CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON HEALTH, MENTAL HEALTH AND DRUG ABUSE

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HELD AT: 250 Broadway
Committee Rm, 16th Fl.

B E F O R E:
G. OLIVER KOPPELL
MARIA DEL CARMEN ARROYO
RUBEN WILLS
Chairperson

COUNCIL MEMBERS:
James G. Van Bramer
Peter F. Vallone, Jr.
Albert Vann
Michael C. Nelson
Gale A. Brewer

A P P E A R A N C E S (CONTINUED)

Paul Mahoney
Assistant Deputy Attorney General
New York State Medicaid Fraud Control Unit

Michael Cusick
Assembly Member
New York State

Tracy Pugh
Policy Associate
New York Academy of Medicine

CHAIRPERSON KOPPELL: Okay.

CHAIRPERSON ARROYO: Upset Nick.

[Off mic]

CHAIRPERSON ARROYO: Kick you out of here.

SERGEANT-AT-ARMS: We're on.

CHAIRPERSON KOPPELL: Okay. Good afternoon, I'm Oliver Koppell, Chair of the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse, and Disability Services. I am pleased to be joined today by our distinguished chairman of the Committee on Health, Maria del Carmen Arroyo, and the Chair of the Subcommittee on Drug Abuse, Ruben Wills. And I might note that Jimmy Van Bramer is here and we want to acknowledge his presence 'cause I know he has to leave fairly soon, but his presence should indeed be acknowledged.

MALE VOICE: Vallone is here.

CHAIRPERSON KOPPELL: Oh, there you are, I didn't see you standing up there, you're too high. Peter Vallone from Queens.

FEMALE VOICE: And very appropriate given the subject.

2 [Laughter]

3 CHAIRPERSON KOPPELL: I didn't mean
4 it in that sense.

5 [Off mic]

6 CHAIRPERSON KOPPELL: I didn't mean
7 it in that sense. I didn't mean--no, we
8 appreciate your being here, sir, we do.

9 So this is a joint hearing on a
10 Preconsidered Resolution that calls upon the New
11 York State Legislature to pass and the Governor to
12 sign legislation which would create an online
13 database to report and track prescription and
14 dispensing of certain controlled substances. The
15 state legislation, which had been proposed by
16 Attorney General Eric Schneiderman, has been
17 introduced because of growing concern on the abuse
18 of prescription drugs, which we are all aware of.

19 Between the--I have some statistics
20 here that may be interesting and should be in the
21 record--between 2005 and 2009, rates of accidental
22 drug overdose deaths, drug overdose deaths
23 actually declined in New York City in all major
24 categories except prescription pain medication and
25 prescription sedatives. The rate of prescription

pain medication misuse by New York City residents who are 12 and older has increased by 40% from 2002 to 2009, and unintentional opioid analgesic poisoning death rate increased by 20% for 2000--between 2005 and 2009.

Many of the drugs which we are discussing are absolutely vital for maintaining decent quality of life for many individuals with a wide variety of health conditions. No one doubts the necessity of doctors prescribing and pharmacists filling prescriptions for pain medication such as oxycodone or morphine, particularly for individuals suffering from severe pain, such as those pain associated with cancer. Nonetheless, we must be aware of the facts surrounding the burgeoning misuse of prescription drugs.

In New York, the number of prescriptions for all narcotic painkillers has increased from 16.6 million in 2007 to 22.5 million in 2010. Since 2007, prescriptions for hydrocodone have increased 16.7%--and the next statistic's quite remarkable--prescriptions for oxycodone have increased by 82%. In 2009, there

2 were nearly 900,000 oxycodone and 825,000
3 hydrocodone prescriptions filled in New York City.
4 Prescription drugs may reach
5 unintended users in several ways. Prescriptions
6 may inadvertently prescribe controlled substances
7 at a higher dosage or quantity than required or
8 they may not recognize the warning signs that a
9 patient is engaged in fraud or doctor shopping--
10 the practice of trying to acquire the same
11 medication from multiple doctors. Patients may
12 share left over medications with others, on the
13 mistaken belief that because it's a prescription
14 drug, it's safe. Doctors may also fail to
15 communicate regarding medication when treating the
16 same patient and patients may not report all
17 medications which they currently receive.
18 Additionally, doctors may intentionally over-
19 prescribe medication or may be the victims of
20 prescription pad theft.
21 In response to the increase in
22 prescription drug abuse, the Governmental
23 Accountability Office, the White House Office of
24 National Drug Control Policy, and the CDC have all
25 called for improved prescription drug monitoring.

