A Roundtable Discussion of Prescription Drug Abuse, Diversion and Policy Solutions

Hosted by:

Senator Jeffrey D. Klein, Chair of the Committee on Alcoholism and Drug Abuse

Senator Kemp Hannon, Chair of the Committee on Health

Senator Carl L. Marcellino, Chair of the Committee on Investigation and Government Operations

Place: Senate Hearing Room, 250 Broadway, 19th Floor, New York, NY
Wednesday, August 31, 2011 10:00am – 1:00pm

NOTICE OF ROUNDTABLE

SENATE STANDING COMMITTEE ON HEALTH
SENATE STANDING COMMITTEE ON ALCOHOLISM AND DRUGS ABUSE
SENATE STANDING COMMITTEE ON INVESTIGATIONS AND GOVERNMENT OPERATIONS

SUBJECT: The Growing Problem of Prescription Drug Abuse and Diversion

PURPOSE: To discuss existing policies and possible policy changes intended to combat abuse of controlled prescription drugs and diversion in New York State.

Senator Jeffrey D. Klein, the Chair of the Standing Committee on Alcoholism and Drug Abuse, Senator Kemp Hannon, the Chair of the Standing Committee on Health, and Senator Carl L. Marcellino, the Chair of the Standing Committee on Investigations and Government Operations will be holding a Roundtable discussion at 10:00 am on August 31, 2011, in 250 Broadway, 19th Floor Senate Hearing Room, NYC to discuss and examine existing policies intended to lower the incidence of abuse and diversion of controlled substances and possible policy changes to enhance our ability to combat this problem. It is anticipated the following questions will be discussed in detail:

- What is the current scale of the problem of prescription drug abuse in New York State? How has the abuse of controlled substances changed in the past few years?
- Are existing policies and regulations designed to combat prescription drug abuse and diversion working as they were intended to work?
- Are there steps that could be taken without the need for legislative action to enhance the effectiveness of existing policies and regulations on prescription drug abuse?
- Are there differences in the way public and private insurers identify and address potential prescription drug abuse?
- Is there sufficient coordination between the various governmental agencies and organizations that oversee the different parts of our prescription drug abuse and diversion policy? Are there ways in which this coordination could be enhanced?
- Is there sufficient coordination between the various private stakeholders that are affected by prescription drug abuse and diversion? What steps could be taken to initiate or enhance their coordination on this problem?
- To what extent does current technology assist in coordinating stakeholders and combating the abuse and diversion of controlled substances? what changes could be made to better utilize existing technology?

- What legislative or regulatory changes could be made in New York State that would help combat the problem of prescription drug abuse and diversion? Have these changes been attempted elsewhere, and if so to what effect?
- How long would it take to implement the proposed policy changes? Which organization or groups would be the most affected by these changes?
- Would suggested policy changes require the state to spend more resources or would they be more than offset by state savings? Could the current resources being spent be distributed in a more effective and efficient manner?

Participation is by invitation only. Any prepared statements or materials to be submitted by participants should be sent in advance. Written comments will also be accepted and may be sent to the attention of the Chairs at 304 Legislative Office Building, Albany, NY. In order to further publicize these hearings, please inform interested parties and organizations of the committees' interest in hearing testimony from all sources. Individuals can also watch the event online on the New York State Senate website at the following web address: http://www.nysenate.gov/event/2011/aug/31/roundtable-discussion-growing-problems-prescription-drug-abuse-and-diversion-throu In order to meet the needs of those who may have a disability, the legislature, in accordance with its policy of non-discrimination on the basis of disability, as well as the 1990 Americans with Disabilities Act (ADA), has made its facilities and services available to all individuals with disabilities. For individuals with disabilities, accommodations will be provided, upon reasonable request, to afford such individuals access and admission to legislative facilities and activities.

New York State Senate Standing Committee on Health
Senator Kemp Hannon, Chair
New York State Senate Standing Committee on Alcoholism and Drug Abuse
Senator Jeffrey D. Klein, Chair
New York State Senate Standing Committee on Investigations & Government Operations
Senator Carl. L. Marcellino, Chair

List of Participants

Joanne Hoffman Beechko, President, Long Island Pharmacists Society and Pharmacists Society of the State of New York

Bridget G. Brennan, Special Narcotics Prosecutor
New York City Office of the Special Narcotics Prosecutor

Sean Doolan
Empire Blue Cross and Blue Shield

Frank G. Dowling, MD, Commissioner of Public Health and Science
Medical Society of the State of New York
Medical Advisor of Police Organization Providing Peer Assistance, and Clinical Professor, Dept. Psychology, SUNY Stony Brook

Thomas Farley, M.D., M.P.H, Commissioner
New York City Department of Health and Mental Hygiene

Andy Fogarty, Director of Government Affairs
NY Health Plan Association

Steve Kipnis, M.D., FACP, FASAM, Medical Director
Office of Alcoholism and Substance Abuse Services

Andrew Kolodny, M.D., Chairman
Department of Psychiatry, Maimonides Medical Center
Physicians for Responsible Opioid Prescribing
New York Society of Addiction Medicine

Paul Mahoney, Chief of Civil Enforcement Division
Medicare Fraud Control Unit
Office of the New York State Attorney General

Anthony V. Merola, RPh, MBA, Clinical Pharmacy Manager,
Medicaid Pharmacy Program, New York State Department of Health

David Vizzini, Clinical Coordinator, Outreach
New York Association of Alcoholism and Substance Abuse Providers, Inc.

BRIEF BIOS OF SPEAKERS

Joint Roundtable concerning Prescription Drug Abuse
New York State Senate Committees on Alcoholism and Drug Abuse/ Health/ Investigations
August 31, 2011

Joanne Hoffman Beechko, President, Long Island Pharmacists Society and Pharmacists Society of the State of New York

Joanne Hoffman Beechko, RPH, is the owner of RxExpress Pharmacy and Surgical of East Northport. The pharmacy is now located in Huntington, NY.

Ms. Beechko currently serves as President of the Long Island Pharmacists Society and is one of two regional representatives from Long Island on the board of the Pharmacists Society of the State of New York. Because of the increase in the number of armed robberies of pharmacies on Long Island, particularly the murders in Medford and the robbery last week of the Plainview pharmacy in which one person was wounded, Ms. Beechko has met repeatedly with local media, law enforcement officials and state legislators to discuss issues surrounding these events and steps to be taken.

She is a graduate of the Arnold and Marie Schwartz College of Pharmacy of Long Island University

Bridget Brennan, Special Narcotics Prosecutor
New York City Office of the Special Narcotics Prosecutor

Bridget G. Brennan has been New York City's Special Narcotics Prosecutor since 1998. Her office is the primary narcotics prosecution agency in the city. The Office of the Special Narcotics Prosecutor handles an average of 3,000 indictments a year, conducts investigations into national and international drug trafficking organizations and participates in large-scale Police Department operations targeting specific areas of New York City. Ms. Brennan joined the Office in 1992 and served as the second in command from 1995 to 1997. Prior to that, she was the Chief of the Special Investigations Bureau overseeing some of the most significant narcotics investigations in the country. Ms. Brennan has been a prosecutor since 1983 when she joined the New York County District Attorney's Office. Ms. Brennan graduated from the University of Wisconsin Law School with a Juris Doctor degree. She holds a Bachelor of Arts degree in Journalism from the University of Wisconsin.

Sean Doolan, Empire Blue Cross and Blue Shield

Sean Doolan of the law firm Hinman Straub is co-chair of the Firm's Government Relations department. In that capacity, Mr. Doolan provides both legal and legislative representation for numerous clients on a wide range of issues at every level of state government, whether it be regulatory or administrative counsel or representation before the legislative and executive branches. Mr. Doolan is also a member of the Firm's Health Law and Health Insurance Departments.

At Hinman Straub, Mr. Doolan has primary responsibility for providing strategic, regulatory and legislative counsel for an array of clients with diverse interests such as health plans (e.g. Empire BlueCross and BlueShield, Excellus Health Plans), health care providers (e.g. Empire State Association of Assisted Living, Parker Institute for Health Care and Rehabilitation); technology companies (e.g. Dell Inc. and EDS); financial services companies (e.g. Stonehenge Capital Corporation); wine and spirits wholesalers; the legal community (e.g. New York State Supreme Court Justices Association) or other general corporate interests (e.g. The Estee Lauder Companies).

He has his bachelor's degree from Siena College and law degree from Albany Law School.

Frank G. Dowling, M.D., Commissioner of Public Health and Science
Medical Society of the State of New York
Medical Advisor of Police Organization Providing Peer Assistance, and Clinical Professor, Dept. Psychology, SUNY Stony Brook

Frank Dowling, MD, is a Clinical Associate Professor in the Department of Psychiatry at SUNY at Stony Brook, and the Medical Advisor to POPPA, the Police Organization Providing Peer Assistance, which is an independent, confidential, voluntary non-departmental assistance program for the New York City Police Department. In addition, he is the Medical Director for Clubhouse of Suffolk, a psychosocial recovery and treatment program for persons with severe and persistent mental illnesses. He is an expert in the area of addressing the mental health needs of police officers, other first responders and healthcare professionals. Dr. Dowling is Commissioner of Public Health and Science for the Medical Society of the State of New York, of which one of his chief roles is to oversee the MSSNY Committees on Preventive Medicine & Family Health and Addiction & Psychiatric Medicine, a committee for which he previously served as Chair. These committees share responsibility for helping to develop policies to guide physicians in the screening and treatment of addiction disorders as well as developing policies to assure policymakers and members of the public are adequately informed of ways to better assure those in need of mental health and addiction treatment can obtain it.

Dr. Dowling intends to present the viewpoint of the MSSNY Committees on Addiction & Psychiatric Medicine and Preventive Medicine & Family Health that the solutions to the problem of prescription drug abuse must be multipronged. It includes increased law enforcement efforts to prevent and punish inappropriate diversion of prescription medications; increased accessibility of treatment for patients suffering addictions so as to reduce the likelihood of inappropriate diversion of prescribed medications; and the need to promote and improve the existing database on all controlled substance prescriptions that is currently managed by the New York State Health Department as well as removing the barriers that currently limit the ability of physicians, other prescribers and pharmacists from accessing this data.

Janet Zachary-Elkind, Director of Pharmacy Programs
Office of Financial Planning and Policy, New York State Department of Health

As Director of Pharmacy Programs (NYSDOH, OHIP, DFPP), I have responsibility for providing strategic leadership and day to day oversight for NY State's Medicaid Pharmacy Program and the Elderly Pharmaceutical Coverage (EPIC) program. I have eleven years of Pharmacy Benefit Management (PBM) experience (with Express Scripts), overseeing the operations that supported the NY State Empire Plan Prescription Drug program and a variety of private sector clients programs. I also worked at Empire Blue Cross and Blue Shield for eight years, where I held a variety of leadership positions in marketing, customer service and account implementation.

Educational Background:
BA in English from Indiana University of Pennsylvania

Thomas Farley, M.D., M.P.H., Commissioner
New York City Department of Health and Mental Hygiene

Dr. Farley was appointed New York City Health Commissioner in May 2009. One of the world's oldest and largest public health agencies, the Department has an annual budget of $1.6 billion and more than 6,000 staff. In recent years, the agency has undertaken a number of innovative initiatives, including a comprehensive tobacco control program, the elimination of trans fats in restaurant food, a requirement for chain restaurants to post calorie information on menu boards, and development of an electronic health record.

Before joining the Agency, Dr. Farley was chair of the Department of Community Health Sciences at Tulane University School of Public Health and Tropical Medicine. He received his MD and Master of Public Health degrees from Tulane University. Trained as a pediatrician, he served in the Centers for Disease Control's Epidemic Intelligence Service and worked for the CDC and the Louisiana Office of Public Health from 1989 to 2000. Dr. Farley is coauthor with RAND Senior Scientist Deborah Cohen of *Prescription for a Health Nation* (Beacon Press). He served as Senior Advisor to New York City Health Commissioner Thomas Frieden in 2007 and 2008.

Andy Fogarty, Director of Government Affairs
NY Health Plan Association

Andy Fogarty is director of government relations for the NY Health Plan Association, an Albany-based organization that represents 25 managed care health plans in New York State. He was formerly legislative counsel to the New York State Department of Health.

New York Health Plan Association (HPA), Inc. was established for the purpose of promoting the development of managed health care plans within New York State and working with state lawmakers, regulators and policy makers to help shape public health policy in the state. Currently, HPA's members include fully licensed managed care plans, prepaid health service plans (PHSPs are plans that primarily serve New Yorkers enrolled through the Medicaid, Child Health Plus and Family Health Plus programs) and managed

long term care plans, which provide or arrange for and coordinate both the health care and long term care needs of their patients.

In his role with HPA, Mr. Fogarty is responsible for the development of public policy positions and advocates on behalf of HPA's 25 member health plans before the Legislature and executive agencies.

Prior to joining HPA, Mr. Fogarty was Legislative Counsel for New York State Department of Health (2007-2004), and served as Legislative Aide to the Minority Leader and Assistant to the Chief Counsel in the Assembly (2004-2001).

Mr. Fogarty is a graduate of Albany Law School, and received Bachelor of Arts degrees in History and Political Science from Alfred University.

Steven Kipnis, M.D., FACP, FASAM Medical Director
Office of Alcoholism and Substance Abuse Services

Dr. Steven Kipnis, M.D., FACP, FASAM, is Medical Director in the Office of Health, Wellness and Medical Direction at OASAS. Dr. Kipnis provides vital medical direction across all sectors of the agency, while emphasizing the important roles health and wellness play in maintaining a successful recovery.

He is a national expert in addiction medicine and was at the forefront in New York with regard to integrating a medical model to treatment. He believes strongly in those with the disease of addiction being treated as a whole person and not just as one with a singular disease. He seeks, through wellness initiatives, to achieve a state of overall health for those who are impacted with the disease of chemical dependency.

