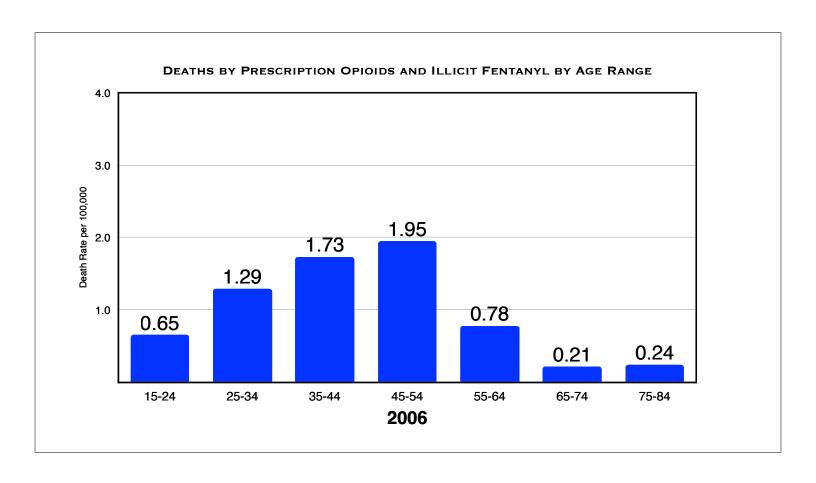




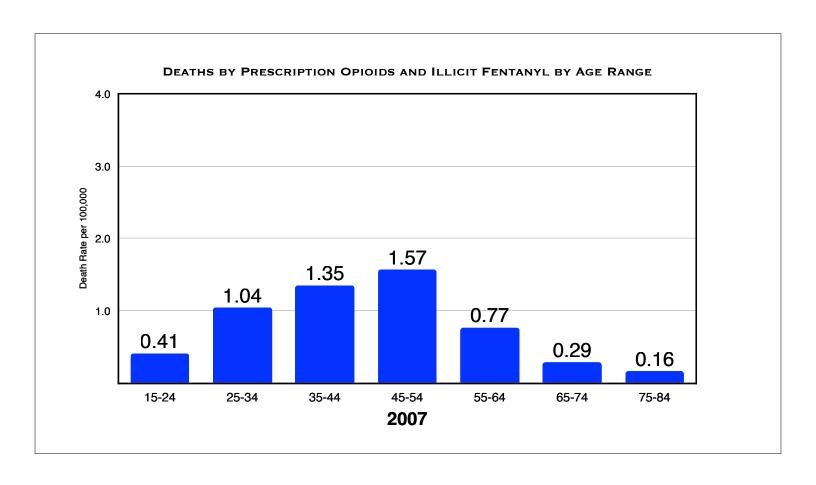
In 2004, it shifts to the 45-54 age group.



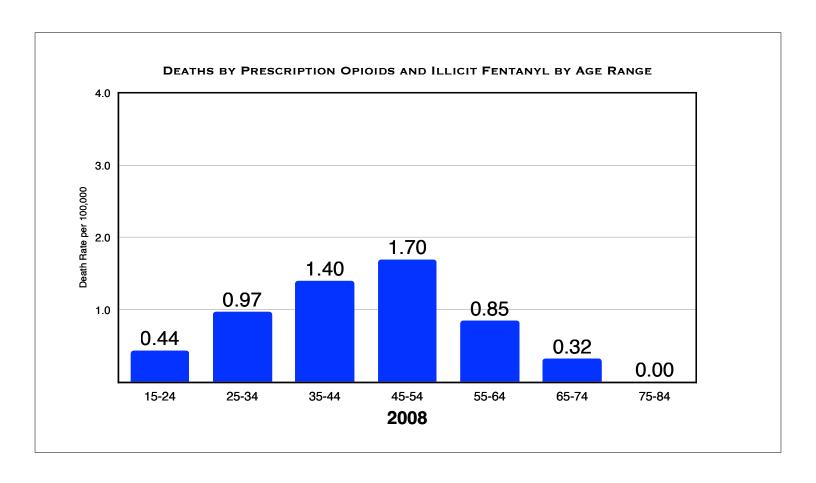
The top death rate age range remains the same in 2005.



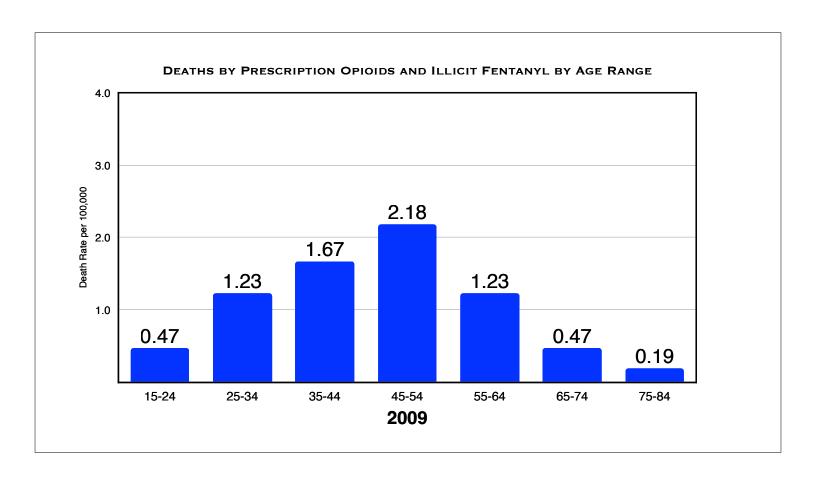
Same in 2006.



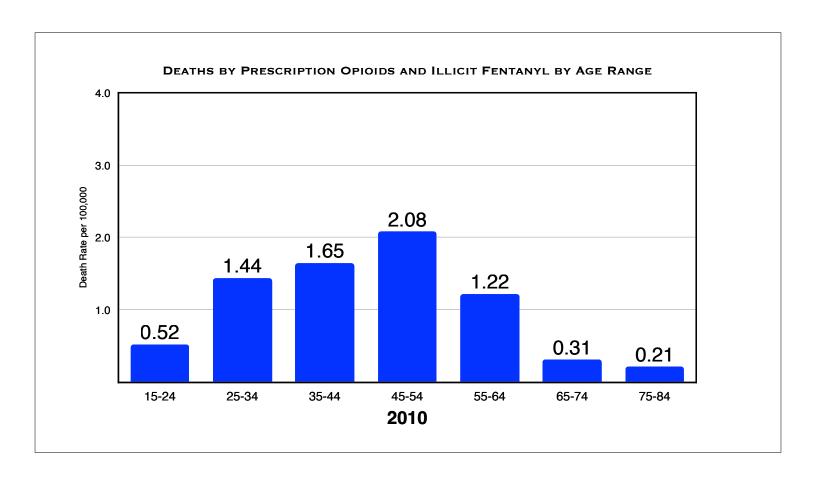


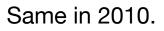


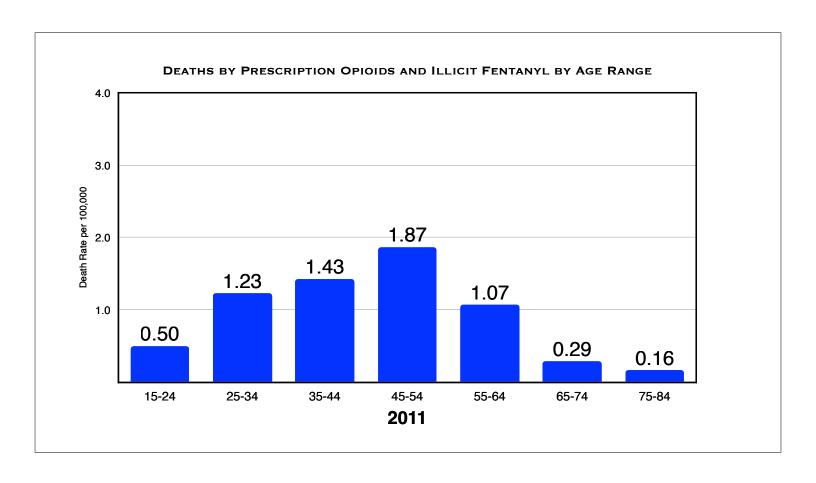




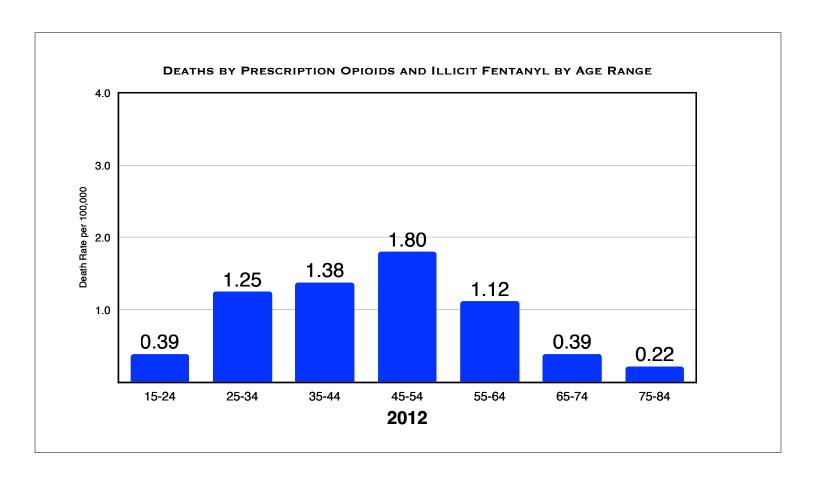
Same in 2009.



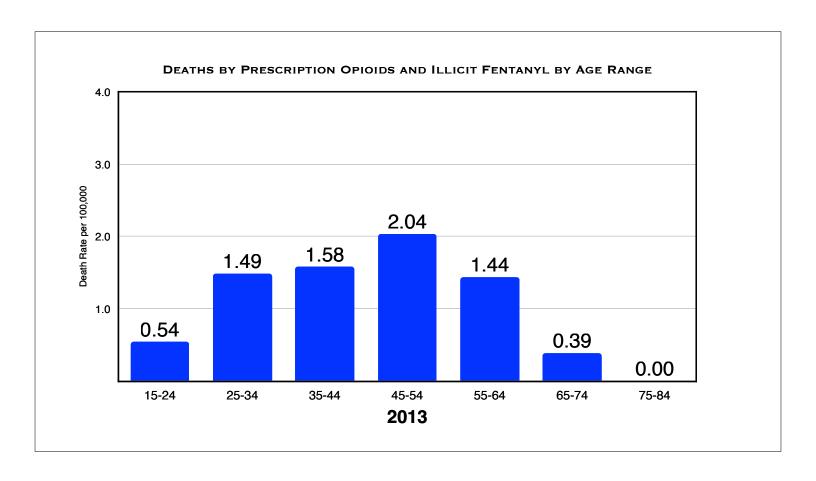




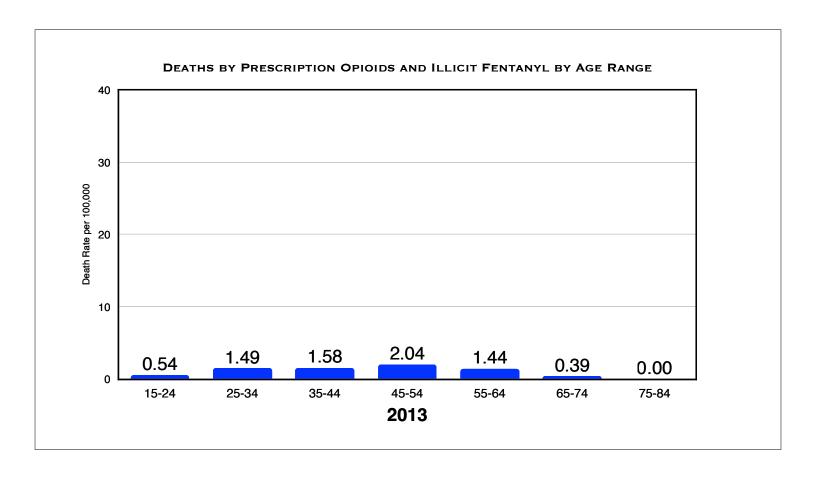




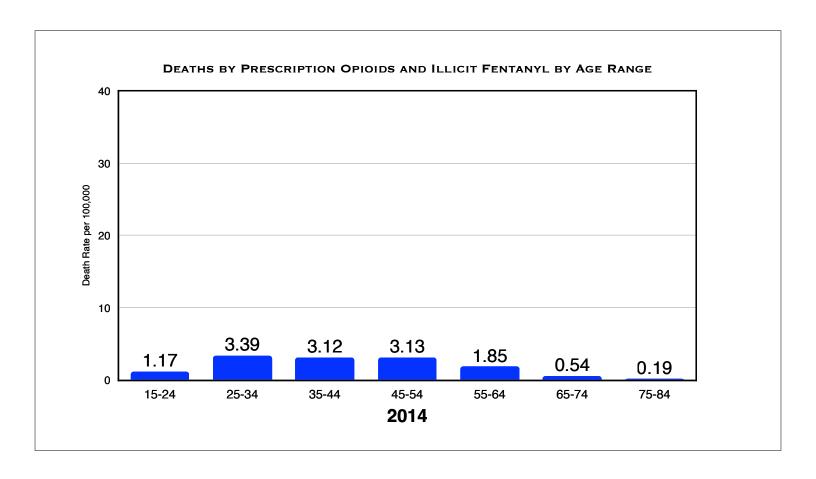




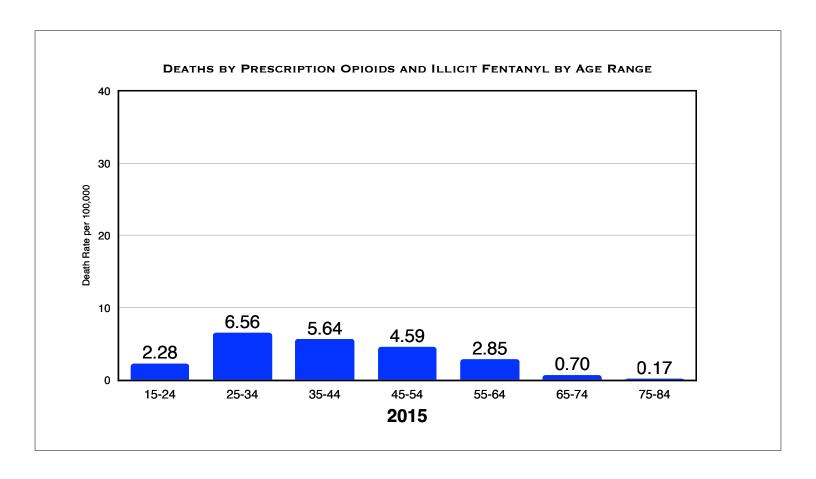
Same in 2013, but 2013 is the start of the illicit fentanyl invasion.



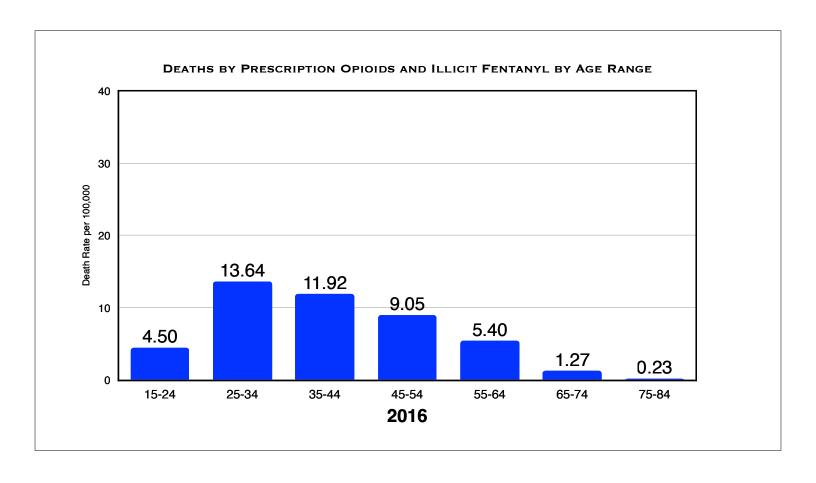
In this graph, I have increased the death rate axis by a factor of ten. This is the same year, 2013, and the same numbers as on the previous graph. The top death rate is in the 45-54 age group.



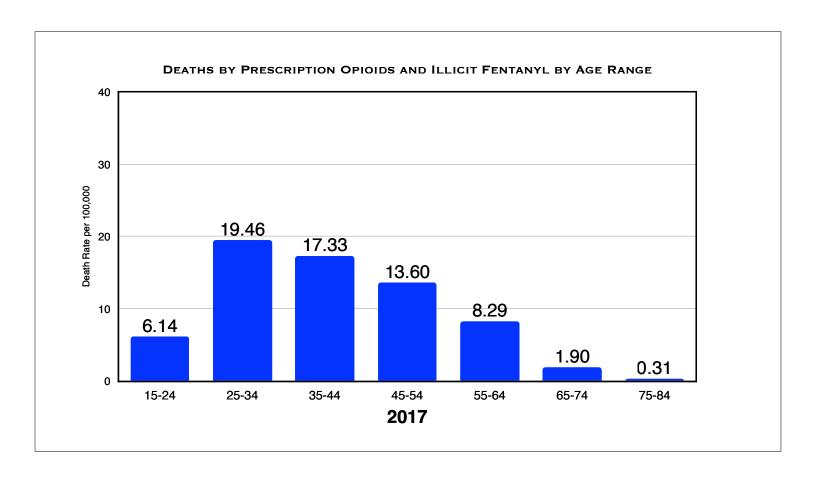
In 2014, the top death rate has shifted from 45-54 age group to the 25-34 age group due to the fentanyl.



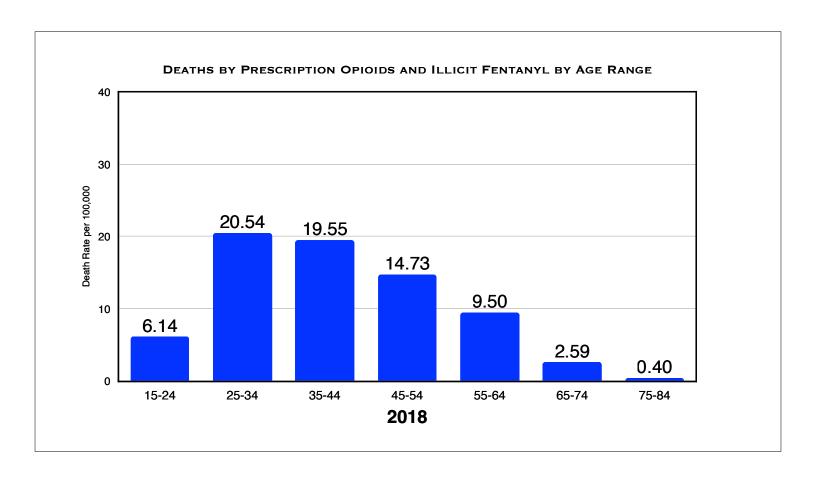
In 2015 there was an increase in fentanyl deaths, but the top age range remained the same.