2 New York's current prescription drug monitoring
3 program collects data on all Scheduled II, III,
4 IV, and V controlled substance prescriptions
5 dispensed. Every pharmacy licensed in New York
6 state to dispense a controlled substance is
7 required to transmit patient, doctor, and drug
8 information for every controlled substance
9 prescription that it dispenses. Physicians,
10 however, are not required to report the
11 prescriptions that they issue in any manner.
12 The I-STOP, which stands for
13 Internet System for Tracking Over-Prescribing Act,
14 proposal--that's what we're considering today--is
15 important because it will close loopholes within
16 New York State's current prescription monitoring
17 program and may reduce the opportunities for
18 prescription drugs to be diverted. By requiring
19 physicians to report data on what prescriptions
20 they provide to individual patients and giving
21 physicians and pharmacies access to this
22 information, the I-STOP system will prevent doctor
23 shopping. The I-STOP Act should also prevent the
24 successful use of stolen or forged prescription
25 pads.

2 I look forward to hearing from all
3 of the interested parties, and I know my
4 colleagues, Council Member Arroyo and Council
5 Member Wills, will somewhat in more detail
6 describe what we're considering.
7 I'd like to acknowledge that
8 members of the committee will be joining us. Do I
9 see anybody else here today that I haven't
10 introduced?
11 [Crosstalk]
12 FEMALE VOICE: Vann.
13 MALE VOICE: Al Vann.
14 CHAIRPERSON KOPPELL: Oh, Al, there
15 you are. Al Vann at the end, I didn't see you
16 there. I'd also like to acknowledge that on the
17 staff associated with my committee, Jennifer
18 Wilcox, who's to my right, helped prepare that
19 excellent statement; counsel Michael Benjamin's on
20 my left; Pamela Corbett, our financial analyst,
21 was here; and I also want to acknowledge Jamin
22 Sewell, who is on my staff, but works very closely
23 on matters that the committee's concerned with. I
24 also understand that Mike Nelson is down there.
25 FEMALE VOICE: Yeah.

2 CHAIRPERSON KOPPELL: Councilman
3 Nelson from Brooklyn.
4 Thank you, and we now will hear
5 from my colleagues.
6 CHAIRPERSON ARROYO: Ladies first.
7 'Cause I'm more bossy than he anyway.
8 Good afternoon, everyone. My name
9 is Maria del Carmen Arroyo, I Chair the Committee
10 on Health in the Council.
11 Today we are conducting a joint
12 hearing with the Mental Health Committee chaired
13 by my colleague, Council Member Koppell, and the
14 Subcommittee on Drug Abuse, chaired by my
15 colleague Council Member Wills, on a Preconsidered
16 Resolution that calls upon the state legislature
17 to pass and the Governor to sign the Internet
18 System for Tracking Over-Prescribing Act, I-STOP.
19 I-STOP is legislation, as my colleague mentioned,
20 championed by our New York State Attorney General
21 Eric Schneiderman, and I don't want to reiterate
22 what my colleague has already articulated so well
23 on the goals of this legislation and this system.
24 I do, however, want to especially
25 thank my co-chairs for convening this hearing and

2 I would like to especially thank Council Member
3 Mike Nelson and Speaker Quinn for introducing this
4 resolution on this important public health issue.
5 And I know that we're going to hear from Council
6 Member Nelson after Council Member Wills does his
7 opening statement.
8 It is really unfortunate, but
9 prescription drug abuse in our city has become a
10 very serious concern, and it is then a dangerous
11 growing trend in our city, as well as the rest of
12 the country. Individuals abuse prescription drugs
13 by taking these medications when they do not have
14 a prescription or taking them in manners
15 inconsistent with how they are prescribed. The
16 effects of this abuse is significant and has not
17 only an impact on individual, but on family and
18 community as a whole.
19 Our Department of Health here in
20 the city reports that approximately one out of
21 seven New York City adults have misused
22 prescription drugs. And the department has also
23 noted that there has been a 40% increase of
24 prescription drug abuse in our city from the years
25 2002 to 2009.