Dr. Kipnis received his medical degree from the University of Miami School of Medicine and continued his education with a residency and fellowship in Internal and Pulmonary Medicine at Nassau County Medical Center. He is board certified in Internal Medicine by the American Board of Internal Medicine and received his certification in Addiction Medicine from the American Society of Addiction Medicine in 1990, with recertification in 2000.

Dr. Kipnis was elected to Fellowship status in the American College of Physicians in 1996 and received his Fellowship from the American Society of Addiction Medicine in 2003. Dr. Kipnis began his career in state government as a Medical Specialist at Blaisdell Addiction Treatment Center in 1982 and was promoted to Medical Director of OASAS in 1999. He was appointed to the faculty of Albany Medical College as a Clinical Associate Professor of Medicine in July 2005.

Dr. Kipnis and his wife reside in New City, N.Y.

Andrew Kolodny, M.D., Chairman
Department of Psychiatry, Maimonides Medical Center
Physicians for Responsible Opioid Prescribing
New York Society of Addiction Medicine

- Co-chair of recent NYS OASAS Workgroup on Responsible Medication Prescribing

- Author of a physician prescribing guide called "Cautious, Evidence-Based Opioid Prescribing." The guide has been distributed by multiple organizations and agencies including the federal Center for Disease Control.

- Currently advising the FDA's Safe Use Team on Patient Provider Agreements for the prescribing of controlled substances.

- Recently founded a non-profit organization called Physicians for Responsible Opioid Prescribing (PROP). PROP's members include physicians in the field of public health, pain, addiction, primary care and emergency medicine who are on the "front-line" of the prescription drug epidemic in the U.S. and Canada. PROP members have been involved in state and federal initiatives to address the epidemic, including the recent legislative effort in Washington state.

- Former Medical Director in the Office of the Executive Deputy Commissioner for NYC Dept. of Health & Mental Hygiene (left in 2005).

- Currently Chairman of the Department of Psychiatry at Maimonides Medical Center

- Clinical practice specializing in the treatment of prescription drug abuse.

Paul Mahoney, Chief of Civil Enforcement Division
Medicaid Fraud Control Unit
Office of the New York State Attorney General

Paul J. Mahoney is an Assistant Deputy Attorney General in the Office of the New York State Attorney General and, under the Deputy Attorney General for Medicaid Fraud Control, supervises over 300 staffers investigating and prosecuting criminal and civil fraud and abuse by healthcare providers in the $40 billion-per-year New York Medicaid program. Paul was previously Chief of the Civil Enforcement Division of the Medicaid Fraud Control Unit. He has been awarded the *Louis J. Lefkowitz Memorial Award* for outstanding performance by an assistant attorney general by Attorney General Spitzer and Attorney General Cuomo.

From 1997 to 2004, Paul served as an Assistant District Attorney, later Senior Investigative Counsel, in the Frauds Bureau of New York County District Attorney Robert M. Morgenthau. His major prosecutions included a seven-month trial of a securities firm and its principals, several other securities fraud operations, and numerous other banking, accounting, and financial frauds.

Before joining the District Attorney's Office, Paul was a litigation associate for seven years at Paul, Weiss, Rifkind, Wharton & Garrison in New York City with extensive experience in securities litigation, advertising and unfair trade practices, and products liability, and was recognized for *pro bono* work by the Legal Aid Society.

Paul Mahoney is a graduate of Cornell Law School and Williams College.

David Vizzini, Clinical Coordinator, Outreach
New York Association of Alcoholism and Substance Abuse Providers, Inc.

David Vizzini is the Clinical Coordinator for Outreach at the Brentwood, Long Island location. I'm a Certified Alcohol and Substance Abuse Counselor (CASAC). I have working in the addictions field for the past 15 years. During that period of time I have been a clinician and an administrator for both outpatient and residential levels of care. My primary area of experience is working with adolescents and young adults between the ages of 12 to 21.

Mr. Vizzini is participating at the roundtable as a representative of the Association of Alcoholism and Substance Abuse Providers, the trade organization in which OASAS approved treatment providers/programs and other umbrella organizations are members.

Anthony V. Merola, RPh, MBA

Tony is the Clinical Pharmacy Manager for the Medicaid Pharmacy Program in the Office of Health Insurance Programs, New York State Department of Health. He is primarily responsible for the clinical and financial management of the Medicaid Preferred Drug Program and Drug Utilization Review Program. He has been with the Medicaid Pharmacy Program for 10 years and has experience in a variety of Medicaid pharmacy areas including policy, reimbursement, and provider communications.

Prior to joining the Department of Health, Tony was a community pharmacist for a retail pharmacy chain. He was responsible for daily pharmacy operations including medication validation, patient education, and inventory management.

Tony holds a Bachelor of Science degree in Pharmacy from the Albany College of Pharmacy and Master of Business Administration degree in Healthcare from Union College.

Daliah Heller, PhD, MPH

Dr. Heller is the Assistant Commissioner for the Bureau of Alcohol and Drug Use Prevention, Care, and Treatment, where she has worked since 2006. She has worked in the area of public health and substance use in New York City for more than fifteen years, developing and managing community-based programs, conducting evaluation and epidemiologic research, implementing system-wide initiatives, and analyzing and advancing public policy.

Senate Standing Committee on Health
Senate Standing Committee on Alcoholism and Drug Abuse
Senate Standing Committee on Investigations and Government Operations

Joint Roundtable on The Abuse And Diversion Of Prescription Controlled Drugs
August 31, 2011
10 a.m.

AGENDA

I. Opening Remarks by Chairmen

The Chairmen of the participating committees will, if interested, make opening statements to the panel.

II. Introductions by Speakers, laying out the problem

Each participant will introduce themselves and summarize their views on what the scope of this problem is and how their organization is affected by this problem. (Maximum three minutes per participant)

III. Discussion Round 1: What has your organization been doing recently in order to cope with or combat the problem?

The panelists will discuss how their organizations have been coping with the problem of the abuse or diversion of prescription controlled drugs, and what programs or policies they have implemented or are currently trying to implement to handle the problem, as well as any work they might be conducting jointly with other participants.

IV. Discussion Round 2: How well are existing programs and policies working?

The panel will discuss their views on the effectiveness of existing programs, policies, regulations, and laws designed to combat the abuse and diversion of prescription controlled drugs. Panelist will address what they think is currently working well and as intended, and what programs or policies might need to be updated or improved.

V. Discussion Round 3: What new policies or programs do you recommend in order to combat this problem?

Panelists will discuss what changes they think need to be made to better combat this growing problem. Panelists can bring up specific proposals that have already been made, or can brain-storm ideas about possible new programs. Panelists can also respond to proposals by other panelists, including making points about how such a new policy would affect them.

VI. Conclusions, closing remarks.

Panelists will be able to make any closing remarks regarding what they have taken away from the roundtable, or any future actions they plan to take post-roundtable. Chairmen will make any closing remarks.

Epi Data Brief

New York City Department of Health and Mental Hygiene

August 2011, No. 9

Drugs in New York City: Misuse, Morbidity and Mortality Update

- More than one million New Yorkers (16%) report using illicit drugs or medications in a manner other than prescribed in the past year. The national rate is 15%. [1]
- Death from unintentional drug poisoning decreased by 24% between 2005 and 2009.[5]
- Despite an overall decrease in unintentional drug poisoning deaths, benzodiazepine and opioid analgesic poisoning deaths increased by 17% and 20% respectively.[5]

Drug use in New York City[1]

- In 2008-2009 marijuana use was reported by approximately 850,000 (14%) New Yorkers aged 12 and older in the past year.
- Also in 2008-2009, 2.9% of New Yorkers reported past year cocaine use, 1.4% reported benzodiazepine use, and 0.1% reported heroin use. Opioid analgesics were reported by 4% of New Yorkers and were the most commonly reported drug, after marijuana

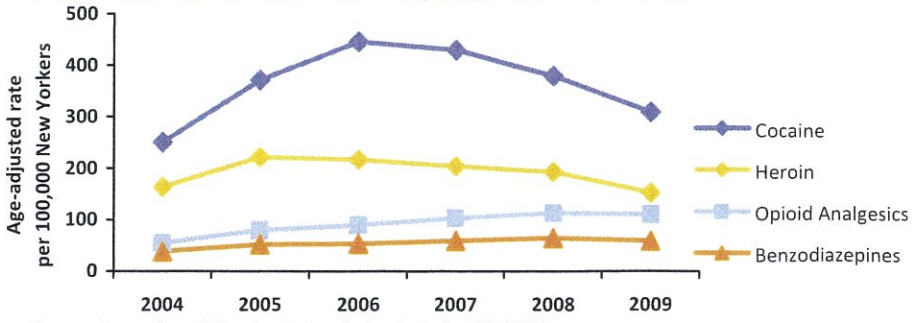
Drug use among adolescents[2,3]

- In 2008, 14% of youth in grades seven through 12 in New York City public and private schools reported any drug use (excluding alcohol and tobacco) in the past month, compared with 18% of students in New York State overall.[2]
- In 2009, lifetime cocaine use among New York City public high school youth in grades nine through 12 was 4.2%, while 15% reported marijuana use in the past month.[3]

Drug-related emergency department visits[4]

- Drug-related emergency department (ED) visits increased 40% between 2004 (33,000) and 2009 (47,000), rising from 408 to 556 visits per 100,000 New Yorkers.
- Drug-related ED visits in 2009 were most common among adults aged 35 to 44 (1,118/100,000).
- The drug most commonly reported in drug-related ED visits was cocaine (309/100,000 in 2009). Between 2004 and 2009, benzodiazepine-related ED visits increased 59% from 38/100,000 to 59/100,000 and opioid analgesic-related visits doubled, from 55/100,000 to 110/100,000.

Drug-related ED visits by drug-type (2004-2009)



Source: Drug Abuse Warning Network; Analysis by SAMHSA, 2009

Data Sources

[1]NSDUH: The National Survey on Drug Use and Health (NSDUH) conducted annually by Substance Abuse and Mental Health Services Administration [SAMHSA] includes a representative sample of NYC residents aged 12 years and older. Two-year averages are presented.

[2]YDS: The Youth Development Survey (YDS) conducted by the NYS Office of Alcohol Substance Abuse Services assesses risk (including substance use) and protective factors for academic success among public and private school students in grades seven through 12. Only 2008 data are presented.

[3]YRBS: The Youth Risk Behavior Survey (YRBS), conducted in collaboration by the Health Department and the NYC Department of Education, is an anonymous, biennial study of NYC public high school students. Only 2009 data are presented.

[4]DAWN: The Drug Abuse Warning Network (DAWN), managed by SAMHSA, is a database of drug-related visits to hospital emergency departments (EDs), including 61 NYC EDs. Data were weighted to produce citywide estimates of drug-related ED visits for 2004-2009.

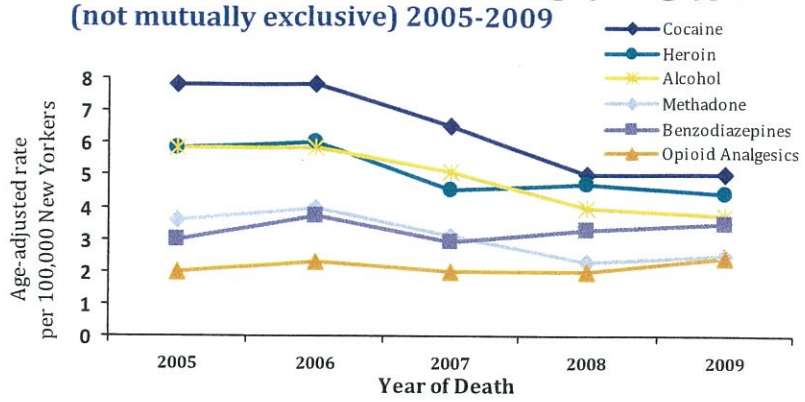
[5]OVS/OCME: Mortality data were collected through an in-depth review of data and charts from the Health Department's Bureau of Vital Statistics and the Office of the Chief Medical Examiner for 2005-2009. Rates are age adjusted to the year 2000 standard population, except those for specific age groups.

Authored by:
Daniella Bradley O'Brien, Denise Paone, Sharmila Shah, Daliah Heller

Unintentional drug poisoning deaths[5]

- Nearly all (98%) unintentional drug poisoning deaths (3,589) involve more than one type of drug.
- More than one quarter (26%) of decedents had three types of drugs in their systems when they died. The most common drug combinations involved cocaine, heroin and alcohol.
- New Yorkers who died of unintentional drug poisoning were more likely to be aged 45-54 and reside in low-income neighborhoods.

