BEFORE THE NEW YORK STATE SENATE
STANDING COMMITTEE ON HEALTH;
STANDING COMMITTEE ON ALCOHOLISM AND DRUG ABUSE; AND
STANDING COMMITTEE ON INVESTIGATIONS AND GOVERNMENT
OPERATIONS

FORUM/TOWN HALL

A ROUNDTABLE DISCUSSION ON THE GROWING PROBLEMS OF
PRESCRIPTION DRUG ABUSE AND DIVERSION THROUGHOUT
NEW YORK STATE, AND POSSIBLE POLICY SOLUTIONS

Senate Hearing Room
250 Broadway, 19th Floor
New York, New York 10007

August 31, 2011
10:00 a.m. to 1:00 p.m.

PRESIDING:

Senator Kemp Hannon
Chairman
NYS Senate Standing Committee on Health

Senator Jeffrey D. Klein
Chairman
NYS Senate Standing Committee on Alcoholism and
Drug Abuse

Senator Carl L. Marcellino
Chairman
NYS Senate Standing Committee on Investigations
and Government Operations

ROUNDTABLE PARTICIPANTS:

Thomas Farley, M.D., M.P.H.
Commissioner
NYC Dept. of Health & Mental Hygiene

Bridget Brennan
Special Narcotics Prosecutor
New York City, NY

Steve Kipnis, M.D., FACP, FASAM
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Andrew Kolodny, M.D.
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Paul Mahoney
Chief of Civil Enforcement Division
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Office of the NYS Attorney General

ROUNDTABLE PARTICIPANTS - CONTINUED:

Frank G. Dowling, M.D.
Commissioner of Public Health & Science,
Medical Society of NYS;
and Medical Advisor of Police Organization
Providing Peer Assistance; and
Clinical Professor, Dept. of Psychology,
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David Vizzini
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Dahlia Heller
Assistant Commissioner
Bureau of Alcohol & Drug Use Prevention, Care, and
Treatment, NYC Health Department

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SENATOR KEMP HANNON: This hearing is being webcast. Presumably the Internet will be working fine, but if it's not, we'll be preserving it, and it will be available on our respective websites; Alcohol Abuse website, Investigations website, Health website, all part of the Senate website.

I am Kemp Hannon, Chair of the Health Committee.

The impetus for this hearing was, Senator Klein, who's Chair of the Alcoholism Committee, and continued with, Senator Marcellino, in Investigations and Government Operations Committee.

We'll each just say a few remarks.

The first concept is, this is a roundtable. And it is very deliberately a roundtable because hearings, to my mind, don't produce an exchange of ideas. They allow people to come, give their thoughts, and then leave, and then we don't have the interaction. And, I think I value the interaction more than anything else.

The fact of where we are is a long way.

As Chair of the Health Committee, a decade ago, we were dealing with removing 40-year-old restrictions from the use of painkillers, which

then were narcotics, that were in State statute, and treated anybody getting pain relief as a subset of being a narcotic addict. That was the type of registration you had to do.

And there was huge examination of what the healthcare system was doing for pain relief.

Well, modern pharmacy has now given us the opioids. We have now had the abuses. We have a whole different viewpoint as to what's going on, and we need to move forward.

And as we speak about dealing with people, what people perceive as a problem, the very way that the State is going to be paying for pharmacy under Medicaid will shift in a couple of months, as it goes from a State-administered program, to it being administered by each of the Medicaid managed care programs, a very large and significant population, and a dispersed responsibility for all of that.

So, that will be changing as we go through.

There's certainly lots of other proposals that have been made.

We're joined by Bridget Brennan, who, earlier, with us and the committee, participated in a hearing on non-controlled substance and the illegal market for that.

A statute that was -- resulted in a statute. It passed the Senate. It's still pending in the Assembly.

And the Department, along with the Attorney General, has put forward different ideas in regard to the use of the database for people who use, especially opioids, in the -- for pain relief, but misuse it, black market, reselling, whatever.

A large, large problem.

So, the hearing notice sets forth, in really good detail, the ideas what we're looking to pursue today, and pursue as we move forward past this roundtable.

And, I look forward to your participation now. And, to anybody who has a submission, idea, proposal, after we end today, we would be all welcome to hear from you.

Senator Klein.

SENATOR JEFFREY KLEIN: I want to thank my two colleagues, Chairman Hannon and Chairman Marcellino.

This is truly an important issue, and I know most of us know how important it is, but I think it's time that the State, and through the

State Senate, and my committee and the two respective committees, we come up with a comprehensive approach.

Like most of the issues that I have been involved in my career, and usually it starts at the local level, I have been bombarded over the last several years with calls from my constituents, about the so-called "pain-management clinics," where the lines start at 7:00 in the morning, and they don't subside until the afternoon.

Why are so many people anxious to get into these places?

And I think the answer is very simple: controlled substances. OxyContin.

Controlled substances, this is a problem.

And I know the health department has a mechanism in place to monitor this, but I think we really need to come up with a comprehensive approach: Education, tougher laws on the books, and a better tracking system.

And I think that's why it's so important that the people here today are really all the stakeholders, to probably try to solve these problems.

I think it's worth mentioning some of the

statistics.

If you look at the numbers, they're quite startling.

If prescription for powerful narcotic painkillers continues to rise in this city, there's 10.7 prescriptions for OxyContin for every 100 people in the city of New York.

In my home county of the Bronx, the rate is 13.8 prescriptions for every 100 people.

And, Staten Island has the dubious distinction of having the highest, at 23 prescriptions per every 100 people.

And that's 2009 data. The most recent data is probably even higher.

This is a problem.

And when you look at the numbers nationally, they are no better.

When the drug of choice for minors is, second, for controlled substances, you know, painkillers, things of that nature -- the only one that beats that is marijuana -- this is a problem, and a growing problem.

So, I'm hopeful today that we're going to listen, we're going to learn, and really come up with a real comprehensive approach, where we can

deal with this problem, and help New Yorkers.

SENATOR CARL MARCELLINO: Thank you.

I'm Carl Marcellino. I chair, as we said before, the Investigations Committee & Government Operations.

My concern is piqued, because we've recently had a rash of pharmacy robberies on Long Island, two in my district, one resulting in the deaths of three people by some nut who decided to shoot everybody rather than just walk away with nothing.

This kind of tragedy has got to stop.

We have young people, as Senator Klein pointed out, are moving into OxyContin. When they can't get that, they are being flipped to heroin.

So, there is an increase in heroin abuse and heroin use amongst young people, which is scary, because everybody knows the end result of heroin is, in many cases, death. We're not talking about something that is a pleasure drug for too long.

It doesn't last, and you can't last too long on it. Yet, they are doing that.

And the pushers are flipping them. When they can't get the prescription drugs, they are flipping them to heroin.

So, this problem is growing.

It is not only a New York State problem, clearly.

New Jersey has a task force on just this issue. And, I saw a presentation from this task force, and one of lawyers who was in charge of the task force, at a recent conference that I attended.

This kind of thing, as I said, and my colleagues have intimated, are growing. It's a growing problem, and it's got to stop. We need a way of controlling it.

Part of it is education, obviously. People have to know that the drugs that are in their medicine cabinets in the bathroom, or wherever, have got to be taken care of, and locked up in some cases.

You just can't mix them. Kids are having actual parties, where they throw all the prescription drugs in a bowl. Mix that with alcohol, grab what they want, pop some in their mouth, and have a party.

After all, it can't be dangerous. They're prescription drugs that grandma takes, or my mother and father take, so how bad could they be?

Clearly, we need an education process.

Clearly, we have to have a situation, where,

if a patient needs 3 pills to tide them over, they can't get a 10-day prescription.

That's something that we -- that the doctors have to pay attention to, and the pharmacies have to pay attention to.

We're all involved here. There's a chain that goes on. So, we need to be able to work together on this.

If you need new laws, that's what we're here for. We're looking for that.

If new laws are the issue, and new laws are the way to go, fine.

If new regulations are the way to go, we'll work that out too.

But, we need some advice, and that's the idea of this roundtable.

And I'm pleased to see the participants that are here, because we should get some very good information out of this, and hopefully move ahead with some joint policy ideas, and ideas for legislation if necessary.

So, I thank you, and I look forward to the conversation.

SENATOR KEMP HANNON: Okay, we're now going to ask each of the participants to give an opening

statement of about three minutes, each.

And we'll start right on my left, with Dr. Farley.

And then, I just ask, if you each would pick up as you will, but, if you would say your name for the webcast, because you all are important people with long titles, and it's impossible to read this print.

DR. THOMAS FARLEY: Thank you.

I'm Tom Farley, the health commissioner for the city of New York.

The New York City Health Department takes very seriously the problem of prescription drug abuse; a problem that we see as one of our major pressing health problems, and one that is clearly growing.

Let me just throw out some of the statistics that we are following on this.

We track it, really, in three ways: By monitoring the number of drug overdose deaths that occur in New York City; by monitoring the number of people coming to emergency departments with health problems -- acute-health problems related to prescription drug use; and, then, by monitoring use in the general population through surveys.

As far as the drug overdose deaths, in New York City now, we have about 150 deaths per year from drug overdose deaths -- from drug overdose in which prescription drugs -- prescription opioids are included.

Now, they're often in combination with other drugs, but 150 people, per year, in New York City dying of this problem. And that number is increasing.

That represents about 25 percent of the drug overdose deaths that are occurring in the city, each year.

It used to be, our major problems with drug overdose were from heroin and cocaine. Those problems appear to be on the decline, but this problem is increasing.

We are also seeing an increase in the number of emergency-department visits for prescription drug overdose. I'm forgetting the percentage increase, but let me just say that it's increased -- okay, we've had about a doubling, from 2004 to 2009, in the number of visits in the emergency departments for that problem.

On surveys, we are now hearing that 4 percent of all New Yorkers, age 12 and over,

report the non-medical use of prescription opioids. That means that they're using these pills even though they were not prescribed by a physician. "4 percent."

And, in another survey of teenagers -- or, children aged, from 7th grade through 12th grade, 10 percent reporting having used, at least once, a prescription opioid that was not prescribed for them.

So this is a very, very common problem as far as use goes.

It's common, as far as, it's causing people to get health problems, seen in the emergency department.

And, it's common, as far as the number of people it's killing.

We have ideas about what we want to do about it, but I don't want to jump ahead in the agenda, so, I'll stop there.

SENATOR KEMP HANNON: Bridget.

BRIDGETTE BRENNAN: Thank you very much.

I'm Bridget Brennan, and I'm the City's special narcotics prosecutor. We have jurisdiction over felony narcotics prosecutions throughout New York City.

And for most New Yorkers, I think the word "narcotics" conjures up images of illegal drugs coming in from South America, transported by bloody Mexican cartels, or of street dealers, or high-end personal delivery services.

However, the most widely abused narcotic drugs in our city today are manufactured by major pharmaceutical companies, they're prescribed by doctors, distributed by pharmacies, and have familiar names like, oxycodone, Vicodin, and are found in our own medicine cabinets.

Just 15 years ago, we saw very little of this kind of problem.

And, perhaps it was because there were many more restrictions on the prescribing of narcotic drugs. I think New York is late coming to this epidemic, compared to some of the other places around the country. And it may be that we had more stringent regulations in place, regarding our stringent oversight regarding the prescribing of narcotic drugs because of New York's sad history with narcotics epidemics.

However, what we have seen from the enforcement side is very alarming. When we start to see the problem, when the police start to see the

problem, and the prosecutors start to see the public health problem spilling over into our cases, you know we have a very, very serious problem to confront, and that's what we're dealing with now.

We have robberies, burglaries. The tragic instance in Suffolk County in June. We have all those events occurring in the city and surrounding areas.

In law enforcement, in my office, about one year ago, I was startled when I saw how many "pill" cases we were handling.

Typically, the "pill" cases that we confronted were more community-nuisance problems. There are areas in the city where it's well known that you can buy pills on the street. Typically, those were the kinds of cases we handled, and rarely did those rise to the felony level.

All of a sudden, last year, when I reviewed our cases, I saw a good 15 to 20 percent of our cases involved opiate drugs, opiate drugs mixed with heroin and cocaine, opiate drugs mixed with guns, opiate drugs found in search warrants, all over the city.

And it was clear to me we had a problem.

I then tried to figure out the source of the

problem because there is a very robust black market in these drugs. But, I was working with the Bureau of Narcotics Enforcement, stunned to learn that the number of opiate prescriptions in New York City had increased by about 100 percent, between 2007 and 2010.

So I knew, that, while we may have a black-market problem on our hands, we also had a problem with respect to the drugs being prescribed.

Our priorities are to cut it off at the supply. We're looking at pill-mill-type cases of the nature that Senator Klein described.

And, I have to thank Senators Klein, Hannon, and Marcellino, for bringing us all together for this kind of a hearing. I think we need to increase the public knowledge about this. We need to all join hands.

I've worked individually with so many of these agencies, and it's great to have this communal effort.

One of the big impediments I see in my investigations, is a lack of a consistent standard for doctors in the prescription of these narcotic drugs. And that is one of the things that I'm very anxious to have, because, for me, when I'm looking

at a pill-mill case, and I'm looking to determine if a doctor is a drug dealer or prescribing for medical purposes, it's critical for me to have some kind of a standard that all doctors are trained on, so that I can compare that against the conduct that I'm seeing.

So, with that, again, my thanks.

And, I will pass off the microphone.

DR. STEVE KIPNIS: Thank you.

Senator Klein, Senator Hannon, Senator Marcellino, my name is Steve Kipnis. I'm the medical director for the New York State Office of Alcoholism and Substance Abuse Services.

And on behalf of my commissioner, Arlene Gonzalez-Sanchez, it's a great pleasure for the opportunity to speak with you today about what we consider a very important issue: prescription drug misuse.

The Commissioner thanks you for bringing this important issue to the forefront.

And, as you noted, prescription drugs account for the second most commonly abused category, after one looks at marijuana being first, and ahead of cocaine, heroin, and methamphetamines.

Prescription drug misuse goes across all

social, economic, geographic, and cultural groups. But one thing we have to watch out for, is that prescription drug misuse poses a really unique challenge, because one has to balance prevention, education, and enforcement with the legitimate use of these controlled medications for pain, and also for opiate dependence.

According to a 2008-2009 national survey, 51.8 million people in the United States use prescription drugs for non-medical reasons. That's 20 percent of the population of the United States.

So, clearly, it's not just a New York issue, but a national, and probably international, issue.

When we looked at our surveys in New York, we have, unfortunately, a significant increase in the residents, in all age groups, using non-medical prescription drugs. And when we look in the 18- to 25-year-olds, in the past year, non-medical use went from 10.45 percent to 12 percent.

So, how do we address this growing problem?

Well, I think we have to look at each of our unique roles: parents, healthcare professionals, and the government.

Government partners are very important, and OASAS continues to work to address this very

important issue within our agency, and also with ongoing collaborations with other agencies, such as New York City Department of Health and Mental Health, and New York State Department of Health.

We have identified some areas of focus, which we include as, data analysis, prevention programs, education, enforcement, outreach, and screening and referrals.

Healthcare practitioners also need to understand the consequences of overprescribing prescription medications. This is done through educational efforts by the Department of Health and OASAS, and the medical field in partnership with us.

Physicians should talk with their patients directly, to ascertain whether they are misusing or abusing prescriptions and other drugs. It is important that they include the risk of -- associated with the practices of borrowing or sharing prescription medications.

And, finally, bringing it down to the level of the parent.

The parent needs to educate themselves about which medications can be misused or abused, and learn about the very real dangers of the risks of this behavior. They need to communicate it in an

effective and honest way with the risk to their children, dispelling the notion that it is safe to use unnecessary or unprescribed medications.

Parents also need to safeguard medications by limiting access to those in their house, with watching, tracking, and -- quantities that they keep in their medicine cabinets.

They also need to properly dispose of their medications.

Parents should work together to help their children be safe, and healthy.

And, again, I would like to thank you, on behalf of my commissioner, for inviting us to this panel.

ANTHONY MEROLA: Good morning.

My name is Tony Merola. I'm a pharmacist with the New York State Medicaid Program.

Prior to coming to the Medicaid program, I was a community pharmacist out there, dispensing medications. That "gentleman behind the counter in the white coat."

Just a couple of comments with regards to Medicaid, for those of you who may not be familiar with the Medicaid program.

The Medicaid -- Medicaid insures over

4 million people in the state, and a payer of over 62 million pharmacy claims, with annual expenditures of over $4 billion.

And we're here just to inform the roundtable, the members here at the committee, of what Medicaid is doing to make sure prescriptions are being used appropriately within the context of Medicaid.

Like many large payers, Medicaid administrators a Drug Utilization Review Program, and clinically based Prior-Authorization Programs, used to ensure and promote the appropriate use of prescription drugs.

I would just like to talk a little bit about the DUR program.

In the formal sense, DUR was created back in the early 1990s, and it was created to establish and implement medical standards and criteria for retrospective and prospective drug-utilization review for Medicaid beneficiaries.

The primary purpose of the Drug-Utilization Review Program is to identify and determine interventions based upon appropriate utilization.

The program also provides an avenue to identify and report suspected cases of fraud and

abuse, aberrant use, to the Office of the Medicaid Inspection General.

As I mentioned, the DUR program has two components: a prospective drug-utilization review component, and a retrospective drug-utilization review component.

The "prospective" component we call "pro-DUR." It's an electronic pharmacy editing system, which alerts pharmacists at the point of service or the point of dispensing.

Warnings are provided electronically to the dispensing pharmacist. Warnings include: drug-disease precautions, drug-to-drug interactions, high dose/low dose, drug-age precautions, therapeutic duplication, overutilization.

The "retro-DUR" program, or the retrospective DUR program, that's more of an analysis of the historical Medicaid claims information, based upon pre-determined clinical criteria. It's more of an educational program for prescribers and pharmacists.

Education letters are sent to providers, requesting the evaluation of the pharmaceutical regiment based upon those clinical criteria.

Another program that we have in place is called our "Clinical Drug Review Program" which legislation was established back in '05, implemented in '06. We use the acronym "CDRP."

"CDRP" is a clinically based prior-authorization program aimed at assuring specific drugs or drug classes are used in a medically appropriate manner.

Under the CDRP, certain drugs require prior authorization, due to concerns related to safety, public health, potential for significant fraud and abuse or misuse.