2 Additionally, accidental drug
3 overdose is the third leading cause of death among
4 New Yorkers between the ages of 25 and 34. And
5 22% of these cases involve prescription drugs.
6 Due to this growing trend, Mayor
7 Bloomberg announced a prescription drug abuse task
8 force in December 2011. The goal of this task
9 force will be to look at public health and public
10 safety strategies to keep New Yorkers safe from
11 the dangers of prescription medication.
12 Given this significant public
13 safety and health risk associated with
14 prescription drugs, government must take
15 affirmative action to keep New Yorkers safe. New
16 York State Attorney General Eric Schneiderman
17 submitted a program bill to the state legislature
18 which would create the Internet System for
19 Tracking Over-Prescribing Act, I-STOP. We will
20 hear more about I-STOP sponsored by Assembly
21 Member Michael Cusick and Senator Andrew Lanza,
22 both from Staten Island, where this problem is a
23 very particular issue.
24 And I think we will hear from our
25 colleague, Council Member Rose, who's a member of

2 the Health Committee, who has also been a very
3 vocal champion on this issue.
4 I want to thank my committee staff,
5 who both happen to be on vacation today, Lacey
6 Clarke and Joe Mancino. Lacey's our committee
7 counsel and Joe is the policy analyst, and also
8 Pamela Corbett, who I know is here somewhere--hi,
9 Pam--our fiscal analyst, they always prepare me
10 for these hearings and make me sound really,
11 really smart.
12 I want to recognize my colleagues
13 in the Health Committee that I think have already
14 been mentioned, but I believe is Council Member
15 Vallone and Council Member Vann, who are members
16 of the Health Committee.
17 And I don't know if we've said, but
18 if you're here to provide testimony, you have to
19 fill out one of these, otherwise we don't know
20 you're here to talk to us, and we do want to hear
21 from you. And we're going to be quiet and take
22 calls outside, otherwise, Nick is going to yell at
23 us. Right, Nick?
24 And now I turn it over to my co-
25 chair for his opening statement, and then we'll

2 hear from Council Member Nelson.
3 CHAIRPERSON WILLS: Good afternoon.
4 Thank you, Chairs Arroyo and Koppell. I am
5 Council Member Ruben Wills, Chair of the
6 Subcommittee on Drug Abuse.
7 As was already echoed by my
8 colleagues, I'm not going to belabor the point,
9 this is to consider a resolution in support of
10 Attorney General Eric Schneiderman's I-STOP
11 legislation, which is currently pending in Albany.
12 Before I do that, I just wanted to
13 give on record kudos to Attorney General Eric
14 Schneiderman for the work that he's done with the
15 foreclosure, so please take him back because it's
16 going to help tens of thousands of people in New
17 York state.
18 So what I want to do is just go
19 over some of the bullet points of what this
20 legislation is going to do, and then I'm going to
21 turn it over to Council Member Mike Nelson, who is
22 the sponsor, along with our Speaker, Christine
23 Quinn, of this resolution.
24 This resolution would require the
25 State Department of Health to establish and

2 maintain an online controlled substance reporting
3 system to track the prescription and dispensing of
4 controlled substances in real time, which is very
5 important; require medical practitioners to review
6 patients controlled substance prescription history
7 before giving new prescriptions; require those
8 practitioners to report prescriptions for
9 controlled substances into the system at the time
10 of issuance, which is also very important; require
11 pharmacists to review the system to confirm within
12 the system to confirm the prescriptions are
13 legitimate before dispensing controlled
14 substances; and require pharmacists to report
15 dispensation of controlled substances at the time
16 they are dispensed.
17 I-STOP is a great start for
18 stemming the tide of over-prescribing of
19 controlled substances and preventing and
20 curtailing abuse of these drugs.
21 I just want to quickly thank the
22 staff of all of the committees involved in today's
23 hearing, particularly the Subcommittee on Drug
24 Abuse staff, Matthew Carlin, the counsel; Joe
25 Mancino, our policy analyst; Pam--yeah, they're