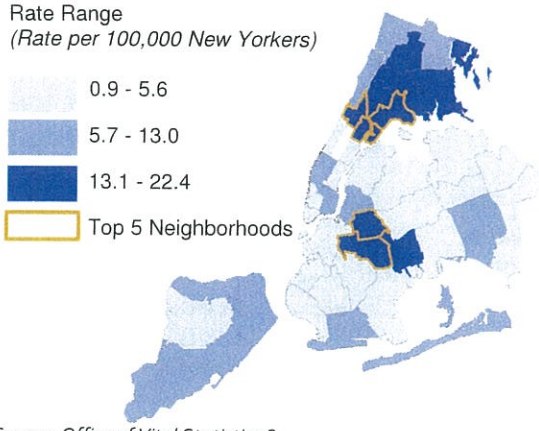
Rate of unintentional drug poisoning by drug type, (not mutually exclusive) 2005-2009



Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2005- 2009

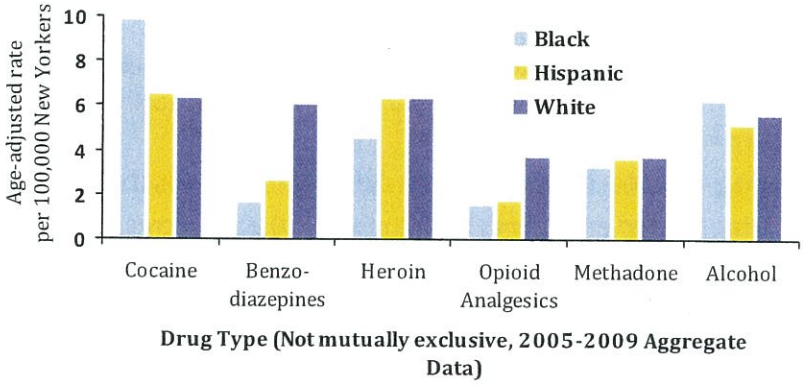
- Benzodiazepines were involved in 38% of the unintentional poisoning deaths in 2009. Alprazolam (Xanax®) was the most common benzodiazepine, present in 43% of those deaths.
- Among the neighborhoods with the five highest rates of unintentional drug poisoning deaths, three were low-income and in the Bronx.
- Cocaine poisoning was highest among blacks (9.8/100,000); benzodiazepine poisoning was highest among whites (6.0/100,000).

Rates of unintentional drug poisoning deaths by NYC neighborhood[5]



Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2005- 2009

Rate of unintentional drug poisoning by drug type and race/ethnicity, 2005-2009



Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2005- 2009

Definitions: The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprised of contiguous zip codes. Income is defined by the percent of households below 200% of the federal poverty level (Census 2000) and separated into three groups: low-income (43%-70%), medium-income (30%-43%) and high-income (13%-30%). Benzodiazepines are central nervous system depressants used primarily to treat anxiety, sleep disorders and muscle spasms. Opioid analgesics are prescription medications derived from both natural and synthetic opioids used to treat pain. For the OVS/OCME data, methadone is analyzed separately. **Notes:** An Epi data brief highlighting opioid analgesic use in NYC was published in May 2011, therefore minimizing any emphasis on opioid analgesic use in this publication. Please see the

MORE New York City Health Data and Publications

- For complete tables of data presented in this Brief, visit www.nyc.gov/html/doh/downloads/pdf/epi/datatable9.pdf
- For more information on drug use, check out the following Health Department resources: Help to Stop Using; Vital Signs: Illicit Drug Use in New York City; and Opioid Analgesic Epi Data Brief
- Visit EpiQuery – the Health Department's online, interactive health data system at www.nyc.gov/health/EpiQuery

Epi Data Brief

New York City Department of Health and Mental Hygiene

April 2011, No. 3

Opioid Analgesics in New York City: Misuse, Morbidity and Mortality Update

- Opioid analgesics (prescription pain medication) are synthetic drugs, such as oxycodone (for example, Percocet® or OxyContin®), hydrocodone (for example, Vicodin®), and codeine, which possess narcotic properties similar to opiates but are not made from "natural" opium.
- In 2009, opioid analgesics were involved in 25% (158) of unintentional drug poisoning (overdose) deaths.[4]

Non-medical use of opioid analgesics in New York City[1]

- In 2008-2009, 4% of New Yorkers aged 12 and older (263,000) reported non-medical use of prescription opioids – without a prescription or use with a prescription in a manner other than prescribed.
- From 2002-2003 to 2008-2009, self-reported, non-medical prescription opioid use increased by 40%.

Opioid analgesic use among adolescents[2]

- In 2008, 10% of students in grades seven through 12 in New York City reported non-medical use of a prescription opioid at least once in their lifetime.

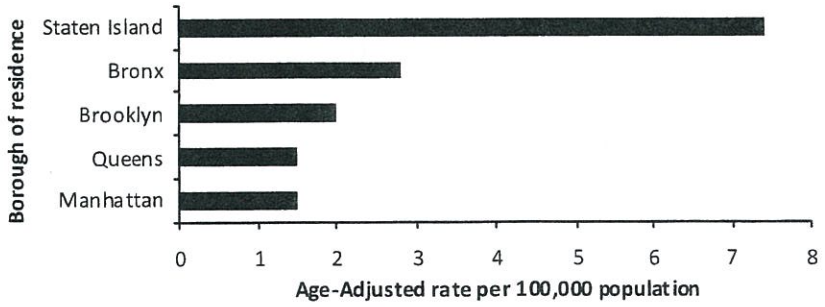
Opioid analgesic-related emergency department visits[3]

- The rate of opioid analgesic-related emergency department (ED) visits doubled between 2004 (4,466) and 2009 (9,254) rising from 55 to 110 visits per 100,000 New Yorkers.
- Opioid analgesic-related ED visits were most common among adults aged 45 to 54 (251/100,000 in 2009), compared with 130/100,000 for those aged 55- to 64 and 222/100,000 for those aged 35-44.

Unintentional opioid analgesic poisoning deaths[4]

- The unintentional opioid analgesic poisoning death rate increased by 20% between 2005 and 2009 from 2.0 to 2.4 per 100,000 New Yorkers, while the heroin poisoning death rate decreased by 24%.
- The Staten Island rate increased by 147% from 3.0/100,000 in 2005 to 7.4/100,000 in 2009 – more than double that of any other borough.

Opioid Analgesic Poisoning Deaths by Borough (2009)



Source: Office of Vital Statistics and Office of the Chief Medical Examiner, 2009

Data Sources

[1]NSDUH: The National Survey on Drug Use and Health (NSDUH) conducted annually by Substance Abuse and Mental Health Services Administration [SAMHSA] includes a representative sample of NYC residents aged 12 years and older. Two-year averages are presented.

[2]YDS: The Youth Development Survey (YDS) conducted by the NYS Office of Alcohol Substance Abuse Services assesses risk (substance use, violence, pregnancy, drop-out, and delinquency) and protective factors (family, school, community, religion) for academic success among public and private school students in grades seven through 12. 2008 data are presented by grade and borough of residence.

[3] DAWN: The Drug Abuse Warning Network (DAWN), managed by SAMHSA, is a database of drug-related visits to hospital emergency departments (EDs), including 61 NYC EDs. Data were weighted to produce citywide estimates of drug-related ED visits for 2004-2009.

[4] OVS/OCME: Mortality data result from an in-depth review of the NYC Health Department's Bureau of Vital Statistics and the Office of the Chief Medical Examiner for 2005-2009. Rates are age adjusted to the year 2000 standard population, except those for specific age groups. Given the large number of methadone maintenance treatment clients in NYC, methadone mortality is reported separately and is excluded from unintentional opioid analgesic death analyses presented here.

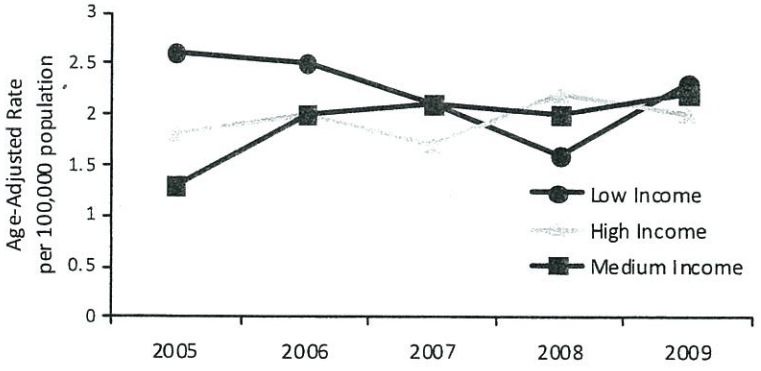
[5]NYS PDMP: The Prescription Drug Monitoring Program (PDMP) managed by the New York State Department of Health, collects data from drug dispensers on schedule II-V controlled substances.

Authored by:
Denise Paone, Daniella Bradley O'Brien, Sharmila Shah, Daliah Heller

Acknowledgements:
Anne Siegler,
Sayone Thihalolipavan

- During the same time period, deaths from opioid analgesic poisoning increased by 75% among Hispanics; however whites had the highest 2009 rate (3.9/100,000).
- Seven in 10 unintentional opioid analgesic poisoning deaths occurred to residents of medium- and high- income neighborhoods.
- Residents of medium-income neighborhoods had the largest increase, by 69%, from 2005-2009.

Rate of unintentional opioid analgesic deaths by neighborhood income, 2005-2009

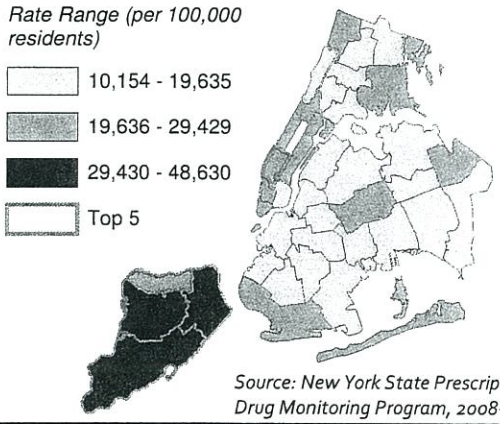


Source: Office of Vital Statistics and Office of the Chief Medical Examiner, 2005-2009

Patterns of opioid analgesic prescribing and death rates in New York City[5, 4]

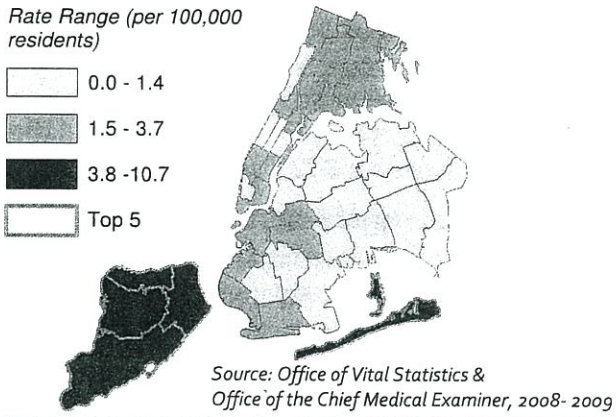
- Oxycodone and hydrocodone were the most commonly prescribed opioid analgesics in NYC in 2008-2009, with nearly 900,000 oxycodone prescriptions and more than 825,000 hydrocodone prescriptions filled in 2009.
- The five NYC neighborhoods with the highest rates of hydrocodone and/or oxycodone prescriptions filled per 100,000 residents were in high and/or medium income neighborhoods.
- Of the five NYC neighborhoods with the highest rates of hydrocodone and/or oxycodone prescriptions filled, four were in Staten Island and overlapped with four of the five neighborhoods where the rate of unintentional opioid analgesic poisoning (overdose) deaths was highest during the years 2008-2009.

Rates of hydrocodone and/or oxycodone prescriptions filled by NYC neighborhood[5]



Source: New York State Prescription Drug Monitoring Program, 2008-2009

Rates of unintentional opioid analgesic poisoning (overdose) deaths by NYC neighborhood[4]



Source: Office of Vital Statistics & Office of the Chief Medical Examiner, 2008- 2009

Definitions: The United Hospital Fund (UHF) classifies NYC into 42 neighborhoods, comprised of contiguous zip codes. Income is defined by the percent of households below 200% of the federal poverty level (Census 2000) and separated into three groups: low-income (43%-70%), medium-income (30%-43%) and high-income (13%-30%). To ensure rate stability, two years of prescription and death data were combined for neighborhood analyses.

MORE New York City Health Data and Publications

- For complete tables of data presented in this Brief, visit www.nyc.gov/html/doh/downloads/pdf/epi/datatable3.pdf
- For more information on prescription drug use, check out the following Health Bulletins: When does Use Become Misuse, Is Your Child Abusing Prescription Drugs, and Help to Stop Using.
- Visit EpiQuery – the Health Department's online, interactive health data system at www.nyc.gov/health/EpiQuery

My Community's Health: Data and Statistics at www.nyc.gov/health/mycommunityshealth

Frequently Abused Prescription and Over-the-Counter Drugs
Identification Chart

NADDI

PainBalance®

PAIN RELIEVERS

Butorphanol Tartrate IV
Stadol NS®
10 mg/ml (Not shown actual size)

Codeine/Acetaminophen III
Tylenol w/Codeine®
30 mg/ 300 mg
60 mg/ 300 mg

Fentanyl II
Fentora®
400 mcg
600 mcg
800 mcg

Duragesic®
50 mcg/hr
(Not shown actual size)
(Also available in 12.5 mcg/hr, 25 mcg/hr, 75 mcg/hr & 100 mcg/hr)

Actiq®
400 mcg
(Not shown actual size)
(Also available in 200 mcg, 600 mcg, 800 mcg, 1200 mcg & 1600 mcg)

Hydrocodone/Acetaminophen III
Lorcet®
5 mg/ 500 mg
7.5 mg/ 650 mg
10 mg/ 650 mg

Lortab®
5 mg/ 500 mg
7.5 mg/ 500 mg
10 mg/ 500 mg

Norco®
7.5 mg/ 325 mg
10 mg/ 325 mg

Vicodin®
5 mg/ 500 mg
10 mg/ 660 mg
7.5 mg/ 750 mg

Generic
10 mg/ 325 mg
7.5 mg/ 750 mg
10 mg/ 650 mg
10 mg/ 660 mg
10 mg/ 325 mg
7.5 mg/ 500 mg
2.5 mg/ 500 mg
10 mg/ 500 mg
10 mg/ 650 mg
7.5 mg/ 650 mg
5 mg/ 500 mg
7.5 mg/ 750 mg