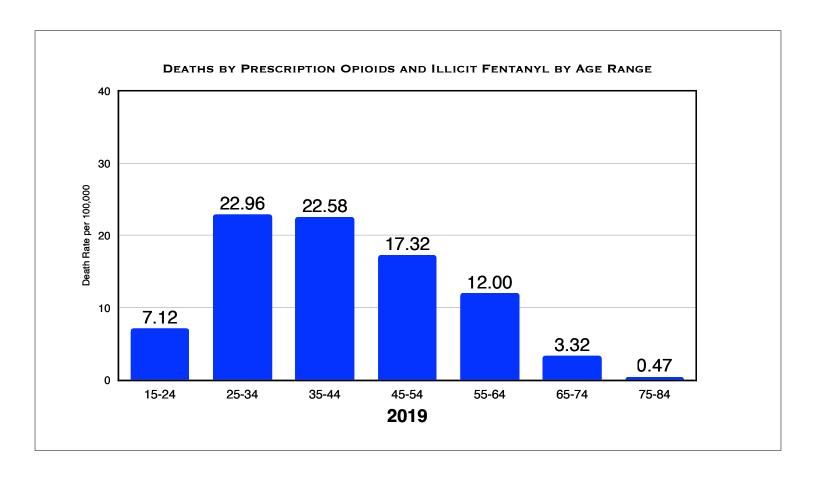
In 2016, there was a large jump in fentanyl deaths.



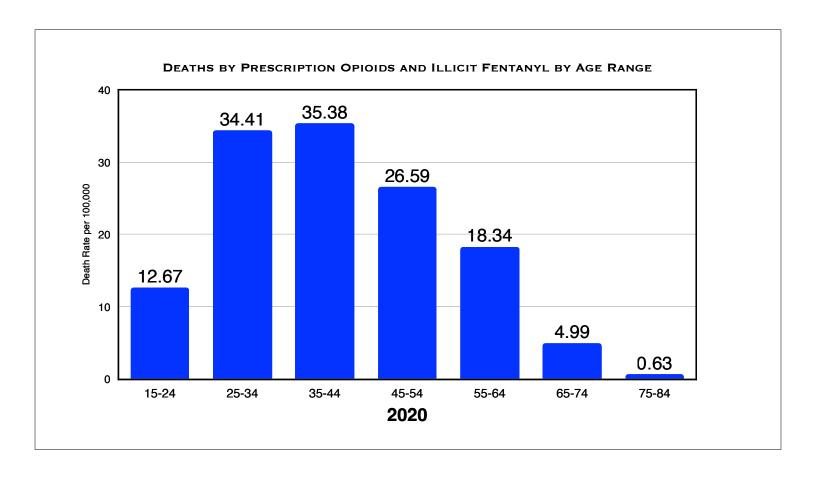
In 2017, there was again a large jump in fentanyl deaths.



In 2018, the increase slowed a little, and the 35-44 age group was catching up to the 25-34 age group.



The same for 2019.



In 2020, there was a very large increase in fentanyl deaths and the top death rate shifted to the 35-44 age group.

This series of graphs shows how the age group for prescription opioid deaths stayed in the older ranges.

Once illicit fentanyl started to be smuggled into the country, the death range shifted to a younger age range, then slowly shifted back to an older age range.

- Is the PDMP legislation constitutional?
- No. It violates Article I, Section 15 of the Missouri Constitution.
- It takes your prescription information and your personal information and places it in a governmental database without your consent and even without your knowledge.

Article I, Section 15. Unreasonable search and seizure prohibited—contents and basis of warrants.

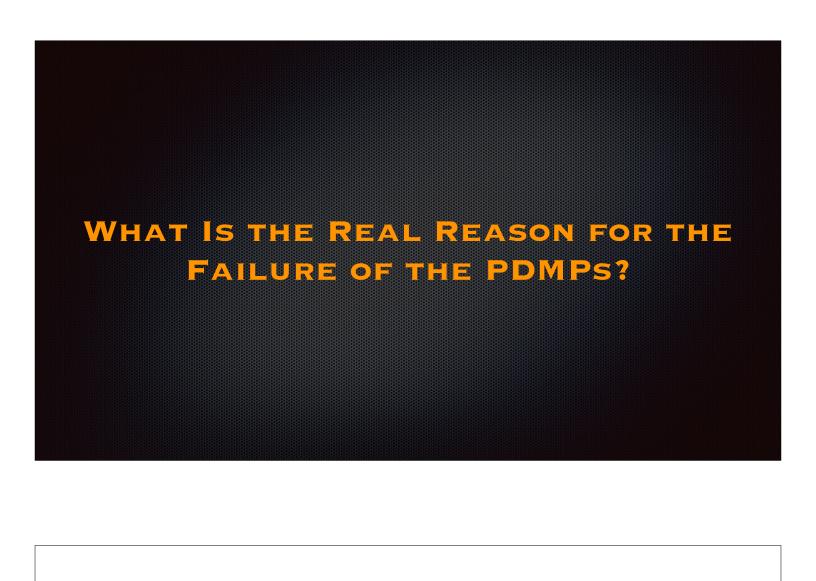
That the people shall be secure in their persons, papers, homes, effects, and electronic communications and data, from unreasonable searches and seizures; and no warrant to search any place, or seize any person or thing, or access electronic data or communication, shall issue without describing the place to be searched, or the person or thing to be seized, or the data or communication to be accessed, as nearly as may be; nor without probable cause, supported by written oath or affirmation.

The phrase "electronic communications and data" was added in 2014 by a constitutional amendment. It was added because of cell phones. When car registration documents became electronic and viewed on your smart phone, you could hand your phone to the law enforcement officer who pulled you over and asked for your registration. There was a lawsuit that now prevents officers from looking any where on your phone when you give it to them. They can only look at the one screen on your phone when you hand it to the officer.

- Private insurance companies and government programs like Medicare, Medicaid and the Veterans Administration have prescription databases.
- When you sign up for the insurance policy or the government program, you agree to become part of that database.
- The PDMP is completely different.
- It is a mandatory, involuntary database which makes it unconstitutional.

When you take a covered prescription to the pharmacy that is mandated to report that prescription, no one asked you if you want to be in a database that could be accessed. It's not voluntary.

Only 11 states will tell you that your prescription is going into a database that can be accessed.



NATIONAL SURVEY ON DRUG USE AND HEALTH - 2020

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Behavioral Health Statistics and Quality

The Department of Health and Human Services produces this report annually.

This survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, non-institutionalized population of the United States aged 12 years old or older.

The 2020 report is 2,083 pages long. In all of the pro PDMP published research on this subject, I have never seen this survey referenced, yet this is the definitive report on what the PDMP proponents claim is the underlying problem, doctor shopping.

Over the past ten years, I have testified against the PDMP in Jefferson City many times. The proponents always have sheriffs that tell stories about a doctor shopper that was buying mass quantities of pain medicine and selling it to poor souls seeking relief of pain.

I started my testimony by stating that I had a business school professor that had many very good sayings. One of the best was, "the pleural of anecdote is anecdotes, not data."

Anecdotal evidence is useless. Look at the actual data.

2020 SURVEY POPULATION

- Main sample size: 36,284 done in quarters 1 and 4 instead of the entire year due to covid.
- **In 2019, the sample size was 67,625.**
- 50% the U.S. population age 12 and older have used illicit drugs some time in their lifetime.
- 21.4% in the past year (2020).

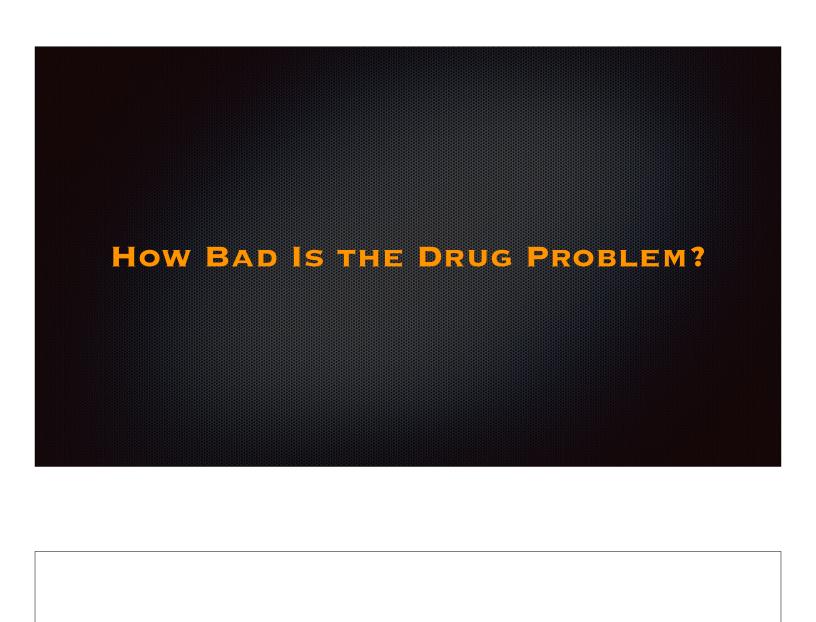


Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month: Among People Aged 12 or Older; Numbers in Thousands, 2019 and 2020

Drug	Lifetime (2019)	Lifetime (2020)	Past Year (2019)	Past Year (2020)	Past Month (2019)	Past Month (2020)
ILLICIT DRUGS ¹	138,027	138,543	57,203	59,277	35,803	37,309
Marijuana	127,139	126,504	48,242	49,634	31,606	32,784
Cocaine	41,445	39,261	5,468	5,172	1,998	1,831
Crack	9,375	9,356	778	657	378	335
Heroin	5,696	6,252	745	902	431	513
Hallucinogens	44,087	43,949	6,010	7,133	1,915	1,761
LSD	27,528	28,123	2,470	2,637	580	649
PCP	5,516	6,141	73	95	*	24
Ecstasy	20,097	20,478	2,539	2,622	663	681
Inhalants	25,090	26,749	2,142	2,390	807	904
Methamphetamine	16,013	15,397	1,999	2,550	1,173	1,722
Misuse of Prescription						
Psychotherapeutics	nr	nr	16,304	16,073	5,337	5,278
Pain Relievers	nr	nr	9,724	9,254	2,819	2,536
Stimulants	nr	nr	4,929	5,092	1,566	1,493
Tranquilizers or Sedatives	nr	nr	5,895	6,205	1,958	2,196
Tranquilizers	nr	nr	5,220	5,460	1,781	1,891
Sedatives	nr	nr	1,098	1,240	304	481
Benzodiazepines			4,841	4,779		
Opioids	nr	nr	10,065	9,490	3,101	2,885
Central Nervous System Stimulants	nr	nr	10,136	10,306	4,264	4,483
Illicit Drugs Other Than Marijuana ²	nr	nr	23,588	23,962	9,333	9,305

This table shows the number of people who have used illicit drugs in their lifetime, in the past year, and past month.

Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month: Among People Aged 12 or Older; Numbers in Thousands, 2019 and 2020

Drug	Lifetime (2019)	Lifetime (2020)	Past Year (2019)	Past Year (2020)	Past Month (2019)	Past Month (2020)
ILLICIT DRUGS ¹	138,027	138,543	57,203	59,277	35,803	37,309
Marijuana	127,139	126,504	48,242	49,634	31,606	32,784
Cocaine	41,445	39,261	5,468	5,172	1,998	1,831
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LSD	27,528	28,123	2,470	2,637	580	649
PCP	5,516	6,141	73	95	*	24
Ecstasy	20,097	20,478	2,539	2,622	663	681
Inhalants	25,090	26,749	2,142	2,390	807	904
Methamphetamine	16,013	15,397	1,999	2,550	1,173	1,722
Misuse of Prescription						
Psychotherapeutics	nr	nr	16,304	16,073	5,337	5,278
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Stimulants	nr	nr	4,929	5,092	1,566	1,493
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Tranquilizers	nr	nr	5,220	5,460	1,781	1,891
Sedatives	nr	nr	1,098	1,240	304	481
Benzodiazepines			4,841	4,779		
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Central Nervous System Stimulants	nr	nr	10,136	10,306	4,264	4,483
Illicit Drugs Other Than Marijuana ²	nr	nr	23,588	23,962	9,333	9,305

There were 9.25 million people who misused prescription pain relievers. Not all of the pain relievers are opioids. So the total misused prescription opioids was 8.8 million.

Table 1.1B Types of Illicit Drug Use in Lifetime, Past Year, and Past Month: Among People Aged 12 or Older; Percentages, 2019 and 2020

Drug	Lifetime (2019)	Lifetime (2020)	Past Year (2019)	Past Year (2020)	Past Month (2019)	Past Month (2020)
ILLICIT DRUGS ¹	50.2	50.0	20.8	21.4	13.0	13.5
Marijuana	46.2	45.7	17.5	17.9	11.5	11.8
Cocaine	15.1	14.2	2.0	1.9	0.7	0.7
Crack	3.4	3.4	0.3	0.2	0.1	0.1
Heroin	2.1	2.3	0.3	0.3	0.2	0.2
Hallucinogens	16.0	15.9	2.2	2.6	0.7	0.6
LSD	10.0	10.2	0.9	1.0	0.2	0.2
PCP	2.0	2.2	0.0	0.0	*	0.0
Ecstasy	7.3	7.4	0.9	0.9	0.2	0.2
Inhalants	9.1	9.7	0.8	0.9	0.3	0.3
Methamphetamine	5.8	5.6	0.7	0.9	0.4	0.6
Misuse of Prescription						
Psychotherapeutics	nr	nr	5.9	5.8	1.9	1.9
Pain Relievers	nr	nr	3.5	<u>3.3</u>	1.0	0.9
Stimulants	nr	nr	1.8	1.8	0.6	0.5
Tranquilizers or Sedatives	nr	nr	2.1	2.2	0.7	0.8
Tranquilizers	nr	nr	1.9	2.0	0.6	0.7
Sedatives	nr	nr	0.4	0.4	0.1	0.2
Benzodiazepines			1.8	1.7		
Opioids	nr	nr	3.7	3.4	1.1	1.0
Central Nervous System Stimulants	nr	nr	3.7	3.7	1.5	1.6
Illicit Drugs Other Than Marijuana ²	nr	nr	8.6	8.7	3.4	3.4

The actual percentage for prescription opioids was 3.2%.

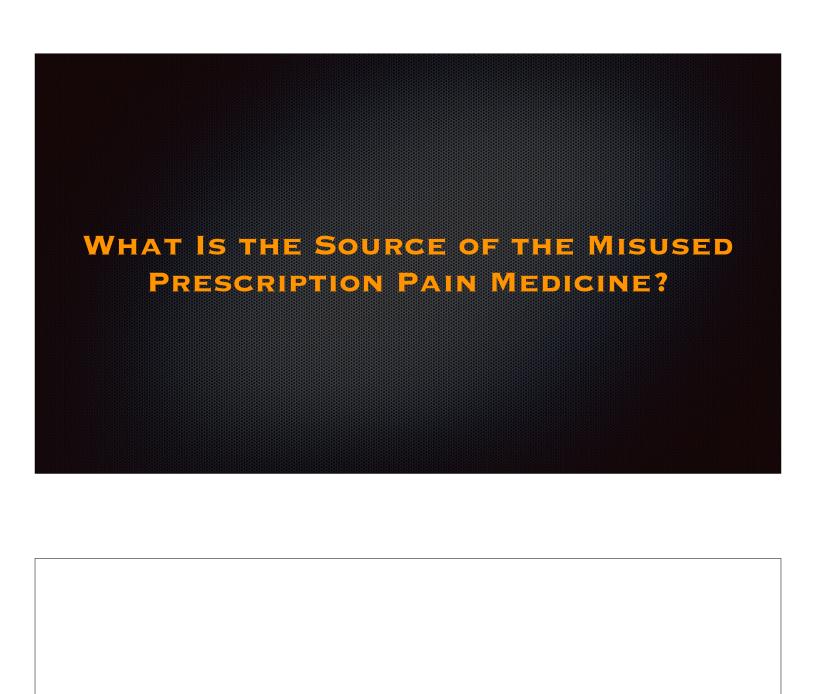


Table 6.5A Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among Past Year Misusers Aged 12 or Older; by Age Group, Numbers in Thousands, 2019 and 2020

Source for Most Recent Misuse among Past Year Misusers of Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	5 Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE PROVIDER	3,420	3,805	171	*	3,249	3,750	485	429	2,764	3,322
Prescription from One Doctor	3,420	3,666	147	*	3,102	3,624	437	387	2,764	3,237
1	3,249	3,000	14/	*	5,102	3,024	43/	38/	2,003	3,23/
Prescriptions from More Than One Doctor	98	90	18	*	81	78	28	22	53	56
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	73	49	7	1	66	48	20	*	46	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	4,627	4,122	239	*	4,388	3,917	892	719	3,496	3,199
From Friend or Relative for Free	3,373	3,001	145	*	3,228	2,846	612	523	2,616	2,324
Bought from Friend or Relative	837	799	44	*	793	764	174	153	619	611
Took from Friend or Relative without Asking	417	322	50	15	367	307	106	43	261	264
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	565	538	25	6	540	532	138	128	402	404
SOME OTHER WAY ¹	500	267	31	*	469	219	106	21	363	198

This table shows the source where prescription pain relievers were obtained for the most recent misuse, age 12 and older in thousands of people.

