METHADONE DEATH AND INCIDENT REVIEW ACT - ESTABLISHMENT OF METHADONE DEATH AND INCIDENT REVIEW TEAM, TEAM DUTIES, DUTIES OF CORONER AND MEDICAL EXAMINER, REVIEW PROCEDURES AND CONFIDENTIALITY

Act of Nov. 25, 2020, P.L. 1228, No. 126 Cl. 35
Session of 2020
No. 2020-126

HB 1662

AN ACT

Amending the act of October 24, 2012 (P.L.1198, No.148), entitled "An act establishing the Methadone Death and Incident Review Team and providing for its powers and duties; and imposing a penalty," further providing for title of act, for short title, for definitions, for establishment of Methadone Death and Incident Review Team, for team duties, for duties of coroner and medical examiner, for review procedures and for confidentiality.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The title and sections 1, 2, 3 heading, (a) and (b)(3), 4, 5, 6 and 8(a) and (f) of the act of October 24, 2012 (P.L.1198, No.148), known as the Methadone Death and Incident Review Act, are amended to read:

An Act

Establishing the [Methadone] **Medication** Death and Incident Review Team and providing for its powers and duties; and imposing a penalty.

Section 1. Short title.

This act shall be known and may be cited as the [Methadone] **Medication** Death and Incident Review Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Department." The Department of Drug and Alcohol Programs of the Commonwealth.

["Methadone-related] "**Medication- related** death." A death where [methadone] **a medication approved by the United States Food and Drug Administration for the treatment of opioid use disorder** was:

(1) a primary or secondary cause of death; or

(2) may have been a contributing factor.

["Methadone-related] "**Medication- related** incident." A situation where [methadone] **a medication approved by the United States Food and Drug Administration for the treatment of opioid use disorder** may be a contributing factor which:

(1) does not involve a fatality; and

(2) involves:

(i) a serious injury; or

(ii) unreasonable risk of death or serious injury.

["Narcotic treatment program."] "**Opioid-assisted treatment program.**" A program licensed and approved by the Department of Drug and Alcohol Programs for chronic opiate drug users that administers or dispenses agents under a narcotic treatment

physician's order, either for detoxification purposes or for maintenance.

"Opioid use disorder." A problematic pattern of opioid use leading to clinically significant impairment or distress.

"Secretary." The Secretary of Drug and Alcohol Programs of the Commonwealth.

"Team." The [Methadone] **Medication** Death and Incident Review Team established under section 3.

Section 3. Establishment of [Methadone] **Medication** Death and Incident Review Team.

(a) Team established.--The department shall establish a [Methadone] **Medication** Death and Incident Review Team and conduct a review and shall examine the circumstances surrounding [methadone-related] **medication-related** deaths and [methadone-related] **medication-related** incidents in this Commonwealth for the purpose of promoting safety, reducing [methadone-related] **medication-related** deaths and [methadone-related] **medication- related** incidents and improving treatment practices.

(b) Composition.--The team shall consist of the following individuals:

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(3) The following individuals appointed by the secretary:

(i) A representative from [narcotic treatment programs as defined in 28 Pa. Code § 701.1 (relating to definitions)] **an opioid-assisted treatment program.**

(ii) A representative from a licensed drug and alcohol addiction treatment program that is not defined as [a narcotic treatment program] **an opioid-assisted treatment program.**

(iii) A representative from law enforcement recommended by a Statewide association representing members of law enforcement.

(iv) A representative from the medical community recommended by a Statewide association representing physicians.

(v) A district attorney recommended by a Statewide association representing district attorneys.

(vi) A coroner or medical examiner recommended by a Statewide association representing county coroners and medical examiners.

(vii) A member of the public.

(viii) A patient or family advocate.

(ix) A representative from a recovery organization.

(x) An office-based agonist treatment provider who is assigned a waiver from the Drug Enforcement Administration, including a special identification number, commonly referred to as the "X" DEA number, to provide office-based prescribing of buprenorphine.

(xi) A representative of the Department of Health who is affiliated with the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) established under the act of October 27, 2014 (P.L.2911, No.191), known as the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act.

(xii) A toxicologist.

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Section 4. Team duties.

The team shall:

(1) Review each **medication-related** death where [methadone] **a medication approved by the United States**

Food and Drug Administration for the treatment of opioid use disorder was either the primary or a secondary cause of death and review [methadone-related] **medication-related** incidents.

(2) Determine the role that [methadone] **a medication approved by the United States Food and Drug Administration for the treatment of opioid use disorder** played in each death and [methadone-related] **medication-related** incident.