Hydromorphone II
Dilaudid®
2 mg
4 mg
8 mg

Generic
2 mg
2 mg
2 mg
2 mg
4 mg
4 mg
4 mg
4 mg
8 mg

Meperidine II
Demerol®
50 mg
100 mg

Methadone II
5 mg
5 mg
5 mg
10 mg
10 mg
10 mg
40 mg
40 mg
40 mg

Morphine II
MS Contin®
15 mg
30 mg
60 mg
100 mg

Oxymorphone Hydrochloride
Opana®
5 mg
10 mg

Opana® ER
10 mg
15 mg
20 mg

Oxycodone II
OxyContin®
10 mg
15 mg
20 mg
30 mg
40 mg
60 mg
80 mg
10 mg (Canada)
20 mg (Canada)
40 mg (Canada)
80 mg (Canada)

Roxicodone®
15 mg
30 mg

Generic
15 mg
30 mg
15 mg
30 mg

Oxycodone/Acetaminophen II
Percocet®
2.5 mg/ 325 mg
5 mg/ 325 mg
7.5 mg/ 325 mg
7.5 mg/ 500 mg
10 mg/ 325 mg
10 mg/ 650 mg

Tylox®
5 mg/ 500 mg

Oxycodone HCl/Aspirin/ Oxycodone Terephthalate II
Percodan®
4.5 mg/ 325 mg/ 0.38 mg
2.25 mg/ 325 mg/ 0.19 mg

Pentazocine/Aspirin IV
Talwin Compound®
12.5 mg/ 325 mg

Pentazocine/Naloxone IV
Talwin NX®
50 mg/ 0.5 mg

Generic
50 mg/ 0.5 mg

Propoxyphene/Acetaminophen IV
Darvocet - N®
50 mg/ 325 mg
100 mg/ 650 mg

Tramadol RX
Ultram®
50 mg

Ultracet® (tramadol w/acetaminophen)
37.5 mg/ 325 mg

STIMULANTS

Amphetamine Mixture II
Adderall®
5 mg
7.5 mg
10 mg
12.5 mg
15 mg
20 mg
30 mg
10 mg
15 mg
25 mg

Dextroamphetamine II
Dexedrine®
10 mg

Methylphenidate II
Ritalin®
5 mg
10 mg
20 mg
20 mg

Generic
5 mg
10 mg
20 mg

Phentermine IV
Adipex-P®
37.5 mg
37.5 mg

Fastin®
30 mg

Ionamin®
15 mg
30 mg

TRANQUILIZERS

Alprazolam IV
Xanax®
0.25 mg
0.5 mg
1 mg
2 mg

Clonazepam IV
Klonopin®
0.5 mg
1 mg
2 mg

Diazepam IV
Valium®
2 mg
5 mg
10 mg

Lorazepam IV
Ativan®
0.5 mg
1 mg
2 mg

Triazolam IV
Halcion®
0.125 mg
0.25 mg

OVER THE COUNTER

Guaifenesin with dextromethorphan (Robitussin® DM)
(Not shown actual size)

Dimenhydrinate (Dramamine®)

Chlorpheniramine with dextromethorphan (Coricidin® HBP cough cold)
(Not shown actual size)

OTHER

Buprenorphine III
Subutex®
2 mg
8 mg

Buprenorphine Hydrochloride Naloxone Hydrochloride
Suboxone®
8mg, 2mg
2mg, 0.5 mg

Carisoprodol RX
Soma®
350 mg

Zolpidem Tartrate IV
Ambien®
5 mg
10 mg

Ambien CR®
6.25 mg
12.5 mg

Pain Relievers | Stimulants | Tranquilizers | Over The Counter | Other

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NADDI 410-321-4600 www.naddi.org.
The National Association of Drug Diversion Investigators has made extensive efforts to feature the top prescription drugs and over the counter drugs of abuse in this poster. However, because of the vast array of generic drugs, it is impossible to display all of the pill possibilities. Law enforcement officers, and others who wish to identify prescription drugs not in this brochure, should contact the National Poison Control Hotline at 1-800-222-1222. By calling this number, you will be automatically connected to the drug and poison information center nearest you, who will assist in identifying the pill.

www.KingPharm.com

07/2010 This poster was made possible through a financial grant provided by King Pharmaceuticals®, Inc.

INFORMATION. EDUCATION. SUPPORT.
PainBalance® - www.painbalance.org, is an educational initiative to provide quality education, practical tools, and current resources to support appropriate care for all patients with pain and the healthcare professionals who care for them. This educational initiative is being developed through the efforts of leaders in pain management practice and supported by King Pharmaceuticals,® Inc.

The Epidemic of Prescription Drug Abuse in New York State

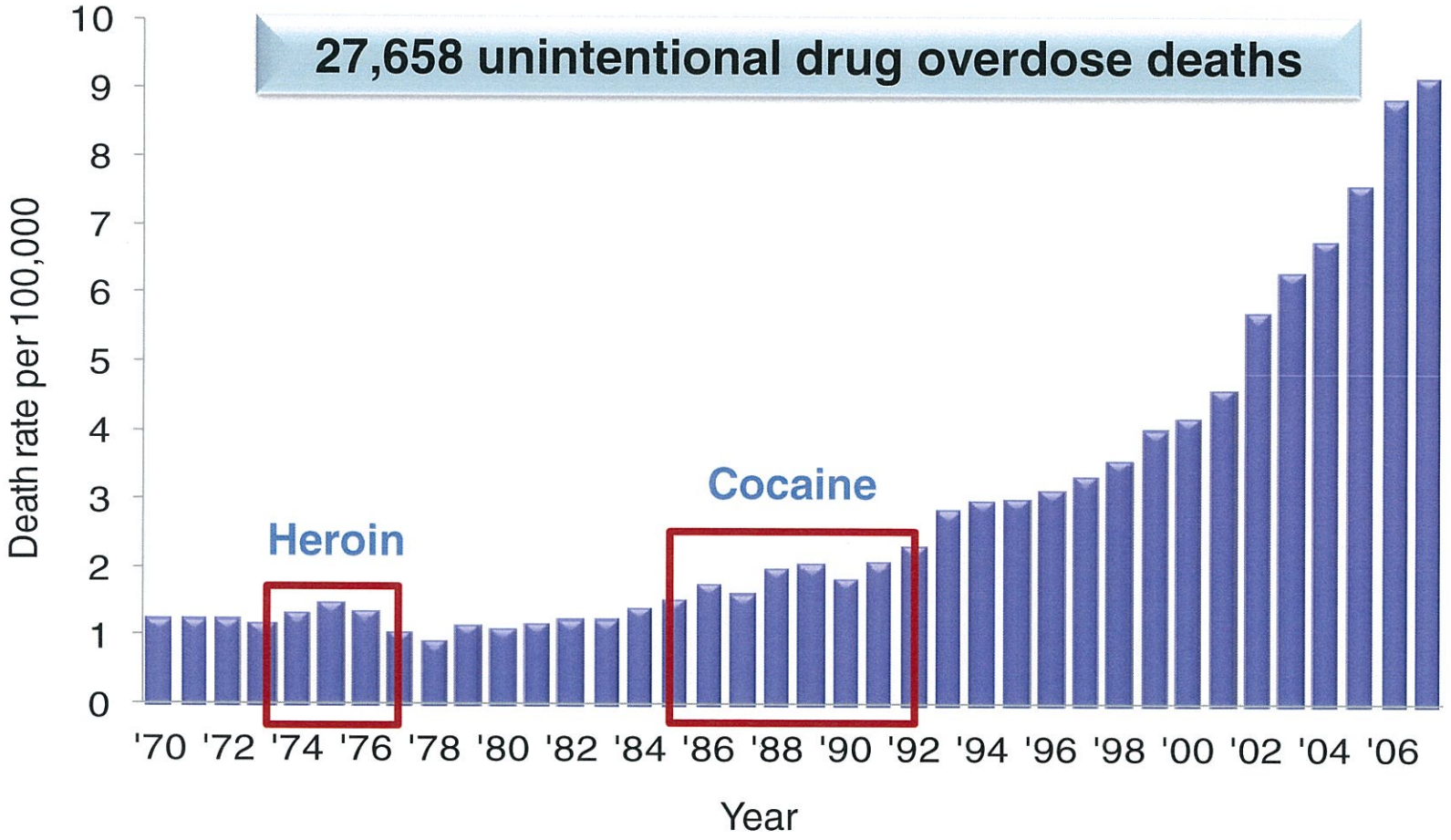
Andrew J. Kolodny, M.D.
Chairman, Department of Psychiatry
Maimonides Medical Center