The prior-authorization requirement is employed to ensure medically appropriate utilization.

And we also have a Medicaid Drug Utilization Review Board, and Pharmacy and Therapeutics Committee, that evaluate these drug for inclusion into this program. And, they provide recommendations to the Commissioner of Health for a final determination.

One last point I would like to make, with regards to "MRT"; or, as we know, the Medicaid Reform Team, Initiative Number 15. And it's actually, a subset of that whole initiative is

quantity and limits associated with opioids.

While opioid analgesics play a significant role in pain management, there's been a significant increase in opioid prescribing in New York State, and nationally.

As utilization increases, evidence demonstrates that fraud, abuse, misuse, and diversion also have a tendency to increase.

To address this issue, the Medicaid is looking to implement MRT15-K, which will limit opioid prescriptions to four in a 30-day period.

But, prescribers that feel that they need more than four for a particular patient will have the ability to request a prior-authorization override.

Thank you very much.

SEAN DOOLIN: Good morning.

I'm Sean Doolin, outside counsel for Empire Blue Cross and Blue Shield.

Thank you, Senators, for inviting us to have a seat at the table.

A couple of other analysis to magnify that this is a legitimate problem.

The Office of National Drug Policy, in a 2010 study, found that there has been a 400 percent

increase in prescription drug abuse, treatment, hospital admissions.

Likewise, in 2010, the NCSL concluded, in its study, that there has been a 96 percent increase in prescription drug abuse deaths over a five-year period.

So, the problem is real.

From the health plan's perspective, one particular area that I would like to draw attention to, and that has become quite pervasive, is what is commonly referred to as "drug-shopping."

"Drug-shopping" is where an individual patient sometimes -- actually, more times than not, has a legitimate health issue, and they will go to a number of different providers, and fill prescriptions at a number of different pharmacies.

And, without a plan properly coordinating -- health plan properly coordinating with a -- with the providers and the pharmacies, they will pay the claim.

There are loopholes in the current insurance law that allows this to happen.

Likewise, there is a shortfall, in terms of collaboration between plans and providers.

And I'll give you one anecdotal example,

through the State Health Insurance Plan, that dramatizes how people can, intentionally, and fraudulently, slip through the cracks.

Just recently, it was brought to -- in two thousand -- or, in February of this year, it was brought to our attention by the State Health -- or, Civil Service Department, that they had picked up an anomaly of claims that were being filed by one State employee.

And what we found, in digging through it, was that, over a two-week period, the individual patient, who had, in this case, a very legitimate health issue, went to 10 different emergency rooms, and filled prescriptions at 12 different pharmacies over that two-week period, for pain relief.

And the problem, was that there was no coordination between the providers and the pharmacies, obviously.

The fact that it was the State Health Insurance Plan magnified the problem, because you had the drug benefit being administered by one plan, doing their own fraud detection; the emergency room visit being administered by a separate plan; and, the outpatient, or medical benefit, being

administered by a third plan.

That all being said, I think this particular individual was somewhat savvy, in that, they were going to the emergency room, which, in the case of the New York State Insurance Law, there's no prior authorization.

So, the plan would require -- was required to pay for the treatment, and pay for the prescription drug benefit without pre-approving and reviewing the claim.

Now, I'm not suggesting that that law should be changed. There's some valid policy reasons to having, what they call, the prudent layperson standard at emergency rooms. But, there needs to be greater data sharing and data mining by the plans themselves, as well as greater collaboration between the provider community, the plans, and the retail pharmacy.

The State Health Department does have -- many states have tried to address this through a drug monitoring and database program. And the State Health Department does have a drug monitoring program, that was initiated in 1972, went through some enhancements last year, to improve data sharing amongst providers, although there still

are a number of challenges, both, providers have -- in terms of, providers having access to the data, but, also, the plans having access to the data, and comparing it to its own data-mining systems.

So, the problem is real. Certainly, we're here to help.

I mean, obviously, prescription drug abuse, as well as healthcare fraud, increases the cost of healthcare coverage, and oftentimes leads to employers dropping coverage altogether, especially the prescription drug benefit.

Thank you.

JOANNE HOFFMAN BEECHKO, R.Ph.: Yes, my name is Joanne Hoffman Beechko. I am the pharmacist, in or out of the white coat, that practices day in and day out.

I'm a board member of the Pharmacy Society of the State of New York, and the president of the Long Island Pharmacists Society.

I have a store in East Northport, Huntington, and was directly involved with all of the pharmacy events out there.

We're pleased to be here. We think this is a crucial meeting, multi-faceted approach to the

problem of prescription drug abuse.

The pharmacists on Long Island, in particular, of course, send out their hearts to all those that are grieving. We know them personally.

We have many ideas in terms of addressing this issue.

Our first being, that we do need to develop a triad of cooperation between the patients, the prescribers, and the pharmacists. And this will ensure the informed healthcare and appropriate definable outcomes for patients.

This can be done, initially, with different kinds of discussions between the State associations, the physician associations, and the pharmacy associations, I think, is the primary starting point for many of these discussions.

Secondly: Pharmacies are, in fact, medical homes. We see patients, sometimes three and four times a week. The same patients, three and four time as week.

We know them personally. We know everything about their families, what their conditions are. We know them as people.

We need to access that electronic data that was just spoken of. We don't have access to, not

only the BNE information that is available to physicians at this point, but not available to pharmacists, but, all of the electronic data.

Through this roundtable discussion, hopefully, we will bring some of these points out.

If we had access to patients' records, we could determine, for example, if liver-function changes were happening, and why is that.

Is it possibly because of too much Vicodin prescriptions, which has an enormous amounts of Tylenol in them.

That's just a small example of how we could participate.

We would like to require both prescribers and pharmacists to complete courses in pain management and in addiction, to heighten our awareness for the signs of addiction.

Right now, in my store, we're talking about numbers of prescriptions, personally in my store, about 10 percent of the prescriptions are controlled substance prescriptions, which, in a store of, maybe, 150 prescriptions, that's 15 -- 12 to 15 prescriptions. Of those, maybe 1 percent are cash-paying customers.

And this is something that becomes

important for people to understand: Pharmacists, every day, as we fill prescriptions, we're transmitting this information through to the health insurance. And that data comes directly back to us immediately.

So, 95 percent of my customers, I know already -- or, my patients, I know already, if they have had another prescription filled elsewhere, inclusive of the Medicaid program.

The Medicaid program does send back DURs to us on a regular basis, so we know what is happening.

And it is really a small percentage of patients, those that are paying cash, that we really don't know what their history is about.

So, being available to have the information from the BNE is important, but it's certainly not the end of the discussion.

We also would like to increase the public awareness of addiction potential, and the signs of addiction, and all of the treatment options that are in the community.

I've had meetings recently with people out in Suffolk County, and we know for a fact that there are not sufficient addiction centers available.

A lot of it could be due to monies available,

but we need more facilities for patients who do have problems. And, we need more public awareness.

I think the horrible occurrences out in Medford has brought this to public awareness now -- clearly brought this to public awareness -- and now is the time that we need to address all of these different aspects.

And, finally, we are considering, as a profession, establishing policy guidelines, as has already been discussed, in limiting the amount of controlled substances of pain-control prescribed, per patient, per month, with the caveat, that we are 100 percent behind pain management, because we all need to have that. That is 100 percent a necessary part of medical management for patients, and we can't lose sight of that.

Thank you.

DR. ANDREW KOLODNY: Hi. My name is Andrew Kolodny. I'm chairman of the Department of Psychiatry at Maimonides Medical Center. I'm also an addiction psychiatrist.

The patients that I treat in my clinical practice are addicted to opioid analgesics. Some of my patients are young adults who became

addicted through recreational use.

SENATOR KEMP HANNON: Let me just ask you, before you start: I see you have a projector for the benefit of those of us here.

Would you be able to give us slides later, so we could put them on the website, so people who are just watching it on the webcast will be able to access those, that information, also?

DR. ANDREW KOLODNY: Yes, I would be happy to.

SENATOR KEMP HANNON: Great. Thanks.

DR. ANDREW KOLODNY: So, among the patients I treat, who are addicted to opioid analgesics, some are -- a large number are young adults who became addicted to opioids through recreational use. Usually, they started with drugs like hydrocodone, or "Vicodin."

And, I also treat a good number of, usually a little bit older patients, who became addicted to opioids through a medical treatment, what one would call "iatrogenic opioid addiction"; addiction caused by medical treatment.

I'm also the president of a recently formed organization called "Physicians for Responsible Opioid Prescribing." This is a group of docs

from -- in the fields of pain, addiction, public health, emergency medicine, primary care.

The mission of our organization is focused solely on the epidemic of opioid overdoses.

Our goal is to reduce morbidity and mortality from opioid analgesics by promoting more responsible, cautious prescribing practices.

And, many of our new members are actually emergency room physicians, who will send me an e-mail, saying, that: I'm tired of declaring young people dead in the emergency room. We're having people, addicted, show up in the emergency room, looking for drugs.

There are things that could be done to bring this problem under control. And they want to get involved, and they want to do something.

[Slide-show presentation commences.]

The first slide -- and I'm going to go quickly through these slides, and many people today have already pointed out some of the very disturbing trends and statistics.

This slide is from the Center for Disease Control.

And what the CDC is saying, is that we are facing our worst drug epidemic in the United States

history. They're saying that, because they're looking at the heroin epidemic of the 1970s. This was 40 years ago.

And they're looking at the crack-cocaine epidemic in, the late '80s, early 90s.

And they're pointing out that the deaths today, largely due to opioid analgesics, are greater than deaths that we were seeing in those epidemics, combined.

As you can see, all of the overdose deaths are certainly not opioid analgesics, but opioid analgesics account for more than heroin and cocaine, combined.

As was mentioned earlier, we're seeing an increase in heroin use.

So, if I were to show you this slide in a few years, I think, I would be willing to bet, that we would see heroin overdose deaths increasing as well.

We have got, right now, a total of about 30,000 drug deaths a year. This is likely an undercount.

When you think about 30,000 drug deaths, that number is hard to grasp. You can try and compare that, perhaps, to the AIDS epidemic.

And, if the current trends continue, within the next two or three years, we will probably have as many deaths from drug overdoses in the United States as we had during the height of the AIDS epidemic.

You could think about deaths in wars.

Since the start of the Afghanistan war, we've had about 2,600 deaths.

This is 30,000 deaths a year in the United States right now.

The other thing to point out, just quickly, is that, we are still paying a price for the heroin epidemic in the 1970s, today, 40 years later, in terms of, infectious diseases, HIV, hepatitis C, in terms of social problems, and in terms of crime.

The problem that we've got today is far worse, and there is no evidence that it's anywhere near under control. This is something we're going to be dealing with for many years to come.

So, you can measure the epidemic in different ways.

I think what's important here, this is looking at treatment admissions. These are people who are addicted, showing up to state-licensed drug-treatment facilities, saying that the drug that

they're addicted to is an opioid analgesic.

This is, the U.S. data.

This is, New York State data.

This is -- it's the same trend.

This is, roughly, a 300 percent increase.

What's important, I could show you slides of overdose deaths, emergency room visits, drug-use surveys; you'll see the same trend. You'll see that this problem begins in the late '90s, and just seems to get worse.

And, I'll explain why that might be in a moment.

When you look at the people who are showing up for drug treatment, saying that they're addicted to opioids, one of the things that's striking, and very different from our past opioid -- or past drug epidemics, is that these individuals are disproportionately White.

"Blue" on this graph represents people who are White.

Other races are, you can barely register on this graph.

This epidemic is disproportionately White. It's disproportionately middle-class and working-class.

Again, very different from past drug epidemics which were disproportionately low-income individuals and disproportionately minority.

So, why is this happening? What happened in the late '90s? What's causing this epidemic?

According to the CDC, what's causing this epidemic is a change in physician-prescribing practices.

In the late '90s, physicians began to change the way in which they were treating pain. They began to treat pain much more aggressively with opioids than they ever had before.

And, this is New York State data.

What you see, beginning in the late '90s, is a very impressive increase in prescribing of oxycodone.

Oxycodone is the active ingredient in Percocet, and it's the active ingredient in OxyContin.

And, you see this taking off in 1996.

1996 was the year that Perdue Pharma introduced OxyContin, and there was large marketing campaign.

But, it wasn't just oxycodone that increased at the time. It was also hydrocodone. This is the

active ingredient in, Vicodin, and Norco.

And, something that we may discuss a little later today, hydrocodone is a Schedule III drug. It is not a Schedule II drug, which means that restrictions on prescribing are much looser than they are for Schedule II drugs.

So, how do you get physicians to change the way in which they practice?

In my hospital, we're trying to gets docs to wash their hands when they come in and out of patient rooms. And we've been trying to do that for years, and we struggle.

And there are many things we'd like docs to do, and it's very hard to get them to change their practice.

How did you get physicians to suddenly start prescribing opioids far more aggressively than they ever had before?

That was done through very aggressive pharmaceutical marketing.

So, by 2001, the tall bar on this graph represents the money that Purdue Pharma was spending marketing OxyContin. Purdue was spending up to $30 million a year in convincing doctors to treat pain with opioids.

This spending on industry-sponsored education, to get physicians to treat pain with opioids, continues to this day.

The messages in these educational industry-sponsored campaigns, are that opioid addiction is rare in pain patients.

So the -- and this may seem hard for many non-physicians to actually believe, because we know that opioids are -- that oxycodone and hydrocodone are the same class of drug as heroin. So, I think, for a non-physicians, the idea that you could treat someone's back pain, indefinitely, with a drug very similar to heroin, and expect them not to get addicted, that would strike many laypeople as odd.

Of course, people -- a large number of people might become addicted.

But, the messaging for physicians was:

That, patients don't actually get addicted to these medications. That, the rate of addiction is extremely rare. That, you can prescribe much more liberally.

This was false.

And, actually, the company that promoted that message got into quite a bit of trouble for that

message.

The other message was, that we're --

That, doctors are letting patients suffer needlessly. That, we should be more compassionate. That, we should be using opioids more aggressively. And, if we're afraid to prescribe an opioid, because we don't want to get our patient addicted, we're suffering from "opiophobia."

And that term is still used today.

Opioids are not a safe and effective treatment for chronic non-cancer pain.

Opioids are a very important class of medication in the treatment of cancer pain, and in palliative-care settings.

Opioids are extremely important in the treatment of acute pain.

Opioids are not a good medication for the treatment of chronic non-cancer pain.

There may be some people who benefit, but it's very difficult to figure out who they are, without getting other patients addicted along the way.

The other message, and a message that's still promoted today, to doctors, is that:

If you have a patient coming into your

office, and they're coming in early -- they're saying, I ran out of my medicine; or, the dog ate the pills; or, I accidentally flushed it down to toilet -- and, you've got a patient that looks addicted to you, well, probably, Doc, the patient is not addicted, and you shouldn't treat them like an addict and stigmatize them. The problem may be you. You're undertreating their pain. You should escalate the dose. And if you give them a higher dose of medication, you'll see that they don't come back early, asking for more, so that there should be no ceiling limit. You should continue escalating the dose.

Which is something that we now know is causing a large number of overdose deaths in pain patients.

So, what needs to be done to bring this epidemic under control?

There are really three broad strategies.

The first thing we need to do is, primary prevention. We need to prevent less people from becoming addicted. That means, we need to expose less patients, unnecessarily, to opioids. We need -- we need to do something about an environment in which we're saturated with opioid analgesics.

Secondary prevention: If we were -- it means, that we have to provide treatment to people who are already affected by this epidemic.

So, if we were to wave a magic wand, and suddenly ensure that doctors were going to be prescribing responsibly, and that there would be -- and even if we were to try and see that there was less availability for -- in medicine chests, we're not going to see an end to this epidemic.

We might see a decline in the number of overdose deaths, but it's not going to do all that much, because people who are opioid-addicted are not going to stop using opioids because their doctor isn't going to prescribe it for them anymore. They are going to go to the black market, or they'll transition to heroin use.

If we want to see a decline in overdose deaths, you have to provide effective treatment for people who are opioid-addicted.

And for this epidemic, that's probably going to mean buprenorphine.

Methadone maintenance clinics were an effective response in the 1970s, when you had an epidemic that was disproportionately urban.

When you have an epidemic that may be

disproportionately suburban and rural, having people show up in a clinic every day to take methadone is not going to be an effective strategy.

And, then, lastly, we have to do something about black-market availability.

It's very difficult to provide effective treatment to people if they can very easily -- if opioids are just so available for them.

If the cost of a doctor's visitor, or a co-pay, on a Suboxone prescription is greater than it is to purchase Vicodin on the street, it's going be very difficult to provide effective treatment for those individuals.

There are things that we could be doing, that we're not, but I think they're in our grasp.

We've got terrific data in New York State. Probably better data than anyplace else in the country, but we're not using it so we know who the high prescribers are.

And some of the high-volume prescribers are docs who are really no better than drug dealers.

But, I think a bigger problem, and what our group feels, Physicians for Responsible Opioid Prescribing, is, the bigger problem is not the doctor who is are really criminals.

The bigger problem is well-meaning physicians, who, when they write an opioid prescription, they think they're doing the right thing for a patient, and don't realize they're harming the patient.

We need to allow providers to utilize the prescription data that's available.

Right now, it does -- the system we've got does not work for clinical practice.

New York State allows physicians to go onto a database, and find individuals who meet a definition for a "doctor-shopper."

But, if you want to see whether or not a patient is already on an opioid before writing them on opioid; or, in the case of psychiatrists, before writing them a prescription for benzodiazepine, to see whether they're on an opioid, you get no data back unless they fit this definition of a "doctor-shopper."

And that's despite the fact that it takes many steps to even get into this very non-user friendly program.

And we have also got terrific data about who the people are that are probably addicted. We could be linking them to treatment. We're not doing that.

And, then, one other thing that could be done, very simply, and that's very important: Physicians should be able to get a monthly statement, or an E-statement, of all of the prescriptions that they're writing.

If I'm going in and out of my office, and my prescription pad is on my desk, I have no way of knowing if people are taking a few pads.

And, one of the cases that Bridget prosecuted this year, involved prescriptions that were being taken from a doctor's office.

Doctors are not -- doctors do not know when prescriptions go missing from a thick pad.

And I'll show you what the pad looks like.