Table 6.5B Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among Past Year Misusers Aged 12 or Older; by Age Group, Percentages, 2019 and 2020

Source for Most Recent Misuse among Past Year Misusers of Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	5 Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE PROVIDER	37.5	43.6	36.7	*	37.6	44.5	29.9	33.1	39.3	46.6
		,		*		44.5				
Prescription from One Doctor	35.7	42.0	31.5	*	35.9	43.0	26.9	29.8	37.9	45.5
Prescriptions from More Than One Doctor	1.1	1.0	3.8	*	0.9	0.9	1.7	1.7	0.7	0.8
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.8	0.6	1.4	0.2	0.8	0.6	1.2	*	0.7	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	50.8	47.2	51.3	*	50.8	46.5	55.0	55.4	49.8	44.9
From Friend or Relative for Free	37.0	34.4	31.1	*	37.3	33.8	37.8	40.3	37.2	32.6
Bought from Friend or Relative	9.2	9.2	9.4	*	9.2	9.1	10.7	11.8	8.8	8.6
Took from Friend or Relative without Asking	4.6	3.7	10.7	4.7	4.2	3.6	6.5	3.3	3.7	3.7
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	6.2	6.2	5.4	1.9	6.2	6.3	8.5	9.9	5.7	5.7
SOME OTHER WAY ¹	5.5	3.1	6.6	*	5.4	2.6	6.5	1.6	5.2	2.8

This is the next table showing the percentage of the people that misuse prescription pain relievers.

Table 6.5B Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among Past Year Misusers Aged 12 or Older; by Age Group, Percentages, 2019 and 2020

Source for Most Recent Misuse among Past Year Misusers of Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	7 Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	5 Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE				*						
PROVIDER	37.5	43.6	36.7		37.6	44.5	29.9	33.1	39.3	46.6
Prescription from One Doctor	35.7	42.0	31.5	*	35.9	43.0	26.9	29.8	37.9	45.5
Prescriptions from More Than One Doctor	1.1	1.0	3.8	*	0.9	0.9	1.7	1.7	0.7	0.8
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.8	0.6	1.4	0.2	0.8	0.6	1.2	*	0.7	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	50.8	47.2	51.3	*	50.8	46.5	55.0	55.4	49.8	44.9
From Friend or Relative for Free	37.0	34.4	31.1	*	37.3	33.8	37.8	40.3	37.2	32.6
Bought from Friend or Relative	9.2	9.2	9.4	*	9.2	9.1	10.7	11.8	8.8	8.6
Took from Friend or Relative without Asking	4.6	3.7	10.7	4.7	4.2	3.6	6.5	3.3	3.7	3.7
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	6.2	6.2	5.4	1.9	6.2	6.3	8.5	9.9	5.7	5.7
SOME OTHER WAY ¹	5.5	3.1	6.6	*	5.4	2.6	6.5	1.6	5.2	2.8

The percentage that got a prescription from more than one doctor which is doctor shopping is 1.0%.

Table 6.5B Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among Past Year Misusers Aged 12 or Older; by Age Group, Percentages, 2019 and 2020

Source for Most Recent Misuse among Past Year Misusers of Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE										
PROVIDER	37.5	43.6	36.7	*	37.6	44.5	29.9	33.1	39.3	46.6
Prescription from One Doctor	35.7	42.0	31.5	*	35.9	43.0	26.9	29.8	37.9	45.5
Prescriptions from More Than One Doctor	1.1	1.0	3.8	*	0.9	0.9	1.7	1.7	0.7	0.8
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.8	0.6	1.4	0.2	0.8	0.6	1.2	*	0.7	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	50.8	47.2	51.3	*	50.8	46.5	55.0	55.4	49.8	44.9
From Friend or Relative for Free	37.0	34.4	31.1	*	37.3	33.8	37.8	40.3	37.2	32.6
Bought from Friend or Relative	9.2	9.2	9.4	*	9.2	9.1	10.7	11.8	8.8	8.6
Took from Friend or Relative without Asking	4.6	3.7	10.7	4.7	4.2	3.6	6.5	3.3	3.7	3.7
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	6.2	6.2	5.4	1.9	6.2	6.3	8.5	9.9	5.7	5.7
SOME OTHER WAY ¹	5.5	3.1	6.6	*	5.4	2.6	6.5	1.6	5.2	2.8

34.4% got them from a friend or relative for free.

Table 6.5B Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among Past Year Misusers Aged 12 or Older; by Age Group, Percentages, 2019 and 2020

Source for Most Recent Misuse among Past Year Misusers of Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	5 Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE										
PROVIDER	37.5	43.6	36.7	*	37.6	44.5	29.9	33.1	39.3	46.6
Prescription from One Doctor	35.7	<u>42.0</u>	31.5	*	35.9	43.0	26.9	29.8	37.9	45.5
Prescriptions from More Than One Doctor	1.1	1.0	3.8	*	0.9	0.9	1.7	1.7	0.7	0.8
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.8	0.6	1.4	0.2	0.8	0.6	1.2	*	0.7	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	50.8	47.2	51.3	*	50.8	46.5	55.0	55.4	49.8	44.9
From Friend or Relative for Free	37.0	34.4	31.1	*	37.3	33.8	37.8	40.3	37.2	32.6
Bought from Friend or Relative	9.2	9.2	9.4	*	9.2	9.1	10.7	11.8	8.8	8.6
Took from Friend or Relative without Asking	4.6	3.7	10.7	4.7	4.2	3.6	6.5	3.3	3.7	3.7
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	6.2	6.2	5.4	1.9	6.2	6.3	8.5	9.9	5.7	5.7
SOME OTHER WAY ¹	5.5	3.1	6.6	*	5.4	2.6	6.5	1.6	5.2	2.8

42.0% got them from one doctor.

Table 6.6A Source Where Friend or Relative Obtained Prescription Pain Relievers: Among Past Year Misusers Aged 12 or Older Who Obtained Most Recently Misused Prescription Pain Relievers from a Friend or Relative for Free in Past Year; by Age Group, Numbers in Thousands, 2019 and 2020

Source Where Friend or Relative Obtained Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 A (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE PROVIDER	2,735	2,477	*	*	2,662	2,366	474	361	2,188	2,005
Prescription from One Doctor	2,664	2,390	*	*	2,598	2,285	457	358	2,141	1,927
Prescriptions from More Than One Doctor	54	26	*	*	49	24	13	*	36	22
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	18	*	*	*	15	*	4	*	11	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	306	285	*	*	289	276	60	84	228	*
From Friend or Relative for Free	193	192	*	*	191	191	43	*	148	*
Bought from Friend or Relative	70	77	*	*	67	72	11	*	56	*
Took from Friend or Relative without Asking	43	15	*	*	30	13	6	*	24	**
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	83	69	*	*	62	60	16	11	47	49
SOME OTHER WAY ¹	53	49	*	*	43	49	12	8	32	*

This table asked the same question about where the friend or relative obtained the prescription pain relievers.

Table 6.6B Source Where Friend or Relative Obtained Prescription Pain Relievers: Among Past Year Misusers Aged 12 or Older Who Obtained Most Recently Misused Prescription Pain Relievers from a Friend or Relative for Free in Past Year; by Age Group, Percentages, 2019 and 2020

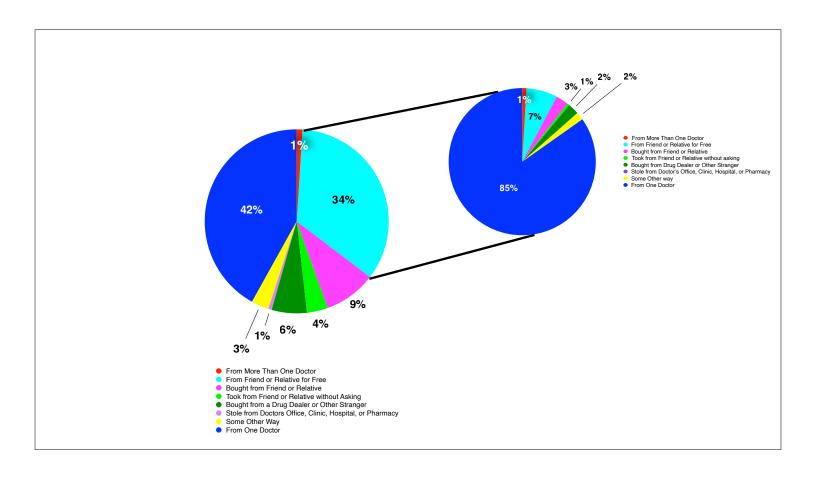
Source Where Friend or Relative Obtained Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17 (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE										
PROVIDER	86.1	86.0	*	*	87.1	86.0	84.4	77.9	87.7	87.7
Prescription from One Doctor	83.8	83.0	*	*	85.0	83.1	81.3	77.3	85.8	84.3
Prescriptions from More Than One Doctor	1.7	0.9	*	*	1.6	0.9	2.4	*	1.4	0.9
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.6	*	*	*	0.5	*	0.7	*	0.4	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR RELATIVE	9.6	9.9	*	*	9.4	10.0	10.7	18.0	9.2	*
From Friend or Relative for Free	6.1	6.7	*	*	6.3	7.0	7.7	*	5.9	*
Bought from Friend or Relative	2.2	2.7	*	*	2.2	2.6	2.0	*	2.3	*
Took from Friend or Relative without Asking	1.3	0.5	*	*	1.0	0.5	1.1	*	1.0	*
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	2.6	2.4	*	*	2.0	2.2	2.8	2.4	1.9	2.1
SOME OTHER WAY ¹	1.7	1.7	*	*	1.4	1.8	2.1	1.7	1.3	*

This table shows those answers in percentages.

Table 6.6B Source Where Friend or Relative Obtained Prescription Pain Relievers: Among Past Year Misusers Aged 12 or Older Who Obtained Most Recently Misused Prescription Pain Relievers from a Friend or Relative for Free in Past Year; by Age Group, Percentages, 2019 and 2020

Source Where Friend or Relative Obtained Pain Relievers	Aged 12+ (2019)	Aged 12+ (2020)	Aged 12-17. (2019)	Aged 12-17 (2020)	Aged 18+ (2019)	Aged 18+ (2020)	Aged 18-25 (2019)	Aged 18-25 (2020)	Aged 26+ (2019)	Aged 26+ (2020)
GOT THROUGH PRESCRIPTION(S) OR STOLE FROM A HEALTH CARE	06.1	96.0	*	*	07.1	96.0	04.4	77.0	07.7	87.7
PROVIDER	86.1	86.0	•		87.1	86.0	84.4	77.9	87.7	
Prescription from One Doctor	83.8	83.0	*	*	85.0	83.1	81.3	77.3	85.8	84.3
Prescriptions from More Than One Doctor	1.7	0.9	*	*	1.6	0.9	2.4	*	1.4	0.9
Stole from Doctor's Office, Clinic, Hospital, or Pharmacy	0.6	*	*	*	0.5	*	0.7	*	0.4	*
GIVEN BY, BOUGHT FROM, OR TOOK FROM A FRIEND OR										
RELATIVE	9.6	9.9	*	*	9.4	10.0	10.7	18.0	9.2	*
From Friend or Relative for Free	6.1	6.7	*	*	6.3	7.0	7.7	*	5.9	*
Bought from Friend or Relative	2.2	2.7	*	*	2.2	2.6	2.0	*	2.3	*
Took from Friend or Relative without Asking	1.3	0.5	*	*	1.0	0.5	1.1	*	1.0	*
BOUGHT FROM DRUG DEALER OR OTHER STRANGER	2.6	2.4	*	*	2.0	2.2	2.8	2.4	1.9	2.1
SOME OTHER WAY ¹	1.7	1.7	*	*	1.4	1.8	2.1	1.7	1.3	*

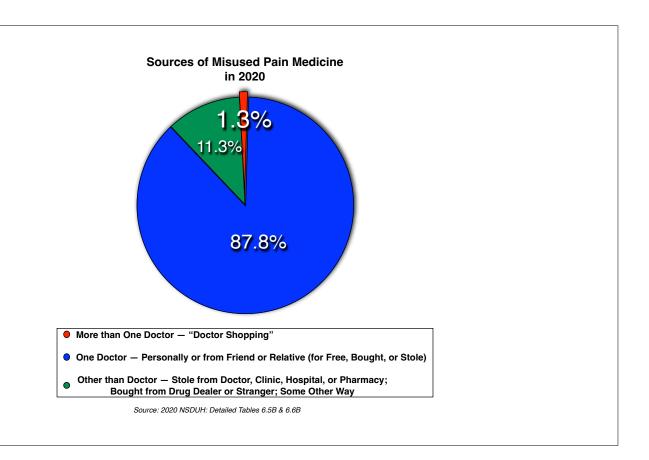
The prescriptions from more than one doctor was 0.9%.



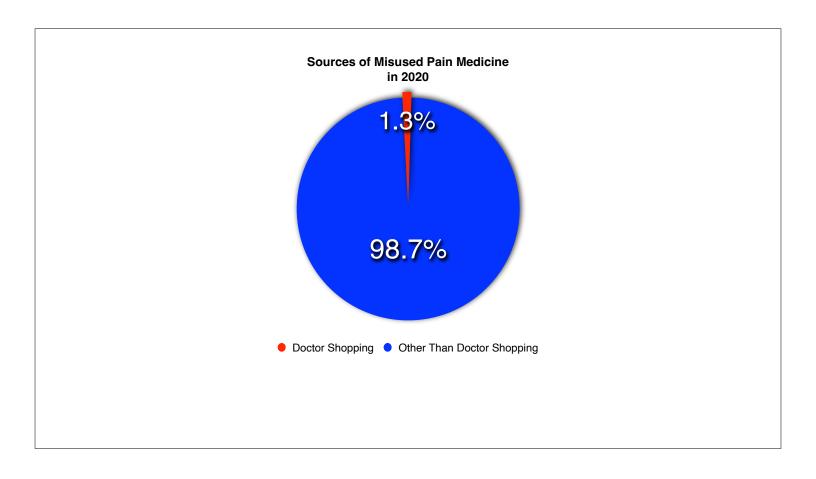
This is a pie chart of both questions. The results from the initial question the source where prescription pain relievers were obtained for the most recent misuse, age 12 and older is on the left.

The results from the second question about the source where the friend or relative obtained the prescription pain relievers is on the right.

If we simplify these graphs into one general graph, we get the following.



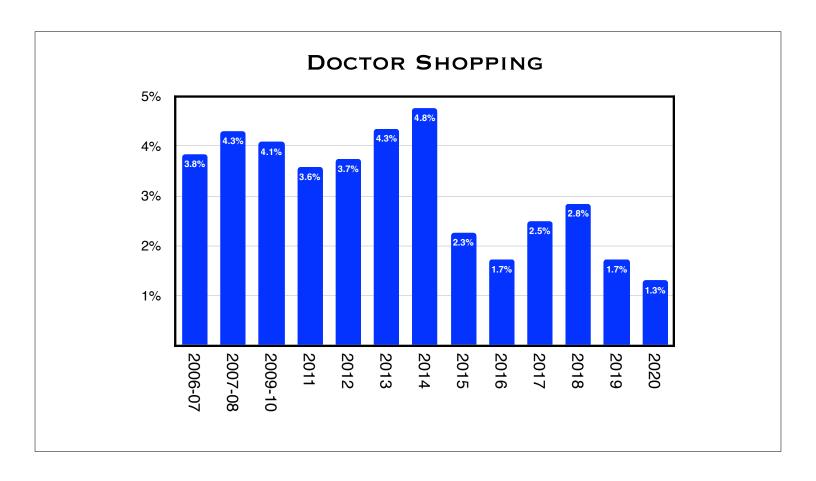
- 1.3% of the people who misused prescription pain medicine obtained it from doctor shopping. 0.9% of 34.4% = 0.3% + 1.0% = 1.3%.
- 87.8% obtained them from one doctor.
- 11.3% obtained them by a method that did not involve a doctor.



The PDMP is a failure because it will not stop 98.7% of misused prescription pain medicine who obtained the medicine from a method other than doctor shopping.

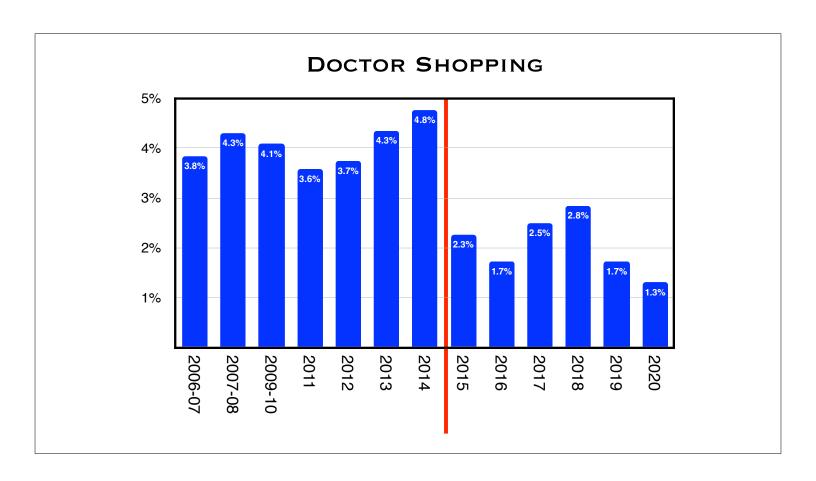
98.7% will never be caught by a PDMP.

Yet this is what proponents based their whole argument on, stopping doctor shopping.

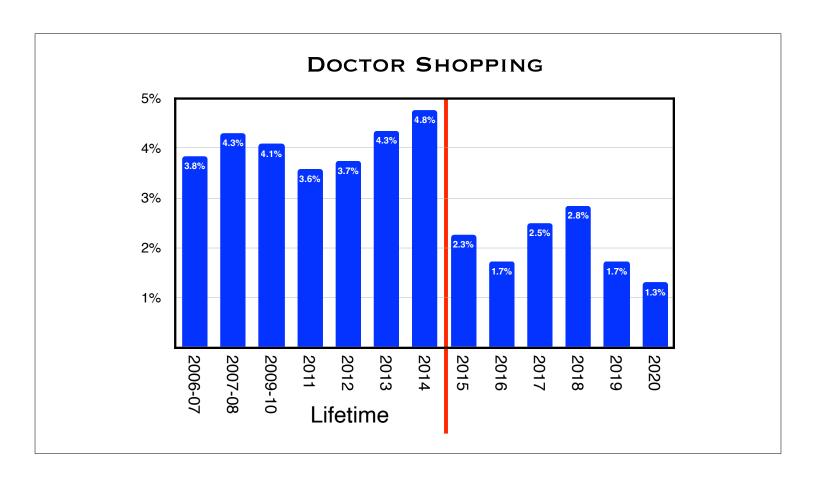


This is a graph of the percentage of doctor shopping from 2006 to 2020. The initial years were averages for both years.