Senate Round Table Discussion

August 31, 2011

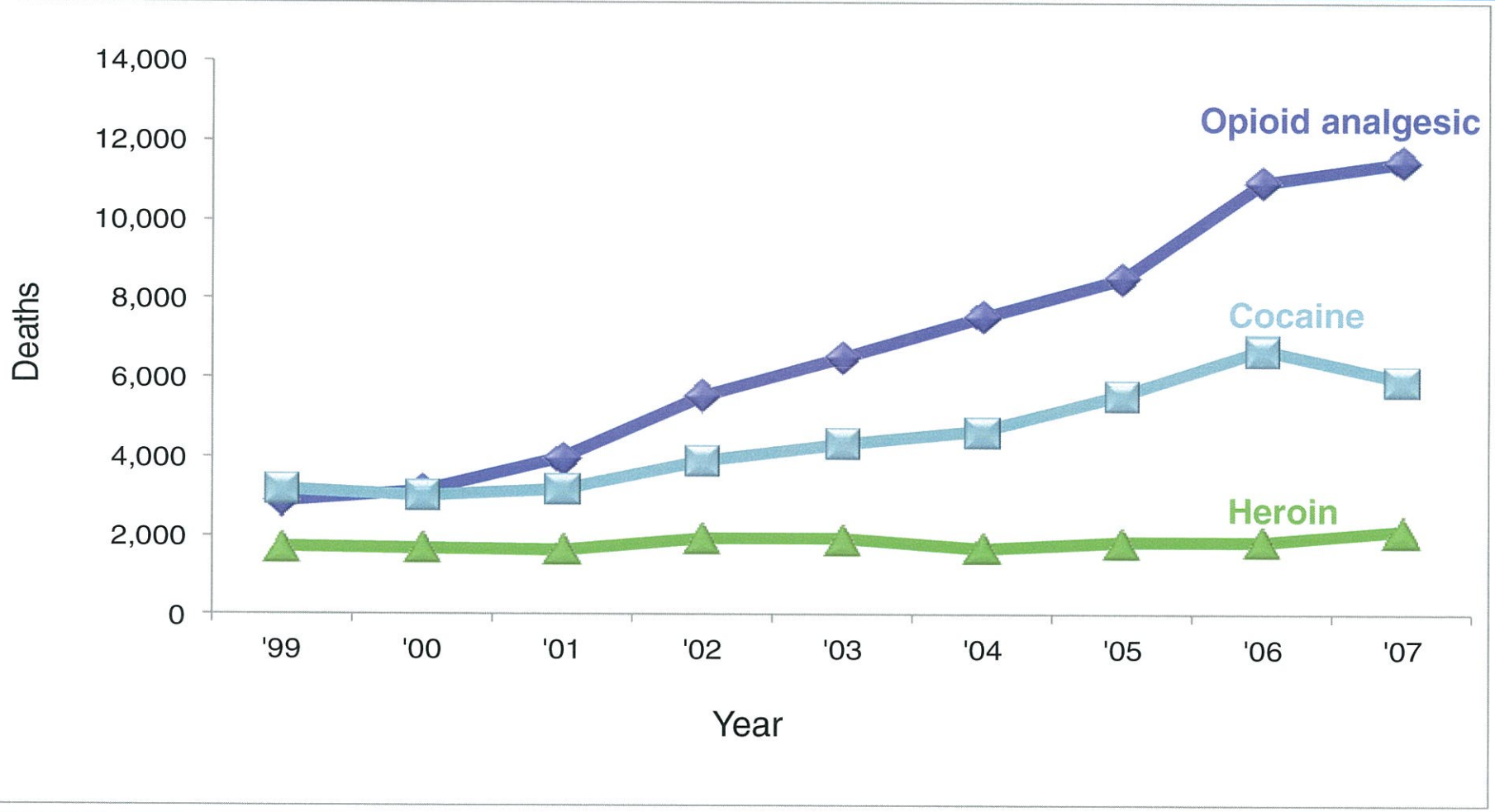
New York, NY

Unintentional Drug Overdose Deaths
United States, 1970–2007



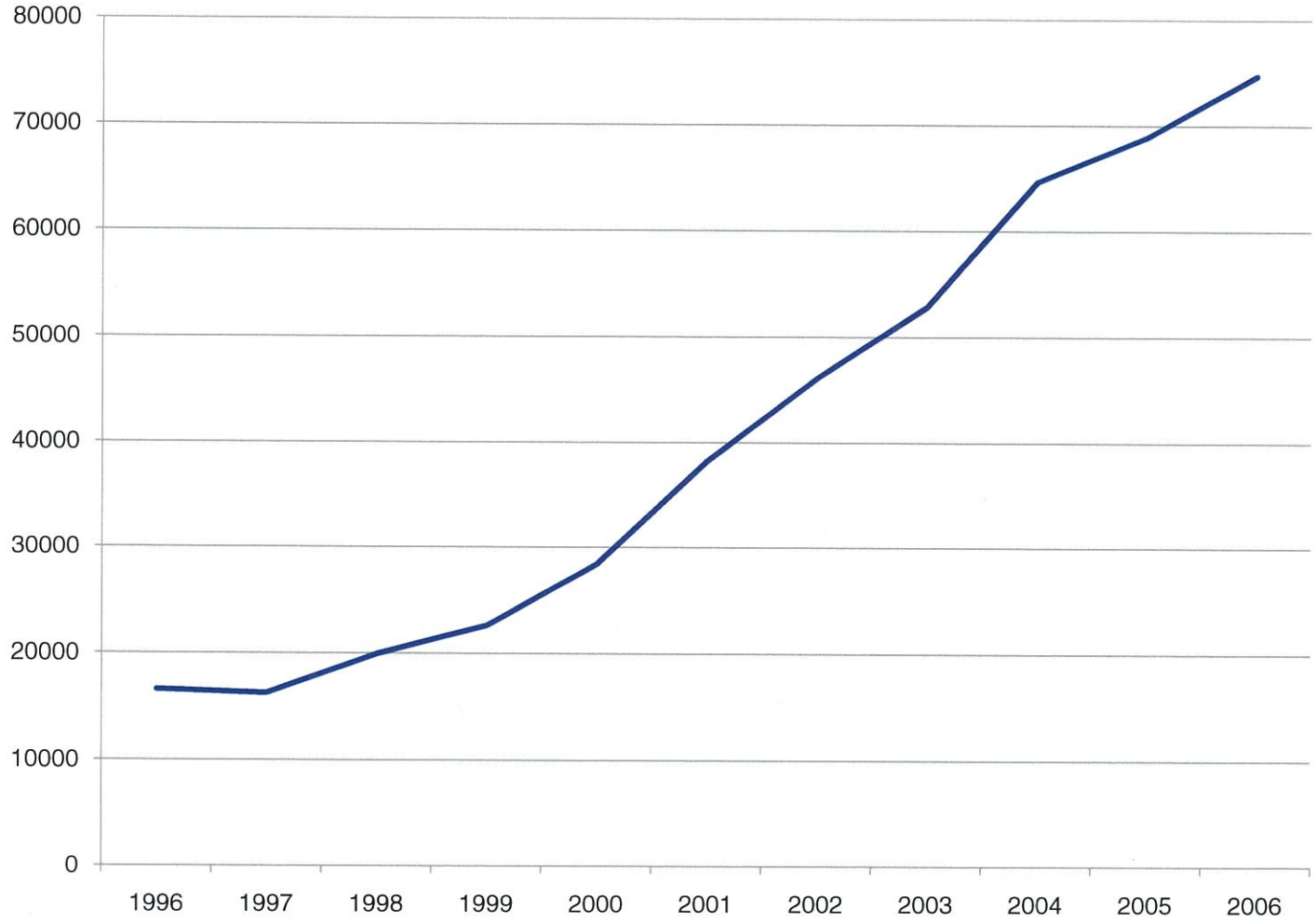
National Vital Statistics System, http://wonder.cdc.gov

Unintentional Overdose Deaths Involving Opioid Analgesics, Cocaine and Heroin United States, 1999–2007



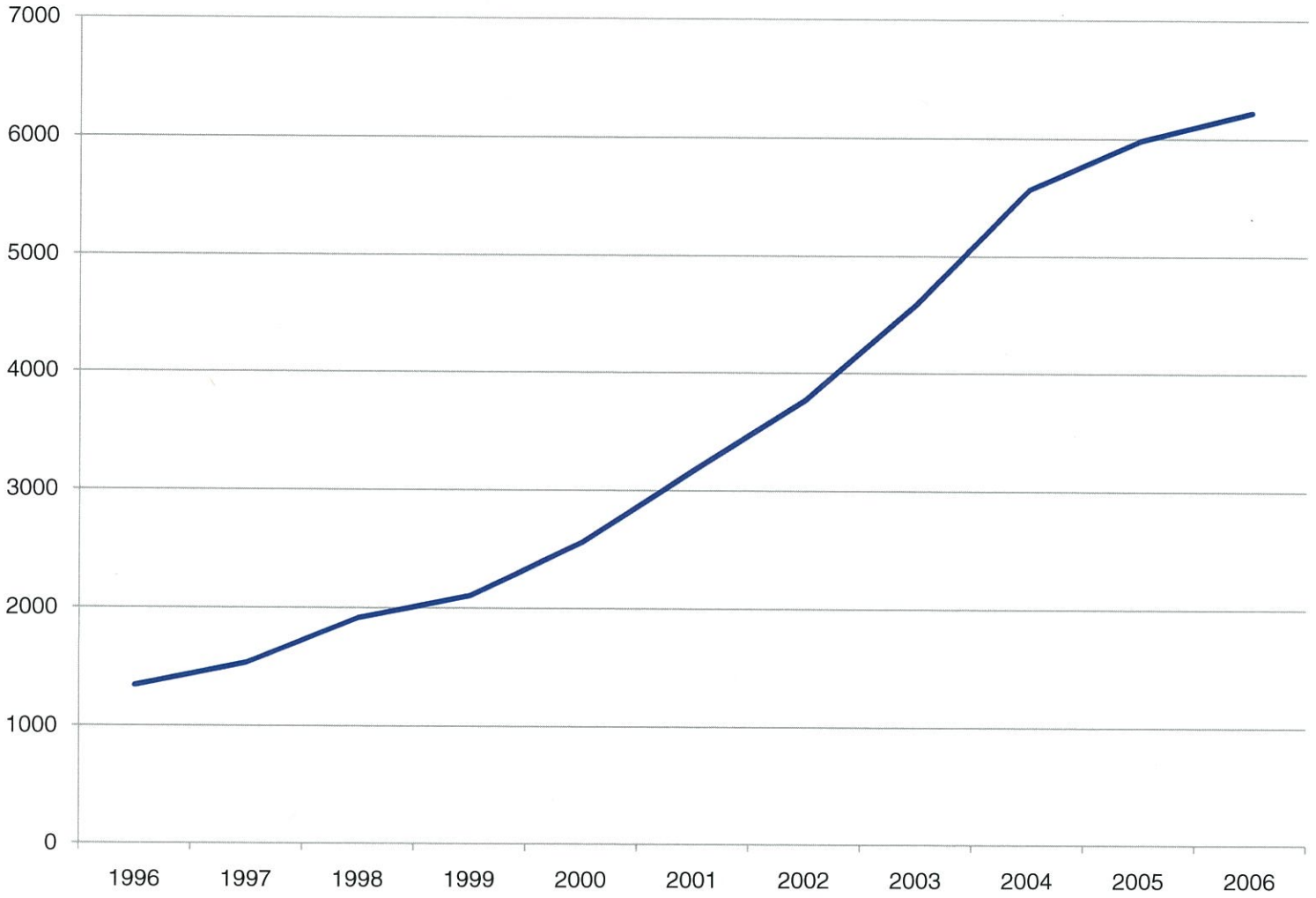
National Vital Statistics System, http://wonder.cdc.gov, multiple cause dataset

Opioid Analgesic Treatment Admissions: U.S.



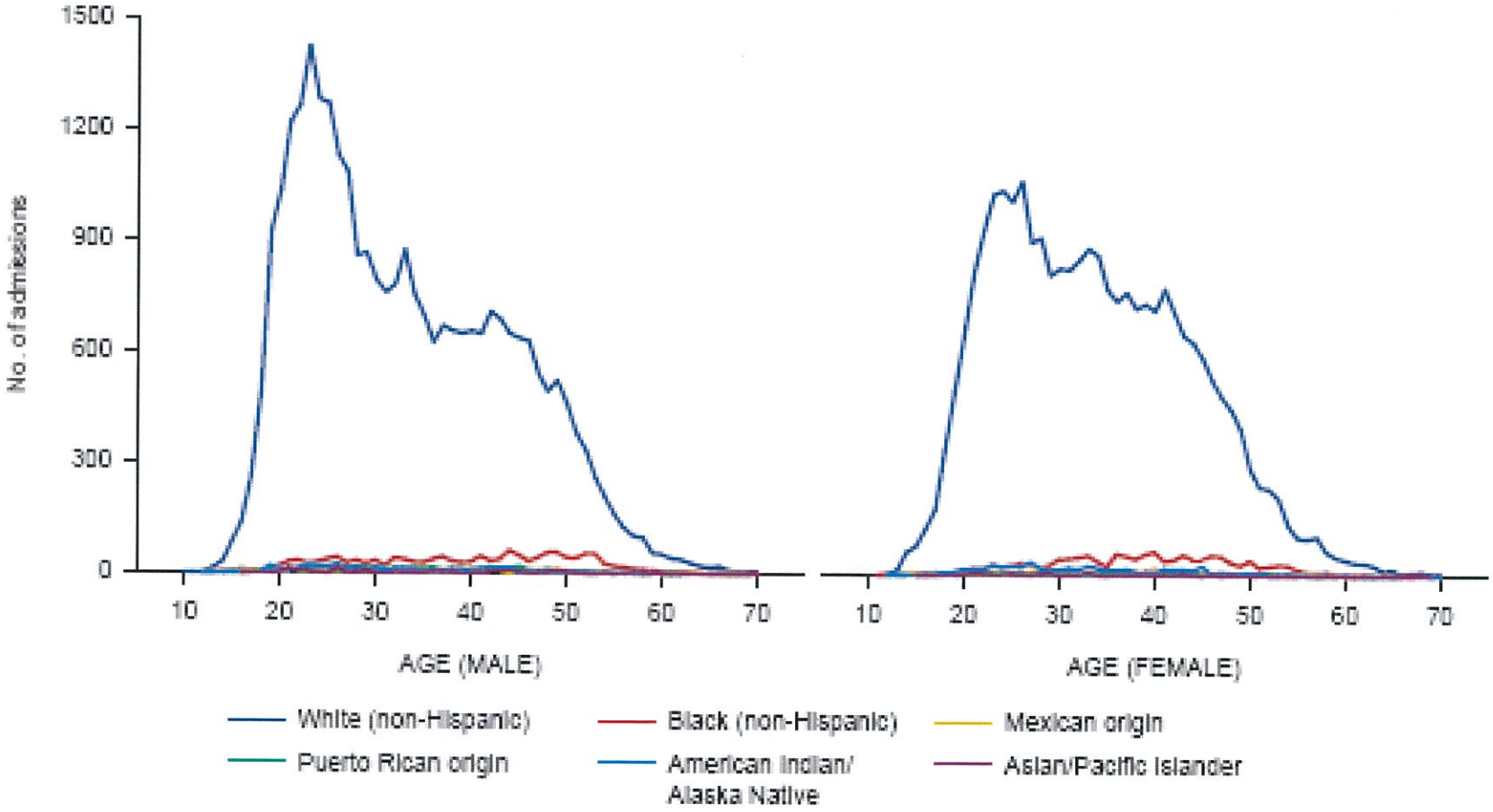
Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS) Highlights - - 2007 National Admissions to Substance Abuse Treatment Services. OAS Series #S-45, HHS Publication No. (SMA) 09-4360, Rockville, MD, 2009.

Opioid Analgesic Treatment Admissions: NYS



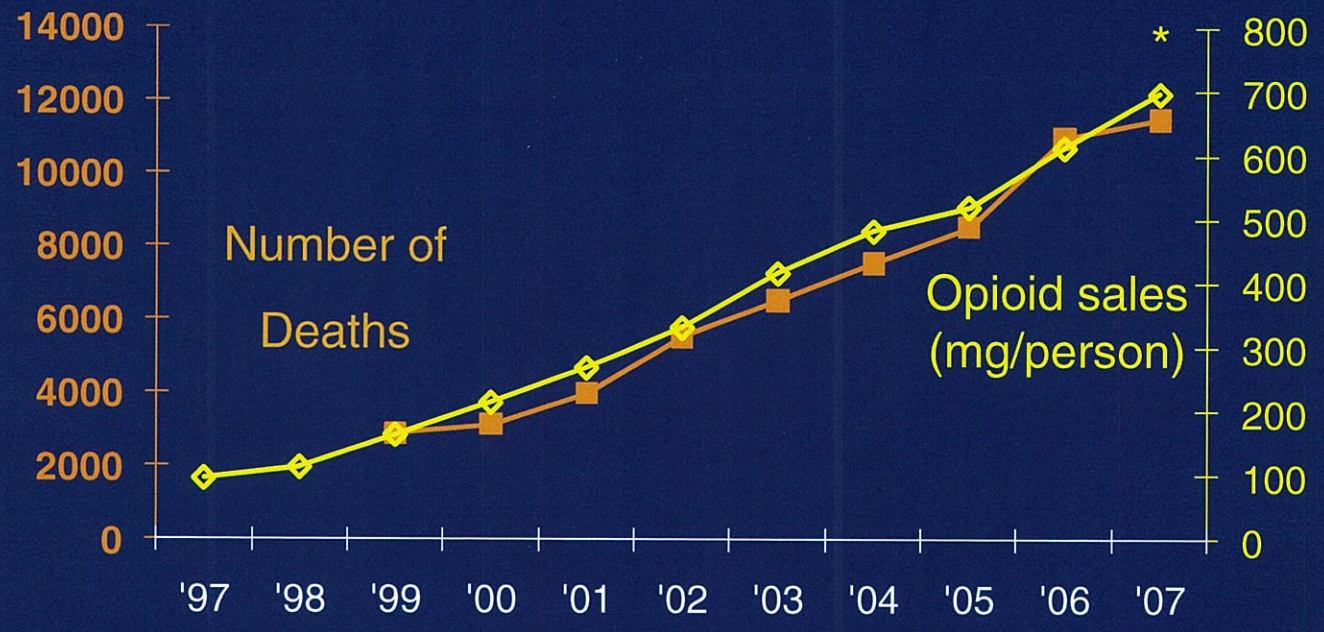
Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS) Highlights - - 2007 National Admissions to Substance Abuse Treatment Services. OAS Series #S-45, HHS Publication No. (SMA) 09-4360, Rockville, MD, 2009.