Physicians should, on a monthly basis, be able to see a record of everything they're prescribing. To see whether there are names appearing there for patients they've never seen. To see whether quantities are being changed.

Maybe the doc wrote "30" -- Dispense 30 -- and someone changed the number to 80.

Doctors should be able to get a report like they would for a credit card statement.

As I mentioned, many -- this is data that comes from Canada, it's likely to be very similar in

New York State, but, a small number of docs account for a very large number of the prescriptions, which means that we've got -- there are interventions, that shouldn't be that expensive, where we could target these physicians.

The physicians that are really drug dealers, and no better than drug dealers, we ought to be able to identify them.

And for the physicians who are prescribing inappropriately, and, either, need better education, or medical-board sanction, we've got the data. We ought to be using it.

These are some of the items I've already mentioned.

One of the single most important things that New York State could do to affect this epidemic, would be to reschedule hydrocodone as a II, from a III.

And I'll talk a little most more about that later today.

As Bridget mentioned, we need standards of care for the treatment of pain, so that -- right now, there are no requirements.

Physicians who are treating chronic pain with opioids don't have to check a urine. They can

prescribe any doses, any amounts. And they're not, right now, at all required to take a look at prescription monitoring data before writing prescription.

I don't think we can require them to do that, though, until we've got a system that works.

A physician doesn't ask a patient even for an ID when the patient comes in for treatment of pain. So, they're writing controlled substances without seeing a photo ID, without seeing a driver's license.

To go into a pharmacy and buy Sudafed, you have to show your driver's license. But, very few pharmacies, that I'm aware of --

And maybe you know otherwise.

-- ask patients for photo IDs when they come in to have a controlled substance filled. They're supposed to be doing it.

Physicians, right now, are not required to do that.

So, in summary: We've got a really severe epidemic in New York State.

Physicians, and the public, need much better information about how dangerous these medications are.

And there are things we could do time impact this epidemic that are really within our grasp.

Thanks.

SENATOR KEMP HANNON: Actually, Paul, start off, and then, Greg.

GREGORY KRACKOWER: Well, I actually wanted to take the lead, if that's okay?

SENATOR KEMP HANNON: No.

PAUL MAHONEY: Thank you, Senators.

And, I'm Paul Mahoney. I'm assistant deputy attorney general for the New York State Medicaid Fraud Control Unit. I'm sort of the day-to-day case manager of that organization.

And it's -- this is a fantastic panel, because it brings together so many elements that we see in our practice.

And rather than repeat, and reiterate, some of the information my counterparts are indicating today, I'd like to just throw an additional element into the mix, from the Medicaid Fraud Control perspective, and that is, the money that's involved.

As we heard from the representatives of the insurance programs -- Medicaid, Blue Cross, and the many others -- there is a tremendous amount of money moving through this system.

And from the point of view of a wrongdoer, controlled substances and, generally, prescription drug abuse, is a wonderful system for making illegal money, and ill-gotten gains.

The Medicaid Fraud Control Unit has traditionally approached it from a larceny standpoint; that, the State of New York, through its Medicaid program, is paying out, recent data is, approximately $1 billion, over four years, from pharmacy-side distribution of controlled substances.

That is a huge pot of money, and extremely attractive to people who would commit crimes.

When you couple the problem of addiction to that, you have an almost -- it's a trite phrase, an overworked phrase -- "perfect storm" of criminality.

You have people who want to make money from engaging in an illegal activity, but want to do it in a safe way. They have the veneer, or the facade, of the medical system prescribing a drug, thereby making it prima facie, legally.

And the beauty, from the criminal's perspective, is that, the government, or a health-insurance entity, is going to be paying for most of it.

And the fraction that is not being paid for

by the government, or a private health-insurance company, can be paid, legally, by the customer who wants the drugs.

The entire aura of traditional criminality, of having people do street-level drug dealing, is therefore removed.

The cash doesn't have to be generated from people engaging in illegal activity. The cash is generated by people engaging in activity that is prima facie legal.

It's really quite -- it's quite remarkable.

When you add on to that, the fact that some of the players have an incentive, even if they are legitimate, and acting in good faith, they have few incentives to look deeply into the root cause, because, the addict, the person who needs that drug, but needs it in a medically inappropriate need, nonetheless, has a physiological need for it.

The doctor who is writing -- the prescriber -- that's not limited to physicians -- who is writing the prescription, has the ability to get paid through an insurance company for their activity in seeing the patient. And the pharmacy is getting paid for dispensing it.

Now, the vast majority of those people are

good-faith actors. But when you're talking about so much money moving through the system, you're creating powerful incentives to, groups of criminals, groups of people, the addicts who are out of control, in terms of drawing a clear line between criminal and non-criminal activity.

So, from Medicaid Fraud Control perspective, we had traditionally attacked this from the overpayment of State money for these activities.

We had, actually, because of the existence of special narcotics prosecutors and traditional prosecutor office and the traditional DAs' offices, we had concentrated on the non controlled substances, which also have a great street value and have the same effect on the same economic causes.

But we're finding, more and more, that, because of the addictive element added on to this, that the incentives, and the drain on State finances, are even greater.

And, we've been moving more and more into looking at controlled substances.

It seems a little bit crass to look at the problem of addiction from a financial perspective, but, every dollar that is going out on to -- to pay for a controlled substance that is being misused, is

a dollar that is not available for substance abuse treatment, for better focused medical treatment for these patients.

And, therefore, as a system, it has a lot of built-in misincentives.

And we are encouraged to see so many parties interested, aligning incentives more appropriately.

Thank you, Senator.

SENATOR KEMP HANNON: Greg.

GREGORY KRACKOWER: Well, thank you.

And the Attorney General thanks, Senator Marcellino and Senator Klein and Senator Hannon, for this extremely important roundtable, and distinguished panelists here.

Dr. Kolodny, who I never met before, had a very important slide about the three prongs that you need to do to solve the problem.

And one of the things that the Attorney General wanted us to talk about here, is a solution that he has proposed in his first, and only -- one of the two program bills that he's established to deal with the third prong, which is controlling the illegal supply of what is a legal substance of a legal schedule of narcotic.

And that is an improvement, if not a revolution, in the State's prescription drug tracking base.

You know, this was the number one topic at a recent national conference of attorneys general, run by a group called "NAAG"; The National Association of Attorneys General.

And states across the country are starting to upgrade these databases, some of which are not existent. But New York's is, actually, from our perspective, one of the weaker ones, at least where it's going.

The lock-tight solution, in terms of monitoring the prescription and the dispensing of drug, must require as Senator Marcellino said, a partnership of doctors and pharmacists and law enforcement.

The Attorney General has proposed a new database, that would require --

And it was in parentheses in one of your slides, but it's actually in the Attorney General's bill.

-- that would require doctors, prior to issuing a script, to check what would be a real-time, on-line prescription monitoring program,

which would have, in secure fashion, and compliant with HIPPA, not just a doctor's prescription history, but all of the doctors's prescription history for a particular patient, prior to issuing the script, so the doctor could see, at the time he wrote the script, or at the time she set up the appointment, that patient's drug history, for writing the script.

And would be required to look at this data, which would be on-screen, and require to enter the script.

Then, in real-time, or in near real-time -- the bill, currently, is in real-time -- the pharmacist would have to double-check, to see, when you cross the street, to cash-in the script to get the dispensary pain medication, that there is a real doctor.

The pharmacist would have to check, and it's prior to dispensing, this system, and look for a matching doctor, to see: Oh, that is a real doctor. That is not a stolen script pad. That is not a forged script pad.

And, by the way, the data that would also show up, would be: Yeah, that's the fourth doctor this 24-hour period; or this week-period -- or, I

think Mr. Doolin said in his example -- in a two-week period, there were 10 different doctors -- 10 different ERs that wrote 12 different scripts, that would show up on, Doctor 3, Doctor 4, Doctor 5, and Pharmacist 3, 4, and 5, or one pharmacist.

That is a tool that solves the four problems of the illegal flow of these otherwise legal substances.

You have a proof record that the physician has seen the prescription data, so that they can say to themselves: Oh, this is really an addict. This person might not look like an addict, but the computer is telling me, this is the fourth doctor they've seen in four weeks with this problem.

So, the Attorney General data base, which he calls the "ISTOP" -- the Internet System for Tracking Overprescribing -- database, is, both, a law enforcement tool, and it is also a diagnostic tool.

And we think that is critical to the support of the program.

If there is a stolen script pad, the pharmacist won't dispense the drug. And the pharmacist will be protected from all liability for that, because they'll say: You know, I went into

the computer, and there was no doctor, with a doctor number, that actually entered in the script.

And stolen script pads, and forged script pads, until the State moves to an E-script system, which is very, very far in the future, is, with a stolen script pad, you can do a lot of damage in a very short amount of time.

So, part of what we wanted to talk about today is solutions and problems.

And, to complete that third bullet point of Dr. Kolodny's excellent presentation, technology has to be brought into the fold, because the tools that law enforcement has used against illegal substances, cocaine and heroin, are semi-effective, even less-than-effective, in the prosecutions for illegal substance, because -- an illegal substance of a prescribed drug, because, the doctor can always say, and our Medicaid Fraud Unit, which has criminal jurisdiction over these, does say, "Oh, the patient lied to me."

And that's a great defense. Juries tend to believe physicians over drug-addicted patients.

Now, yes, you can do undercovers in there, and sort of give the doctor every way out.

And Paul can talk about some of the cases

that Medicaid Fraud has -- has accomplished.

But, to stop it at the source, to really do a holistic tracking program, technology is the answer.

Oklahoma is also talking about a real-time database.

New York is behind the times in its current program, with the general lack of doctors even accessing the system, although some can.

We think, given the cost of our Medicaid program, it is actually very cost-effective. Ultimately, it will pay for itself; although, we are working on, exactly, costing the bill.

And, we'll have an answer for that by next session, certainly.

And the Attorney General is taking this time to partner with many of the people here.

We want to partner with pharmacists and doctors and law enforcement, and, of course, the Department of Health, who has done an incredible job in administering all of the programs that we have. And, partnering with other stakeholders too, including advocates for patients and Medicaid providers and the Medicaid Redesign Team, and everything.

So, this is an opening salvo, in terms of

bill. It was introduced late last session.

And we -- it's a deeply important problem that has come to the AG's attention, not only because of the slides and the drug problem, but, also, this is nationwide.

This what attorneys generals are talking about.

And this is where the nation is going. And, New York has a chance to be a leader here.

You know, we were a leader in Medicaid fraud. We created the first Medicaid Fraud Control Unit. And everyone thought: Well, it's too expensive. It won't work.

It was so effective, the federal government mandated that all states have one.

And we think this is an opportunity for New York to be a leader again.

SENATOR KEMP HANNON: Dr. Dowling.

DR. FRANK DOWLING: Thank you.

I'm Dr. Frank Dowling, clinical associate professor of psychiatry at SUNY at Stony Brook; the medical advisor to "POPPA" -- Police Organization Providing Peer Assistance -- here in New York City; and I have a private practice in Suffolk County, in Happauge.

I'm also counselor for the Medical Society of the State of New York, and one of my chief roles is to oversee the committees on Addiction and Psychiatric Medicine, and, Preventive Medicine and Family Health.

We greatly appreciate the opportunity to participate in this important discussion on ways to address the problems of prescription drug abuse and diversion. And we're eager to work with all of you in this room, to identify and implement targeted, workable solutions to the problem that will not unduly interfere with the ability of patients to obtain prescriptions that are needed to treat illnesses or manage pain related to illness or injury.

In preparation for this meeting, physicians from the Addiction and Psychiatric Medicine, and Preventive Medicine and Family Health, committees had a spirited discussion last week regarding ways to address this problem.

Several points came from this meeting, but the key theme of the discussion, is that there have to be -- a multi-pronged solution.

This will include law enforcement efforts to prevent and punish inappropriate diversion and

misuse of prescriptions.

It also includes the need for increased accessibility of treatment for patients suffering addictions, to reduce the likelihood of inappropriate diversion, and, frankly, the market for people who are legally profiting from the system.

It includes better use of existing databases, such as the one New York State has on all controlled substances.

And, it includes the need for additional resources for associations representing prescribers, as well as dispensers, so they can be educated, and their members can be educated, about the existence of the database, and circumstances of patients presenting themselves in healthcare settings that should trigger someone to check the database.

In addition, it's imperative that the Department of Health educate the public regarding the dangers of prescription misuse and diversion, as well as the legal requirements to inform all prescribers of any controlled drugs that they are taking.

It's important to note that the media have, in our view, inaccurately portrayed that

New York State does not have a database as other states have.

We do have a database, and New York has been collecting data for many years.

The issue is, the information that already exists, how it could best be used, and improved, to inform physicians, and other non-physician prescribers, including pharmacists who dispense, so that we can reduce doctor-shopping and diversion and misuse.

If it has to be a new database, we're certainly open to discussing that, but, we wonder how the current database can be improved.

It's only the last two years that physicians have had access to this database.

And one of the key points that came out of our discussion, is that the current database is cumbersome, to get onto the database and to access the information.

Getting a health commerce account and maintaining the account is challenging for a lot of physicians. And if a physician wants to look up a given patient, the current system is cumbersome and slow.

In addition, a physicians's staff; a

physician cannot designate someone in their office to check the database, which would be a more efficient use of time.

The current database is very limited to a short time frame of information available, and too high a threshold of filling multiple prescriptions from multiple prescribers, and being filled at multiple pharmacies.

What should be there, is that, if a physician can look up any patient, anytime, and get any information on controlled substances that have been prescribed, as far back, and as recent, as the database goes, even if it's one prescription.

And, finally, the database does need to be promoted to the medical community. And MSSNY would be happy to partner with the Department of Health in that area.

We also would be supportive of legislation that would permit pharmacists to check the database, so they can better communicate with physicians regarding questions or concerns in this area.

It's also important to keep in mind, that as we look at ways to prevent misuse and inappropriate diversion, we need to be careful that

we don't actually overcorrect the problem.

Physicians, in fact, are often criticized, that we actually undermedicate pain, and are uncomfortable with prescribing medications to patients with legitimate needs.

So, physicians have concerns on both ends of the spectrum.

We are also concerned that mandatory reporting, and checking of a database, could have an unintended negative impact that could reduce prescribing when it is necessary. And also add additional administrative and time-consuming burdens to physicians' practices, where physicians are already struggling to keep practices running.

We look forward to further discussion that we're going to have today. And we are optimistic that we really can work together to come up with many workable solutions, balancing the need to assure prescribing medications only to those where there is a legitimate medical need, while also not interfering with patients' ability to obtain prescriptions when they are needed to treat legitimate pain and other medical conditions.

Thank you.

SENATOR KEMP HANNON: David.

DAVID VIZZINI: Good morning, everyone.

I want to start by saying, thank you for inviting me.

I work for Outreach.

Outreach is an alcohol and substance abuse provider for New York State.

I have been working with adolescents and young adult for about 15 years. We service people between the ages of, 12, all the way to 25, outpatient and residential.

And, I kind of wanted to talk to you about their story a little bit.

When I meet a client for the first time, over the last five years, who is addicted to some type of painkillers, it's always the same story.

It starts with, that, their friends talked about it. You know, they were 14-, 15-, 16-years-old, in high school. They went to a party. Somebody tried it. Then they rummaged through, mom, or grandma's, medicine cabinet to see what they got. Used the Internet to figure out what they have, and if it's something that can get them high or not get them high.

From there, they start buying it from their

friends. And then, from there, they go to dealers. And then, from dealers, you know, they end up, hurting themselves, or doing some things, so they can get to a doctor, and get to, like, you know, the full force of the medication, and get as much quantity as possible.

I permanently work out in, Nassau, and Suffolk, County, on Long Island. And a lot of the things that were said was about providing treatment.

You know, and I think treatment is very important. I think that education and prevention is important.

But, the people that we're talking about here, who are addicted to these substances, you know, they need treatment. And they need high-quality comprehensive treatment, working with their families, working with the schools, working to deal with their behavioral issues, and the issues that are causing them to self-medicate through these substances that are becoming so easily available to them.

If you know, we have to link better, I believe, with the treatment providers, to the legal referents, to the doctors, to the pharmacists, because, if you go out on

Long Island, I don't know any treatment provider that is full; as in, like they can't take another client in.

Most of them are, you know, undercapacity, because, that they're not get enough referrals from the people who need it.

I think that, you know, one of the efforts of this committee, and other committees to come, is to really look at that issue, and linking people to the services they need to get.

And people that are addicted, and using OxyContin and Percocets, and all different types of drugs, that, you know, the kids call the "Roxys" and the "Oxys," and so on and so forth -- I mean, they have their own names for these things -- these people are taking them, weekly, and daily.

You know, they need good residential treatment. They have to get away from their environments.

You know, social pressure behind these substances are the killer for young people.

And, the bottom line is, is that until that we help them, the problem is just going to keep going and going, around and around and around.

We have to treat them, as well as everything

else that we're doing.

And, I would like to say: Thank you, again, for having, you know, a treatment provider at the table at this time with everyone else, because it means a lot to us.

So, thank you.

SENATOR KEMP HANNON: Mr. Fogarty.

ANDY FOGARTY: My name is Andy Fogarty. I'm the director of government affairs for the Health Plan Association of New York.

I would like to thank Senators Marcellino, Klein, and Hannon, for inviting us here today.

The Health Plan Association represents 25 managed care plans in New York State that cover approximately 6 million New Yorkers.

Healthcare plans in this discussion are sort of an important element, as touched on by the OMIG and the -- you know, the State Attorney General representatives here today. And that, you know, much of the money that is focused through, you know, the healthcare system is paid for by the plans, as well as by the State.

So, when it comes to traditional, sort of, healthcare fraud, all plans have, you know, units in place to monitor those elements.

With the advent, or sort of the increase, in prescription drug abuse, plans have had to adapt to meet these, you know, emerging issues as well.

Many plans, right now, have programs in place that monitor, you know, prescription drug abuse. In many cases, what it is, is, as Sean pointed out, it really does boil down to care coordination.

Plans look at the claims data that we get, and, you know, we sort of identify those instances where you may have a doctor-shopper; somebody that's going to visit a physician or an emergency room at a very frequent basis.

At that point, the plan would reach out to the individual. And, you know, perhaps see, if they're using the emergency room, about a primary-care physician.