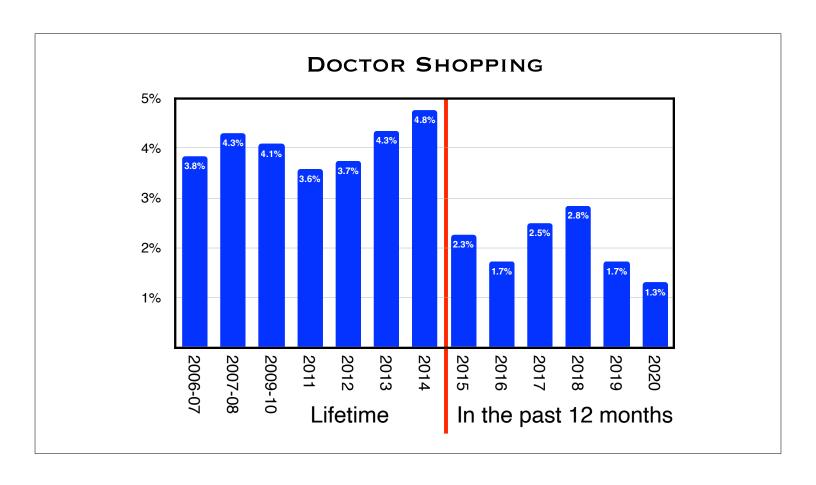
For the worst year, doctor shopping only represented 4.8% of the people that misused prescription pain medicine.



In 2015 there was a considerable decrease in the percentage of doctor shopping. Why?



Through 2014, the survey asked the question about getting it from more than one doctor in your "lifetime."



In 2015, the question changed to "in the past 12 months."

ASSOCIATION BETWEEN PRESCRIPTION DRUG MONITORING PROGRAMS AND NONFATAL AND FATAL DRUG OVERDOSES: A SYSTEMATIC REVIEW

Annals of Internal Medicine June 5, 2018

This was large study published in 2018.

Conclusion — Evidence that PDMP implementation either increases or decreases nonfatal or fatal overdoses is largely insufficient, as is evidence regarding positive associations between specific administrative features and successful programs. Some evidence showed unintended consequences. Research is needed to identify a set of "best practices" and complementary initiatives to address these consequences.

This was their conclusion.

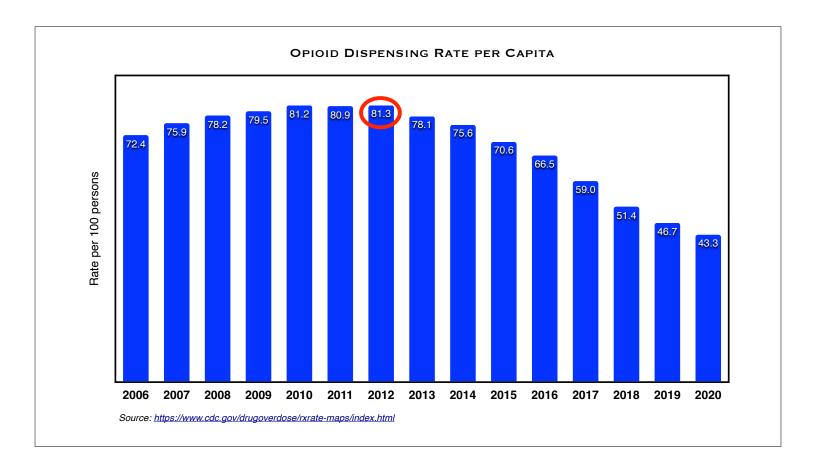
15 years ago Brandeis University had an entire department focusing on the PDMP. They produced volumes of research on best practices. There are no "best practices" that work, because the PDMP does not work.

What were the unintended consequences?

 Implementation of PDMPs may have unintended negative outcomes—namely, increased rates of heroin-related overdose.

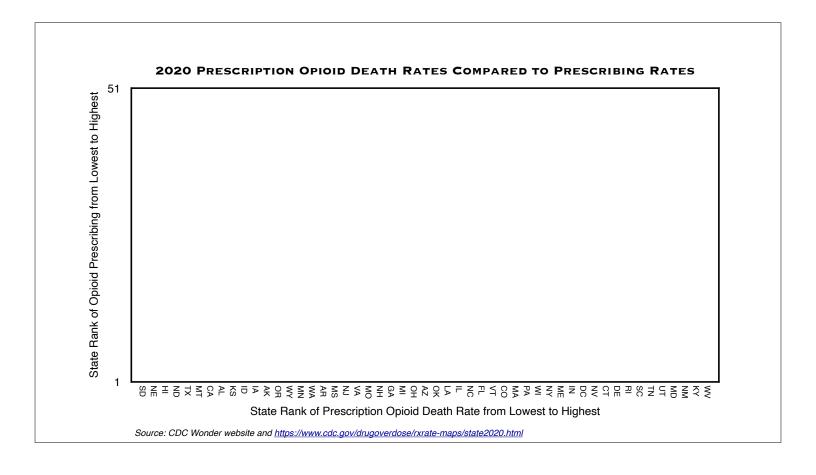
It's called supply and demand. When the supply of prescription opioids decreases and the demand for opioids does not change, an alternate supply increases.

IS THE OPIOID DEATH RATE DUE TO OPIOID PRESCRIPTION WRITING?

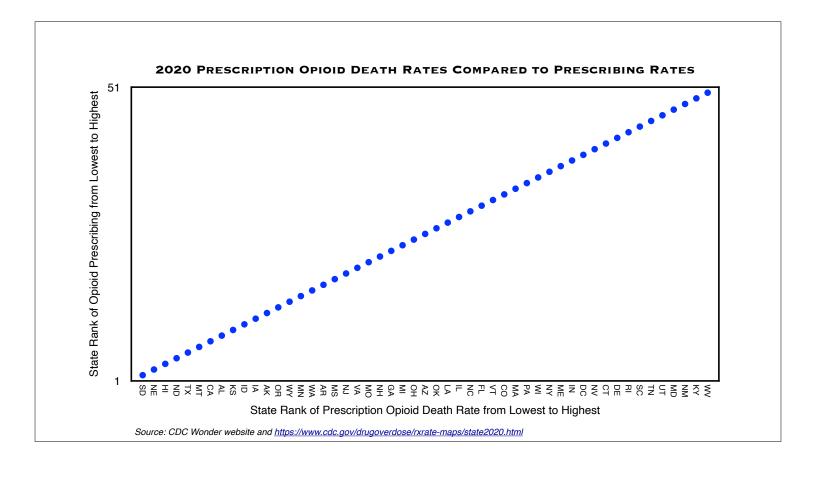


This graph shows the opioid dispensing per capita from 2006 to 2020.

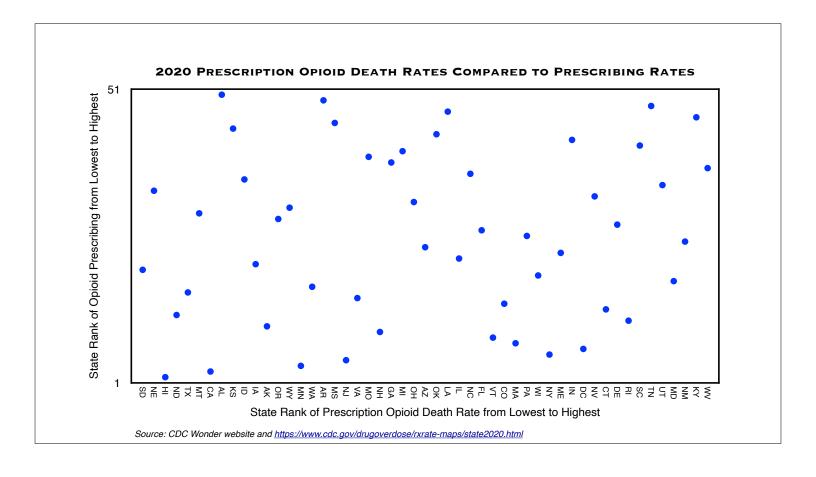
The peak was in 2012 and the rate has been falling through 2020.



This graph shows the ranking of the opioid death rate by state from lowest to highest on the X-axis. The ranking of the opioid prescribing rate by state from lowest to highest is on the Y-axis.

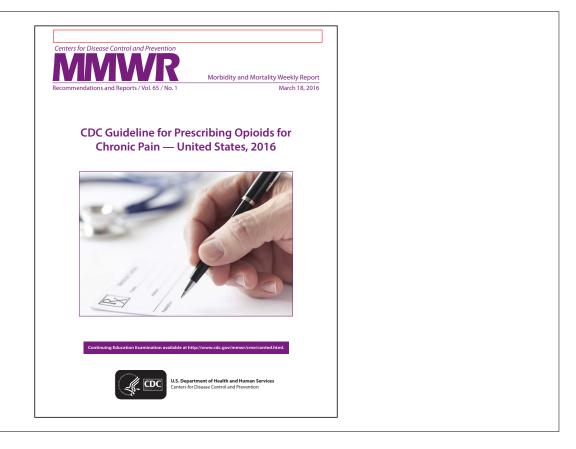


If opioid prescribing correlated with opioid deaths then the points on the graph should be a straight line like this.



Instead of a straight line, the actual graph looks like this.

Obviously there is no correlation between opioid prescribing and opioid deaths.

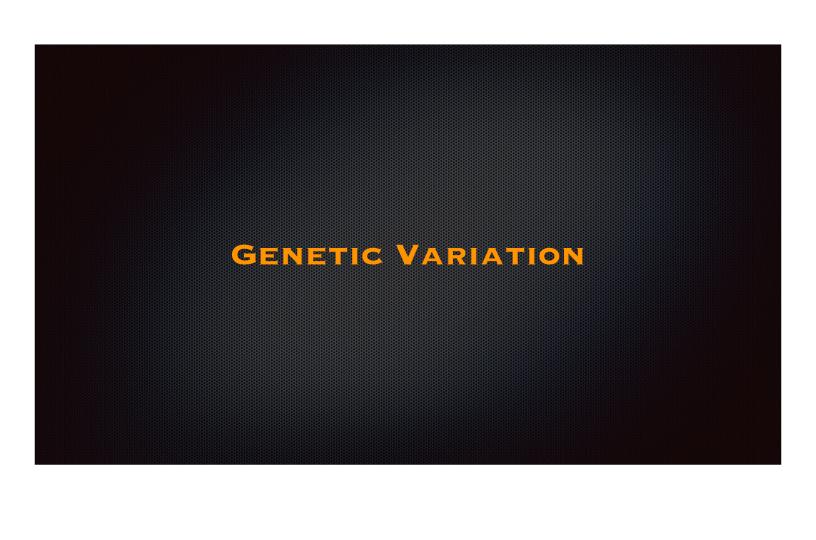


This is the cover of the CDC opioid prescribing guidelines that were published in 2016.

"The recommendations in the guideline are voluntary, rather than prescriptive standards."

 CDC Guidelines for Prescribing Opioids for Chronic Pain - 2016, page 2

Even though the guidelines specifically state they are voluntary, some businesses treat them as mandatory. Physicians that have prescribed pain medicine at doses over the guidelines have been banned from Walmart pharmacies. The Walmart ban covers more than just opioids. Walmart will not fill any controlled substance prescription for any patient written by a banned physician. So the patient of a banned physician that has bad diarrhea has to go to another pharmacy to get a prescription for some anti-diarrhea medicine.



Another fact that is completely ignored by the CDC Guidelines is genetic variation.

Phenotype: Negative
Alleles Tested:

QUEST RESULT SEE NOTE
Comment Component Name: HTR2A
Genotype: re7997012 A/G
Phenotype: Reterozygous for the A allele
(rs7997012)
Alleles Tested: -14380-A, 1020-T, rs7997012
Genotype: 104380-A A/A
Phenotype: Homozygous for the A allele (rs6311)
Alleles Tested: -14380-A, 1020-T, rs7997012
Genotype: 1020-T 7/T
Phenotype: Homozygous for the T allele (rs6313)
Alleles Tested: -14380-A, 1020-T, rs7997012
QUEST RESULT SEE NOTE
Comment Component Name: HTR2C
Genotype: 1141381440-G G/G
Phenotype: Homozygous for the G allele (rs1414334)
Alleles Tested: 1141381440-G
QUEST RESULT SEE NOTE
Comment Component Name: HTR2C
Genotype: 1241391440-G
QUEST RESULT SEE NOTE
Comment Component Name: HTR13
Genotype: Resurable Genotype Response
Alleles Tested: rs12979860
QUEST RESULT SEE NOTE
Comment Component Name: MTBTR
Genotype: Reduced MTBTR Activity
Alleles Tested: rs12979860
QUEST RESULT SEE NOTE
Comment Component Name: MTBTR
Genotype: Component Name: MTBTR
Genotype: 12186AD-C C/A
Phenotype: Reduced MTBTR Activity
Alleles Tested: c.1286AD-C, c.6650-T
Genotype: Normal MTBTR Activity
Alleles Tested: c.1286AD-C, c.6650-T
QUEST RESULT SEE NOTE
Comment Component Name: NODT15
Genotype: Normal MTBTR Activity
Alleles Tested: c.1286AD-C, c.6650-T
QUEST RESULT SEE NOTE
Comment Component Name: NODT15
Genotype: 1/*1
Phenotype: Normal MtBTR Activity
Alleles Tested: c.1286AD-C, c.6650-T
QUEST RESULT SEE NOTE
Comment Component Name: SUOT15
Genotype: 1/18 SEE NOTE
Comment Component Name: SUOT15
Genotype: 1/18 SEE NOTE
Comment Component Name: SUOT16
Genotype: 1/18 A/G
Phenotype: Decreased Serotonin Transporter
Expression
Alleles Tested: L1, S. Lg

Phenotype: Decreased Serotonin Transporter
Expression

This is a page from the Quest Pharmacogenomic Test on an actual patient.

QUEST RESULT SEE NOTE Comment: Component Name: NUDT15 Genotype: *1/*1 Phenotype: Normal Metabolizer Alleles Tested: *2, *3 QUEST RESULT SEE NOTE Comment: Component Name: OPRM1 Genotype: A118G A/G Phenotype: Altered OPRM1 Function Alleles Tested: A118G QUEST RESULT SEE NOTE Comment: Component Name: SLC6A4 Genotype: S/La Phenotype: Decreased Serotonin Transporter Expression Alleles Tested: La, S, Lg

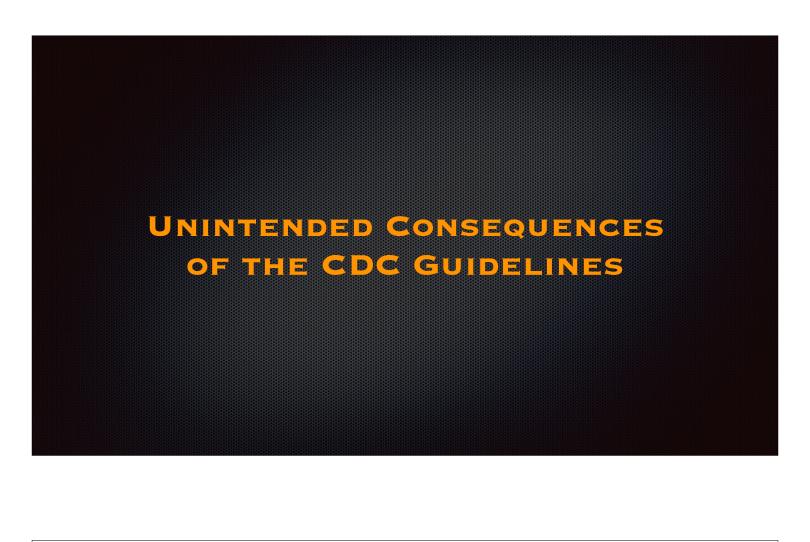
At the bottom of the page it shows the result of the OPRM1 gene. This patient has an altered OPRM1 function. This means that this individual needs a higher dose of opioids to achieve the same pain relief effect as someone with a normal functioning OPRM1 gene. The CDC Guidelines did not factor this into their recommendations.

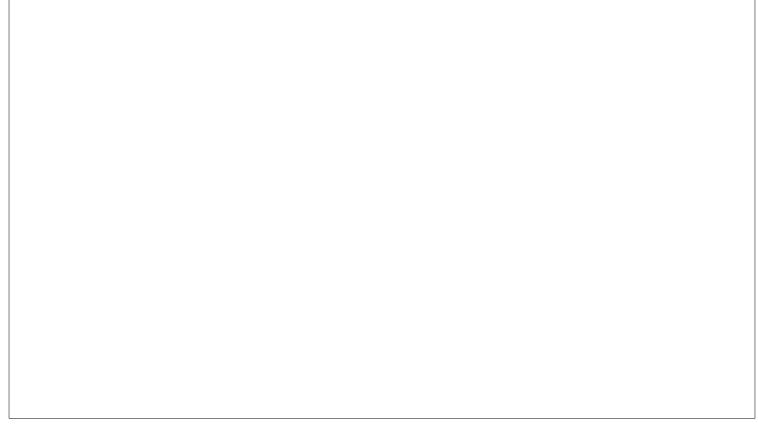
OPIOIDS AND CHRONIC PAIN: AN ANALYTIC REVIEW OF THE CLINICAL EVIDENCE

This study was published in August 2021.

"The reasons for the high variability in opioid dosage needed to achieve control of chronic pain are not well understood. Severity of pain must be a factor. Genetic differences in hepatic metabolism can account for 3-fold or greater variability. Genetic differences in the receptor interactions of different opioids and in neural transmission also appear to be important."

Again, this was completely ignored by the CDC guidelines.





HEALTH · Published December 10, 2018

As doctors taper or end opioid prescriptions, many patients driven to despair, suicide

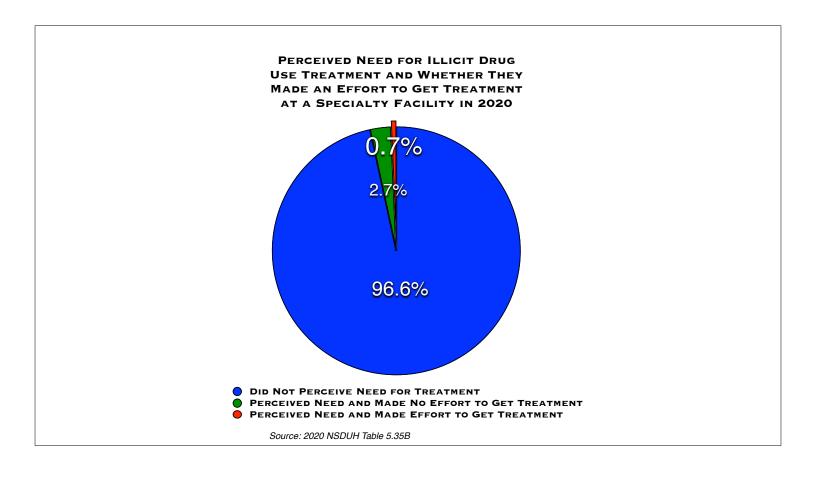


This was a Fox News report in December 2018.