(3) Communicate concerns to regulators and facilitate communication within the health care and legal systems about issues that could threaten health and public safety.

(4) Develop best practices to prevent future [methadone-related] **medication-related** deaths and [methadone-related] **medication- related** incidents. The best practices shall be:

(i) Promulgated by the department as regulations.

(ii) Posted on the department's Internet website.

(5) Collect and store data on the number of [methadone-related] **medication-related** deaths and [methadone-related] **medication- related** incidents and provide a brief description of each death and incident. The aggregate statistics shall be posted on the department's Internet website. [The team may collect and store data concerning deaths and incidents related to other drugs used in opiate treatment.]

(6) Develop a form for the submission of [methadone-related] **medication-related** deaths and [methadone-related] **medication- related** incidents to the team by any concerned party.

(7) Develop, in consultation with a Statewide association representing county coroners and medical examiners, a model form for county coroners and medical examiners to use to report and transmit information regarding [methadone-related] **medication- related** deaths to the team. The team and the Statewide association representing county coroners and medical examiners shall collaborate to ensure that all [methadone-related] **medication-related** deaths are, to the fullest extent possible, identified by coroners and medical examiners.

(8) Develop and implement any other strategies that the team identifies to ensure that the most complete collection of [methadone-related] **medication- related** death and [methadone-related] **medication-related** serious incident cases reasonably possible is created.

(9) Prepare an annual report that shall be posted on the department's Internet website and distributed to the chairman and minority chairman of the Judiciary Committee of the Senate, the chairman and minority chairman of the [Public Health and Welfare] **Health and Human Services** Committee of the Senate, the chairman and minority chairman of the Judiciary Committee of the House of Representatives and the chairman and minority chairman of the Human Services Committee of the House of Representatives. Each report shall:

(i) Provide public information regarding the number and causes of [methadone-related] **medication-related** deaths and [methadone-related] **medication-related** incidents.

(ii) Provide aggregate data on five-year trends on [methadone-related] **medication- related** deaths and [methadone-related] **medication-related** incidents when such information is available.

(iii) Make recommendations to prevent future [methadone-related] **medication- related** deaths, [methadone-related] **medication-related** incidents and abuse and set forth the department's plan for implementing the recommendations.

(iv) Recommend changes to statutes and regulations to decrease [methadone-related] **medication-related** deaths and [methadone-related] **medication-related** incidents.

(v) Provide a report on [methadone-related] **medication-related** deaths and [methadone-related] **medication- related** incidents and concerns regarding [narcotic] **opioid-assisted** treatment programs.

(10) Develop and publish on the department's Internet website a list of meetings for each year.

Section 5. Duties of coroner and medical examiner.

A county coroner or medical examiner shall forward all [methadone-related] **medication-related** death cases to the team for review. The county coroner and medical examiner shall use the model form developed by the team to transmit the data.

Section 6. Review procedures.

The team may review the following information:

(1) Coroner's reports or postmortem examination records unless otherwise prohibited by Federal or State laws, regulations or court decisions.

(2) Death certificates and birth certificates.

(3) Law enforcement records and interviews with law enforcement officials as long as the release of such records will not jeopardize an ongoing criminal investigation or proceeding.

(4) Medical records from hospitals, other health care providers and [narcotic treatment programs] **opioid-assisted treatment programs**.

(5) Information and reports made available by the county children and youth agency in accordance with 23 Pa.C.S. Ch. 63 (relating to child protective services).

(6) Information made available by firefighters or emergency services personnel.

(7) Reports and records made available by the court to the extent permitted by law or court rule.

(8) EMS records.

(9) Traffic fatality reports.

(10) [Narcotic treatment program] **O pioid-assisted treatment program** incident reports.

(11) [Narcotic treatment program] **Opioid-assisted treatment program** licensure surveys from the program licensure division.

(12) Any other records necessary to conduct the review.

Section 8. Confidentiality.

(a) Maintenance.--The team shall maintain the confidentiality of any identifying information obtained relating to the death of an individual or adverse incidents regarding [methadone] **medication,** including the name of the individual, guardians, family members, caretakers or alleged or suspected perpetrators of abuse, neglect or a criminal act.

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(f) Attendance.--Nothing in this act shall prevent the team from allowing the attendance of a person with information relevant to a review at a [methadone] **medication** death and incident team review meeting.

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Section 2. This act shall take effect in 90 days.

APPROVED--The 25th day of November, A.D. 2020.

TOM WOLF