If you're seeing that, you know, at that point, also reaching out to the physician, providing them with sort of informational details regarding, you know, the member, and, you know, the use of the drugs that are being prescribed.

And then, as well, goes to the pharmacists. The plans reach out and provide, you know, sort of, informational details to the pharmacies, in --

you know, when we're seeing a prevalence in, you know, these type of prescriptions that are most likely to be abused.

So, from the plan perspective, you know, this is something that is definitely very, you know, important to us. And, certainly, you know, as everyone here has, you know, already stated, an important issue across the board, especially to, you know, the individuals who are putting themselves in, you know, sort of an increasing spiral of either, you know, hurting themselves, or, you know, moving, to, you know, sort of greater criminal activity.

So, this, you know, it is a very important discussion to have today, and I want to thank you for inviting us.

SENATOR KEMP HANNON: Thank you.

We've now gone through the opening, which has actually meandered into what we wanted to do in Phase 2 and 3 and 4, but, that's okay. That's fine.

Actually, we'll take -- we have two more phases -- three more phases, and I'm going to discuss them, and then just want to address the first one, because it may give us some immediate action, which government legislators always like.

And, then, the second would be, policy

changes.

But the three things were:

What's your organization doing right now to deal with the problem? Not what you want to do, but, what are you doing right now?

Dr. Kolodny mentioned, what the hospital is trying to do to get doctors just to wash their hands.

It's an incredible ongoing public health problem.

But -- so, that's going -- I'm going to come back and ask each one of you: What are you doing right now?

Afterwards, we want to talk about, some people have already discussed the --and the attorney general have talked about what programs you have now, that are working.

And, what would you do to change those programs?

And, some of you have touched on it, others haven't.

So, that's where I want to divide it, in two rounds.

The first will be: What's working now?

And then, then, specifically: What do you

want to see take change? Whether it's government, or it's state or local, or federal.

And, what do, you, yourself? Maybe you need greater power.

And, we're from the State. One of the things that people always come and talk to us about is, the need for money.

And we always agree, but, we have a certain set of circumstances that are going on.

So, you might temper those thoughts.

So, I'm going to do the next round.

What are you doing right now?

Now, your boss left, he left you in charge.

What's the City doing?

DAHLIA HELLER: Thank you, and good morning.

My name is Dahlia Heller. I'm the assistant commissioner for the Bureau of Alcohol and Drug Use Prevention, Care, and Treatment at the New York City Health Department.

So, what are we doing right now?

I think -- well, you have, actually, evidence of, one of our pieces of work that we found was really important, was to actually look at: What is the scope of this problem in New York City?

You have an Epidata brief in your packet.

And, I believe another one was distributed before we began the roundtable.

So, that just kind of reviews. And, the Commissioner discussed that a little bit when he spoke.

What we see right now are the trends around prescription opioid misuse and health-related problems, morbidity, and mortality.

It doesn't speak to the whole state, it speaks to the City as our purview.

So, what are we doing about this?

We've heard a lot already, talking. And it's actually very heartening to hear the support for improving and strengthening the use of the prescription drug monitoring program and the database. And, we see that as very important.

We've been speaking with, and working with, our partners at the State Health Department, and collaboration with our partners at State OASAS, to look at what are the opportunities for that.

And, I guess I'll hold off on our specifics, for Round 3. I don't want to miss my chance, but I'll hold off.

What we're doing, then, immediately, and in the meantime, is, we're in the final stages,

actually, of preparing "City Health Information," which are the publications we developed for healthcare providers; go out to healthcare providers across the city, to promote best practices in clinical practice.

And, so, we developed, and we found it was very important, and we've actually been spending quite a bit of energy on this. It's a very nuanced topic, but, the need for a "City Health Information," to look at the -- at pain-management treatment, and, specifically, really looking at opioid prescribing, and talking about both acute- and chronic-pain management, because I think we sometimes forget acute pain when we start talking about the subject.

In particular, we get caught up in the chronic-pain management, and how opioids are prescribed; specifically, for non-cancer chronic-pain, you know, standard, we think about back pain, for example. But, we often forget, also, about how opioids are prescribed for acute pain as well.

And that, even if they're prescribed for a short-course treatment, they can be prescribed in large quantities. And, without follow-up with the

patient, with the physician-patient relationship.

And, it's an opportunity to really talk about what we mean when we talk about pain, and then, how we look at pain management.

So, we look forward to putting that "City Health Information" out next month.

I can get into details, but I'm not going to bore you with the details of, maybe, very nuanced clinical practice around this.

I think it's important to say, a number of the strategies that Andrew talked about in his presentation, such as, urine-test monitoring for ongoing chronic-pain management. A real relationship between the physician and the patient, very important.

And really thinking about looking at -- and I think we do issue some recommendations in there, about, what is the value of chronic non-cancer pain management over the long term.

And that's, I think, really where a lot of our energy needs to be focused, is, how we think about chronic non-cancer pain management.

Another point I think we make in there, and that's made in our Epidata brief, loud and clear, is, when we think about drug overdose deaths, what

we've seen in the data is that, as the Commissioner mentioned, when he spoke earlier, we don't see deaths from a single drug alone, or a single substance alone.

98 percent, and in some years 100 percent, of deaths in unintentional drug-poisoning deaths in New York City are involving polysubstance use; or, polysubstances.

And the drugs we typically see on board with prescription opioids include, buprenorphine, another prescription medication that we're not talking about here today, but I think is important to recognize that it's widespread. It's used very commonly to treat a number of psychiatric and low-level psychiatric issues.

And, in combination -- not alone, but in combination with a prescription opioid, or any opioid, it can cause respiratory depression, leading to death. So, that's a drug overdose.

Important to note, that we're seeing these two together because that's another medication that's widely available in New York City.

DR. ANDREW KOLODNY: [Inaudible comment.]

DAHLIA HELLER: What did I say?

DR. ANDREW KOLODNY: Buprenorphine.

DAHLIA HELLER: Oh, I'm sorry.

"Benzodiazepine."

Oh, wow!

Not talking about buprenorphine.

My apologies.

"Benzodiazepine."

SENATOR KEMP HANNON: Thank you, Doctor. I was totally going, wait a minute, that's the antidote.

DAHLIA HELLER: Thank you.

Yes, I mean, benzodiazepine.

Please pull back on that, and actually scratch that out. This is a live webcast.

My apologies.

Really, actually, benzodiazepine, very important, many, many, many prescriptions. Many, many, many more than buprenorphine.

We have thousands of benzodiazepine prescriptions going out in New York City every year. And, I'm talking about on drugs like, Xanax, and Clonopin, for example.

So, alcohol is the other substance we see commonly on board with a prescription opioid-involved accidental drug overdose deaths. Also important to recognize the relationship,

drinking is legal, it's a social behavior widely accepted. But, drinking with prescription opioids, even -- and unbeknownst to the patient, patient might be on prescription opioids, and maybe took one too many today, and then has a few drinks, and is really putting themselves at risk for overdose.

So, we need a lot better education around that.

So, working on the "City Health Information," and we look forward to issuing that next month. I think we'll be talking about it widely when it does come out.

In addition, we've been working for many years now, to expand access and availability of buprenorphine, the drug I mistakenly mentioned earlier, which is actually an enormous step forward from the treatment of opioid dependence, because it is the first -- the second drug we have made available for the first time in 40 years, after methadone, to be able to successfully use a medication to treat opioid dependence.

And that not -- treatment does not mean you're on buprenorphine forever. And especially when we're talking here, about patients who may

develop a dependence on a prescription opioid, such as an oxycodone, such as OxyContin, through treatment with their provider, with their physician, their physician should be able to offer that patient the opportunity to taper the tolerance and dependence that develops when a patient is on an opioid for even more than a few days.

And I think that's very important to recognize here.

It's been mentioned around this table, patients don't develop drug tolerance because they have a preponderance towards addiction. Drug tolerance develops with opioids because that's the nature of the physiological mechanism of an opioid.

So, it's important to make buprenorphine available for treating dependence, and tapering patients who have become tolerant to an opioid and have completed a course of treatment.

We also worked -- are working on, continue to work on, expanding availability and information on no-lock zone, which is an opioid antagonist used in emergency medicine, and is being made available through the advent of opioid overdose prevention programs, which are authorized, or registered, or

certified by the State Health Department, and can train laypeople to recognize and respond to an opioid overdose with the administration of no-lock zone after calling 911.

We have seen over 400 reversals now, reported in New York City, using no-lock zone by laypeople responding to a recognized opioid overdose.

And, in the -- in partnership with calling 911, we think this is a very important opportunity to prevent and reduce opioid overdose mortality in New York City.

Of note, most of that work is going on through groups and organizations who work largely with individuals using, for the most part, heroin. And we've seen deaths involving heroin actually start to decline in this city.

So, we don't see the same pattern in prescription opioid-involved deaths.

Finally, we're partnering with community coalitions around the city.

For example: There's a group in Staten Island, where we are seeing a much higher rate of prescription opioid-involved death; a group, Take Care Staten Island, that is really -- has

identified this as one of the major issues they're working on, and want to develop a community-coordinated response to.

And, so, we're working closely with them, and look forward to more of that, to really doing targeted information and interventions to reduce this problem.

Thank you.

SENATOR KEMP HANNON: Bridget.

BRIDGETTE BRENNAN: Thank you.

The main thing that we have done, of course, is prosecute cases with respect to these drugs. And, these are very non-traditional investigations for us.

Typically, our work has involved illegal substances which comes -- which come in from outside the country. And there are relatively predictable organizations behind the distribution of these drugs, cocaine and heroin primarily.

With prescription drugs, it's a whole different ballgame.

We have jurisdiction over narcotic drugs, and that includes oxycodone. It does not include, for example, Xanax.

So, even there, we have some unusual issues

to deal with.

The means that they're coming in, that they're finding their way to the streets, that they're finding their way to be abused, are -- you can't count the number of ways.

And we have formed a prescription drug unit in order to deal with these issues.

The cases are tremendously resource-intensive. They take a lot of time of investigators, and of assistant district attorneys.

And, it takes specialized knowledge as well. We work very closely with the Bureau of Narcotics Enforcement from the State Department of Health.

There are very important confidentiality issues involved that we have to be aware of. We have been doing a lot to educate our assistants, as to the law, as to the health issues.

Dr. Kolodny has been to visit us, and to discuss these issues with us.

And, we have worked with the City medical examiners, in order to help us prioritize our cases.

When we are investigating a particular prescriber, we, of course, want to know, because we have been deluged with referrals, how high a priority should we give this particular prescriber.

One way of analyzing that, is to work with the medical examiner, and to find out, for example, how many overdose deaths are related to a particular prescriber.

And, so, we have been doing a tremendous amount of work in the area.

Have created a specific unit; designated it to handle these cases.

And, of course, we have asked the City to help us fund this unit because the resources involved are just tremendous.

We have been working with the Drug Enforcement Administration on drug disposal.

One of the biggest issues that we are finding, one of the most common calls we get, is: What do I do with these drugs?

The calls come from nursing homes; from private people; from people whose parents have died and have all kinds of drugs left.

I think it's an issue that's probably more easy to deal with than any of the other ones that

we're facing, but there's not, right now, an easy protocol to refer people to.

The DEA has had some "Drug Take-Back" days.

It is critically important just to take drugs out of supply, off the market, and that's one of the big fixes.

You'll hear us making a lot of noise, if we can, whenever we make one of these prescription drug cases. It's part of our education effort.

We've handled a case in Staten Island, where there was a drug-distribution ring actually distributing drugs out of a -- OxyContin out of an ice cream truck.

And whenever we make a case, we try to draw attention to it, because it's one way of educating the public about the dangers of addiction, about the dangers of these drugs.

The other thing we continue to work on is the heroin supply.

There's a huge heroin supply now in the city. We're seeing a bigger-than-ever -- bigger-than-in-recent-years market for it. We see it as going hand-in-hand with the prescription drugs.

So, that's an area that we're working on.

And in addition, as Senator Kemp mentioned earlier, we have been working on the issues that are not currently addressed by State law.

We have seen what we believe to be huge fraud involved with the non-controlled substances.

We have submitted a bill. We've been working with Senator Kemp on that.

But, it also addresses some issues that we have seen with the prescription drugs; some oversights in laws that were drafted when prescription drugs were not a big currency, were not a big problem.

So, we've submitted legislation in that regard.

And, I think that summarizes our work in that area.

SENATOR JEFFREY KLEIN: I just had one question, Bridget.

When you're actually, prosecuting, investigating, these cases, how are they different from your standard, you know, elicit drug case?

I know that it's probably -- when you do undercover, it must be very difficult in some of these cases, as far as, you know, a doctor is held to a very, very high standard in prescribing drugs.

BRIDGETTE BRENNAN: Well --

SENATOR JEFFREY KLEIN: Or, maybe not a high standard. Probably can do almost anything in prescribing drugs.

BRIDGETTE BRENNAN: Yes.

And I think, probably, what I can clearly talk about, is the case we did with the Attorney General's Office a few years ago, about a doctor -- regarding a doctor in Staten -- Long Island who was convicted, Dr. Chait, I think his name was.

And in that case, we did have undercover officers going into the doctor's office, and asking specifically for oxycodone, to treat -- because of the undercover, I think, said that he was trying to quit smoking.

I mean, the -- in order to prosecute a doctor, there's only -- there's really a limited number of statutes you can prosecute them under. And, the conduct has to be egregious.

And, so, merely looking at data that indicates a doctor is a big prescriber of drug, you know --

SENATOR JEFFREY KLEIN: Not enough.

BRIDGETTE BRENNAN: -- certainly, not enough.

And rightfully so.

I mean, there are doctors who specialize in pain management, there are doctors who treat a lot of cancer patients, but, that's not how we focus our investigations.

We get information in the traditional way: from the street; from the street-level sales, from the guys over in Union Square Park, who are selling their drugs.

And then we find out from them, where they're obtaining their drugs.

Or, I passed out a packet of information, including some photographs, of seizures.

We focused on a drug delivery service that was delivering to individual customers, cocaine, heroin, fentanyl, OxyContin, Vicodin. And, again, a huge supply of drugs inside the car when we stopped it.

And, again, we track it back, where are those drugs coming from. And that's how we can identify a -- a medical provider who has gone off -- gone off the path.

SENATOR JEFFREY KLEIN: So, in other words, it's probably much easier to get an office manager that steals a prescription pad than the actual

doctor?

BRIDGETTE BRENNAN: Exactly. And those aren't easy either, frankly.

That was -- our Staten Island case was an office manager who stole prescription pads and supplied them -- sold the pads. But, it took months to make that case.

And, actually, the most interesting thing about that case -- and this is addressed in the legislation we proposed -- is that the office manager, ultimately, was facing a less-severe penalty and less-severe sanction than the people who were recruited to present the prescriptions in the pharmacy and have the pharmacy deliver the drugs to them, and they turned around and kept some of the drugs because many of them were addicts, and sold the rest to the Lickety-Split ice cream man, who then sold them out on the streets in Staten Island.

SENATOR KEMP HANNON: Bridget, you know, we passed that legislation in the Senate.

One of the things the State did, about six years ago, is introduce, what they call "forge-proof prescription pads," which were dealing with the certain problem at that point.

But, I'm wondering if you have encountered,

besides the simple theft of it, what Dr. Kolodny referred to as "other scams," in regard to the current pads, and what steps might be taken on --

BRIDGETTE BRENNAN: Yes.

I mean, we've heard from our colleagues around the state about -- you know, with people being as savvy as they are about computers, duplicating things, et cetera, et cetera, I think there's no proof any -- there's no forge-proof anything anymore.

And, certainly, we have heard from our colleagues around the state, that there have been people arrested, who presented prescriptions that were -- that they produced with their own computers.

SENATOR KEMP HANNON: Now, the federal DEA has proposed some regulations for electronic prescribing of the controlled substances.

And I know the State DOH is working on trying to implement what would have to be legislation or regulations on that regard.

And I don't know if you've worked with the DEA, and those -- the electronic prescribing, and whether that, cures, or introduces, the problems we're talking about.

BRIDGETTE BRENNAN: That, I couldn't really answer. I don't know whether it will.

I mean, you know, conceptually, the link that was described earlier, that a -- in real-time; a pharmacist could see that in real-time, a physician prescribed a drug, would eliminate certain aspects of it. But, then, you know, it's like one of those games, where you pound down one peg, only to have it come up a different way.

And that's what we have seen in this area. The diversion is more -- it's not so crude, it's more clever. There's big money involved.

And, so, I can't really say whether or not that would be an effective remedy.

I'm sure there are people who would know better than I.

I was recently down in Washington, to meet with the director of the Office of the National Drug Control Policy, who is talking about other things DEA wanted to do, including, make training mandatory for doctors who are going to prescribe Schedule II opioid analgesic medication before they would be licensed to prescribe those drugs.

Something like that would be helpful to me, only from the perspective of, now I have a standard,

now I know doctors have been trained, with regard to the prescribing of the drugs.

Some of the things that are seen in pill-mill clinics, I mean, when Ms. Heller referred to prescribing Suboxon, plus an opioid drug at a time, your ears rang, because you knew that was wrong.

Well, we see it.

And, I don't know if it's written in any brochure or pharmaceutical manual that you're not supposed to do it, but that's the kind of thing that indicates to us, a physician who is not necessarily prescribing drugs just to treat pain.

SENATOR CARL MARCELLINO: Can I just, before you go ahead?

Is it a crime right now -- I mean, out of complete ignorance.

Is it a crime right now for someone to go from doctor to doctor, I have a problem. My back is killing me. I've got severe pain. I can't -- Dr. so-and-so, I need help.

Dr. so-and-so prescribes five days of oxycodone...whatever.

I go to Dr. Smith. "Doctor, I've got a problem."

Five more days.

Go to Dr. Jones. "Doctor, I've got a problem."

Five more days.

Is that a crime right now?

BRIDGETTE BRENNAN: Yes. I mean, there are crimes you could prosecute right now.

Specifically, do we have a crime that addresses it?

I think we do, under the Public Health Law, maybe. But, you can also address it through some of the other crimes that are more general crimes.

Unlawful possession of a controlled substance, you could prove that -- you might be able to do it.

But, I do believe there's something specific in the Public Health Law that would address that.