Our government does not care that the CDC guidelines are causing suicides.

DRUG ADDICTION TREATMENT

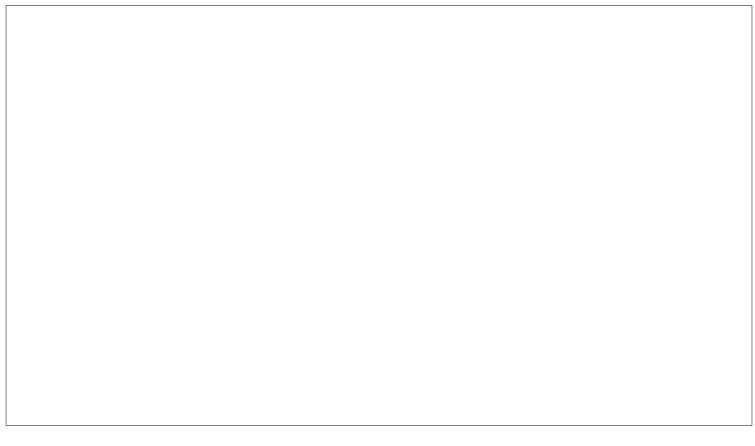
- Proponents claim the PDMP is needed to identify people addicted to opiates and get them into treatment?
- Unfortunately, getting an addict into a program does not guarantee a successful outcome.



If we again look at the National Survey on Drug Use and Health, we will find that only 0.7% of individuals who need treatment for illicit drugs want the treatment and made an effort to get treatment. 96.6% do not perceive the need for treatment and 2.7% perceived the need, but did not make an effort to get treatment.

99.3% of addicts will not stop even if they are forced into a treatment program. Getting those individuals into a treatment program is futile. Addicts will only succeed if they want to stop for their own benefit.



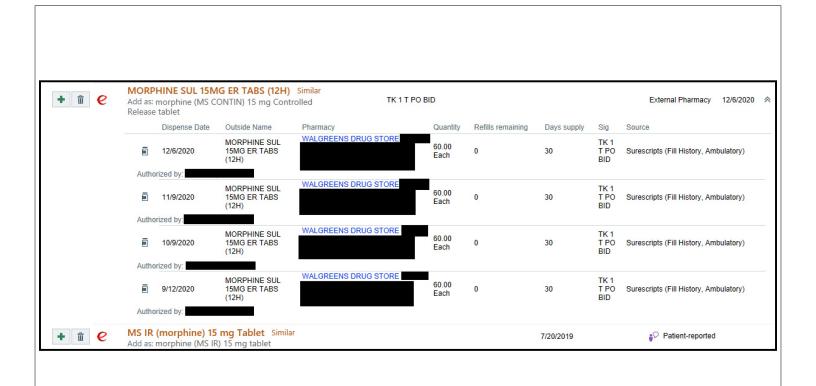




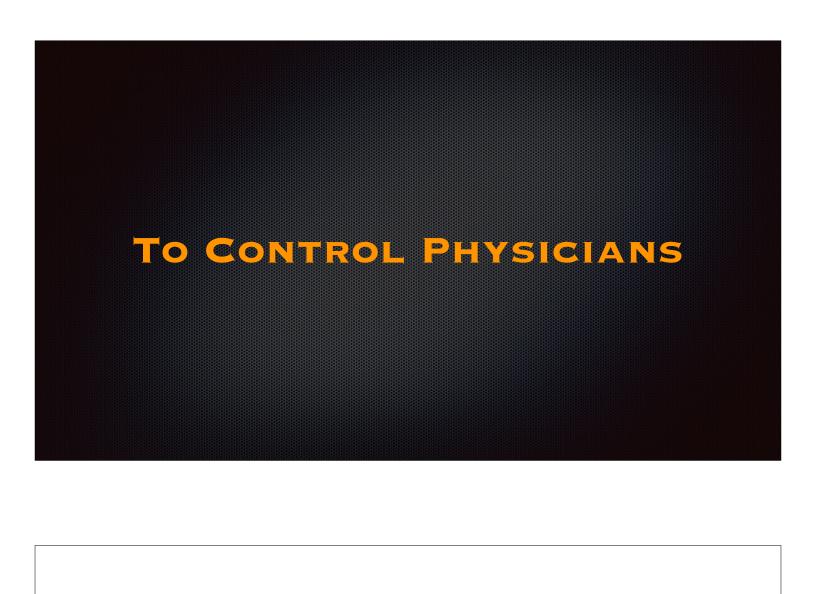
This is from the author's electron medical record that shows the patients medications.

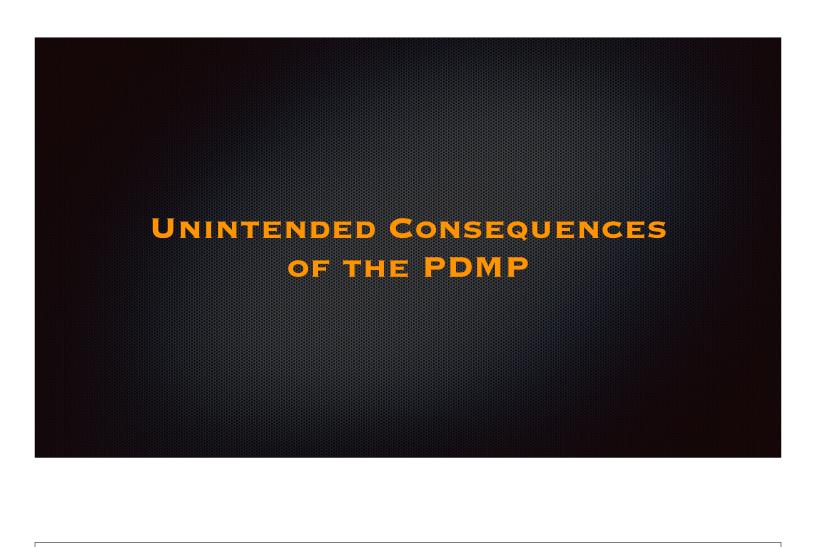


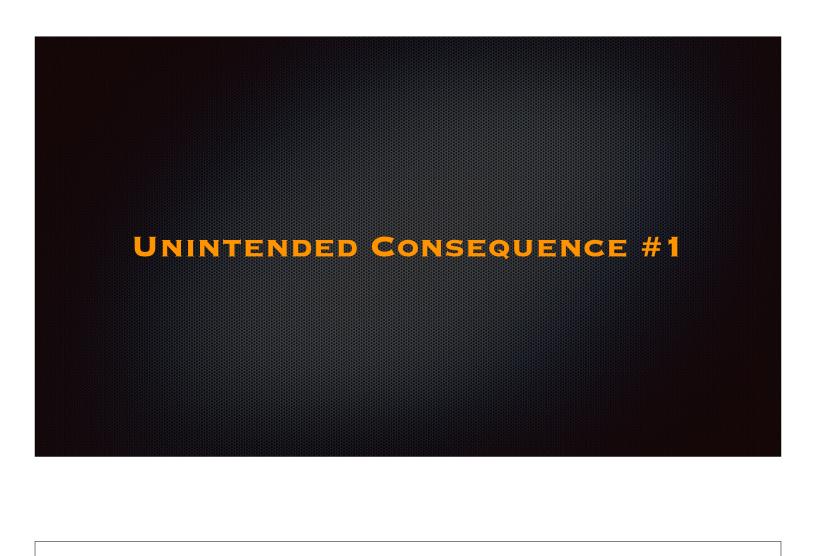
If you click on the "Go Reconcile" tab you get the following slide.



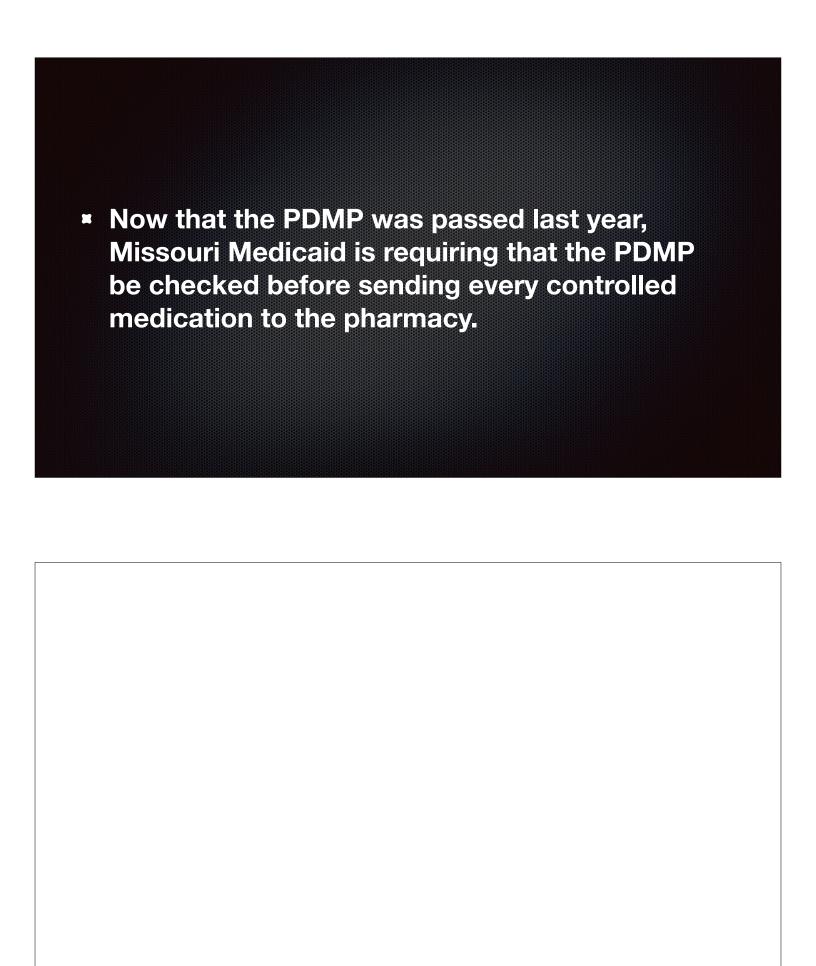
This shows morphine being prescribed by another physician in a different system going to a Walgreens pharmacy and the dates on which the medication was dispensed. This is NOT a government database and it is not kept in a third party database. The computer query is a one time only event. This does not cover every opioid or other controlled medication prescription, but it is a viable private sector solution. Why does the government want a database?

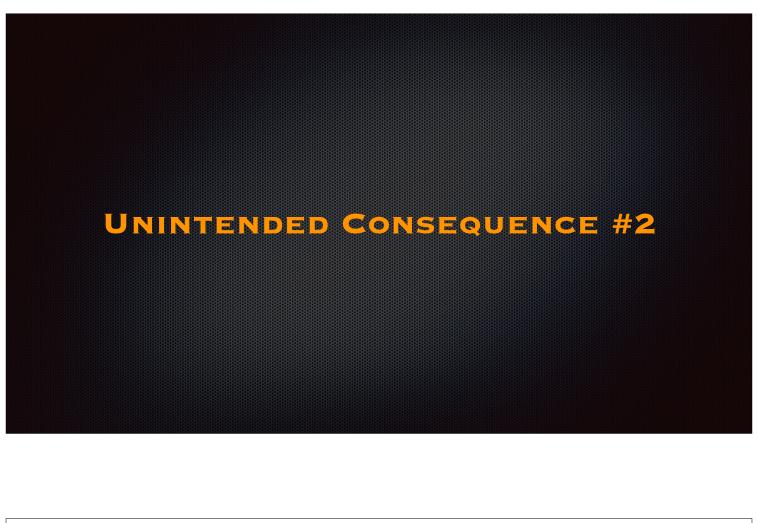


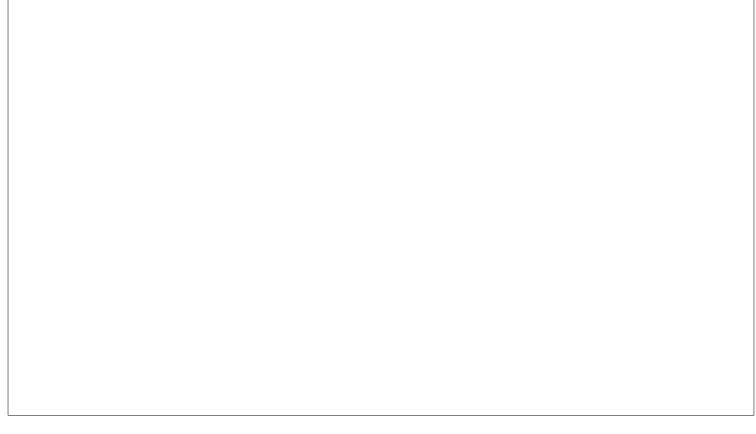


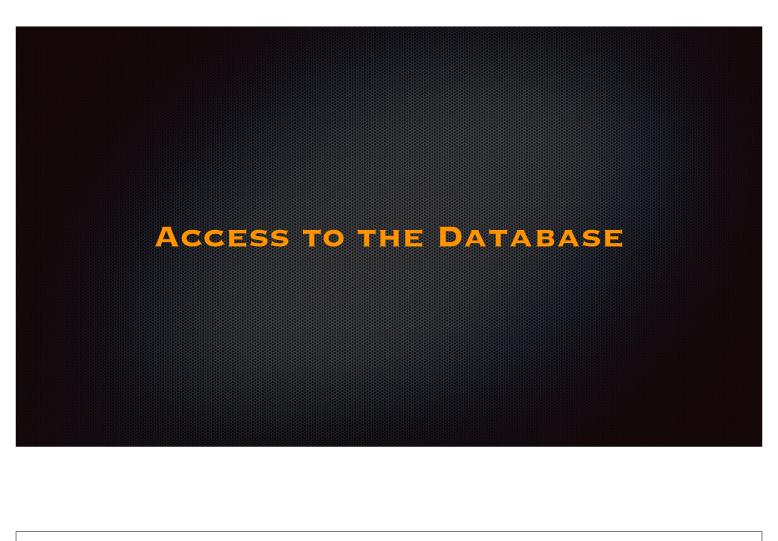


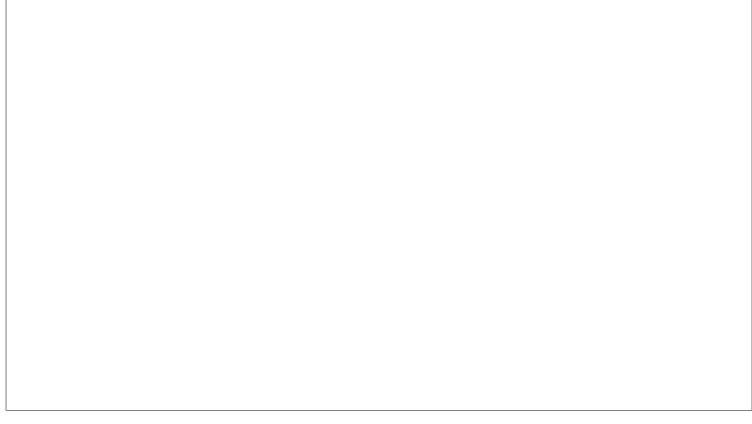
- * About 8 years ago, at the Missouri State Medical Association's Annual Convention, then Senator Dr. Rob Schaaf wrote an amendment to the resolution that supported passing a statewide PDMP. The amendment required using the PDMP every time a scheduled prescription was written.
- The amendment was roundly defeated.









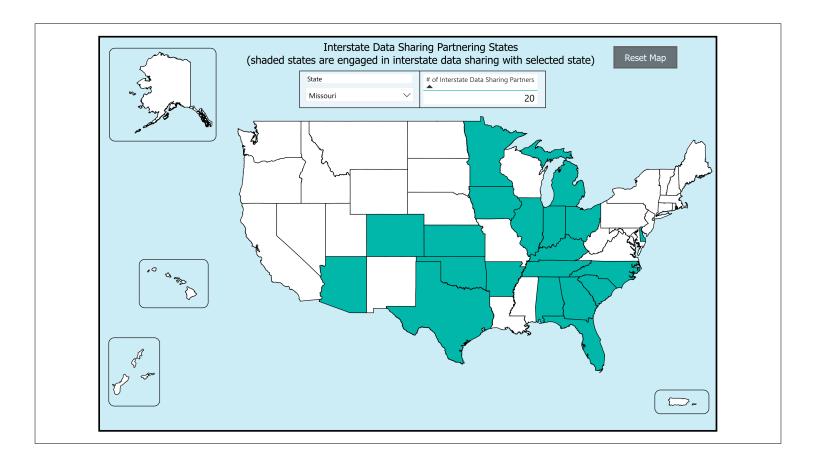








The Prescription Drug Monitoring Program Training and Technical Assistance Center is a subsidiary of the U.S. Department of Justice. It produces volumes of information on all of the states PDMPs.



This is a map of the states that share their PDMP data with Missouri. For the country it ranges from 45 states and the District of Columbia that share their data with Arizona to zero for California. The average is 31.