2 all on vacation--again, Pam Corbett, the finance
3 analyst; and a new addition to my staff, India
4 Sneed, who is in the corner.
5 And now I guess the Chairs, we'll
6 turn it over to Council Member Michael Nelson? Is
7 that--okay.
8 COUNCIL MEMBER NELSON: Thank you,
9 Chair Wills, and thank you, Chairs Arroyo and
10 Koppell, and members of all of the committees.
11 Good afternoon, I'm pleased to have
12 the opportunity to testify in support of the
13 Preconsidered Resolution calling upon New York
14 State to enact I-STOP, an Internet System for
15 Tracking Over-Prescribing Act would create an
16 online database to report and track the dispensing
17 of certain addictive prescription drugs.
18 Prescription drug abuse is the
19 nation's fastest growing drug problem and
20 prescription drug overdose is the second leading
21 cause of accidental death in the United States.
22 Every population group in our society has been
23 affected. It is now most urgent that New York
24 join the 43 states which have already enacted laws
25 and committed resources to utilize computer

2 technology in the fight against the abuse of
3 prescription drugs.
4 Data from the National Survey on
5 Drug Use and Health shows that nearly one-third of
6 people age 12 and over who use drugs for the first
7 time in 2009 begin by using prescription drug non-
8 medically. Teens in particular mistakenly believe
9 that prescription drugs are safer than illegal
10 drugs because they've been prescribed by a health
11 care professional and dispensed by a pharmacy.
12 Unfortunately, the current controlled substance
13 laws no longer provide a complete safeguard
14 against prescription drug abuse, which the Centers
15 for Disease Control and Prevention have classified
16 as an epidemic.
17 There's a real time information gap
18 between medical practitioners and pharmacists that
19 allow abusers to escape existing regulations.
20 This resolution being heard by the committee
21 today, when enacted into law by New York State,
22 will implement prescription drug monitoring
23 programs that will effectively fight prescription
24 drug abuse. New York's proposed monitoring
25 program would utilize the Internet to most

2 effectively use available data to detect multiple
3 prescriptions issued to individuals engaged in
4 doctor shopping--the practice of visiting several
5 different doctors and pharmacies for prescription
6 drugs--as well as other illegal acts of diversion
7 from people who originally received a prescription
8 for a legitimate purpose. The latest National
9 Survey on Drug Use and Health has found that 70%
10 of people abusing prescription pain relievers
11 receive them from friends or relatives.
12 I urge your enthusiastic support
13 for this most important legislation. Again, I
14 thank you, Chairs.
15 CHAIRPERSON KOPPELL: Thank you
16 very much, Council Member Nelson. I might note
17 that we're pleased to have Assemblyman Cusick here
18 this morning--or this afternoon, I should say, who
19 is the sponsor and he--normally we allow elected
20 officials to go first. He has graciously
21 consented to have Paul Mahoney from the Attorney
22 General's office lead off since the proposal here
23 emanates from the Attorney General's office. I
24 want to acknowledge receiving this very detailed
25 presentation, and ask Mr. Mahoney to come forward

2 and testify. Thank you, Assemblyman Cusick, for
3 being willing to go second. As a former state
4 official, I have a partiality toward State
5 Assembly people particularly.
6 [Off mic]
7 PAUL MAHONEY: Thank you very much,
8 Members of the Committee and Members of the
9 Council, for inviting us here today and hearing
10 from the perspective of Attorney General
11 Schneiderman on this important issue. My name's
12 Paul Mahoney, I'm the Assistant Deputy Attorney
13 General for the New York State Medicaid Fraud
14 Control Unit, and under the supervision of the
15 unit's director, we have 300 staff who investigate
16 and prosecute criminal and civil fraud and abuse
17 of the New York State Medicaid program. And we'd
18 like to thank, on behalf of the Attorney General,
19 Assemblyman Cusick and Senator Lanza, for
20 sponsoring the I-STOP legislation, which is set
21 out in the report, which I'm not going to go
22 through in detail because as I was sitting here
23 and I heard the Council Members review the
24 proposed resolution and their summary of the
25 problem, I cannot add a single fact that would