Unfortunately, I just got back from vacation a few days ago, and my head isn't back into the narcotics world, otherwise I would have that at my fingertips for you.

But, I can get back to you on that.

PAUL MAHONEY: If I may jump in for a second.

It all depends, Senator, on whether the person who is going from doctor to doctor, is going for a medical reason, or to obtain the drugs.

And the law enforcement proof problem is the interaction between that patient and the doctor, as a --

SENATOR CARL MARCELLINO: I go to seven doctors. I tell them I have the same problem.

Maybe I legitimately have the problem.

And, I go to seven different doctors, each one gives me the same prescription.

I know I'm gaming the system. You know I'm gaming the system.

The question is: Can you prove it, and is it a crime?

What do we do to stop that?

PAUL MAHONEY: That's exactly right, Senator.

The problem is, that the contrast to Ms. Brennan's traditional heroin and cocaine cases, are that, if you're in possession of heroin or cocaine, you're already committing a criminal act. And you're, at least presumptively, committing a criminal act.

When you're in possession of the pill form of a controlled substance, you are in possession of something that, under the right circumstances, you're entitled to have.

And so many of the players have the ability

to point to someone else in the chain, and say, it was their misjudgment, or their wrongful act, that put me in possession of that drug, that it makes these cases very difficult to prosecute.

If your name is on the pill bottle, you are presumptively entitled to be in possession of that.

SENATOR CARL MARCELLINO: So there is no limit to the amount of OxyContin an individual can have?

PAUL MAHONEY: As a raw number, that's correct.

UNIDENTIFIED MALE SPEAKER: If there's a health insurance claim involved, it would be insurance fraud.

SENATOR CARL MARCELLINO: Okay, so now we're getting somewhere.

So, there is a potential, that, I'm gaming the system clearly. I don't need to go to seven different doctors, get the same prescription, and build up my supply more than -- you know, ten times more than I possibly could need to resolve my medical problem.

I'm assuming each doctor -- big assumption -- that each doctor is giving me the appropriate prescription for the problem.

So, now, I've gone -- and the insurance company is reimbursing me each time. Paying the claim each and every time.

So, I'm defrauding the insurance company. I'm in possession of a drug I don't need, a certain amount of --

DR. FRANK DOWLING: Can I make a comment in regards to this issue, that's very important?

I don't know whether it's law or regulation, but I am certain that it is one or the other.

And as a physician, I think of law and regulation as being equivalent.

That, if a patient has been given any controlled drug prescription in New York State, from one prescriber, the patient is expected, under New York State law, to inform any other potential prescriber what they're getting, from whom they're getting, et cetera.

The fact is, many patients don't report that, so patients don't have the information -- doctors may not have the information unless the patient is willing to be open and honest, and report it.

And that's one of the reasons why a database that will report any prescriptions would

be very useful.

But, I'm pretty certain. We've had several discussions with OASAS, Department Health, Bureau of Controlled Substances, about this issue; that that is a matter of law regulation, that a patient must report any controlled substance prescriptions being given from another prescriber if they're seeing a current potential prescriber of any medications.

JOANNE HOFFMAN BEECHKO, R.Ph.: May I add something to that as well?

As the dispenser of the medication, we currently do see, in 95 percent of the prescriptions, we do get the information immediately back from the insurance companies.

We see -- and Medicaid as well, we'll get a notice back that says, other prescriber, other drug.

So, we know --

SENATOR KEMP HANNON: How quickly do you get that notice?

JOANNE HOFFMAN BEECHKO, R.Ph.: When we submit a prescription through to Medicaid, or when we submit through the private insurance, it's instantaneous.

So, we know immediately, whether a

prescription has been written for that same patient, for most patients, when it's electronically allowed, when we can see this information, immediately.

And then you said, What are we doing?

Currently -- we are, currently, every single prescription that is coming through to us, we are monitoring this flow of medication.

If I get a prescription back that says that a patient has filled something somewhere else, with another doctor; or even the same doctor, another medication, we, as pharmacists, are obligated by many different laws and regulations, to question, both, the patient and the physician, as to whether they are aware of the medications that are being prescribed for this patient.

So, it is already, currently, an ongoing entity.

It's something that you need to keep in mind.

SENATOR KEMP HANNON: You spoke before about wanting to access, and the Attorney General has recommended accessing a database.

But, if you're now getting this information --

JOANNE HOFFMAN BEECHKO, R.Ph.: For Medicaid?

SENATOR KEMP HANNON: -- for Medicaid, and for anybody covered by health insurance.

JOANNE HOFFMAN BEECHKO, R.Ph.: Uh-huh?

SENATOR KEMP HANNON: So, that would account for, 75 percent of your prescriptions?

JOANNE HOFFMAN BEECHKO, R.Ph.: More.

SENATOR KEMP HANNON: More?

JOANNE HOFFMAN BEECHKO, R.Ph.: I would have to say -- I would have to say, probably 90 percent of my prescriptions that come through to me now, I can see if the patient has had a prescription prescribed to them already.

And I would like to point out --

SENATOR KEMP HANNON: No, no, I'm just trying to see is, what -- what is it that you're seeking additional to what you're getting now?

JOANNE HOFFMAN BEECHKO, R.Ph.: The remaining -- the patients that come in, who are -- who are buying their prescriptions with cash, those -- that's the only information right now that I don't have.

But, the information is available to the State. Every prescription, because of the coding on the bottom, that data goes through to the State.

SENATOR KEMP HANNON: For a controlled

substance?

JOANNE HOFFMAN BEECHKO, R.Ph.: For a controlled substance, yes.

So, what currently happens now is, once a month, pharmacies are required by law to submit that data to the State.

The State then -- I don't know, honestly, what the State does with that data, but the data is there.

And, so, that all -- all of the prescriptions, any controlled substance prescription, that has been prescribed, and dispensed, that data is available, monthly, to the State.

DAHLIA HELLER: Can I just -- I'll just speak to that.

Yeah, the prescription drug monitoring program that's run by the State Health Department, Bureau of Narcotics Enforcement, actually does contain all of that information.

And the issue which was raised, I think by several people in their opening statements here, with respect to the threshold for information access on patients, is really the issue that a lot of providers face when they want to look up a

patient's medication history.

So, you can only get information now, on a patient's medication history.

I think somebody's already mentioned this, but just to remind everybody: For the past 30 days, if they've gone to two or more doctors, and had a medication -- controlled substance medication dispensed by two or more pharmacists.

So, that's a very high threshold, you can imagine.

And, if I go to one doctor, and five pharmacists, and pay cash, or -- or, the pharmacist is not using the claims database, really, to look at my history, and have that conversation, either, with the prescriber, or with the patient right there, or both, then you won't be able to see my history, and you won't know.

And I think, really, if we move upstream a little bit, into, what's the source of the medications?

Because, I think -- and what's -- what are the structural -- what's the structural environment influencing how doctors prescribe, I think we can, maybe, make a little bit more of a dent in the problem, because I think this whole problem is, that

the drug-seeking patient -- I think it's been mentioned here -- represents a very small proportion of the group of people who are adversely affected by opioid prescribing in this society.

Right?

Opioid prescribing has become very common.

As Dr. Kolodny showed us, the graphs, we've had this enormous increase in prescriptions going out. And those weren't drug-seeking patients necessarily. I think those were folks who were getting prescribed legitimately by their provider.

So, if we made data more accessible, more timely, in the prescription drug monitoring program. And, I think that's been raised here several times.

There's a bill the Attorney General's Office has introduced, that would actually create a brand new system, that would be immediate.

But, in the absence of that, our existing program can actually be tweaked to do some of this; to make data available soon after it's been prescribed. Much sooner than now. It could be up to a 45-day time lag.

And to make information available on all

controlled substances prescribed to a patient, regardless of, whether, or how many providers, or pharmacists, they visited, to access or receive prescriptions in the past, whatever time period.

So, those are all opportunities for improving existing systems that are at our fingertips, really.

And I know we've been talking to the State Health Department about that, and I think it's something we've heard around this table, it would really change the environment.

SENATOR KEMP HANNON: I've skipped over, but I have to make a comment, that, all of the electronic systems in this nation, starting from, prior to healthcare reform, under -- and then accelerated under the Stimulus Act with billions of dollars of money, for electronic health records, for regional health-exchange information, the State of New York, starting with Eliot Spitzer, had a technology chief in the Health Department, who's been succeeded by someone else right now, Commissioner Block.

So, they're moving, in a major way, for electronic health records, what you're finding.

And, then, the State itself has had several

revisions, and things going on, in regard to E-MEDNY, and trying to coordinate it, because the City of New York has a very sophisticated system.

So, they're in the -- there's -- in the middle of all of this, there's a lot of information.

And the question is, I think, as Ms. Beechko pointed out today, is, how do you best use it, and find gaps that are not being addressed?

And maybe the best way to do is, to address those gaps first.

But, this is an enormously instructive discussion.

BRIDGETTE BRENNAN: Yeah, I might just point out, that, in the cases that we've seen, the patients tend to use cash insurance and Medicaid, the ones who are drug-seeking patients, they're trying to get their drugs.

And, so, that would avoid the detection by either Medicaid or the insurer, when they keep bouncing around for different -- you know, using different methods of payment.

SENATOR KEMP HANNON: Those would tend to be the people who are addicted?

BRIDGETTE BRENNAN: Yes -- well -- yeah.

Or --

SENATOR KEMP HANNON: And then there's -- would there be another pattern for people who are doing this for profit?

BRIDGETTE BRENNAN: See, the ones who are addicted or the ones who are doing it for profit would use the same mechanisms.

Because, the ones who are doing it for profit -- in Staten Island, in that case, all the people who were using the prescriptions, almost all used cash, because, they could pay $200 for a prescription for OxyContin.

Get 30 pills. Each pill, they might sell for $20. So, they make a nice profit on it.

Now, if you can use insurance, you'll make an even bigger profit on it, see, because then you pay, you know, dollars for the prescription, and your profit is still the same.

Same thing for Medicaid.

And, so, these organizations, just depends on what they can get away with. It's --

SENATOR JEFFREY KLEIN: It also appears to be that, Medicaid is looking for Medicaid fraud, and the insurance industry is looking for insurance fraud. And, the cash payment, also, isn't being tracked.

BRIDGETTE BRENNAN: Right. Cash is -- if they're really trying to skate under the radar, then they use cash.

However, especially if you see really highly organized groups that are just trying to maximize profit, then you'll see them using more insurance or Medicaid.

You see a nice industry, a nice corrupt industry, where they'll use Medicaid dollars to buy the pills, sell the pills back to an unscrupulous pharmacy, which will then sell the pills again for Medicaid -- you know, bill Medicaid again for the same pills.

So, there are just a lot of different variations on the same theme.

SENATOR JEFFREY KLEIN: Thank you so much.

SENATOR KEMP HANNON: All right, we've jumped all around.

Senator Marcellino.

SENATOR CARL MARCELLINO: I'm sorry.

You're raising an issue here of, people paying cash, beating the system, in that sense, because it's not in the prescription scheme, but, that goes to the point of the pharmacist.

Is there a control, as to the amount of --

pick a drug -- that you have? Do you have to report, I've got so many pills of OxyContin, so many numbers of pills of this drug, X drug, Y drug; do you have to make a report?

And I've dispensed so many of them, via prescription, or cash.

I'm assuming, you're not going sell a controlled drug without a prescription, so there has to be a prescription, cash or not.

So, is there any control as to the number of pills that, you, the druggist, has to dispense?

JOANNE HOFFMAN BEECHKO, R.Ph.: There is no report that we're required to, except for the fact that you have to keep in mind, that every single prescription, that, for a controlled substance, that data does go through to the State.

So, the State has information on every controlled substance that is prescribed, dispensed, and where it's being dispensed, and who the patients are.

So, in essence, yes, we already are reporting all of that information.

SENATOR CARL MARCELLINO: See, I recently had to go -- I went on this trip to -- where I met the New Jersey Inspector General.

And, I went to the doctor, and I needed my prescriptions filled for the drugs that I take.

The pharmacist filled one of the two.

I said, "Why didn't I get the second?"

"You're not due yet. The insurance company will not pay. It's another week before we can fill this prescription."

I said, "But I'm traveling."

"Doesn't matter. You got to call, get permission."

A week later -- I had enough. But a week later, I got a call from the drug store: Your prescription is here. We'll hold it for another couple of days, because the time had passed. Another couple of days, for you to come pick it up.

So, they kept it. They kept the prescription, and filled it afterwards.

So, my point is, the information, apparently, is available, that we're all looking for.

JOANNE HOFFMAN BEECHKO, R.Ph.: Uh-huh.

SENATOR CARL MARCELLINO: You're saying the State has it all already.

It's a matter of, putting it all together?

DR. ANDREW KOLODNY: Not really.

The patient you described --

SENATOR CARL MARCELLINO: I thought it was going to real simple.

DR. ANDREW KOLODNY: -- no, the patient is a doctor-shopper, whether they're doctor-shopping because they're suffering from addiction; or whether, because they're selling the pills. Or, very often it's both.

They know very well, that if they try to use their insurance twice in a month, to pick up a prescription, that it's going to get stopped, and that somebody may even call the doctor who wrote the prescription.

So, they may fill the first prescription with an insurance plan, and then they'll pay cash for the other prescriptions.

The State has the data.

If the data was available to the pharmacist before the pharmacist filled the prescription, the pharmacist would know immediately, that this is a patient who's been to five different doctors, and you could stop it right there.

Or, if the doctors had that information available to them.

BRIDGETTE BRENNAN: Yeah, a little caveat on that.

I think the pharmacies have to fill out the information, not simultaneously, but by the end of the month.

JOANNE HOFFMAN BEECHKO, R.Ph.: By the 15th.

BRIDGETTE BRENNAN: Okay, by the 15th.

And, again, those people who are involved in these diversion rings know what the reporting requirements are.

The big chains tend to fill it out simultaneously.

The smaller pharmacies tend not to, and that's where we see, either the doctors -- you know, the addicts or the diversion rings hit up the mom-and-pop pharmacies a lot.

They know the tricks.

JOANNE HOFFMAN BEECHKO, R.Ph.: One thing that you didn't --

PAUL MAHONEY: Fundamentally --

JOANNE HOFFMAN BEECHKO, R.Ph.: -- oh.

PAUL MAHONEY: [inaudible.]

So, the prescription, it's recording, not the presentation of a prescription, but the dispensing of the prescription. So, by the time the data hits the existing database, the drugs are already out on the street.

SENATOR KEMP HANNON: This is the database that's in the Department of Health?

PAUL MAHONEY: That's correct.

SENATOR KEMP HANNON: And, then, do you have real-time access to that?

PAUL MAHONEY: No, we do not.

SENATOR KEMP HANNON: Does the Office of Medicaid Inspector General have real-time access to that?

PAUL MAHONEY: I believe not.

I believe that every law enforcement agency has to make a request of some sort to the Bureau of Narcotics Enforcement in order to comply with the restrictions on data confidentiality.

So, without going too deeply into the law enforcement aspects, we can request, or, in some cases subpoena, a report, but, it's historical data at the time we do it.

SENATOR KEMP HANNON: Is that what you're reporting to; you're reporting it to the DOH, Department of the -- Bureau of Narcotics?

JOANNE HOFFMAN BEECHKO, R.Ph.: Correct.

ANDY FOGARTY: If I may, I also understand, that --

SENATOR KEMP HANNON: Mr. Fogarty.

ANDY FOGARTY: -- I also understand, there's a month lag in your reporting.

So, you report once a month, so that's not exactly current data upon which the State has.

They may have all the data, but it's not current because it's reported once a month by the pharmacies.

And, also, one of the things I think that's important to note on, that's missed in that data collection, is the formulations of the drugs.

That, you may be taking one form of a drug, but you can take, like, you know, one version of an opiate, and then there's another opiate with a little bit of Tylenol in it, so it's a different drug.

So, it's one of those things, you maybe have the -- sort of the chemical formula be slightly different, so that you're still getting an opiate, but, it's -- you know, when you look at what scripts are being filled, are two different drugs.

SENATOR CARL MARCELLINO: But the information reported has, the drug, whichever; the doctor who prescribed it, and the person who claimed it?

ANDY FOGARTY: Correct.

SENATOR CARL MARCELLINO: Okay, so you've got

all the information, which is what was said before.

ANDY FOGARTY: Yeah.

SENATOR CARL MARCELLINO: You got all the information, someplace.

And I frankly don't care if it's historical because, eventually, you'll be able to track, that, John Jones has picked up all of these prescriptions, and you go chase John Jones.

ANDY FOGARTY: No, absolutely, the State does have the data. It's just a question of, how quickly.

You know, like I said, if you're looking for real-time, you know, that's where --

SENATOR CARL MARCELLINO: There's real-time, and there's real-time.

PAUL MAHONEY: Senator Marcellino, not to interrupt, but can I give one illustration, of: It's a question of degree, but, the question of degree and timing is very significant, especially for prosecution purposes.

Earlier, Ms. Brennan mentioned the Chait case, and we can use that one because it's fully public.

Dr. Chait was prosecuted, served three years.

Under what is essentially the existing system, he was, nonetheless, able to write, have filled -- we don't even know how many he actually penned -- but, he was able to have filled, 490 controlled substances in a 3-month period.

Total billings to all insurers, and traceable cash, were about $900,000-and-change, just shy of a million dollars. And, some 400 patients were affected.

And, he was reported, he was picked up, but not -- by the existing system, and variations on it, in the sense that, he was so flagrant, that he raised red flags. But, nonetheless, he -- to get a proveable case against him required very sophisticated undercover tactics. The same sort of undercovers that you would send in for a drug -- a classic drug raid, because, at the end of the day, we had to be able to show, through the investigative techniques of several offices, that this fellow was writing the scripts regardless of what the patient was saying to him.

That, the investigators had to come in, and say: I need OxyContin because I have a really bad hangnail.

And, then, a little bit facetiously: Okay,

do you want 30-days or 60-days supply?

He was actually much more leery than that. And, it was a much more sophisticated case.

Yes, the data was there, but the intent was not clear from the data. It still had to go back to traditional law enforcement techniques.

SENATOR JEFFREY KLEIN: So, in other words: It's enough for a doctor to ask the question, you know, "What hurts?"

Touch someone's knee, and say, "Yeah, it hurts there"; and, they can write a prescription?