Other opiates
Admissions by sex, age, and race/ethnicity: TEDS 2004



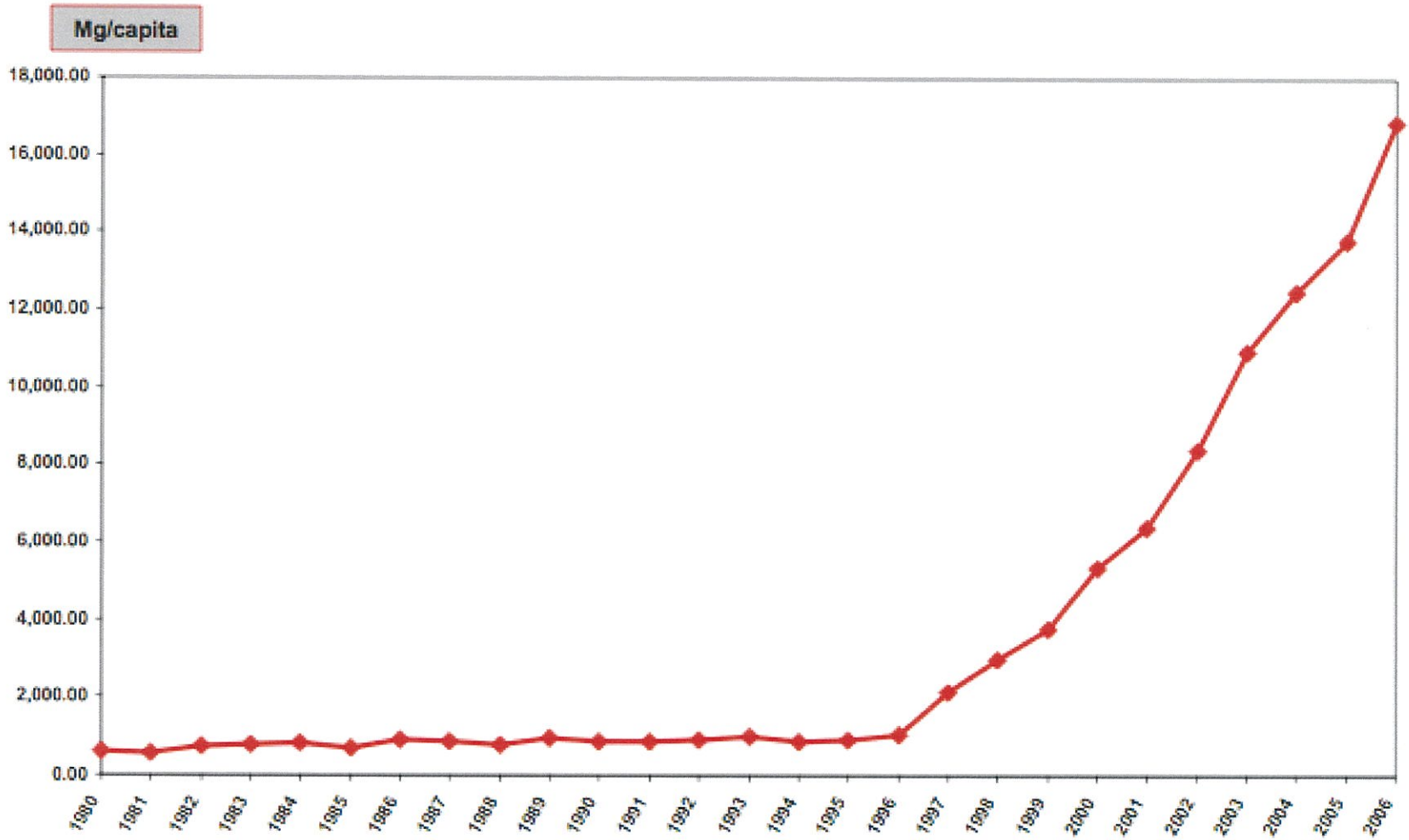
SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 2.1.06.

Unintentional overdose deaths involving opioid analgesics parallel per capita sales of opioid analgesics in morphine equivalents by year, U.S., 1997-2007



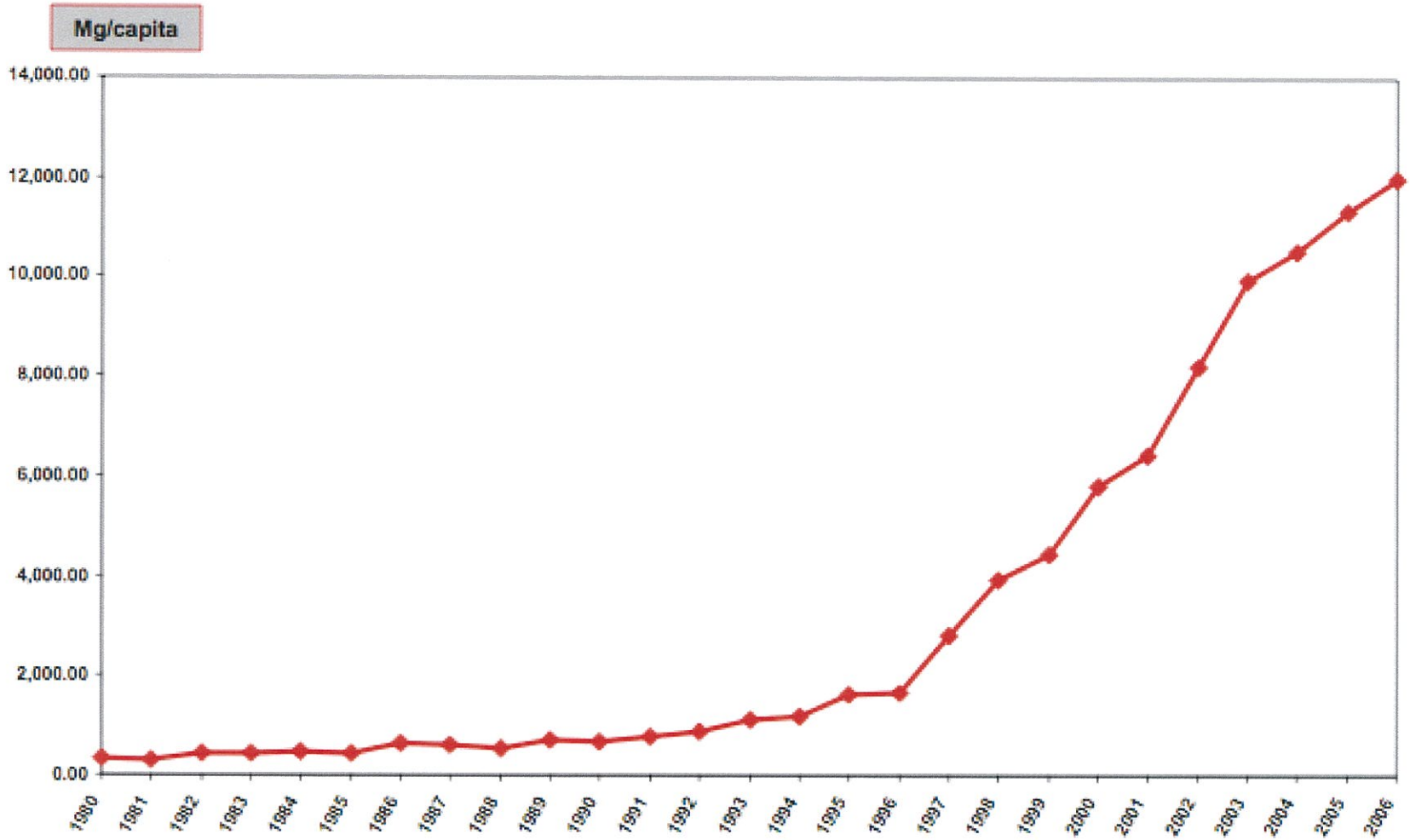
Source: National Vital Statistics System, multiple cause of death dataset, and DEA ARCOS
* 2007 opioid sales figure is preliminary.

New York Consumption of Oxycodone 1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

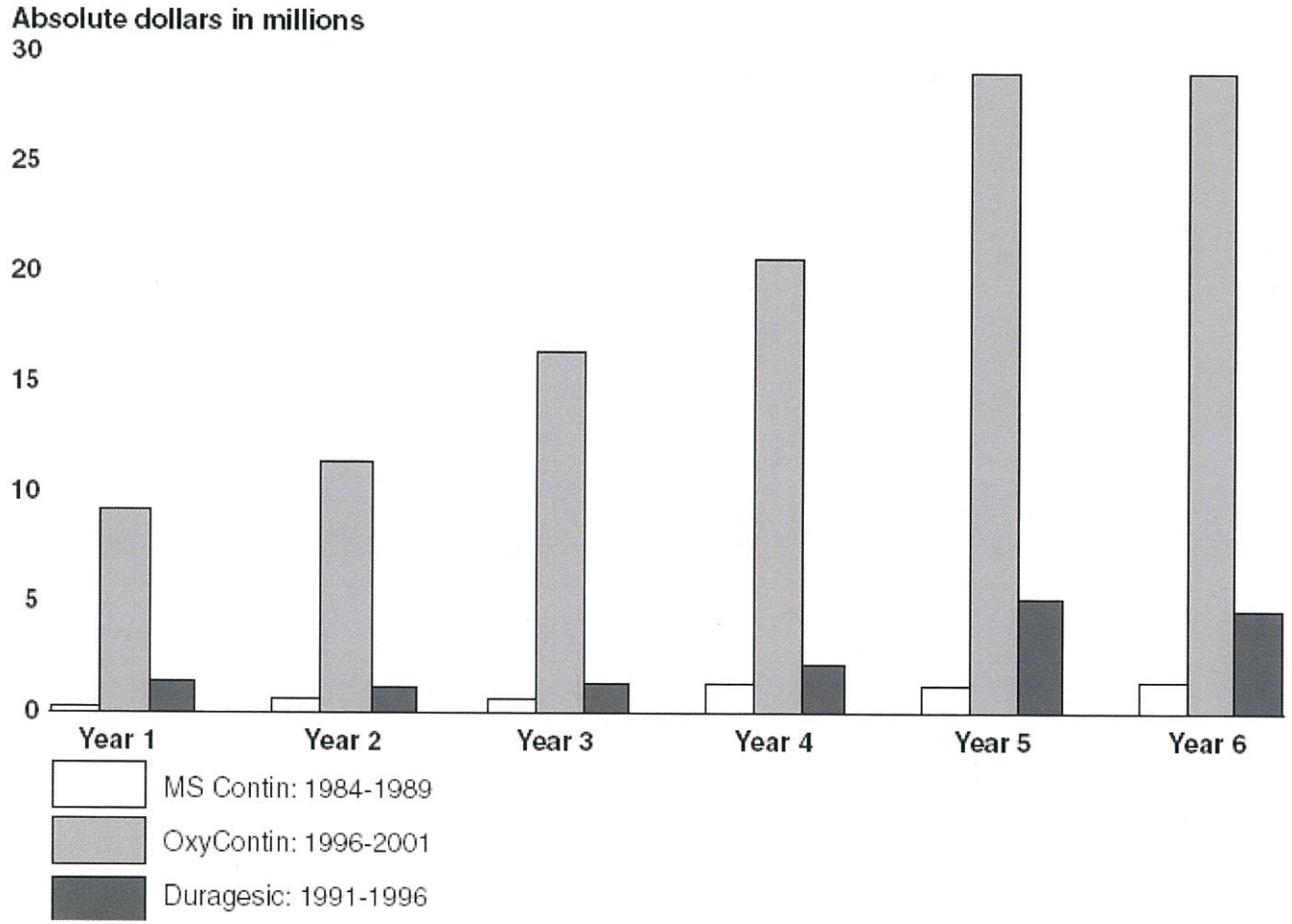
New York Consumption of Hydrocodone 1980 - 2006



Sources: U.S. Dept of Justice, Drug Enforcement Administration, Office of Diversion Control

Dollars Spent Marketing OxyContin (1996-2001)

Figure 1: Promotional Spending for Three Opioid Analgesics in First 6 Years of Sales



Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

Physician Education Regarding Opioids for Chronic Non-Cancer Pain Emphasizes:

- Opioid addiction is rare in pain patients.
- Physicians are needlessly allowing patients to suffer because of "opiophobia."
- Opioids are safe and effective for chronic pain
- Patients who appear to be drug seeking may have "pseudo-addiction."