PDMP T rescriptor Drug Monitoring Rogram Training and Tec	A Infect Assistance	Center				F	DMP	s Autl	horiz	ed an	d En	gaged	l in S	endin	g Sol	icited	and	Unso	licite	d Rep	orts	to He	alth (Care F	Provid	ders a	and Pat	ients	i		
		Pres	criber		Di	Dispenser (Pharmacy or Pharmacist)				Physician Assistant				Nurse Practitioner				Prescriber Delegate (Licensed or Unlicensed)			Disper	ser Deleg Unlice		nsed or	Patient				Drug Treatment Provider		
State	Aut Sol.	hority Unsol.	Eng Sol.	gaged Unsol.	Aut Sol.	hority		aged Unsol.	Aut Sol.	nority Unsol.	Eng Sol.	gaged Unsol.	Aut Sol.	hority Unsol.	Enį Sol.	gaged	Aut Sol.	hority Unsol.		gaged	Aut Sol.	hority Unsol.		aged Unsol.	Auth Sol.	ority Unsol.	Engage Sol. U		Authori Sol. U		Engaged
labama	х	X	Х	х	Х	х	х	Х	Х	X	Х	х	Х	х	Х	X	Х		Х												
aska	Х	Х	Х		Х	Х	Х		Х		Х		X		Х		Х				X				Х		Х				
zona	Х	Х	х	Х	Х		Х		х	Х	х	Х	х	Х	х	Х	х		Х		х		Х		х		Х				
kansas	Х	X	Х	Х	Х	Х	Х	Х	Х	X	Х	Х	X		Х		Х		X		X		X		Х		X				
ifornia	Х	Х	X	Х	Х	Х	Х		Х	X	Х	Х	X	Х	Х	X									Х		Х				
lorado	Х	Х	Х	Х	Х	Х	Х	Х	х	X	х	Х	X	Х	Х	X	х		Х		X		Х		Х		X		Х		Х
nnecticut	Х	Х	X	Х	Х	Х	Х	Х	Х	X	Х	Х	X		Х		Х		Х		X										
laware	Х	Х	Х	Х	Х	Х	Х	Х	х	X	х	Х	X	Х	Х	Х	х	Х	Х		X	Х	Х		Х		X		Х		Х
trict of Columbia	Х	Х	X		Х	Х	Х		Х	X	Х	Х					Х				X				Х						
rida	Х	Х	Х	Х	Х	Х	Х		Х	Х	Х	Х	Х		Х		Х		Х		Х		Х		Х		Х				
orgia	Х	Х	Х		Х		Х		Х	X	Х	Х	Х		Х		Х		Х		Х		Х		Х		Х				
iam	Х	Х	Х		Х	Х	Х		Х	X	Х	Х	Х		Х										Х		X				
iiswaii	х	X	Х		Х	х	х		Х		Х		Х		Х		Х		Х		Х		х								
aho	Х	Х	Х	Х	Х	Х	Х	Х	Х		Х		Х		Х		Х	Х	Х		Х		Х		Х		X				
nois	х	X	Х	х	Х	х	х	X	Х	X	Х	х	Х	Х	Х	X	Х				Х				х		X		х		х
diana	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	X	Х	Х	X	Х		Х		Х		Х		Х				Х		Х
wa .	х	X	Х	х	Х	х	х	X	Х	X	Х	х	Х	X	Х	X	Х		Х		Х		х		х		X				
nsas	Х		Х		Х		Х		Х		Х		Х		Х		Х		Х												
ntucky	Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		Х								
uisiana	Х	х	Х	х	Х	Х	Х	Х	Х	Х	Х	х	Х	х	Х	Х	Х		Х		Х		Х		Х		Х		х		
aine	Х	Х	Х	Х	Х	Х	Х		Х	X	Х	Х	Х	Х	Х	X	Х		Х		Х		Х		х		Х		х		Х
aryland	Х	Х	Х	х	Х	Х	х	Х	Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		х		х
assachusetts	Х	х	Х	х	Х	Х	х		Х	х	Х	х	Х	х	Х	X	Х		Х		Х		Х		Х		х			_	
chigan	Х	Х	Х	Х	Х		Х		Х	X	Х	Х	Х	X	Х	X	Х		Х		Х		Х								
innesota	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х		Х		Х		Х		Х		Х			_	
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ebraska	Х	Х	X	Х	X	Х	X	Х	Х		Х	v	Х	Х	X	v	Х		Х		X		X		Х					_	
evada	Х		Х						Х	Х	Х	Х	Х	Α	Х	X	Х		Х												
ew Hampshire	X	X	X	Х	X	X	X	Х	X	Х	X	Х	X		X		X		X		Х		Х		X		X		Х	х	
w Jersey w Mexico	X	X	X	Х	X		X		X	X	X	X	X	Х	X	Х	X		X		х		Х		X		X		X		х
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ew York orth Carolina	X	X	X	Х	X	X	X	Х	X	Х	X	Х	X		X		X		X		X		X		X		X		Х	_	х
orth Dakota	X	X	X	X	X	X	X	X	X	Х	X	Х	X	X	X	X	X		X		X		X		X		X		Х		х
orthern Mariana Islands	X	X	X	X	X		X	Α	X	X	X	X	X	X	X	X	X		X		X		X		^		^		^	_	^
io	X	X	X		X	Х	X		X	X	X	X	X	_^	X		X		X		X		X		Х	_					
lahoma	X	X	X	Х	X	X	X	х	X	X	X	X	X	Х	X	Х	X		X		X		X		^			-			
egon	X	<u> </u>	X		X	_	X	^	X	^	X	^	X	_^	X	_	X		X		X		X		Х		х				
nnsylvania	X	х	X		X		X		X		X		_		_		X		^		X		^		X		-	_			
erto Rico	X	x	X	Х	X	Х	X	X	_		_						_				X		Х		^						
ode Island	X	X	X	X	X	X	X	X	х	×	х	х	х	x	х	×	х				X		- "		Х	х	x				
uth Carolina	X	X	X	X	X	X	X		X	X	X		X	_	X	_	X		Х		X		Х		X		X		х		Х
uth Dakota	X	X	X	X	X	X	X	х	X	X	X	х	X	Х	X	X	X		X						X		X	_	X		X
inessee	X	X	X	X	X		X		X	X	X	X	X	X	X	X	X	Х	X	Х	Х	х	Х	Х	X		X				
kas	X	X	X	X	X	Х	X	х	X	X	X	X	X		X		X		X		X		X		X			_			
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rmont	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X		Х		X		Х		X		х	_			
ginia	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X		X		X		X		X		X				
shington	X	X	X	- ~	X	X	X		X	X	X	X	X		X		X		X		X		- "		X		X	_			
est Virginia	X	X	X	Х	X	X	X	X	X	X	X	X	X	Х	X	X	X	х	X	Х	X	х	Х	Х							
sconsin	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X		X		X		Х	Х	х	_	х		
yoming	X	×	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		-		X				X	X	X	Х		x	x x

This is a table of health care entities that have access to the database in each state. It includes physicians, resident physicians, pharmacists, physician assistants, nurse practitioners, prescriber delegates, dispenser delegates, patients, and drug treatment providers.

PDMP	ŢΛ	C		Р	DMP	's Auth	orize	ed and		aged ir					l Uns	olicite	d Re	ports t	0		
Prescription Drug Manitoring Program Training and Tec	hrical Assistan	nce Center	www.pdmpassist.org																		
		Law Enfo	rceme	nt		Prose	cutor		Co		Drug	Court		Med	ical Exam	iner / Coroner					
State	Aut	hority	Eng	gaged		hority	En	gaged	Aut	hority	Eng	gaged		hority	Eng	gaged	Aut	hority	Engaged		
	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	
Alabama Alaska	X		X				v		v				v		v		v		v		
Arizona	X	Х	X		Х	Х	Х		X		Х		Х		Х		X		Х		
Arkansas	X	X	X	х							^						X		Х		
California	X	-	X	-	х		Х										X		X		
Colorado	Х	х	Х			Х											X		X		
Connecticut	X	X	Х	X													X	X	X		
Delaware	Х	х	Х	х	Х	Х	Х										Х		Х		
District of Columbia	X		Х		Х								Х				Х	X			
Florida	Х	х	Х	х	Х		Х										Х		Х		
Georgia	Х	х	Х		х	х	х														
Guam	Х	х	Х		Х		Х										Х		Х		
Hawaii	Х	х	Х		х												Х				
Idaho	Х	Х	Х	Х	Х		Х		Х		Х		Х		Х		Х		Х		
Illinois	Х		Х		х		х		Х		х		х		х		Х		Х		
Indiana	Х	Х			Х		Х		Х		х		Х		Х		Х		Х		
lowa	Х		х														х				
Kansas																	Х		Х		
Kentucky	X		Х		Х		Х		Х		х		Х		Х		Х		Х		
Louisiana	X	Х	Х	Х	Х	Х	Х	Х	Х				Х	х	Х		Х	Х	Х		
Maine	X		Х														Х		Х		
Maryland	Х		Х		Х		Х										Х		Х		
Massachusetts	х	х	Х	х	Х		Х										Х		Х		
Michigan	Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		
Minnesota	X		Х														Х		Х		
Mississippi	X		Х						Х		Х		Х		Х		Х		Х		
Missouri	X	Х	Х			Х															
Montana	X		Х		Х		Х										Х		Х		
Nebraska																					
Nevada	X	Х	Х														Х		Х		
New Hampshire	X		Х										Х				Х		Х		
New Jersey	X	Х	Х	Х	Х		Х	Х									Х				
New Mexico	Х	х	Х		Х		Х		Х		Х		Х		Х		Х		Х		
New York	Х		Х		Х	Х	Х										Х		Х		
North Carolina	X	Х	Х	Х													Х		Х		
North Dakota	Х	Х	Х		Х		Х		Х		Х		Х				Х		Х		
Northern Mariana Islands																					
Ohio	Х	Х	Х	Х	Х		Х		Х	Х	Х	Х					Х		Х		
Oklahoma	X	х	Х		Х	х	Х		Х	х	Х						Х	X	Х		
Oregon	X		Х														Х		Х		
Pennsylvania	X				-												X				
Puerto Rico	Х		Х		Х		Х										Х		Х		
Rhode Island	Х		Х														Х		Х		
South Carolina	Х	Х	Х	Х	Х		Х		Х		Х		Х				Х		Х		
South Dakota	X		Х		Х		Х		Х		Х		Х		Х						
Tennessee	X		Х		Х								Х		Х		Х		Х		
Texas	X	-	X	-	Х	_	Х	_		_							X		Х		
Utah	Х	Х	Х	Х	Х				Х								Х				
Vermont	Х		Х														Х		Х		
Virginia	X	Х	Х	Х		Х			Х		Х						Х		Х		
Washington	X	-	Х	-	Х		Х		Х								X		X	-	
West Virginia	X	Х	Х	Х													Х	Х	Х	Х	
Wisconsin	X	Х	X	-	X	X	Х		X	v	X	v	X	V	X	-	X	-	X		
Wyoming	Х	Х	Х	Х	Х	Х			Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	Х	X	

This is a table of law enforcement entities that have access to the database. It includes officials in law enforcement, prosecutors, correctional supervision officers, drug courts, medical examiners and coroners.

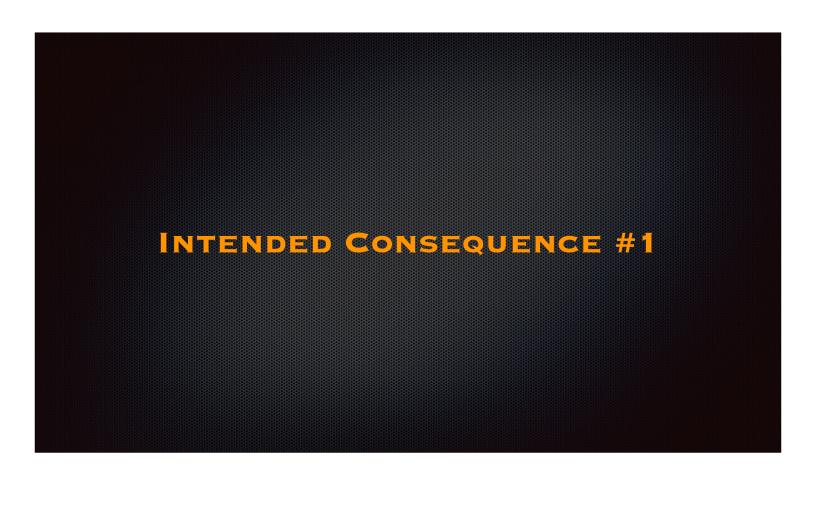
PDMP T	TA	C				PD	MPs	Autho	rized			ged in ind Pr						olicit	ed R	eport	s to			
rescription Unity Monitoring Program araning and lead			ud and	Abuse	Medic	aid Drug	Utiliza	tion and		Med	icare		St	ate Wor	kers Co	mp	Worl	ers Con	np Insu	ance		3rd Part	y Payer	s
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Arizona	X		X		X		X																	
Arkansas	Х		Х		Х		Х														Х			
California																								
Colorado																								
Connecticut	Х		Х																					
Delaware	Х	Х	Х	Х	Х		Х																	
District of Columbia Florida	Х	Х			Х	Х			Х	Х														
ieorgia	Х				Х																			
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ławali																								
daho	Х	Х	Х		Х	Х	Х		Х	Х	Х													
llinois									Х		Х		Х		Х		Х							
ndiana	Х		Х		Х																			
owa																								
Cansas	Х		Х		Х																			
Centucky Louisiana	X		X		X		X																	
Maine	^		^		Α.		Α.																	
Maryland	х		х		х																			
Massachusetts	X		X		X		х																	
Michigan	Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		Х		Х	
Minnesota																								
Mississippi	Х		Х																					
Missouri	Х		Х		Х		Х																	
Montana	Х		Х		Х		Х		Х		Х													
Nebraska	Х		Х		Х		Х														Х			
Nevada New Hampshire	Х		Х		Х		Х																	
New Jersey	х	х	х	Х																				
New Mexico	X	^	X	^	Х		Х		Х		Х		х		х		х		х		х		х	
New York			-								-													
North Carolina																								
North Dakota	Х		Х		Х								Х	Х	Х									
Northern Mariana Islands																								
Ohio	Х	Х	Х	Х	Х		Х		Х		Х		Х		Х		Х		Х					
Oklahoma	Х		Х		Х		Х																	
Oregon	×				×																			
Pennsylvania Puerto Rico	X		х		×		х																	
Rhode Island																								
South Carolina	Х		Х		Х																			
South Dakota	Х		Х		X		Х		Х		х		х		х		х		х		х		х	
ennessee	Х		Х		Х		Х																	
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/ermont	Х		Х		Х		Х																	
Tirginia	Х		Х		Х								X											
Vashington Vest Virginia	X		X		х		V						X		X						х		х	
West Virginia Visconsin	X		X		X		X		х		х		Х		Α.						X		X	

This is a table of insurance entities that have access to the database. It includes individuals involved in Medicaid fraud and abuse, Medicaid drug utilization, Medicare, state workers compensation, workers compensation insurance, and 3rd party payers.

	TA					iorized icited F								
hescription Drug Monitoring Program Training and Te	chrical Assistan	ce Center				ww	w.pdm	passist.	org					
	Licensi	ng / Reg	ulatory	Boards		Peer R	eview		State	e Health	Depart	ment		
State		ority		aged	Auth	ority	Enga	aged		ority	rity Engaged			
	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unsol.	Sol.	Unso		
Alabama	Х		Х	х					Х					
Alaska	Х	х	Х						Х		Х			
Arizona	Х	х	Х						Х					
Arkansas	Х	х	Х	Х					Х		Х			
California	х		Х											
Colorado	Х	х	Х						Х		Х			
Connecticut	х								Х	х	Х			
Delaware	Х	х	Х						Х					
District of Columbia	Х	х							Х					
Florida	Х		Х		Х									
Georgia	Х	х	Х						Х					
Guam	Х	Х	Х						Х		Х			
Hawaii									Х					
Idaho	Х	Х	Х	х										
Illinois	х		Х						Х		Х			
Indiana	Х	Х	Х						Х					
lowa	х		х											
Kansas	Х		Х											
Kentucky	х	Х	Х	х										
Louisiana	Х	Х	Х	Х					Х					
Maine	Х	х	Х	х										
Maryland	Х		Х		Х									
Massachusetts	х	х	Х	х					Х					
Michigan	Х		Х											
Minnesota	х		Х											
Mississippi	Х		Х											
Missouri	Х	х	Х											
Montana	Х		Х						Х					
Nebraska														
Nevada	Х	Х	Х											
New Hampshire	Х	х	Х	Х	Х									
New Jersey	Х	Х	Х	Х										
New Mexico	Х	х	Х	х					Х					
New York	х	х	х	Х					х		х			
North Carolina	х	х	Х	х										
North Dakota	Х	Х	Х		Х	Х	Х							
Northern Mariana Islands														
Ohio	Х	Х	Х	Х	Х				Х					
Oklahoma	х	х	х	Х					х					
Oregon	Х		Х											
Pennsylvania	х	Х							Х					
Puerto Rico	х		Х											
Rhode Island	х	Х	Х	х	Х	Х	Х	Х	Х	Х	Х	Х		
South Carolina	Х	Х	Х											
South Dakota	х		х		Х		Х							
Tennessee	Х	Х	Х		Х		Х		Х		Х			
Texas	х	Х	Х											
Utah	Х		Х						Х					
Vermont	х	Х	Х						Х					
Virginia	Х	Х	Х	х					Х					
Washington	х	Х	Х						Х					
West Virginia	х	Х	Х	х										
Wisconsin	X	Х	Х		х				х		х			
Wyoming	X	Х	Х	Х										

This table shows regulatory agency entities that have access to the database. It includes licensing and regulatory boards, peer review committees, and state health department personnel.

Not every state has all of these, but that's an extensive list. The problem is not one individual hacking the database, but thousands of individuals looking at a specific person's information. Those individuals accessing the system for personal reasons will never be caught.





April 9, 2018

TO: Members, Subcommittee on Health

FROM: Committee Majority Staff

RE: Hearing entitled "Combatting the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care For Patients"

I INTRODUCTION

The Subcommittee on Health will hold a hearing on Wednesday, April 11, 2018, at 2:15 p.m. in 2123 Rayburn House Office Building. The hearing will continue Thursday, April 12, 2018, at 10:15 a.m. in 2322 Rayburn House Office Building. The hearing is entitled, "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care For Patients."

II WITNECCEC

The hearing will consist of two panels of witnesses. The first panel will be held on Wednesday, April 11, and the second panel will be held on Thursday, April 12.

Panel 1

 Kimberly Brandt, Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Panel 2

- Michael Botticelli, Executive Director, Grayken Center for Addiction, Boston Medical Center:
- Toby Douglas, Senior Vice President, Medicaid Solutions, Centene Corporation;
- David Guth CEO Centerstone:
- John Kravitz, CIO, Geisinger Health System; and,
- Sam Srivastava, CEO, Magellan Health.

This was the agenda from a U.S. House of Representatives hearing in 2018 on the "Opioid Crisis". Let's zoom in on the Witnesses.

II. WITNESSES

The hearing will consist of two panels of witnesses. The first panel will be held on Wednesday, April 11, and the second panel will be held on Thursday, April 12.

Panel 1

• Kimberly Brandt, Principal Deputy Administrator for Operations, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services.