PAUL MAHONEY: The standard is not much higher than that.

SENATOR KEMP HANNON: I want to jump ahead, since we smashed protocol here.

Dr. Kolodny, the question is: What are you doing now?

Not so much in the sense we've been talking about, but, you know, heading the Department of Psychiatry at Maimonides, you're trying to deal with the other doctors. Dealing with the doctors in the ER, who are being, probably gamed, if people come in to doctor-shop.

And then, also, just, how do they deal in a regular course of treating people who have chronic

pain?

DR. ANDREW KOLODNY: I'll tell you about one of the things we tried to do, that didn't work, and I'll tell you why.

But, psychiatrists don't generally prescribe opioids for the treatment of pain, but we do prescribe benzodiazepines for anxiety. Hopefully, less often, Xanax, which is more abusable than some of the other.

But, we had -- in our clinic, which serves about 1,200, in the course of a few months, we had a few of our patients die of -- were dead. And, we had to do an investigation, because our clinic is licensed by Office of Mental Health. Every time one of our clinic patients dies, whether it's for a natural cause or not, we have to take a close look.

So, we had four deaths of patients in our clinic. We took a close look.

And, all four of those patients, within a short period of time, were patients who are were getting benzodiazepine prescriptions from our psychiatrists, and they were getting opioid prescriptions prescribed elsewhere.

And, as Dahlia mentioned, when she meant "benzodiazepine," the two together are a very

dangerous combination.

So, you know, as we investigated this, it seemed to me, that we should take advantage of the State's new health commerce program, where you can go in and take a look at a patient's prescription record.

And my intent, at the time, was to have a policy for our department: Before any psychiatrist is going to write a benzodiazepine prescription, they have to make sure the patient isn't on an opioid. They have to go in and check that database.

So, I picked out, to just test out the system, a patient who was in our clinic, who I knew from our own electronic records system, that the patient was on both an opioid and a benzodiazepine.

I typed their name into the system. No information came back, because this was a patient who did not fit the current definition, which, as Dahlia mentioned, is -- the patient has to be filling controlled substances from two or more physicians, at two or more pharmacies.

So, if the patient is getting all of their medications from one pharmacy, you get no information back. Or, if they're going to different pharmacies, but they're getting all of their

prescriptions from the same doctor, you get no information back.

So, in effect, the system that we have, it was useless for our purposes.

In terms of things that my organization, Physician for Responsible Opioid Prescribing, is doing, many of us are on the front line of this problem in different parts of the country.

Some are working in public health departments. Many are working with State legislatures, like -- like I'm here today.

And, some states have come up, like Washington State, with very effective legislation to help this problem; for example, dosing limits.

One of the issues that's really a problem here is, high-dose prescribing of opioids.

So, you've got patients who don't have -- or, individuals who don't have to go to four or five different doctors. You hit the right doctor who's giving you whatever you want, enormous supplies of opioids, and that's what we would call "high-dose prescribing."

And, in many cases, there are patients taking all of those opioids. And they're at a very high risk of an overdose death, and they're

getting other side effects.

But, many of these individuals are diverting, and there is no way for a physician to know if their patient is diverting.

Very often, the patient --

SENATOR KEMP HANNON: What's "diverting"?

DR. ANDREW KOLODNY: "Diverting" means, somebody who's coming in, getting a prescription, and selling it.

And, if you look at the value of these medications, a 40-milligram OxyContin is $40.

If you're getting 320 pills a month, you can support a family on that prescription.

There's no way for a doctor to know.

If the patient is really clever, they'll take a little bit of the medication before they come in, and the doctor would see it on a urine test and it looks like the patient is taking it.

But, very few doctors are doing any urine toxicology.

Anyway, the high-dose prescribing is something that's very harmful to patients. And, it leads to a tremendous amount of diversion.

It's one of the standards of care that could be potentially legislated that could help this

problem.

Other things that our organization is doing, is advocacy, on the federal level, for a rescheduling of hydrocodone.

New York State's Controlled Substance Act, with regard to scheduling of drugs, in many ways, is almost a copy-and-paste from the federal Controlled Substances Act.

DEA asked FDA to reschedule hydrocodone several years ago, from a III, to a II.

The FDA has been sitting on this for years.

This is something New York State could do. The states are allowed to be more respective.

SENATOR KEMP HANNON: And we've actually -- we're actively looking into rescheduling it. And, then, looking at any of the trade name drugs that will use it, because it's all -- it's just not a one-to-one type of thing. And, then, looking at any of the other variations that are being -- being mentioned as being misused, including, then, when Ms. Brennan mentioned about one of the drugs, that is Xantax [ph.] --

BRIDGETTE BRENNAN: "Xanax."

SENATOR KEMP HANNON: -- Xanax --

BRIDGETTE BRENNAN: We don't have

jurisdiction.

SENATOR KEMP HANNON: -- you don't have jurisdiction.

So there's questions of: What's the most appropriate thing to do in terms of scheduling?

But, you know -- and this, obviously, from what you said, it's part of one of the approaches to the problem.

DR. ANDREW KOLODNY: Right.

And then, the last thing, and the main thing, that our group is doing, is trying to provide physicians and prescribers with better information.

We've talked quite a bit this morning about that third prong, and black-market availability, and doctors who are really no better than drug dealers.

But a bigger problem here, if we want to prevent new people from getting addicted, are the well-meaning physicians who are overprescribing because they think that's the proper way to practice.

They've been given bad information. Much of their education comes from companies that want them to prescribe more.

And we're trying to counter that.

SENATOR KEMP HANNON: Have you involved yourself with the fact that, about three years ago, the State of New York introduced its own counter to pharmaceutical detailing, which is the selling of drugs by the pharmacies, so that counter-information would be brought by a not-for-profit objective group to physicians?

DR. ANDREW KOLODNY: I wasn't aware of that.

That sounds very promising.

SENATOR KEMP HANNON: I mean, that's along with, many of the universities, many of the medical centers, many of the large group practices, saying, that, they're going to have a whole way of acquiring information about drugs that is different than allowing someone to go in and buy a pizza for lunch, and making a pitch. They want to do it in a more systematic, regulated way.

DR. ANDREW KOLODNY: Certainly, my organization would be happy to get involved with that.

SENATOR KEMP HANNON: Well, absolutely.

Now, I have a question for you, and to Dr. Dowling, is: How do you change the patient -- the physician behavior here, without either

overdoing it or burdening them with?

I don't know many physicians who tell me that they have a spare time during the course of a day.

DR. FRANK DOWLING: That's a great question.

And, actually, if you don't mind, I wanted to summarize some of the things that the Medical Society has been doing, in partnership with "ASAM"; American Society of Addiction Medicine.

SENATOR KEMP HANNON: As long as you respond to my question.

DR. FRANK DOWLING: I'm sorry?

SENATOR KEMP HANNON: As long as you respond to my question.

DR. FRANK DOWLING: I will. I definitely will, because I think it touches on that question; it's all around that same question.

One of the things that's important to keep in mind is, that doctor, who is basically part of a scheme to illegally sell drugs, is a small number, a small percentage of doctors, but they give all doctors a black eye.

We certainly want to go after that doctor.

I think Dr. Kolodny is correct, that there are many well-intended physicians who, one, aren't

getting accurate information from patients; or, two, may not be able to tell, really, what's the limit.

Do you really need this med, at this dose, and this number of tablets? Or is it double that?

And these are very difficult clinical decisions to make.

I don't know if everyone in this room is aware, that, in every hospital in the state of New York, every day, if not every shift, a healthcare worker asks someone about their pain symptoms, and rating it, and to show that it's addressed.

That's how far it is on the other side; that doctors are being disciplined, and being sued, for undermedicating pain, while on the other hand, trying not to overmedicate or miss.

So, with that information, with what we've been talking with the Department of Health, with OASAS, with Office of Mental Health, is, is we have been requesting that the database threshold be, any and all information.

What will it take for the database to do that?

Can a staff member from my office, who's been

trained by me, and understands privacy regulations, pull up all the information on people I'm going to see today? -- because I may not have time to do that on everyone? And so on.

Can information be shared with pharmacies? And so on.

Can they have access to the same data?

It's very difficult.

We've also partnered with the Department of Health in many ways, over the years, to educate physicians in challenging areas.

And this is one area where we've had conversations with the Department of Health and OASAS.

So, we would like to partner with educating in this area.

But, we've also asked that the Department of Health really work hard to educate patients in this area.

The physician-patient relationship is so important. And it's very difficult for a physician to ask a patient, how you're doing this, why you're doing it, where you're doing, and it not be seen as someone who is challenging them and critical of them.

And, yet, we do need to do that in a delicate way. It takes a lot of special training to be able to do that.

Many psychiatrists have the skills. Quite, frankly, some psychiatrists don't.

But, for a general practitioner, the non-addiction and non-psychiatric specialists, it's even more challenging to be able to do that balancing act.

But, patients just don't know that it's illegal. And for some privacy reasons, stigma reasons, they're often uncomfortable even saying that they're seeing a guy like me, even if they're not on a controlled drug, let alone if they are, because they're afraid they'll be treated differently. And sometimes they are treated differently.

So, we've really asked for education of patients on the law, and also on open communications with their doctor.

And that needs to come from physicians, but also from outside of physicians' offices, because we can't be seen as, physician and law enforcement, at the same time. It just doesn't work.

So, I hope that does answer your question.

It's a tough decision, clinically, with every individual patient. And patients and physicians both need to be educated on these issues.

SENATOR KEMP HANNON: But to the extent we address the problem, and it needs to be addressed, to what extent do you then deter doctors from an appropriate prescription of medicine?

DR. FRANK DOWLING: Well, that's -- if that's the specific question, that's where we would recommend, at this point: Let's look at what we have, and have voluntary looking at the database, but the threshold be any prescriptions.

Because, if we go the other way, with mandatory looking and mandatory reporting, and go too strong the other way, patients will be even more afraid to discuss prescriptions they're getting. Patients, particularly with chronic pain, and addiction problems, will be afraid to discuss these issues.

And -- and that's where there's a risk on the other side of this.

One of the things about diversion; yes, diversion is, certainly, when I get 120 tablets of a prescription, I use 60, and I sell 60, or I share

them with someone else for other drugs.

That's, certainly, is an example of diversion.

But, if someone is in substance abuse treatment, and being prescribed a controlled drug, even Suboxone, which is a good example of a drug that has a double-edged sword, it can be lifesaving, family-saving, career-saving; or, it could be exactly the opposite.

Well, if I'm treating someone with addiction to opiates, and I give them Suboxone, for example, if they come in, and they admit that they shared a couple of pills with a friend, or even half that prescription, that's diversion.

And they need to be able to do that, openly discussing that with me. And I need to be in a position of discussing that in treatment, and maybe upping the level of care, the intensity of care, and what we do, but not necessarily have to report them to the State of New York, because, even if it's promised that that information is kept private, the perception among patients may be, that it isn't, and that they're going to face consequences.

And I don't know where you draw the line. It's very difficult, that, where does diversion

become, now it must be reported to law enforcement, and where doesn't it.

SENATOR KEMP HANNON: Well, let me -- Suboxone is the trade name for -- I'm going to mispronounce it --

DR. ANDREW KOLODNY: Buprenorphine.

SENATOR KEMP HANNON: -- buprenorphine.

And that's supposed to be the anecdote to opiate addiction.

SENATOR CARL MARCELLINO: "Antidote."

SENATOR KEMP HANNON: Antidote?

SENATOR CARL MARCELLINO: You said "anecdote."

SENATOR KEMP HANNON: Antidote. "Antidote."

My problem is, you mentioned that people might misuse it, and share, Suboxone, buprenorphine, with somebody else.

Is it also addictive itself, or is it truly a counteragent to opioids?

DR. FRANK DOWLING: That's a great question.

It is an addicting drug. No doubt about.

And it can be used properly, and help someone move away from other addicting opiates.

And then, in my view, most often, when they're ready, gradually come off the medication.

Addictionologists who I have spoken to, have said to me, there is a subset of people who may need to be on this for a longer period of time, just the office-based analogy of methadone maintenance.

But, it can be abused.

Almost any drug that can be used to treat addiction, that's a controlled drug, can also be abused.

DR. ANDREW KOLODNY: If I could, I have -- I sort of agree, just a slightly different view of it.

Buprenorphine is an opioid, like the other opioids, but it acts differently. It's what we would call, a "partial agonist."

So, unlike the other opioids, it's very difficult for someone to overdose on it.

And for people who are opioid-addicted, when they take buprenorphine, it doesn't produce a euphoria.

There is diversion of it. There are people who will trade their buprenorphine to get other drugs, or sell their buprenorphine. It has a street value.

It does appear that, much of the street use, are people who are opioid-addicted, who are using itself self-therapeutically in some ways.

But, it's still a serious issue.

Just to briefly answer your first question: How do we give the right message to docs, but not wind up with physicians undertreating pain? -- and I think the first rule for physicians, with any kind of treatment, whether it's a medication or a procedure, is, first, "Do No Harm."

And that forces physicians to weigh the risks and benefits when they're deciding on a course of treatment.

When it comes to the treatment of chronic pain with opioids, you have very significant risks. And the best evidence, is that long-term patients don't benefit.

So, if physicians had proper education about how to do that risk-benefit analysis, they would prescribe much less frequently.

When they had someone with severe intractable pain, who had tried other remedies, they might say, in that case, maybe the benefit -- the potential benefit for this patient outweighs the risk. But, right now, they don't have the proper information.

They've been given information, that the medicines are more effective than they are, and they've been given information that they're less

risky, so, they don't make the proper risk-benefit analysis.

SENATOR KEMP HANNON: One totally different topic, back to Mr. Dowling, though: You talked about a database doctors can now access personally, about the prescription history of one of their patients.

To what extent has that been a positive? To what extent does it need tweaking?

DR. FRANK DOWLING: That's a great question, as far as the database.

My understanding, from conversations with the Department of Health and OASAS, is that the database, overall, is likely underused. And that's for a variety of reasons.

One is, it is a slow, clumsy system. And, physicians find it challenging, just to stay updated in the health commerce account, if they don't in the natural course of their practice, just to keep using it on a regular basis.

Then, from that health commerce account, if they want to look up an individual patient, you've heard about the threshold, two or more prescriptions from two or more physicians, filled at two or more pharmacies.

And if someone meets that threshold -- yes, yes, yes -- then information is given; however, it's only information that's limited to the last couple of months or so, so it doesn't even go back a year or two. And, yet, the information in there could be, say, 30 days behind, depending on when pharmacists enter the information.

And, then, I don't know what Department of Health does; if there's anything they do to clean up the information.

And I don't mean that to criticize pharmacists at all. They're asked to make sure this data is updated by the end of the month, or the 15th of the month.

So, if I come in on, the 16th, 17th, it was updated on the 15th, it's pretty accurate.

If I come in on the 13th, it may not be.

So what happens is, if you try this, and the yield, the likelihood of getting positive information, is so small, after you've jumped through all of these hoops and time.

And imagine a primary-care doctor, in a rural county in Upstate New York, where they're treating chronic pain, they're treating addiction, they're treating depression and anxiety, because there

aren't enough specialists to do this, seeing 40 people a day. And they're challenged to look at this database 15 times out of 40 people, which probably isn't an unrealistic number, and the yield is always nothing, nothing, nothing.

If you were seen in the emergency room last night -- or, say, a week ago -- there's got to be some reasonable lag -- and you were given Valium for severe anxiety, and then referred to my practice, and I'm seeing you a week later, and I look you up in the database, I'm not going get anything.

You know, it -- so those things have to really be improved, and then physicians would likely use it more.

And the other part I mentioned earlier, in opening comments, about, if a designated staff person can look this up.

Imagine a surgery center. You just finished surgery. The surgeon is going on to the next case, but they've got to stop and look you up in a database.

Imagine a walk-in center, an urgent-care center, an emergency room, and the physician has to look someone up, each and every time, and trying to get information, yet, how positively that

information could be used, to find out someone just we want to three different emergency rooms or four different pharmacies in the last month, and change the conversation, if a staff person can look up that information.

SENATOR KEMP HANNON: Okay.

JOANNE HOFFMAN BEECHKO, R.Ph.: If I might extend this conversation to computers and software, there are, probably, 80 different physician systems out there that's electronically send.

I don't know how many different pharmacy systems there are.

I would suggest that, that we extend this out to the software community, for this particular instance of information. Because, if you look at the Medicaid system, I get back a response from Medicaid that shows me, any number -- although it's not as much information as I would like -- several different medications that a patient may be on, several different doctors. It doesn't give me specifics, but it will say, you know, you are -- that this drug is conflicting with another drug of a same type, dispensed by another doctor, at a different pharmacy, one, two, three, four.

So, I can immediately see.

So, I would suggest that the BNE, that this particular program consult the software with the Medicaid program, and see, what are we missing here?

There are programs out there that are capturing and providing information.

SENATOR KEMP HANNON: Were that it was that easy.

[Laughter.]

SENATOR KEMP HANNON: There is, right now, an RFP for the Medicaid system, out, that the RFP alone, took out 1,300 pages.

And so, there's, that.

There's a healthcare exchange.

There's the State Information Network for New York, called "SINNY," (ph.)

So there's -- many of those things are going on. And the question is, trying to take what is available now to address a problem now.

And, so, some of what you've said before is enormously valuable.

This is the -- that was the granular thing.

I said there would be another part, which is your recommendations.

So, we'll call this "the closing roundtable."

And since there's no intellectual barriers

to wandering into any other topic, that's okay, but let's just go around, and ask the recommendations, from what you've heard, from what you came here with, from what you haven't said. And, we'll see if we can do this in a reasonable order.

And just because I was -- we started, here, and everybody jumped in, we'll start, over here.

Greg, you can start.

We already know your bill, but you can talk more.

GREGORY KRACKOWER: Well, thank you, Senator.

And, again, this has been very edifying, and funny.

We are reaching out too. We are in the process of discussing with software vendors, to both, cost, and analyze what the ultimate system is.

One benefit of a government system set up in a universal to, catch all, or catch most -- theres no such thing as a catch-all system; right?

There's a catch-most system, and if you take away a functionality, you catch less, is that, it becomes a standard by which vendors can, over time, and stakeholders, over time, you know, log in to connect with. They know what's out there. It's not the -- to analogize 50 different systems.