Controlling the epidemic:
A Three-pronged Approach

- Primary Prevention- prevent new cases of opioid addiction

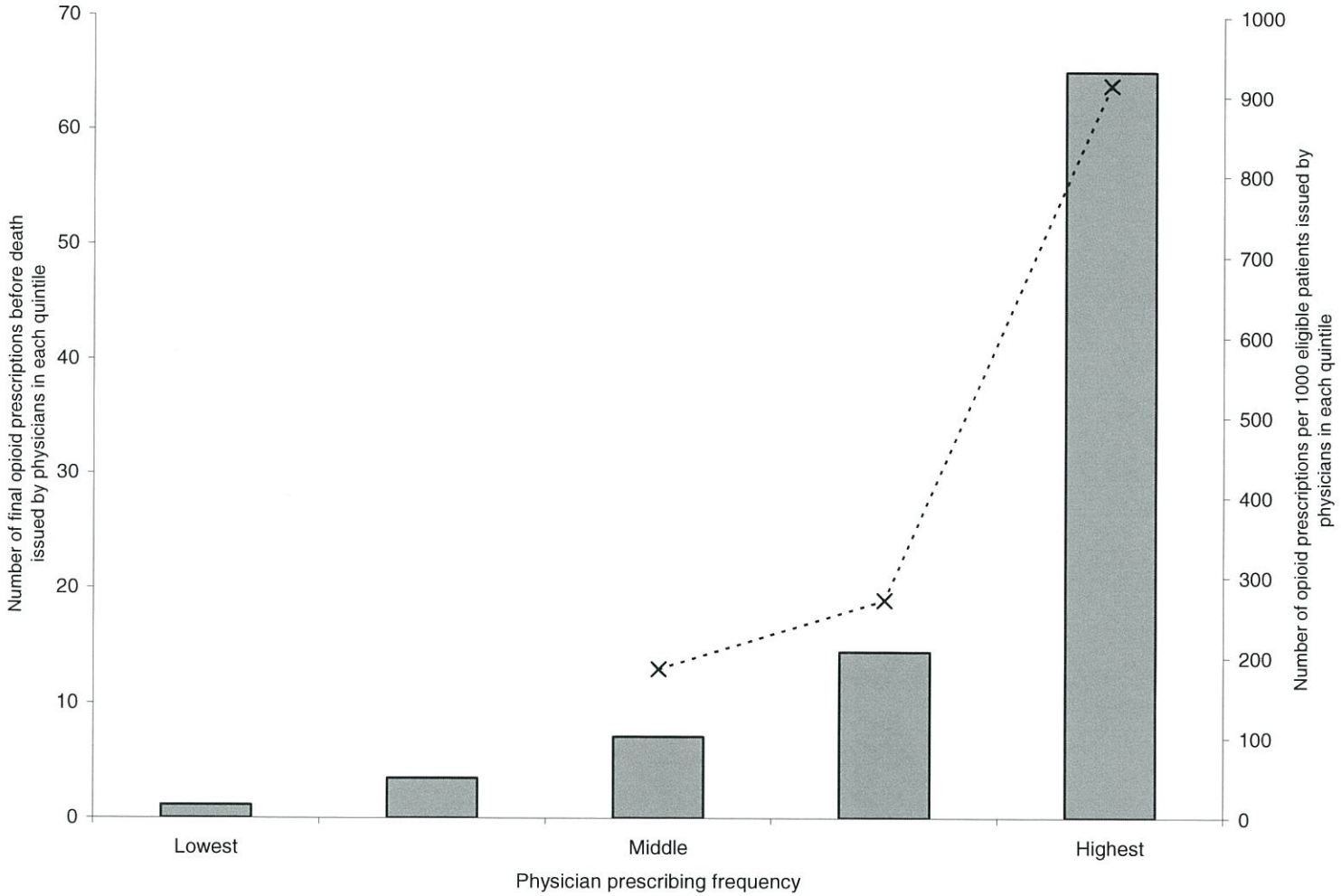
- Secondary Prevention- provide people who are addicted with effective treatment

- Supply control- collaborate with law enforcement, DEA and OPMC to limit black-market availability

Data from Prescription Drug Monitoring Program Can Be Used to:

- Flag high volume prescribers.
- Allow (or require) providers to utilize data.
- Provide prescribers with their own prescription history.
- Identify patients in need of addiction treatment.

Some family docs prescribe a lot, others not so much



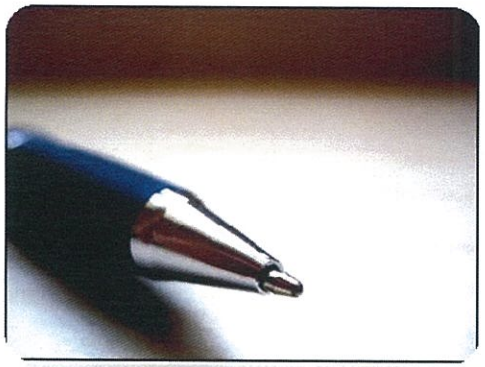
Dhalla I et al Canadian Family Physician in press

Regulatory & Policy Interventions

- Utilize PDMP data
- Up-schedule hydrocodone (Vicodin & Norco) products
- Establish standards of care for prescribing of controlled substances
  - urine tox
  - dosing limits
  - use of PDMP data
- Prescriber/pharmacy requirements to view patient photo IDs

Summary

- New York State is in the midst of a severe prescription epidemic
- Prescribers and the public need to be better informed about risks of opioid use/misuse
- The effective interventions to control this epidemic are within our grasp.



"To write prescriptions is easy, but to come to an understanding with people is hard."

– Franz Kafka, *A Country Doctor*

SCHNEIDERMAN UNVEILS PRESCRIPTION DRUG BILL TO FIGHT ABUSE & ADDICTION

Schneiderman Targets Prescription Drug Addiction – Part Of National Movement to Address America's Prescription Drug Crisis

"I-STOP" Legislation Would Improve Health Care, Monitor Potential Abuses Like 'Doc-Shopping'

NEW YORK – Addressing the growing wave of prescription drug abuses in New York State, Attorney General Eric T. Schneiderman today unveiled legislation that would create an online database to report and track the prescription and dispensing of certain controlled substances.

The "Internet System for Tracking Over-Prescribing Act," or "I-STOP," would provide health care practitioners and pharmacists with centralized information to avoid over-prescribing, help shut down prescription drug trafficking, and identify and treat patients who seek to abuse prescription drugs. Attorney General Schneiderman's program bill expands on a proposal made by Assemblyman Michael Cusick (D – Staten Island), who is sponsoring the bill in the Assembly. In the Senate, the bill is sponsored by Andrew J. Lanza (R – Staten Island).

"The rise of prescription drug abuse in New York and across the country demands a better system for both our health care providers and law enforcement officials to track the flow of potentially dangerous substances," **Attorney General Schneiderman** said. "I-STOP utilizes our online technology to streamline communication between health care providers and pharmacists to better serve patients, stop prescription drug trafficking, and provide treatment to those who are addicted."

Senator Andrew J. Lanza said, "The legislation would allow our physicians and pharmacists to access real-time prescription histories to ensure that patients' prescription use is legitimate – not lethal. I am proud to sponsor the Attorney General's legislation to improve health care service, and help shut down prescription drug trafficking and abuse."

Assemblyman Michael Cusick said, "The information gap between doctors and pharmacists allows addicts and abusers to slip through our regulatory cracks. The Attorney General's legislation will better coordinate health care services so that patients receive the medication they need, while addicts and those who profit off of abuse receive the treatment they deserve."

Staten Island District Attorney Daniel M. Donovan Jr. said, "I commend the Attorney General on his efforts to create a database that would help law enforcement and the medical community combat prescription drug abuse – similar to a national prescription drug database that would be created under legislation I have worked on

with Congressman Michael Grimm. I only hope the other 49 state Attorneys General follow Mr. Schneiderman's lead."

According to the federal Office of National Drug Control Policy, prescription drug abuse is the country's second most prevalent illegal drug problem, and recent reports and studies have documented corresponding data in the state. For example:

- Oxycodone prescriptions rose 66 percent in New York City from 2007 to 2009, with a great number of those prescriptions filled in Staten Island;

- In Buffalo, New York's largest methadone clinic outside of New York City, Catholic Health System, is beginning to reorganize its service to accommodate an increase in care needed to treat the number of addicted expected mothers and their newborns;

- This past summer, as the drug manufacturer of OxyContin altered its current formula to prevent abuse, prescriptions for another opioid, Opana ER increased. In Nassau County, Medicaid prescriptions for OxyContin decreased 43 percent, while Medicaid prescriptions for Opana ER increased 45 percent during the same time period.

I-STOP would amend the New York State Public Health Law to establish a controlled substance reporting system by setting up an online, real-time database. Health care practitioners and pharmacists would be required to report specific information to the database when Schedule II, III, IV, and V controlled substances are prescribed and dispensed. Such controlled substances include: oxycodone and morphine (Schedule II); vicodin (Schedule III); Xanax and Klonopin (Schedule IV); and pyrovalerone (Schedule V).

In addition to reporting the information, practitioners and pharmacists will be required to consult the I-STOP database before prescribing and dispensing a Schedule II, III, IV, or V controlled drug. Practitioners will be able to ensure, among other things, that the prescription is "medically necessary," and that the patient receiving the prescription is not an addict or habitual user. Pharmacists will be able to ensure that the prescription presented matches prescription data reported by a practitioner to the I-STOP database. The New York State Department of Health will be responsible for maintaining the database.

This enhancement of the state's prescription drug monitoring program will assist in patient care, and also help crack down on 'doc-shopping,' the practice of visiting several different doctors and pharmacies for prescription drugs. With real-time information, physicians and pharmacists will be able to track potential abuses, treat addiction, and stop those who enable and profit off of the illegitimate use of prescribed drugs.

I-STOP would also require practitioners, pharmacists and law enforcement officials to complete continuing education programs on the proper uses of the substance reporting system. The proposed legislation prohibits the disclosure of all the data collected in the

online database, unless authorized by law. Prescription drug monitoring programs operate in 43 states.

Legislative Bill Drafting Commission
11782-01-1

S. --------
Senate

IN SENATE--Introduced by Sen

--read twice and ordered printed, and when printed to be committed to the Committee on

-------- A.
Assembly

IN ASSEMBLY--Introduced by M. of A.

with M. of A. as co-sponsors

--read once and referred to the Committee on

PUBHEALA
(Enacts the Internet System for Tracking Over-Prescribing (I-STOP) Act)

Pub Heal. I-STOP; track prescript

AN ACT

to amend the public health law, in relation to creating an on-line real time controlled substance reporting system to monitor the prescribing and dispensing of certain controlled substances

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

IN SENATE_____

Senate introducer's signature

The senators whose names are circled below wish to join me in the sponsorship of this proposal

s21 Adams	s44 Farley	s54 Kennedy	s19 Montgomery	s23 Savino
s11 Addabbo	s02 Flanagan	s36 Klein	s54 Nozzolio	s28 Serrano
s51 Alesi	s08 Fuschillo	s26 Krueger	s52 O'Mara	s51 Seward
s11 Avella	s59 Gallivan	s27 Kruger	s37 Oppenheimer	s09 Skelos
s40 Ball	s12 Gianaris	s24 Lanza	s21 Parker	s14 Smith
s47 Bonacic	s27 Golden	s35 Larkin	s15 Peralta	s25 Squadron
s46 Breslin	s47 Griffo	s03 LaValle	s30 Perkins	s16 Stavisky
s38 Carlucci	s60 Grisanti	s52 Libous	s51 Ranzenhofer	s35 Stewart-Cousins
s50 DeFrancisco	s06 Hannon	s45 Little	s48 Ritchie	
s31 Diaz	s36 Hassell-Thompson	s05 Marcellino	s53 Rivera	s49 Valesky
s37 Dilan		s07 Marcha	s56 Robach	s17 Young
s25 Duane	s10 Huntley	s62 Maziarz	s41 Saland	s03 Zeldin
s31 Espaillat	s04 Johnson	s43 McDonald	s15 Sampson	

IN ASSEMBLY_____

Assembly introducer's signature

The Members of the Assembly whose names are circled below wish to join me in the multi-sponsorship of this proposal:

a049 Abbate	a107 Crouch	a095 Jaffee	a038 Miller, M.	a011 Saladino
a052 Abinanti	a034 Curran	a057 Jeffries	a052 Millman	a113 Sayward
a105 Amedore	a063 Cusick	a135 Johns	a103 Molinaro	a029 Scarborough
a084 Arroyo	a045 Cymbrowitz	a112 Jordan	a015 Montesano	a016 Schimel
a036 Aubry	a034 DenDekker	a099 Katz	a133 Morelle	a140 Schimminger
a124 Barclay	a081 Dinowitz	a074 Kavanagh	a035 Moya	a145 Schroeder
a040 Barron	a114 Duprey	a065 Kellner	a002 Murray	a064 Silver
a082 Benedetto	a001 Englebright	a100 Kirwan	a027 Nolan	a036 Simotas
a073 Bing	a071 Farrell	a125 Kolb	a128 Oaks	a146 Smardz
a121 Blankenbush	a137 Finch	a025 Lantman	a065 O'Donnell	a093 Spano
a055 Boyland	a007 Fitzpatrick	a091 Latimer	a051 Ortiz	a079 Stevenson
a008 Boyle	a137 Friend	a015 Lavine	a134 Palmesano	a011 Sweeney
a026 Braunstein	a140 Gabryszak	a050 Lentol	a088 Paulin	a110 Tedisco
a044 Brennan	a090 Galef	a125 Lifton	a141 Peoples-Stokes	a115 Tenney
a131 Bronson	a133 Gantt	a072 Linares		a033 Thiele
a046 Brook-Krasny	a077 Gibson	a127 Lopez, P.	a056 Perry	a061 Titone
a147 Burling	a145 Goplan	a053 Lopez, V.	a087 Pretlow	a031 Titus
a127 Butler	a088 Glick	a001 Loaiquadro	a021 Ra	a061 Tobacco
a101 Cahill	a150 Goodell	a126 Lupardo	a057 Rabbitt	a061 Weinstein
a096 Calhoun	a075 Gottfried	a111 Magee	a004 Rath	a020 Weisenberg
a043 Camara	a005 Graf	a120 Magnarelli	a008 Ramos	a024 Weprin
a106 Canestrari	a098 Gunther	a059 Maisel	a134 Reilich	a070 Wright
a089 Castelli	a130 Hanna	a060 Malliotakis	a105 Reilly	a094 Zebrowski
a086 Castro	a129 Hawley	a030 Markey	a078 Rivera, J.	a023
a138 Ceretto	a148 Hayes	a019 McDonough	a080 Rivera, N.	a027
a093 Clark	a083 Heastie	a104 McEneny	a076 Rivera, P.	a054
a047 Colton	a028 Hevesi	a017 McKevitt	a115 Roberts	a116
a010 Conte	a048 Hikind	a108 McLaughlin	a050 Robinson	
a032 Cook	a018 Hooper	a022 Meng	a066 Rodriguez	
a142 Corwin	a144 Hoyt	a121 Miller, D.	a067 Rosenthal	
a085 Crespo	a042 Jacobs	a102 Miller, J.	a118 Russell	

1) Single House Bill (introduced and printed separately in either or both houses), Uni-Bill (introduced simultaneously in both houses and printed as one bill, Senate and Assembly introducer sign the same copy of the bill).

2) Circle names of co-sponsors and return to introduction clerk with 2 signed copies of bill and 4 copies of memorandum in support (single house); or 4 signed copies of bill and 8 copies of memorandum in support (uni-bill).

LBDC 05/12/11

Section 1. This act shall be known and may be cited as the "Internet System for Tracking Over-Prescribing (I-STOP) Act".