Panel 2

- Michael Botticelli, Executive Director, Grayken Center for Addiction, Boston Medical Center;
- Toby Douglas, Senior Vice President, Medicaid Solutions, Centene Corporation;
- David Guth, CEO, Centerstone;
- John Kravitz, CIO, Geisinger Health System; and,
- Sam Srivastava, CEO, Magellan Health.

This is the bottom of the page which shows the witnesses at the hearing.

The Panel 1 witness was a government bureaucrat.

The Panel 2 witnesses were all nonprofit organizations.

What did all of them have in common?

None of them were there to tell the congressmen the truth. All of them were there with their hands out wanting government money. "I can solve this problem, but I need money."

"Despite this extensive evidence and broad-based support, the use of MAT (medication assisted treatment) when combined with psychosocial interventions continues to be underutilized, representing a small percentage of individuals with OUD (opioid use disorder) and other SUDs (substance use disorders) whom seek and are in need of treatment."

- Sam K. Srivastava, CEO, Magellan Health

This was part of the testimony of one of the witnesses.

EXECUTIVE SUMMARY

Reauthorizes \$500 million for each of fiscal years 2019-2021 in opioid grant funding created by the 21st Century Cures Act.

The following nine pages are from the executive summary of the hearing. Expands a grant program to train first responders administering naloxone, the drug that reverses opioid overdoses. The expansion allows for training on exposure to fentanyl, carfentanil, and other dangerous drugs. Provides \$36 million annually from 2019 to 2021, an increase of \$24 million annually from current law.

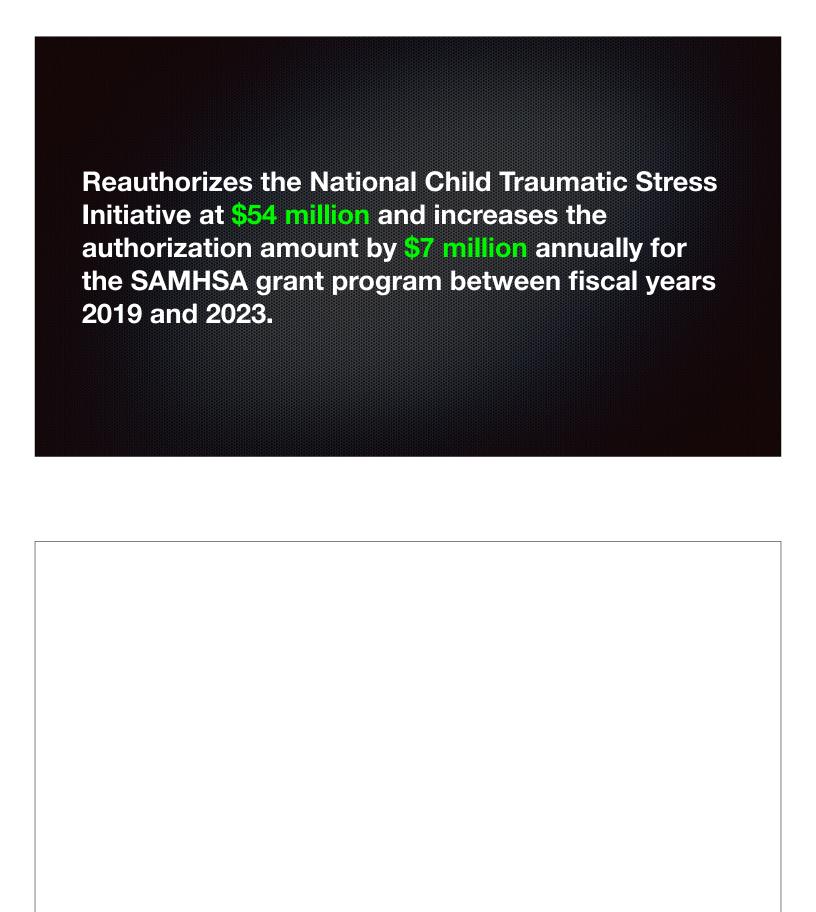
Authorizes \$60 million in annual funding for fiscal years 2019-2023 to states for collaboration between their health, welfare, and related state agencies to develop and oversee "plans of safe care" of substance-exposed infants. Plans of safe care assess and monitor the health and substance abuse treatment needs of infants and families.

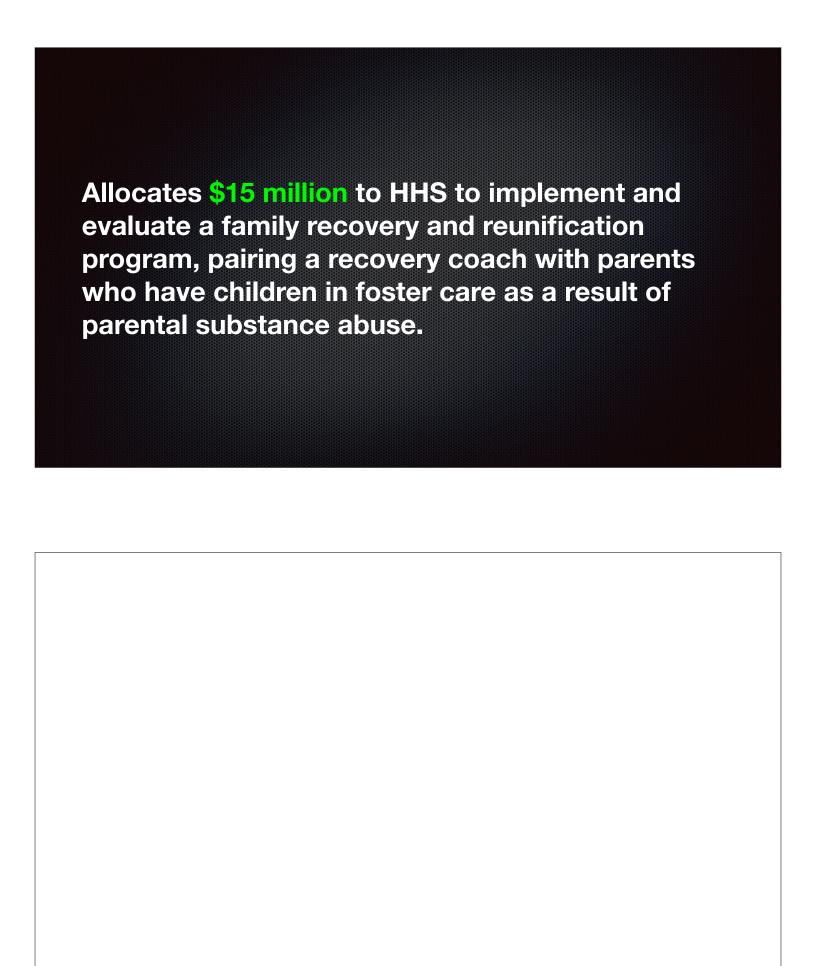
Authorizes \$486 million for CDC data collection and analyses of overdoses related to controlled substances. The authorization would expand prescription-drug monitoring programs and provide grants to states to encourage and improve data sharing between states.

Reauthorizes SAMHSA's Residential Treatment for Pregnant and Postpartum Women grant program at \$29.9 million in funding each year for fiscal years 2019-2023. The program increases access to residential substance abuse health services for pregnant and postpartum women.

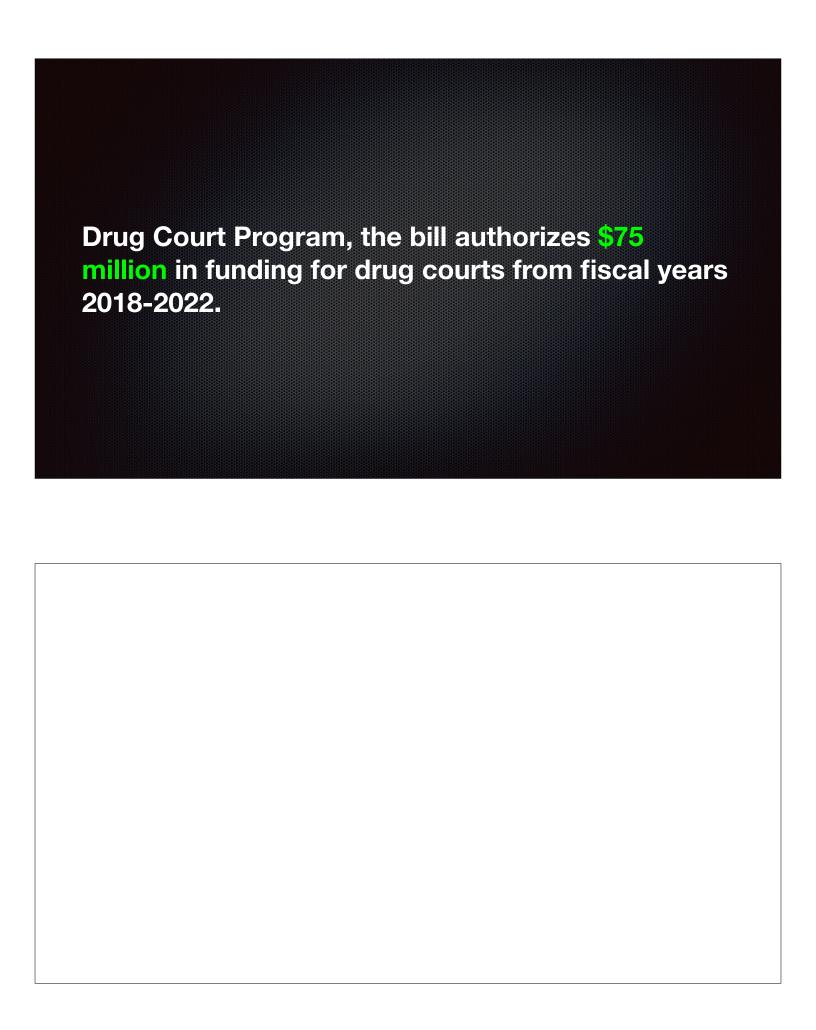
SAMHSA is the Substance Abuse and Mental Health Services Administration.

Reauthorizes the National All Schedules
Prescription Electronic Reporting grant program
at \$10 million annually in years 2022 through 2026.
The program promotes increased data sharing
between states by allowing prescribers and
pharmacies to better detect and prevent
substance abuse.





For fiscal years 2019-2023, authorizes \$20 million for states to develop, enhance, or evaluate family-focused residential treatment programs. The goal is to increase the number of evidence-based programs that will qualify for funding under the Family First Prevention Services Act.

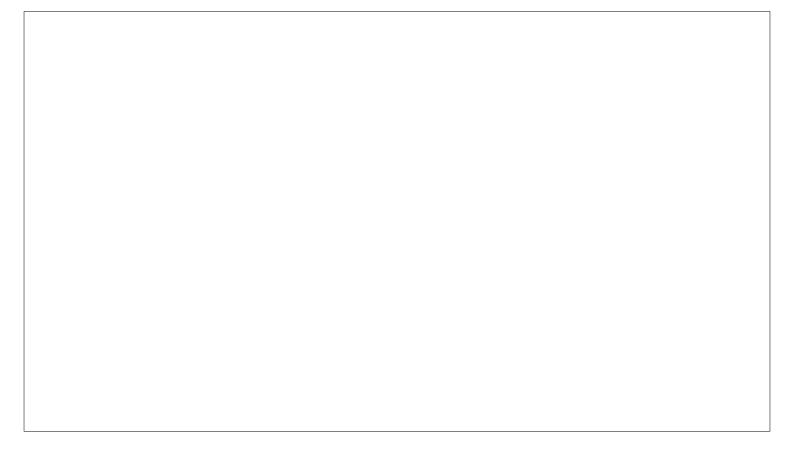


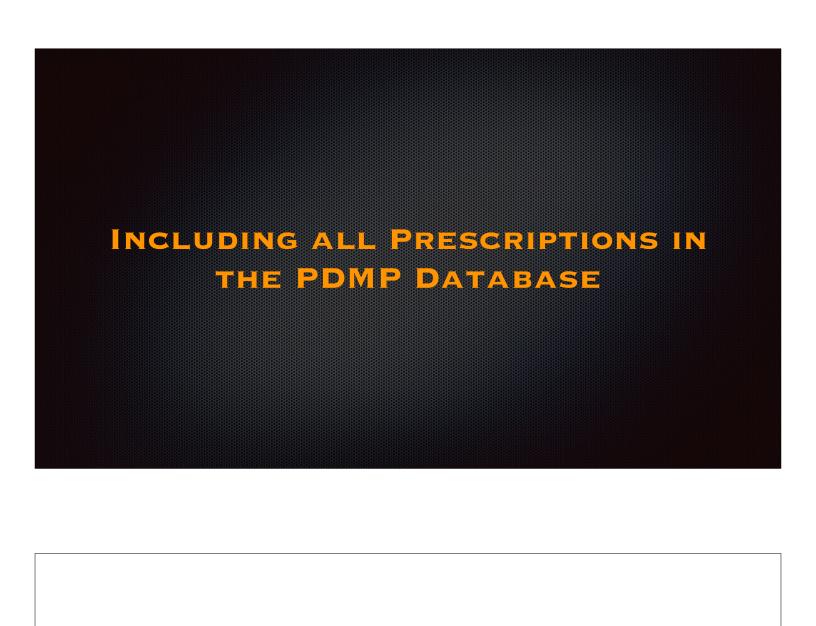
\$1.3 BILLION IN THE FIRST YEAR, THEN \$738 MILLION ANNUALLY

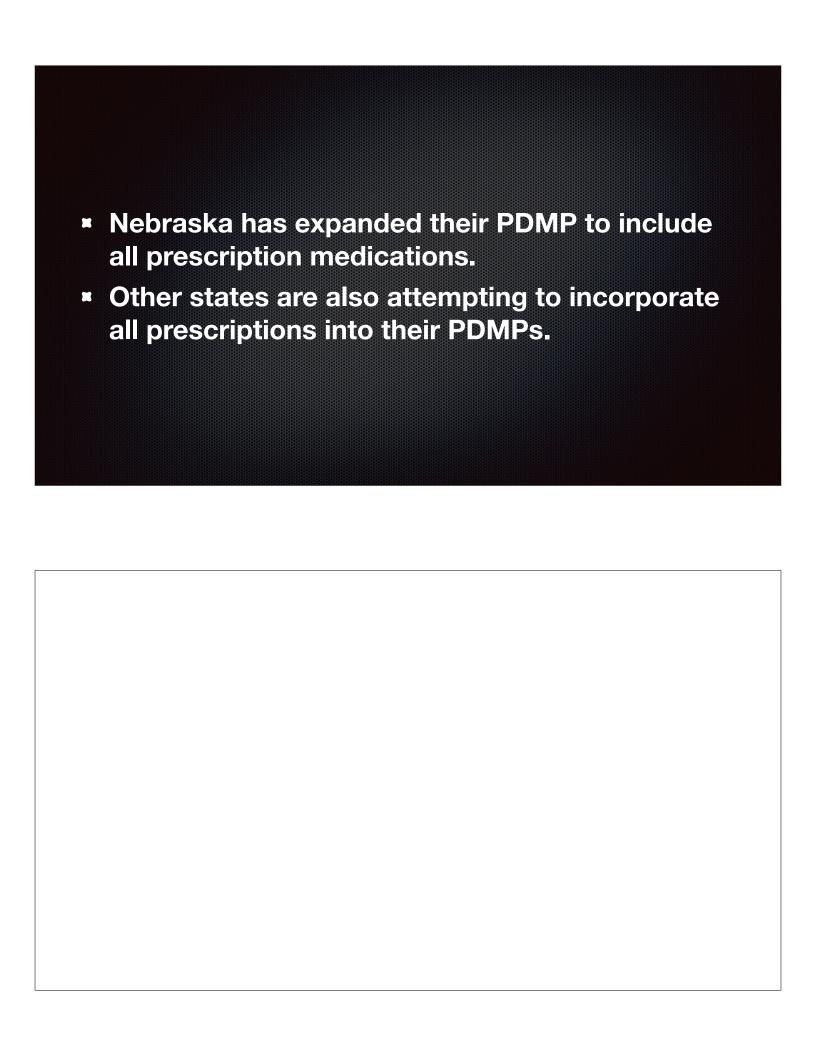
This is the total of all of the additional funding requested in the legislation.

The bill passed.









71-2454. Prescription drug monitoring; system established; provisions included; not public records.

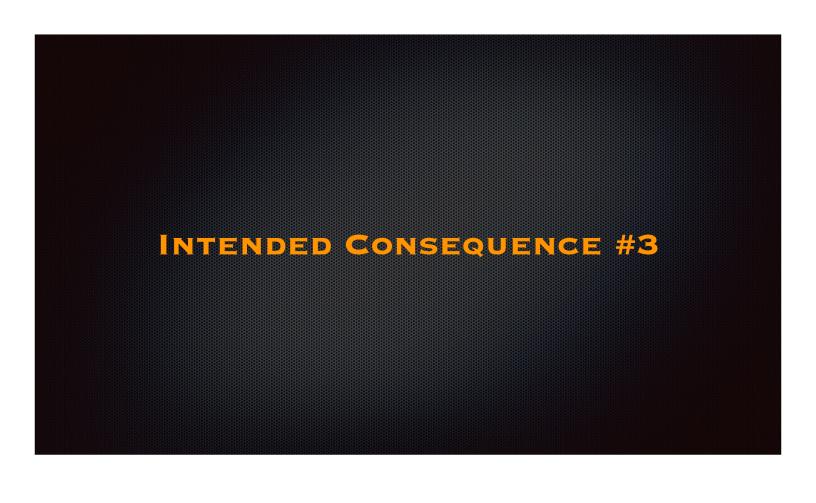
- (1) An entity described in section 71-2455 shall establish a system of prescription drug monitoring for the purposes of (a) preventing the misuse of controlled substances that are prescribed, (b) allowing prescribers and dispensers to monitor the care and treatment of patients for whom such a prescription drug is prescribed to ensure that such prescription drugs are used for medically appropriate purposes, (c) providing information to improve the health and safety of patients, and (d) ensuring that the State of Nebraska remains on the cutting edge of medical information technology.
- (2) Such system of prescription drug monitoring shall be implemented as follows: Except as provided in subsection (4) of this section, all prescription drug information shall be reported to the prescription drug monitoring system. The prescription drug monitoring system shall include, but not be limited to, provisions that:

This is Nebraska's statute on the PDMP.

71-2454. Prescription drug monitoring; system established; provisions included; not public records.