If there's one system that was designed, and continually improved, to deal with this system, that becomes a standard technology. And, presumably, that RFP would allow many act sets.

It is important to note, that not every physician has Internet access in this state, particularly in the Southern and Western Tier.

The Department of Health, Mr. Clancy, is laughing, because we recently discussed this.

And that, pharmacists' system, some are legacy systems. And, not all pharmacists are chains.

And that all has to be addressed, both in -- that's one reason why, you know, the RFPs are long.

But, technologically, you know, this is not a leap into the future. This is something that the other states all clearly think -- I mean, no one thinks of Oklahoma as a leader in technology; but, yet, they're moving toward something, like what the Attorney General of New York,
Attorney General Simon, has produced.

So, this is within the -- well within the ballpark of modern technology.

A couple of points on suggestions.

Absolutely --

SENATOR CARL MARCELLINO: Before we move on, does that bill that you proposed does that have a number?

SENATOR KEMP HANNON: I think Senator Lanza has --

GREGORY KRACKOWER: Yes. It's, Senator Lanza, and it's Representative Cusick.

SENATOR KEMP HANNON: 5720.

GREGORY KRACKOWER: 5720.

And we're also working with Representative Gottfried.

And, if I didn't thank those three earlier, as they're -- you know, all thanked, by the AG.

The -- so -- sorry.

So, the couple of things to think about, is, education. Education is critically important.

There is an education component in the Attorney General's legislation.

Educating providers, educating pharmacists, educating health insurance providers, that has to be part of any system.

Education of, how to use. And education for the diagnostic function of such a system.

Right?

Someone says, Well, how do you make, you

know, doctors change their prescribing, if you believe, as many do, that they're overprescribing?

Well, that's tough to do in a law. It's tough to do as a healthcare guideline.

One thing you can do, though, is say: Well, here's the information you have. So, when you're making your decision, you have more information on prescription drug history, that a patient doesn't have that exact narcotic, but something similar.

You can also, with a database, use it for an immense research tool when it's something like all-encompassing.

You could have, you know, we could call it: computer versions of yellow flags.

That person who walks into the office --

SENATOR KEMP HANNON: I have to tell you, because it's only due consideration to the current new health commissioner of the state, who recommended that the State embark on getting an "all provider/payer" database.

And, so, work at -- it was in the budget, and work has begun. And it's really, ongoing, in a very intensive way, so that, down the road, his goal was, that we would have exactly that.

So -- it's in progress.

GREGORY KRACKOWER: Right, no, that's absolutely correct.

And, in fact, things like this roundtable is part of the progress of designing whatever we're going to design.

And, so -- I mean, you know, Senator Hannon, Senator Klein, you know, this is part of that leadership effort. And the Department of Health has been part of the leadership effort. And, you know, the AG is -- is -- is entering -- you know, is -- is entering, in the role of the law enforcement.

There were two bullet points in that wonderful slide. We're not even addressing those two -- potentially, not the function of the Office of Attorney General -- there's also a Medicaid component, and a billing.

And OMEG has been -- you know, we have one of the most effective Medicaid fraud units in the country.

So, we're all sort of doing our part. And this is encouraging.

You know, we don't think this is anything radical, or anything anyone's going beyond. In fact, this is a team effort, involving, not only the states, but also the localites.

New York City system and New York City's, I think, nationwide, leading prosecution teams -- one of them -- is on this. And it is.

And it is.

That's what other folks talk about, is: How can we be more like New York City?

And California is saying: How can we be more like Oklahoma?

And California just updated their system. Something called the "CURE" system out there.

So, this is not only happening with leadership all over the state, but all over the nation. And, we just doesn't don't want to fall behind.

But, the education component is critical, just to go over my point.

And, also, the -- you know, having inputs and having, uhm -- you know, when you have a database, when you have any database, you can see trends, yet you know, we can't target doctors, simply because they write, has been said before, high numbers of narcotics, because they're patient-based, and their practice might involve with that.

But, once you have a more universal sense,

and more robust data sense, you know, you can do statistical regression, and start weeding out those things.

So, for doctors who have those things, you know, who's high and who's low, as a research thing, not as a law enforcement, to give flags for: Hey, you are on the upper end of a doctor with a particular practice.

You know, and these would be reports put out. And that is always been a teleological function of a database, as you learn more about what doctors in your state are doing --

"Doctors," as an aggregate, not individuals.

-- what doctors are in the western tier.

I mean, there are these cost studies involving the price of healthcare, that came up with the debate of the Patient Protection Act, about, prices of surgeries; the Mayo Clinic, versus Boston, versus New York.

And that is all available because of robust databases that health insurance companies have. And governments tend to sometimes follow, you know, the private sector.

And, so, that -- you know, there are benefits

into what everyone's talking about. And whatever degree, you know, everyone's comfortable with, that -- that we can catch.

And, I -- again, I think this is all what we must remember: This is all not a catch-all system. There is no catch-all system.

Right?

But, if New York State does things, we'll catch, we think, a lot more than now.

PAUL MAHONEY: Thank you, Senator.

I think, the only thing to add to what Greg said, is that, the legislation that the Attorney General is proposing, does have these mandatory elements in it, because we've been considering, from a law enforcement perspective, and a cost-control perspective, for a long time, that the bad guys, the hypothetical one-half of one percent of people in any one of the professions involved, who won't participate voluntarily, nonetheless, if they're not mandated, will have the exact same protections as to intent that the completely bona fide practitioners have.

If they have the option to retain the current commoditization of a prescription, that cloaks the transaction with a veneer of legitimacy, the

bad-faith practitioner being able to say, "Who do you believe, me, the doctor, or the lying addict, drug-diverting person?" that prosecution is always going to be impaired.

The point of the legislation tries to balance some of those elements, tries to find a few abilities.

For example: This legislation has a provision, that, an agent of the doctor, a bona fide agent of the doctor, can do the data entry and retrieval.

And, so, that to bring these elements into balance, to stop that prescription from getting out on the street, and having it as a valuable commodity in the first place, and doing it, getting these elements together close to simultaneously, rather than waiting for that next sea-change in prescribing, or the next sea-change in insurance.

I think if we proceed that way, the Dr. Chaits of the world will be diminished. And each one of those guys seemed to cost us at least a million dollars every time they crop up.

GREGORY KRACKOWER: And if I may, I just have one small point; the word "mandate" comes up.

You know, one thing we're very cognizant

about, as public policy-makers, as we said: Not every doctor has Internet access. Not every pharmacist is a chain, and some have legacy systems, and some are in very small rural communities in the Southern Tier, particularly the Western Tier as well.

One of the benefits, you know, I think of a "mandate" as a -- tends to be a bad word sometimes, but, if you had this system, and you didn't have, not only a goal, but an actual timeline of making it, you know, a universal access, with a mandate, the tort system will do it. And, that, no one wants.

No one wants a doctor who's a small practice, sued, because they don't have access to a new database that was just developed by the government. And, "Why don't you have access, when you prescribed my daughter a pill without checking this database?"

So, the mandate is --

SENATOR KEMP HANNON: Of all the things we have problems with, the tort systems, that's not one of them.

GREGORY KRACKOWER: But -- right, but we don't want to augment it.

Right.

But, you will [unintelligible] a system.

In fact, that's why, actually, Senator, just on a historical basis, from care: For anyone who has glasses -- and I've had glasses since 4th grade -- you get a glaucoma test.

I don't think they told you in law school, that was from a famous lawsuit. That, if you're going to fit someone with glasses, you know, you have the simple blow test. And if you don't do it, you're negligent.

If there is a system that enables someone to look up drugs, and some physicians don't have that, the tort system will attempt to address that.

I'm just saying, a why of goal of a mandate is less.

I'm not suggesting that that's one thing, but that's something to think about; is, if you have a system and some don't use it, and there's no government plan to help to assist to get there, that system does come into play.

And, something that you just need to think about.

I'm not saying that it's a conclusive argument, but that's something --

SENATOR KEMP HANNON: You don't want.

GREGORY KRACKOWER: -- we don't want.

Yeah.

PAUL MAHONEY: You're asking, at this point, for a proposed solution.

SENATOR KEMP HANNON: Proposed solutions. You may have addressed all of them, and you can just say: Well, I'll stick by everything I've said before.

That's okay.

PAUL MAHONEY: Several of the points I did make before, and I think that we need to continue those discussions, and go further.

We all know funding is very tight in this country, and in this state, but we need to find funding for more education of patients, coming from the state. And, physicians, coming from the Department of Health; partnering with physicians to do that.

And I'm glad that there's others in the room that we can also partner with, among physicians, to work on that.

MSSNY has been communicating with members, and educating members, regarding the database, and use of the database, through print and electronic

media.

And MSSNY has done some education of, not just members, all physicians, regarding pain management, and the legitimate way of prescribing pain medications, as well as cautions for misuse and diversion.

And, that's included some live CME, but also, CMECD, that went to some 10,000 physicians in New York State.

And things like that, you know, need to be ongoing, repeated, and updated.

And, you know, essentially, we are really glad to be here today. And we really support the intentions of the Attorney General's bill, and, the concerns that have been expressed.

And we really want to talk further with the Attorney General's Office, with the pharmacy association, with other interested parties, to come up with practical solutions to make change quickly.

I do want to finish, just by saying, that, if we could allow physicians to look up any patient if they feel there's a clinical need to do so, and find any prescription, controlled drug, that's been given, as far back as the database will go, and as recently as it can allow, and, we educate patients

of the legal need, and clinical need, to share that information with any potential prescriber, that we will reduce accidental opioid deaths, clinically significantly, and statistically significantly, within months.

And over the years, we'll reverse that trend; but, also, treat people with addictions earlier and earlier, when it's much more treatable.

SENATOR KEMP HANNON: David, you have been quiet.

DAVID VIZZINI: Well, I mean, I'm not a doctor, but it sounds like we do have our hands full with this issue.

And I guess my contribution would be, is that, you know, a lot of this committee was addressing it, from the top, down, with the doctors and the computer systems, and kind of stopping them from happening.

But, through a member of that, you know, treatment of the addict is also important, because, if we address, from the bottom, up, as well, and meet someplace in the middle, I think that we'll get to the solution of the problem a lot faster than just coming at it from one direction.

And I think that, in collaboration with the

doctors and pharmacists, like I said before, and the legal agencies, to get these addicted people referred to good-quality, comprehensive treatment services, you know, will definitely provide a great solution, you know, with everything else that's being done by this committee.

And I would say, you know, that would be the benefit to the addicted people who are suffering.

SENATOR JEFFREY KLEIN: I have a quick question, David.

Your clients are coming to you, and your clients could provide a lot of information on how they're getting such easy access to prescription drugs.

DAVID VIZZINI: Uh-huh.

SENATOR JEFFREY KLEIN: Does that come about a lot, with --

DAVID VIZZINI: Our clients, when they walk in the door, you know, they're not very quick to give us a lot of information, other than the general --

SENATOR JEFFREY KLEIN: But, you know, there's therapy that takes place --

DAVID VIZZINI: Yes.

SENATOR JEFFREY KLEIN: -- and there's other

things that take place.

DAVID VIZZINI: Yes.

They do. They give us information about what happens, and how they go about things.

Maybe they don't give us, so much specifics, with people, places, and things.

You know, I mean, we do have a duty to report, and we also have a duty to a confidentiality. But, you know, through the education of them, and trying to work with them through our therapies, to let them know that the behavior was wrong, and to learn a different way to coping with the issues which made them go and, you know, try to use the substances, is where we spend most of our time, focused on.

SENATOR KEMP HANNON: I mean, "duty to report"; this year, we passed a bill to -- what we call "Good Samaritan" bills, so people who had an overdose didn't feel they would be at risk of getting arrested if they turned themselves over to an emergency department; nor would their friends who brought them in.

So, there was this balancing. And, what an incredible, difficult way of trying to balance.

What do you find with your duty to report?

Is that -- does that deter people from coming for treatment? Do they have a feeling of confidentiality? Do they -- what's the --

What's happening on the ground, in the field?

DAVID VIZZINI: Well, what I would say is that, again, trust is number one priority in treating these people.

I think that, you know, we have a duty to warn, and we have a duty to, you know, protect, you know, other people, and the individuals, if they're going to harm themselves or harm somebody else.

But I think that it does -- people are not going to give you information up that they feel they could get themselves in trouble, or other people in trouble, so, it is difficult to come by.

But, we always try to tell them that it's in their best interest to be as open and honest in the whole process of their addiction, you know, not just their specific individual acts, you know, in order to try to help the larger problem.

And as they get further along in the treatment, I think they can get there. And I think that they become proactive on their owns, to solve the problems, and to reach out to the people, and

help other people as well as, if they have to turn people in, or do things like that.

I mean, those things do happen. I mean, not regularly, you know what I mean, but, those things do happen.

SENATOR KEMP HANNON: People who are on heroin, which is why, especially in the minority communities, people view anybody, now, getting into heroin is, like, crazy.

But, people in heroin have been able to maintain lives over 20 and 30 years, using methadone.

Is there -- what happens to somebody who's using opioids, after 10 years, or something like that?

DAVID VIZZINI: Well, I think that -- first of all, what I want to say about heroin, is, is that heroin is a lot more readily available, and a lot more popular than you may think.

I mean, there are -- heroin is probably the cheapest drug that you can buy today.

SENATOR KEMP HANNON: Oh, no, on Long Island, I have a feeling that someone's trying to flood the market, and all of that.

And I've talked at length with the detectives

in the Nassau County Police Force there.

No, I'm aware of how much it is.

But, I'm just looking, trying to focus on, the nature of the addiction to opioids, and figuring out what will happen to the individual.

Do you have a maintenance for them? Do they get -- you know, do they just age-out of using this as a drug? Do they eventually have a premature death?

DAVID VIZZINI: Well, I think that, you know, there are the medical treatments like, buprenorphine, Suboxone, which were mentioned, which helps the people. I think that that really works, with conjunction with treatment.

You know, you're not going to find somebody that's going to take a pill, to substitute another pill, to solve the problem. You do need treatment.

And, normally, through the therapies that treatment providers provide, like at Outreach, we provide behavioral and cognitive therapy with them. And through our program, which is, you know, in great detail, but, by going through the program, we're teaching them the things that they need to learn, to become better people, to become recovered in their addiction, and to learn how to maintain

long-term recovery, by, you know, taking care of themselves in better ways.

And that's what we try to do.

And we hope, through that method of, you know, getting them off all substance, and to maintain their lives, and be, you know, productive, off all substances.

But, if people need any type of medication, if it's, Suboxone, buprenorphine, if it's psychiatric medication for mental health issues, which normally go -- coincide with drug addiction, you know, and all those things, that we treat them on site for that.

So, I mean, there could be someone who comes in, and never taken a pill in their lives, other than from a drug dealer, but leaves on many different types of maintenance medications for their mental health, as well as for their addiction, but, it makes them better and successful in their lives.

So, whatever is necessary for that individual.

SENATOR KEMP HANNON: Thank you.

Andrew.

ANDY FOGARTY: I guess to use the adage,

information is power. And on the whole conversation that we've had today, I think we really touched on, that -- you know, we've really focused on data collection, and how that information is used.

I think it really comes to play that, you can collect all the data, you can have all the information, but if you don't use it appropriately, you're not going to achieve anything that you're, you know, desiring.

So, I think what we need to do is look at the data that is collected.

You know, as Senator Marcellino pointed out, you know, if we are collecting all this information on who's prescribing, who's it going to, and where are they getting it filled, you know, we can utilize that to now focus a little bit better, and provide the information to folks, whether, if it's the individual to get treatment, or the prescriber to, perhaps, educate them on their prescribing habits, or to put quantity limits in.

If a drug is -- you know, if you utilize something in excess, it's not good for you. So, why should we have -- you know, are you able to get a script for something that would be in a dosage that would be more harmful than beneficial.

So, you know, certainly that.

And from the pharmacy perspective, you know, give them the ability to access the data so that they can see, that, if this individual's, you know, got four different doctors prescribing the same drug, or if it's being filled at two other pharmacies.

You know, it's, again, we have this information; how is the best way to use it?

And I guess, you know, that's what makes the discussion, like today, you know, key to that point.

SENATOR KEMP HANNON: Okay.

Dr. Kolodny.

DR. ANDREW KOLODNY: Thank you.

I would agree with all of the recommendations that were mentioned previously, so I'm just going to mention a few that haven't been discussed, although I did mention earlier, rescheduling of hydrocodone.

Hydrocodone was scheduled by the Controlled Substances Act 40 years ago, and a mistake was made. The actual abuse liability of hydrocodone was not well understood, nor was its potency.

The Controlled Substances Act treats the

potency like it's six-times weaker than morphine. The potency is identical to morphine, taken orally, in hydrocodone.

So, hydrocodone needs to be rescheduled.

If we don't want our high schools, our college dorms, our medicine chests, flooded with opioids, it has to be put into the proper classification.

Doctors should not be allowed to write a prescription for hydrocodone with five refills. A drug that is as addictive as heroin should not -- you should not be able to write five refills on it.

To sort of answer a question you asked about the difference between heroin addiction and pain-pill addiction, it is the same addiction. Hydrocodone, oxycodone, and heroin are all the same drug.

People are not switching to heroin because it's got more of an effect or it's a better high. They switch because it's cheaper.

The effects from oxycodone and hydrocodone, the high, the euphoria, may actually be better with hydrocodone than oxycodone because they're designer versions of an opioid.

Another thing that was mentioned, we really do -- Dr. Dowling mentioned, we need useful prescription clinical data so that can guide a physician prescribing. They should be able to access the patient's records.

But, physicians really need to get a report back, or available to them, on a monthly basis, of what they've been prescribing.

If somebody takes a -- pulls a bunch of these prescriptions off of my pad -- I went to the bathroom, they pull these prescriptions off, I am not going to know.

If a monthly report was made available to me, and I see a bunch of names on it for patients who I've never seen, or I see changes or quantities or doses that I don't typically prescribe, something can be done about it. Otherwise, a doctor has no way of knowing.

This is something that would done pretty simply, and it doesn't have to be expensive.

And, then, lastly, we really do need to find a way to legislate a standard of care.

SENATOR KEMP HANNON: Nothing dealing with computers could be done simply and inexpensively.

DR. ANDREW KOLODNY: I hear you.