§ 2. The public health law is amended by adding a new section 3343-a to read as follows:

§ 3343-a. On-line real-time controlled substance reporting system. 1. Establishment of system. The commissioner shall, in accordance with the provisions of this section, establish and maintain a system for collecting, monitoring and reporting data concerning the prescribing and dispensing of schedule II, III, IV, or V controlled substances, or any other substances specified by the commissioner, that are prescribed or dispensed. Such system shall allow practitioners and pharmacists to monitor and report such data by means of an internet portal and a website and any other electronic means deemed appropriate by the commissioner. Such system shall enable practitioners and pharmacists to monitor and report such data at the time a prescription is issued or such substance is dispensed. The commissioner shall adopt and such system shall maintain procedures and safeguards to ensure the privacy and confidentiality of patient information and to ensure that any data collected or reported is not unlawfully accessed or disclosed. The commissioner shall also establish acceptable error tolerance rates for data and procedures for practitioners and pharmacists to follow in the event of a technological failure.

2. Reporting obligations. Every practitioner or pharmacist within the state or any other dispenser who has obtained a license, permit or other authorization to operate from the commissioner of education, or any agent thereof, shall report to the commissioner the data specified in paragraph a or b of this subdivision through an internet portal and website maintained by the commissioner and any other method deemed

appropriate by the commissioner, upon issuing a prescription or dispensing a schedule II, III, IV, or V controlled substance or any other substance specified by the commissioner; provided that such reporting shall not be required for any such substance administered directly to a patient, or for such substance dispensed pursuant to section three thousand three hundred thirty-four, three thousand three hundred thirty-seven or three thousand three hundred forty-two of this chapter or any rule or regulation promulgated under those sections.

a. Data to be reported by practitioners. Data concerning schedule II, III, IV, or V controlled substances or any other substances specified by the commissioner that are prescribed shall include but not be limited to the following: practitioner prescription number; practitioner national identification number; patient name; patient address, including street, city, state, zip code; patient date of birth; patient's sex; date prescription issued; metric quantity; national drug code number of the drug; number of days supply; practitioner drug enforcement administration number; date prescription written; serial number of official prescription form, or an identifier designated by the department; payment method, and number of refills authorized.

b. Data to be reported by pharmacists. Data concerning schedule II, III, IV, or V controlled substances or any other substances specified by the commissioner that are dispensed shall include but not be limited to the following: pharmacy prescription number; pharmacy's national identification number; patient name; patient address, including street, city, state, zip code; patient date of birth; patient's sex; date prescription filled; metric quantity; national drug code number of the drug; number of days supply; practitioner drug enforcement administration number; date prescription written; serial number of official

prescription form, or an identifier designated by the commissioner; payment method; number of refills authorized; and refill number.

3. Duty to consult database; prohibitions. Every practitioner or pharmacist within the state, including any other dispenser who has obtained a license, permit, or other authorization to operate from the commissioner of education, shall make inquiry to the on-line controlled substance reporting system established pursuant to subdivision one of this section prior to prescribing or dispensing any schedule II, III, IV, or V controlled substance or any other substance specified by the commissioner; provided that this subdivision and paragraphs (a) and (b) hereof, shall not apply to any such substance administered directly to a patient or for any such substance dispensed pursuant to sections three thousand three hundred thirty-four, three thousand three hundred thirty-seven or three thousand three hundred forty-two of this chapter and any rule promulgated thereunder.

a. No practitioner shall prescribe any schedule II, III, IV, or V controlled substance or any other substance specified by the commissioner without reviewing a patient's controlled substance presctiption history as set forth in the on-line controlled substance reporting system to determine that such prescription is medically necessary and would not otherwise violate section three thousand three hundred fifty of this article, or, for prescriptions eligible for reimbursement by the medicaid program, section one hundred forty-five-b of the social services law.

b. No pharmacist shall dispense any schedule II, III, IV, or V controlled substance or any other substance specified by the commissioner without confirming the existence of a matching report provided by a practitioner through the on-line controlled substance reporting system.

4. Limitations on use; disclosure restrictions. a. No practitioner or pharmacist shall disclose or be required to disclose any data viewed or received through the on-line controlled substance reporting system unless so required by a provision of law specifically relating to the treatment of a patient or relating to the mandatory reporting of an illegal use or abuse of a controlled schedule II, III, IV or V substance or any other substance specified by the commissioner. Disclosure by a practitioner or pharmacist to any other person or entity, including disclosure in the context of a civil action where the disclosure is sought either for the purpose of discovery or for evidence, is prohibited.

b. The commissioner may not disclose data collected for the on-line controlled substance reporting system unless specifically so authorized by law.

c. The commissioner shall be authorized to review by electronic means or otherwise the date collected or published for the on-line controlled substance reporting system. The commissioner shall be authorized to disclose data collected for or published on the on-line controlled substance reporting system, without necessity of subpoena, to: (i) the director of the office of the professions of the department of education or his or her designee who is responsible for the licensure, regulation, or discipline of practitioners or pharmacists; (ii) the deputy attorney general for medicaid fraud control or his or her designee; (iii) the medicaid inspector general or his or her designee; (iv) a judge or a probation or parole officer administering a diversion or probation program of a criminal defendant who is eligible to participate in a court-ordered drug diversion or probation program; or (v) a practitioner or pharmacist, or their agent, who requests information and certifies

that the requested information is for the purpose of providing medical or pharmaceutical treatment to a current patient. Any person to whom the commissioner discloses such data pursuant to this paragraph shall not provide such data to any other person or entity except by court order, which shall be granted only upon application by such person and only upon a showing that such an order is necessary for such person to carry out his or her duties as a public officer or as a practitioner or pharmacist; provided that the commissioner of the department of education may submit the data as evidence in any administrative hearing as authorized by law.

d. The commissioner shall be authorized to provide the data reported to or collected for the on-line controlled substance reporting system upon receipt of a subpoena issued to a police officer, district attorney, or grand jury, or any federal or state law enforcement agency.

e. The commissioner may use any data or reports collected for or reported to the on-line controlled substance reporting system for the purpose of identifying medicaid recipients whose usage of controlled substances may be appropriately managed by a single outpatient pharmacy or primary care practitioner.

f. Nothing in this subdivision shall be interpreted to allow a disclosure of information otherwise prohibited by federal law.

5. Immunity. No public officer acting in good faith nor the state of New York nor any department, bureau, board or political subdivision thereof shall be subject to civil liability arising from any false information of any data submitted to or reported by the on-line controlled substance reporting system; or any failure of the system to accurately or timely report such data; or for disclosure of any data

maintained by the system resulting from such officer acting in good faith in the discharge of his or her duties.

6. Civil penalties. Notwithstanding any other provision of this article relating to violations of this article:

a. Any practitioner or pharmacist who knowingly fails to transmit data to the commissioner as required by subdivision two of this section shall be liable to the state for a civil penalty of five hundred dollars for the first prescription issued which is not properly reported; one thousand dollars for the second prescription not properly reported; and five thousand dollars for each prescription not properly reported thereafter.

b. Any practitioner or pharmacist who knowingly fails to review data prior to prescribing or dispensing any substance in violation of subdivision three of this section shall be liable to the state for a civil penalty of five hundred dollars for the first prescription so issued; one thousand dollars for the second prescription so issued; and five thousand dollars for each prescription issued in violation of subdivision three of this section thereafter.

c. Any practitioner or pharmacist who knowingly discloses information in violation of subdivision four of this section shall be liable for a penalty of not more than five hundred dollars for the first such disclosure; one thousand dollars for the second such disclosure; and five thousand dollars for each such disclosure issued in violation of subdivision three thereafter.

d. Nothing in this section shall be interpreted to preempt or restrict any civil action by any individual for damages resulting from an illegal disclosure of information in violation of subdivision four of this section, or any other civil or criminal action by the commissioner or any law enforcement agency.

7. Education and outreach. The commissioner shall work with the state education department and any other governmental or private professional organization responsible for the licensure, regulation, or discipline of practitioners, pharmacists, and other persons who are authorized to prescribe, administer, or dispense controlled substances, for the development of a continuing education program about the purposes and uses of the on-line controlled substance reporting system established by this section. The attorney general shall work with the department of criminal justice services for the development of a continuing education program for law enforcement officers about the purposes and uses of the electronic system for monitoring established in this section.

8. Rules and regulations. The commissioner shall promulgate rules and regulations necessary to effectuate the provisions of this section; provided however, the commissioner shall not promulgate any rule or regulation that requires any practitioner or pharmacist to pay a fee or tax specifically dedicated to the operation of the system.

§ 3. This act shall take effect immediately; provided, however, that subdivisions 2, 3, 4, 5, 6 and 7 of section 3343-a of the public health law as added by section two of this act shall take effect one year after such effective date.

NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)

BILL NUMBER:

SPONSOR: Cusick

TITLE OF BILL: An act to amend the public health law, in relation to establishing an on-line, real-time controlled substance reporting system.

PURPOSE OR GENERAL IDEA OF BILL: To establish an on-line real-time controlled substance reporting system that requires practitioners and pharmacists to search for and report certain data at the time a schedule II, III, IV, or V controlled substance prescription is issued and at the time such substance is dispensed to identify and stop the over-prescription and abuse of schedule II, III, IV, and V controlled substances.

SUMMARY OF SPECIFIC PROVISIONS:

Section 1 of the bill establishes the title of the Act as the "Internet System for Tracking Over-Prescribing(I-STOP) Act".

Section 2 adds a new section 3343-a to the Public Health Law to: (1) require the Department of Health to establish and maintain an on-line, real-time controlled substance reporting system to track the prescription and dispensing of schedule II, III, IV, and V controlled substances; (2) require practitioners to review a patient's controlled substance prescription history on the on-line, real-time controlled substance reporting system prior to prescribing a schedule II, III, IV, and V controlled substance; (3) require practitioners to report statutorily-required data to the on-line, real-time controlled substance reporting system upon issuing a schedule II, III, IV, and V controlled substance; (4) require pharmacists to review the on-line, real-time controlled substance reporting system to confirm the person presenting a prescription for a schedule II, III, IV, and V controlled substance possesses a legitimate prescription prior to dispensing such substance; (5) require pharmacists to report statutorily-required data to the on-line, real-time controlled substance reporting system upon dispensing a schedule II, III, IV, and V controlled substance; (6) prohibit disclosure of all statutorily-required data collected on the on-line, real-time controlled substance reporting system by a practitioner, pharmacist or commissioner of health, unless authorized by law; (7)provide immunity for public officers acting in good faith and provide civil penalties for those persons who knowingly violate the a provision of Article 33 of the Public Health Law; (8) provide continuing education programs to practitioners, pharmacists and law enforcement about the purposes and proper uses of the on-line, real-time controlled substance reporting system; (9) order the Commissioner of Health to promulgate rules and regulations to effectuate this section; and (10) prohibit the Commissioner of Health from imposing a

fee or tax on a practitioner or pharmacist for the specific operation of the on-line, real-time controlled substance reporting system.

Section 3 is the effective date; this act shall take effect immediately; provided however, that subdivisions 2,3,4,5,6 and 7 of section 3343-a of the Public Health Law as added by section two of this act shall take effect one year after such effective date.

JUSTIFICATION:

The United States is experiencing an epidemic. Americans consume 80 percent of the supply of pain pills in the world and recent data collected by the Drug Enforcement Administration (DEA) has found that more than 7 million Americans admit to abusing prescription drugs. Further, the DEA has concluded that prescriptions drugs have surpassed marijuana as the number one gateway drug for first-time drug abusers in the United States. And, emergency room visits for reactions to opioid painkillers, like oxycodone, have more than doubled from 2004 (144,600) to 2008 (305,900).[1]

New York State has not been immune to this epidemic. In New York City, oxycodone prescriptions rose 66 percent from 2007 to 2009, with a great number of those prescriptions filled in Staten Island.[2] In Buffalo, Catholic Health System, New York's largest methadone clinic outside of New York City, has begun to reorganize its services to accommodate an increase in care needed to treat the number of addicted expecting mothers and their newborns.[3] This past summer in Nassau County, Opana ER, an opioid, began to replace OxyContin, as the drug manufacturer began altering OxyContin's current formula to prevent its abuse. Specifically, as Nassau County Medicaid prescriptions for OxyContin decreased 43 percent between August and February, Nassau County Medicaid prescriptions for Opana ER increased 45 percent during the same time period.[4]

The solution to the over-prescription of controlled substances, such as OxyContin, is practitioner and pharmacist awareness. Yeshiva University conducted a two-year review of administrative and medical records of more than 1,600 primary care patients who received regular prescription opioids and found that fewer than half of the patients saw their physicians regularly. This legislation would connect practitioners and pharmacists to a greater source of centralized information to avoid the over-prescribing, and help identify and treat patients who seek to abuse prescription drugs.

41 States have some form of prescription drug monitoring laws. New York State currently operates a limited prescription monitoring program.

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[1] Roni Caryn Rabin, *Hazards: Emergencies Over Legal Drugs Increase*, New York Times, June 21, 2010.
[2] Abby Goodnough, *A Wave of Addiction and Crime, with the Medicine Cabinet to Blame*, New York Times, September 23, 2010.
[3] [3] Henry L. Davis, *Treating the Tiniest Addicts Mothers' Pill Abuse Leads to Newborns' Exposure*, Buffalo News, June 1, 2011.
[4] Timothy Bolger, *Officials Warn of New Drug of Choice on Long Island*, Long Island Press, May 10, 2011.

PRIOR LEGISLATIVE HISTORY: New bill.

FISCAL IMPLICATIONS: To be determined.

EFFECTIVE DATE: This act shall take effect immediately; provided however, that subdivisions 2,3,4,5,6 and 7 of section 3343-a of the public health law as added by section two of this act shall take effect one year after such effective date.