- (1) An entity described in section 71-2455 shall establish a system of prescription drug monitoring for the purposes of (a) preventing the misuse of controlled substances that are prescribed, (b) allowing prescribers and dispensers to monitor the care and treatment of patients for whom such a prescription drug is prescribed to ensure that such prescription drugs are used for medically appropriate purposes, (c) providing information to improve the health and safety of patients, and (d) ensuring that the State of Nebraska remains on the cutting edge of medical information technology.
- (2) Such system of prescription drug monitoring shall be implemented as follows: Except as provided in subsection (4) of this section, all prescription drug information shall be reported to the prescription drug monitoring system. The prescription drug monitoring system shall include, but not be limited to, provisions that:

Remember what I said about laws for the health and safety of the public. Here is a good example. The road to tyranny is paved with laws for the health and safety of the citizens.



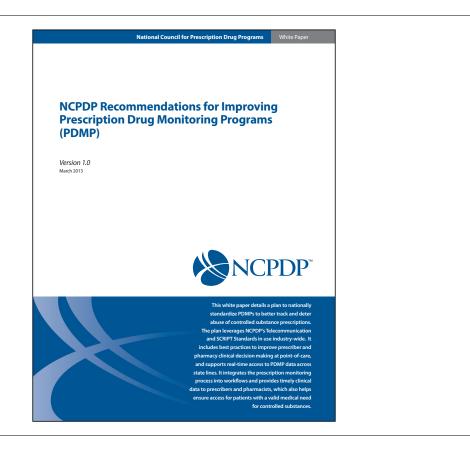
This is the bad one. This is the one that is coming in a few years, maybe sooner.

NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS

This is a non-profit organization. The following is from their website.

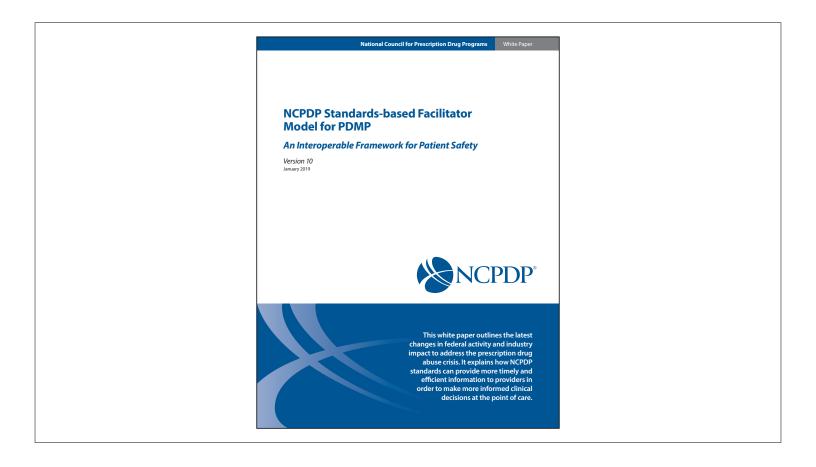
We Make Healthcare Better, Safer and More Efficient.

NCPDP is the problem-solving forum for healthcare - successful and respected throughout the industry. We bring diverse stakeholders together to improve the exchange of healthcare information for patients and everyone involved in delivering care. We've been doing this for 40 years. If you don't know us, you should. Collaborate with us to change healthcare for the better.

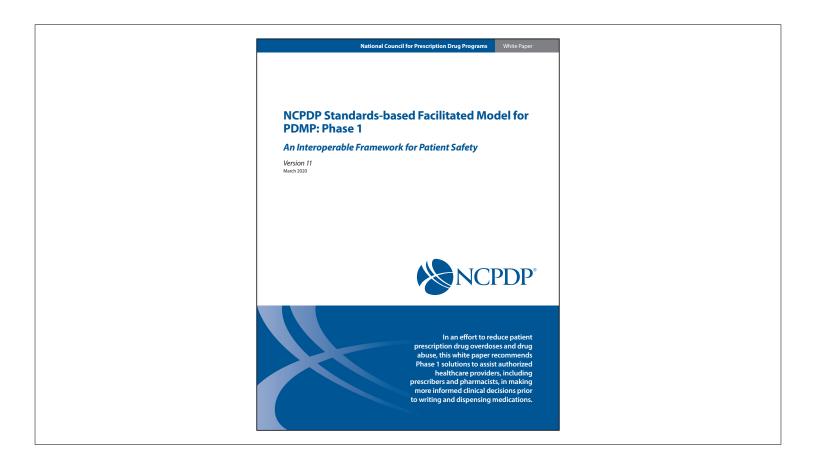


This was the first PDMP white paper they produced in March 2013. It was the result of a 2012 focus group of pharmaceutical industry representatives. The goals of the focus group are (1) to complete the white paper and send it to the Office of the National Coordinator (ONC) by March 2013 to coincide with the MITRE contract timeline, and (2) make the white paper available to the industry.

This is version 1.0.

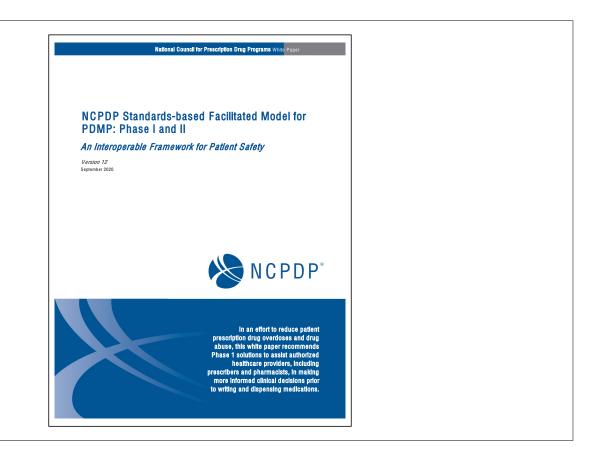


This was a white paper from January 2019. This is version 10.



This was an updated white paper from March 2020.

This is version 11.



This was the most recent updated white paper from September 2020.

This is version 12.

NCPDP Standards-based Facilitator Model for PDMP

An Interoperable Framework for Patient Safety

Version 10 January 2019

NCPDP Standards-based Facilitated Model for PDMP: Phase 1

An Interoperable Framework for Patient Safety

Version 11 March 2020

NCPDP Standards-based Facilitated Model for PDMP: Phase I and II

An Interoperable Framework for Patient Safety

Version 12 September 2020

The titles for the most recent white papers include "for PATIENT SAFETY."

2019 EXECUTIVE SUMMARY

Even though heavy investment in Prescription Drug Monitoring Programs (PDMP) has been made in the recent year, the problem of prescription drug abuse has continued to be the fastest growing drug problem in the United States. Data from the National Vital Statistics System, Mortality in 2017, there were 70,237 drug overdose deaths in the United States.

The 70,237 number includes all drug overdose deaths, both legal and illegal drugs. The problem is illicit fentanyl, not prescription opioids.

Current PDMPs lack methods to share prescription information effectively to address potential drug abuse and diversion or evaluate patient risk. The current prescription monitoring communication process is outside the provider's workflow and does not provide information in a timely manner in order to make clinical decisions at point of care.

2020 EXECUTIVE SUMMARY

- Even though heavy investments in Prescription Drug Monitoring Programs (PDMPs) have been made in recent years, the problem of prescription drug abuse continues to be a significant problem in the United States.
- The current prescription monitoring communication process often occurs outside of the provider's workflow and does not provide enough accurate information in a timely manner in order to make clinical decisions at the point of care.

PROPOSED SOLUTION

In an effort to reduce patient prescription drug overdoses and drug abuse, NCPDP recommends the following Phase I solutions to assist authorized healthcare providers, including prescribers and pharmacists, in making more informed clinical decisions prior to writing and dispensing medications:

1. Create a comprehensive repository for all PDMP data.

- ➤ Phase II includes all of the functionality of Phase I in addition to leveraging existing NCPDP standards, when feasible, to communicate identified risks to providers (prescriber and pharmacy).
 - Support the use of real-time reporting
 - Provide tools (risk scores) to support clinicians in determining risks for individual patients.

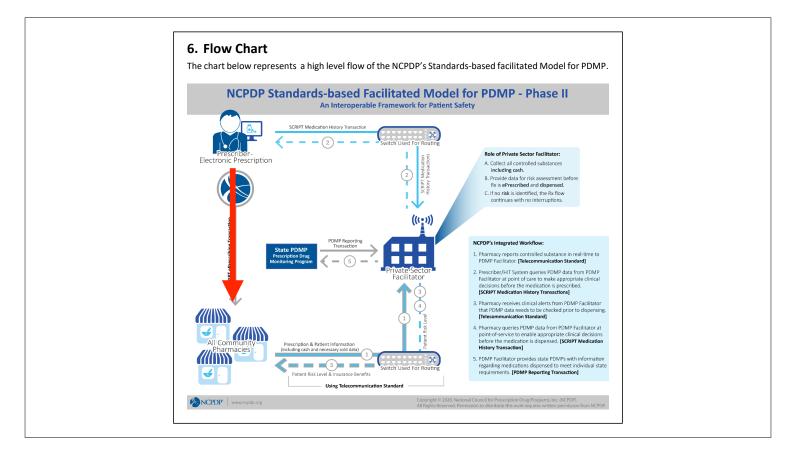
Question:

If states are not contributing their controlled substance data to the facilitated model, will Phase I compromise current PDMP arrangements and solutions that provide data for the same patient across multiple PDMPs?

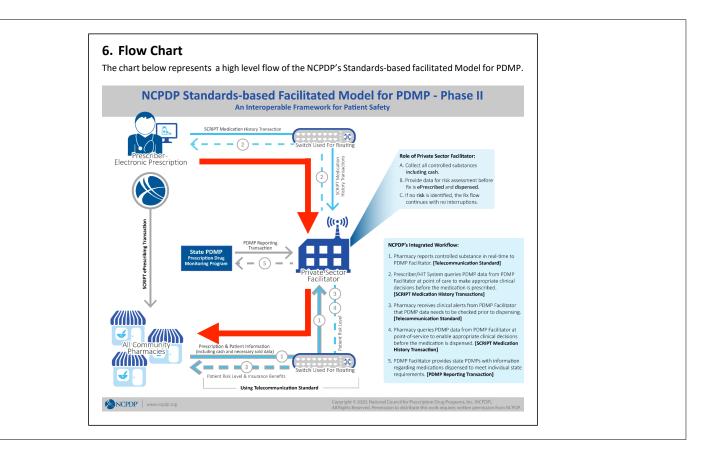
Answer:

Phase II Response: The facilitator will have all PDMP data.

Question: Will PDMPs still require direct provider inquiry to the PDMP? **Answer:** Phase II Response: All provider inquiries will be made to the facilitator.



This diagram is on page 15 of the white paper. In the past, your electronic prescription went from you to the pharmacy.



Now electronic controlled substance prescriptions do not go directly to the pharmacy. They go through the private sector facilitator. When we get to Phase II, they will get evaluated by the private sector facilitator.

Let's look at the blue square.

Role of Private Sector Facilitator: A. Collect all controlled substances including cash. B. Provide data for risk assessment before Rx is ePrescribed and dispensed. C. If no risk is identified, the Rx flow continues with no interruptions. NCPDP's Integrated Workflow:

- B. Provide data for risk assessment before prescription is electronically prescribed and dispensed.
- C. If no risk is identified, the prescription flow continues with no interruptions.

What if the risk is identified? Then the flow does not continue and your prescription does not go to the pharmacy.

Who is this private sector facilitator?

THE FACILITATOR

August 2021

PatientPing + Appriss Health officially relaunches as Bamboo Health. This strategic move unifies Appriss Health and PatientPing under a single brand and vision to revolutionize care collaboration.



It's not care collaboration.

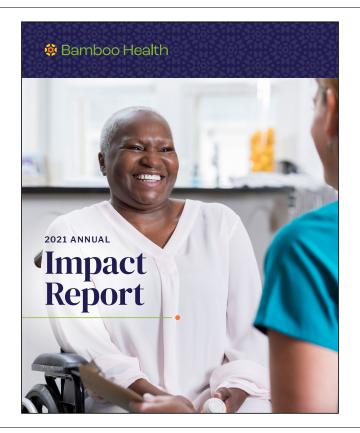
THE FACILITATOR

August 2021

PatientPing + Appriss Health officially relaunches as Bamboo Health. This strategic move unifies Appriss Health and PatientPing under a single brand and vision to revolutionize government control.



It is government control.



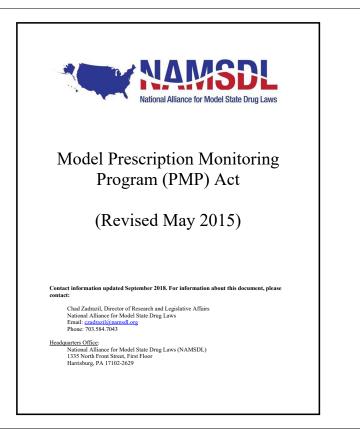
This is the 2021 Annual Impact Report from Bamboo Health.

Prescription Drug Monitoring Programs are critical for pharmacists and clinicians to identify risky prescription medication use, but before our study the association between the Narx Score and other indicators of opioid use or risk had not been externally evaluated. Our research shows that Bamboo Health's NarxCare metric is a useful initial screening tool for prescribers to determine whether a patient is at risk for opioid misuse. Bamboo Health's PDMP solutions are used in more than 40 states and territories.

This is from that report.

We will soon lose control of patient care. It will then be the government that is deciding what is best for our patients.





The image on the left is from a Bamboo Health and the one on the right is from NAMSDL. Notice that both refer to PMP (Prescription Monitoring Program) not PDMP (Prescription DRUG Monitoring Program). The goal is to control all prescription writing.



So what is the future of medicine?

The "art of medicine" will be reduced to a computer algorithm including all prescription writing.	
So why do you need an expensive physician to a computer algorithm?	run

"You never want a serious crisis to go to waste.
What I mean by that is an opportunity to do things
that you think you could not do before."

- Rahm Emanuel, Feb. 13, 2013

If the government came to the physicians and told us they were going to control what prescriptions we could write, we would have said no. But when there is a "crisis" and the government says they have the solution, we gladly turn over control to the government.



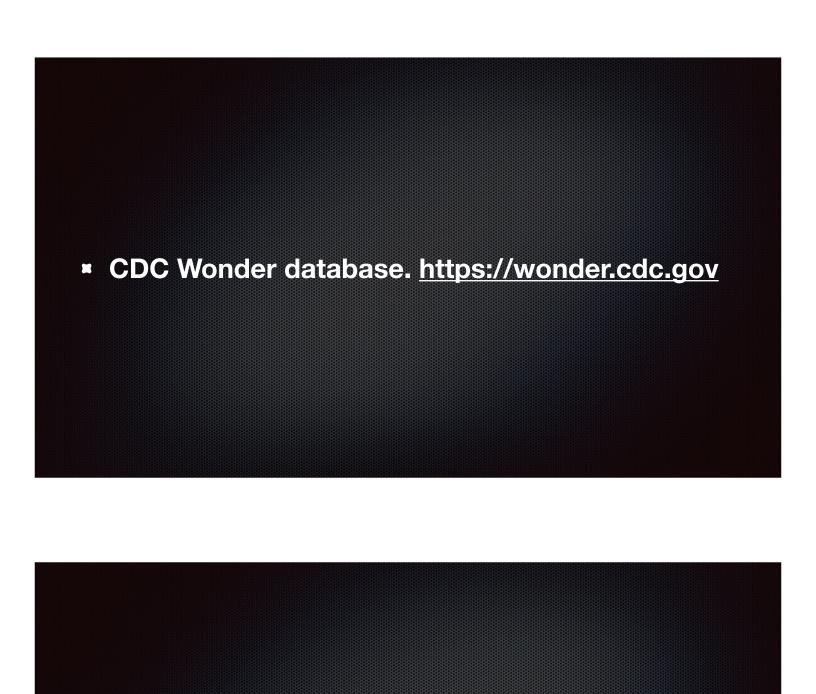
If the government came to the physicians and told us they were going to control what prescriptions we could write, we would have said no.

But when there is a "crisis" and the government says they have the solution, we gladly turn over control to the government.

Sourges

- President's Commission on Model State Drug Laws. <u>https://namsdl.org/doc-library/?</u>
 <u>fwp document source=presidents-commission-on-model-state-drug-laws</u>
- Model Prescription Accountability Act. https://namsdl.org/wp-content/uploads/Model- Prescription-Accountability-Act-Volume-3-Section-A.pdf

 National Alliance for Model State Drug Laws https://namsdl.org



Missouri Constitution. https://www.sos.mo.gov/pubs/constitution

Center for Behavioral Health Statistics and Quality. (2021). Results from the 2020 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Center for Behavioral Health Statistics and Quality. (2021). 2020 National Survey on Drug Use and Health (NSDUH): Methodological summary and definitions. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/ Center for Behavioral Health Statistics and Quality. (2016). 2015 National Survey on Drug Use and Health: Methodological summary and definitions. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2015national-survey-drug-use-and-healthmethodological-summary-and-definitions

- Results from the 2008 National Survey on Drug Use and Health: National Findings; table G:6
- Results from the 2014 2020 National Survey on Drug Use and Health: Detailed Tables; table 1.1B

- U.S. Opioid Dispensing Rate Maps. https://www.cdc.gov/drugoverdose/rxratemaps/index.html
- U.S. State Opioid Dispensing Rates, 2020. https://www.cdc.gov/drugoverdose/rxratemaps/state2020.html

CDC Guidelines in Prescribing. Centers for disease Control and Prevention, Morbidity and Mortality Weekly Reports. Recommendations and Reports / Vol. 65 / No. 1 March 18, 2016. https://www.cdc.gov/mmwr/volumes/65/rr/ rr6501e1.htm?

CDC AA refVal=https%3A%2F%2Fwww.cdc.go v%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr650 1e1er.htm Prescription Drug Monitoring Program Training and Technical Assistance Center https://www.pdmpassist.org

Nebraska state PDMP statute. https://nebraskalegislature.gov/laws/statutes.php?
statute=71-2454

- NCPDP.
 https://ncpdp.org/?
- NCPDP White Papers.
 https://www.ncpdp.org/Resources/
 Prescription-Drug-Monitoring-Programs-(PDMP)

COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021 by Physician Advocacy Institute http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/ PAI%20Avalere%20Physician%20Employment% 20Trends%20Study%202019-21%20Final.pdf? ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d