SENATOR KEMP HANNON: Rule One of budget-making.

DR. ANDREW KOLODNY: I hear you, but it is -- the tool is available to us. And not treating this problem is extraordinarily expensive.

Then, I guess the last thing I wanted to mention is, a need to legislate a standard of care. There should be some requirements.

If doctors are going to treat chronic pain with opioids, they should be required to do a random urine test, at least at some point.

That doesn't exist.

There should be some limits or recommendations on dosing so that physicians can't prescribe extraordinary quantities and doses to patients.

And, other key elements of standard of care need to be legislated.

SENATOR KEMP HANNON: Okay.

JOANNE HOFFMAN BEECHKO, R.Ph.: I agree with just about everything that people have been saying here.

The electronics are not up to par yet, and so we have to be very careful about putting into legislation things that are going to require us to

mandatorily review things, when all of our systems are not where they're supposed to be.

Better so, it should be made available. This information, we really need to focus on how to make this information available.

And I would say that, pharmacies, and pharmacists, would welcome increased knowledge and increased standards for the prescribing of controlled substances.

We're on the front lines every day. We are the last people. The prescription comes to my counter, and at that point in time, I have to determine whether or not I can dispense this medication, and whether this person is going to respond to my yes-or-no answer in an appropriate manner.

So, we welcome any kind of standards with regards to controlled substances, and enhanced knowledge, both on the pharmacists' and on the prescribers' side, so that understanding of addiction potential and pain management is better understood.

And the last thing that I would like to say also, is, if you look at these numbers here, with regards to admissions to hospitals, there is an

extraordinary number of patients that are between, 10 -- 12 years old and 22 years old, that are being admitted to hospitals.

And I would wonder, whether the management of these medications in the homes, is something that we really not have spoken of at all, except with regards to educating the public.

And, this has to become a part of the discussion, because, once the medication leaves the pharmacy, once it has been prescribed, we have no control over any of that at that point.

And if families don't realize that these are medications that need to be maintained in a safe environment, that the discussions have to be made with the children, with the relatives, with the brother-in-law, that these are not medications that can easily -- that should be taken, that that's -- everything is going to just fall off.

So, I would suggest that we look at that as well.

DAVID VIZZINI: I also agree with that, because, you know, when we do assessments on children between the ages of, 12, and 15, 16 years old, historically speaking, you would see tobacco, marijuana, alcohol, maybe, you know, here and there,

some different things, but, those were your primaries.

And over the last couple of years, we have been seeing a real spike in prescription pills. You know, everything from, the oxycodones to the Xanax and to -- you know, to anything and everything in the medicine cabinet.

And that's an excellent point, you know what I mean?

And, again, we're seeing that, you know, on the lines as well, on the other side. These young, young people coming in, and, you know, it's just as common as marijuana, as you're seeing, you know, a prescription pill that they took.

And I can tell you, like, I would say, at least 80 percent of the time, it's coming from a mom or grandma's medicine cabinet.

SENATOR KEMP HANNON: Mr. Doolin.

SEAN DOOLIN: Clearly, one of, if not the major, theme that's been repeated today, has been the use of data, and the use of data to ascertain patterns of practice.

And a primary focus has been on the Health Department's data monitoring program, and whether making it easier to access it, which,

obviously, they just did last year by -- for the first time, allowing electronic access -- or, by lowering the thresholds for access, or taking the approach of the Attorney General, by mandating, you know, review of the data, both of which I think has its challenges.

Two programs which Empire has developed, that might be worth considering duplication, takes the data, but has the system generate its findings in terms of determining patterns of practice.

One is called "Operation Pillbox." Not my title.

And, what that does is, it reviews, specifically, prescription drug claims data, for determining -- and it looks at it, not only from the user's perspective, the patient, but also the providers'.

In terms of the patient's perspective, they look at prescriptions similar to the State's monitoring program, where, if there are greater than three -- three or more prescriptions that have been written, or three or more providers that have written prescriptions, the system itself will generate, a teaser, or a tickler, that, you may want to look at that particular provider, or that

particular patient, for purposes of, either care management -- and this is at the interesting thing, from the health plan's perspective -- it's -- there's a -- two, you know, overriding themes.

One is, care management, to determine whether, you know, the appropriate use of a drug that is perfectly legal is inadvertently intersecting, or contravening, the use of another drug: a diabetes medication, or insulin, versus, you know, heart medication.

That is one pathway for the use of the data.

The other pathway, is for purposes of fraud detection.

And having the system generate the use pattern allows us to make a determination from both perspectives.

You know, secondly, from the provider's perspective, the system will generate based on utilization patterns.

And this gets at, after your Dr. Chait situation, where a particular provider is prescribing an anomalous amount of controlled substances, you know, Level II controlled substances, so that -- and, again, maybe for very legitimate purposes, but the system generates it,

we review it, and determine whether it's appropriate or not, for -- both, for purposes of care management, as well as for purposes of fraud and abuse.

The second program is more targeted towards the unusual emergency room-visit case, where, for our -- from our perspective, as I mentioned earlier, our hands are somewhat tied in terms of a prospective review, but that clearly is an area where you have the greatest potential for abuse.

And, here, what we do, in the -- what we call the "Frequent Flyer Program," is, we will review those members who have submitted claims, who visited the emergency room, at least three times a month.

And in those cases, again, you take a look at it, both, from a care management perspective, should they be going to their primary-care doctor as opposed to the emergency room, but also for purposes of abuse of practices as well.

Two programs that the plan has just implemented this year, in 2011, that might be worth considering, from either the Health Department's end, or, for that matter, from MUPHOCO (ph.) or the State's end, where the system is generating the use,

as opposed to either mandating it on a provider or having voluntarily access.

SENATOR KEMP HANNON: Thank you.

Tony.

ANTHONY MEROLA: Just a quick update with regards to where Medicaid is heading with regards to technology.

We're looking to enhance our point-of-service pharmacy systems, scheduled to be implemented by the end of the year.

The technology will give us the ability to look at diagnosis, and potentially build more complex algorithms.

For example: A patient -- a patient that has -- is getting an opioid for a cancer treatment, being able to build in specific quantity or frequency at its -- for that particular patient population, where being more -- you know, potentially being more stringent on patients that are not diagnosed with cancer.

That information will be passed on to the pharmacist so they can make more educated decisions at their level.

We continue to work -- you know, work with the pharmacy community. Anytime we send

point-of-service messaging to them, we appreciate their phone calls at my office with regards to, trying to fish through some of that information, you know, how complex it is, given some of the real, real complex medical or pharmaceutical regimes that Medicaid patients are taking.

SENATOR KEMP HANNON: What's the technical name of the database you're improving?

ANTHONY MEROLA: Well, that would be our point-of-service system. I believe the commercial name is RXPERT (ph.), R-X-P-E-R-T.

And, again, we're working with our systems people to get that system up and running. And, again, it's scheduled for, somewhere, the end of this year, the beginning of next year.

SENATOR KEMP HANNON: Okay.

Steve.

DR. STEVE KIPNIS: I'm not going to talk anything about data.

[Laughter.]

DR. STEVE KIPNIS: You're taught in medical school, really, that service coordination is really important, and you should get consultants and people who are experts.

My agency looks at it as, agency

coordination, and partnerships.

Certainly, under Commissioner Gonzalez-Sanchez, we put together a group, in March, which involved just about every agency in New York State, State Ed., the OMIG, Medical Society.

And, to address what Bridget brought out, we really need a set of guidelines to help doctors know what's best practice. We need a set of guidelines to help patients know what's the best practice.

And we're also leaving out the dentists.

I am a physician, but we should consider dentists because they write scripts too. So, we had the Dental Society as one of our members.

And we're in Phase 2 of that, working with New York City Department of Health, to really get one set of guidelines, as opposed to twelve different sets that no one is ever going to read.

We do think education is important. And a lot of the different initiatives that we put together are for education.

We're the only state agency in the country that has an Addiction Medicine Unit, that has

education for providers, and also for the public.

We get over 50,000 hits a quarter on it, so it's a huge resource for just about everyone.

And the last thing that was talked about just a little bit, that I'm really sort of proud of with our work with the Department of Health, is the overdose prevention initiative.

While it's important to prevent addiction, and I think we have to go back, and really remember, that the addicted person -- and I hate the word "addict" -- it's the substance-using person, has a disease, and they should be treated as anyone else with a disease.

There are people who are addicted, who do illegal things, as well as there are doctors who do illegal things. And lawyers.

But -- but the overdose prevention really brings us to someone who has the problem, and we could save their life. And it allows everyone in New York State to be a lifesaver.

And I don't know if you're aware of it, but we put in, with the Department of Health, for the Governor to proclaim today, "Opioid Overdose Prevention Day," which he did do.

And we look at this as just another way of

educating the person in New York State, to know that they could save a life, as well as a doctor could or an emergency tech, or anyone like that.

So, we're really pretty proud of the Governor, you know, proclaiming it. And, also, that we continue to get New York State people to look at it as a worthwhile endeavor.

SENATOR KEMP HANNON: Thank you very much.

BRIDGETTE BRENNAN: [audio/video technical difficulty.]

...with pills, it's a very difficult addiction.

And what we've seen with defendants who we normally would refer to rehabilitation programs, are defendants, who are addicted to prescription pills, just aren't interested.

So, that, I think is critically important to educate young -- a program -- information campaign directed towards teens and young adults, to inform them about just how addictive these pills are, and how terrible their lives can become as a result.

Also, directed towards the public, to convince them to secure their pills.

I think we need to develop protocols for

disposal of these drugs.

Standards for doctors are critical.

And, I think the Bureau of Narcotics Enforcement, with the Department of Health, has done an incredible job under very difficult circumstances.

They have few investigators. They have a creeky old system that they do their best with.

And, I think that we could not have done the kind of work we have done without them. And I think their efforts need to be -- or their resources certainly need to be enhanced, to deal with the problems that they're -- that we're facing right now.

And, finally, we've already put together a bill, that we've worked on with Senator Hannon and Senator Klein, that addresses some of the oversights that we see in the current law.

Thank you.

SENATOR KEMP HANNON: Thank you.

Dahlia.

DAHLIA HELLER: So, I won't repeat what everyone's said.

I do want to clarify a couple of things that have been noted around the tables.

Just one is: With respect to the source of prescription opioids that people report, we see, kind of consistently, from the survey that we sort of consider the gold standard on drug use in the country, conducted by SAMHSA, a national survey on drug use and health, 75 percent of people who report past-year non-medical use or use without a prescription or in a manner other than prescribed, of prescription opioids, report that they got them from family or friends.

So, this idea of diversion, that makes -- that's what we're talking about being extremely difficult when we talk about, the need for disposal, the need for education...education, education.

So, one of the things that's been mentioned, also, around the table a lot, is the idea of clinical guidelines for opioid prescribing.

As I mentioned, we're putting out the "City Health Information" publication next month. We see it as a first step in that direction. It's -- obviously, it's a publication. It's intend for educational purposes, but we do want to raise this discussion here in New York State.

In Washington State, they have actually -- and I'm not sure, nobody's -- I think it's been

alluded to here, but, they did legislate clinical guidelines for opioid prescribing. It's the first state in the country to do that.

And, not something that we generally do with clinical practices, is legislate the patient-provider relationship, because we recognize that, there is an art to medicine, and every patient has different, very specific, medical needs.

But, there are some aspects of clinical practice that we can pay closer attention to. And that's the intent of that legislation that Washington State has passed.

Simple things, like, if you are going to do chronic pain management, do chronic opioid -- prescribe opioids for chronic pain in your practice, requiring the doctor to do a monthly assessment, and have that on file, so it becomes parts of the doctor -- the expectation of the doctor, when they're audited, when their license is reviewed, that they have shown that they have reviewed the treatment plan with the patient.

And, then, after a certain period of time, saying that, maybe that treatment -- if that treatment is not working, if they're showing there's no improvement in the patient, it's not appropriate

to continue prescribing; there's no improvement in pain.

So, things like that, can be opportunities to actually change physician practice, which can be very controversial, because, recognizing that we are intervening on a very specific patient-provider relationship.

But, to raise that conversation, hopefully, we'll have having more of that in the future, the task force convened by OASAS, and working with our partners at the State.

We've talked a lot about data. I'm not going to get into anymore of that.

I've actually learned some additional ideas, listening to folks around the table, so I appreciate that.

And -- but, just to say, recognizing Mr. Krackower from the Attorney General's Office mentioned this idea of mining data; you know, thinking about looking, we have this prescription drug monitoring program. We can probably identify patterns and prescribing in there. It can't be too hard to mine that data, and develop a better understanding of the types of doctors, for example, orthopedic surgeons, you know, or the

types of doctors, and dentists -- I'm glad they were mentioned around the table -- who tend to prescribe more, or prescribe -- I'm -- you know, for example, a rheumatologist --

And I'm not going to name specialties, because, then I'll start leaving out specialties, and I'm not trying to point fingers.

-- just to make the point, that, there may be opportunities with existing data sets to actually identify patterns, and to target specialty practices differently. And, to think about clinical practice differently for different specialty practices.

Mentioning emergency departments, also in here, we've thought about. And Washington State has just issued guidelines, voluntarily, for hospitals in Washington State, to limit opioid prescribing from emergency departments, altogether.

So, that's very specific.

We could, for example, limit, or prevent, eliminate, or restrict, or not allow, the prescription of long-acting sustained-release opioids, such as OxyContin, from emergency departments.

And, frankly, I mean, emergency department

docs will say, all the time, how difficult it is for them, to have a patient sitting in front of them, saying, they lost their prescription. "It's Friday night, or Saturday morning. You're not going to get any doctor until Monday. Can you just give me"...whatever.

And having to deal with that patient, and decide whether they're making the right clinical decision in prescribing, when they've got an emergency department full of patients.

So, there's also an opportunity to look at clinical practice, very specifically, in emergency medicine.

Thank you for holding this roundtable.

SENATOR KEMP HANNON: Thank you.

Senator Marcellino.

SENATOR CARL MARCELLINO: Yes, thank you very much for everyone who attended, and participated.

It's been a very good up one.

I thank my two colleague for allowing me to join them in this process.

I know I learned a lot today. And we're going to go forward together, and work on some positive legislation.

I hope this is not the end of this. I hope

this is the beginning; because, again, good valuable information has been put out here, but now it's got to be collated, refreshed, honed, and put together.

What I see here is -- you know, we're coming on the tenth anniversary of 9/11.

It was always suggested, that the information -- that there was information in different locations that might have been used, if put together, at the right time, to prevent -- or, allow law enforcement to take action that might have prevented the tragedy of 9/11.

What I see, a lot of that here today: We have information. A lot of it in different locations.

Could we put that together in a location, in a way that it could be utilized, so that we could attack this very serious problem?

I think we do, and I think we can, and I think we will, because, the desire is there, and the impetus is there, and the need is there.

What I'm seeing also, is, we're emphasizing the doctor, we're emphasizing the system.

I'd like to go back to the street.

I was a teacher for 20 years.

We talk about teenagers, and young people.

I did a lot of work with drug abuse in the '60s, '70s, and '80s, in the schools.

When you say "teens," when you say "children," involved, somehow that softens it. Somehow that makes it less of a crime situation, more of a, we have to solve it, we have to cure it.

This is an organized-crime gang situation.

Gangs are involved in the sale of these drugs. They're getting their hands on the pills.

How they're getting them, where they're getting them, I think we can all figure out.

It's all because there are limited sources; but, they're getting them.

The gangs, the pushers, are flipping kids who can't get the money up to buy the oxycodone. They're flipping them to heroin, which is why you're seeing a spike in heroin abuse.

It's in all of our schools. It's there.

I've talked to number of teachers.

I've talked to a number of them, as Senator Hannon has, I'm sure as Senator Klein has.

And the law enforcement individuals, they will tell you: It's in the schools. It's in all the neighborhoods. Where there's money, there's drugs.

And where there is money, and drugs, there's organized crime. I have no doubt whatsoever.

So, I would urge the law enforcement agencies here, please, don't; don't back off on your prosecution of traditional drug crime, because, in my mind, a lot of this is traditional drug abuse, drug crime.

Approach it from that. Don't soften it, because a lot of kids are involved, a lot of teenagers may be involved. It may be true.

We can deal with that.

But, I think that you have to look at it as a crime situation too, and not lose sight of that.

And I hope that comes out of this.

And, again, this has been very productive.

And as I said before, I hope it continues, and I hope we do more of them, because I think there's a need here.

And, we can really work together, and get some very good legislation.

Work with the Attorney General's bill. I like that idea.

Maybe we can soften some of the edges, and work with it, so that we can eliminate some of the problems, and not make it so onerous.

But, it's something that we're going to go to, and make the information available to everybody who needs it.

Thank you.

SENATOR KEMP HANNON: Senator Klein.

SENATOR JEFFREY KLEIN: I want to thank, also, my two colleagues: Senator Marcellino, Senator Hannon.

This is -- I think was very worthwhile. I know, personally, I learned a lot.

And I think what we learned is what we probably already knew: we need to take a comprehensive approach.

And I think it starts with education.

I think Dr. Kolodny is correct; we need a standard of care for treating chronic pain.

I think, as Senator Marcellino said, I think the data could be utilized in a simpler fashion, shared by more individuals in a timely fashion. And I think that's not being done right now.

I think, finally, to make Attorney General Schneiderman's job, and Special Prosecutor Bridget Brennan's job, we need to really allow them to prosecute these cases a lot easier. Have a standard which will provide them the

ability to prosecute these cases against doctors who are giving out prescriptions illegally.

So, I think we learned that we all need to be on the same page. We all need to, I think, share information.

I still believe that the providers can play a very, very important role, in letting law enforcement, letting the State Health Department, know about firsthand knowledge of individuals who are very -- where they're getting, from these pain management clinics, very easily, prescription drugs.

And I think, by taking this approach, I think we'll be, hopefully, effectively, have a piece of legislation, and deal with this problem.

So, I thank my colleagues.

And, I thank you all.

SENATOR KEMP HANNON: Well, Senator Klein, Senator Marcellino, have said it all.

I just want to thank everybody for the enormous amount of time and preparation you've put into this. For the work you're doing on, ongoing.

And, if anybody has items that they would like us to consider, please submit them.

Thank you.

(Whereupon, at 1:37 p.m., the New York State Roundtable Hearing concluded.)