2 change the analysis of the problem, you set out
3 the problem very well from different perspectives.
4 And so I thought I would concentrate my remarks on
5 the approach we took to this legislation, which
6 was intended to address as many of those concerns
7 and as many of the issues as possible.
8 When the Attorney General
9 Schneiderman asked us to look at the problem of
10 controlled substance monitoring early last year,
11 before most of the more noteworthy recent events
12 took place, it was due to the recognition it was a
13 growing problem and a need--a recognition in the
14 need to address it. But when we looked at the
15 approach from our perspective, we realized we had
16 to find a solution that took into account
17 information, accessibility of that information,
18 and accountability of the people involved, and we
19 think a complete solution, as set forth in the I-
20 STOP proposal is the correct approach. There are
21 many half solutions, partial solutions, and tweaks
22 of the existing prescription monitoring program
23 out there, and we're here to advocate for a
24 complete solution.
25 And my explanation for that is

2 fairly simple from our own direct experience. The
3 Medicaid Fraud Control Unit, which has existed in
4 one form or another since 1975, has traditionally
5 addressed the problem of controlled substance and
6 prescription drug abuse from the perspective of
7 financial fraud, that is our core jurisdiction.
8 And from 2007 to 2012, the state paid out $1
9 billion in Medicaid payments alone for scheduled
10 controlled substances, that's roughly $250 million
11 a year, and every investigation we've done simply
12 from a Medicaid fraud perspective has uncovered at
13 least a million dollars in fraudulent billing in
14 each such circumstance, and we're hardly the
15 prosecutors, we're the monopoly of that sort of
16 investigation.
17 So we took a different perspective,
18 what's the incentive here, and the incentive is
19 that controlled substance abuse creates a nearly
20 ideal situation for any person in the chain of the
21 prescription to act in bad faith, and it all
22 starts with the paper prescription. Because once
23 that paper prescription is issued, everything that
24 happens after that paper prescription is issued is
25 prima facie lawful. And if you think of it from

2 traditional controlled substance narcotics
3 investigation, the mere fact of possession is the
4 criminal conduct, and what we do through
5 prescription drug transactions is we cloak
6 everything in the veneer of lawfulness.
7 I brought with me a roll of 250
8 prescriptions that was seized as evidence during
9 the course of one of our recent investigations.
10 And in fact, the person who had possession of
11 these scripts was sentenced to four to eight years
12 in prison this morning in the Bronx, so I was
13 finally able to take this out of the office. The
14 problem is I brought a roll of 250 prescriptions,
15 it started as a roll of 500--250 of them were--
16 well four of them were seized as evidence in a
17 pharmacy, which led to the original investigation,
18 but the other 246 were believed to be transacted
19 in one form or another. So the question is what
20 causes 246 to get on the street, and that
21 accounted for probably 90 pills per prescription,
22 so the math adds up to about 2,500 pills and about
23 $250,000 in Medicaid payments. So that tells us
24 right there it's very lucrative.
25 It's lucrative in multiple senses:

2 The drug abuser, who could very well be a person
3 who has a true medical addiction and needs true
4 medical treatment, there's no question about that,
5 nonetheless, because of that physiological
6 problem, has a real incentive, a need really, to
7 engage in doctor shopping. To get a doctor to
8 write that prescription, because once a doctor
9 writes that prescription, that prescription has
10 multiple values. If they're not too ambitious,
11 they can go and find someone who's willing to buy
12 that piece of paper from them. If they want to
13 get drugs in their possession to use, they can go
14 to a pharmacy and negotiate that--I mean, and have
15 that prescription filled. If they want to cover
16 both their financial interest and their health
17 abuse interest--and their abuse interest, they can
18 get those pills, keep some of them for their own
19 needs and their own purposes and have some to
20 sell. So from the abuser's point of view, it's a
21 highly lucrative and when they have that script,
22 it's an okay transaction.
23 The sellers of the drug are
24 probably a person wearing a white coat, either a
25 bad faith doctor or a bad faith pharmacist and

2 that person can get paid in any one of a number of
3 formats: They can get paid by private insurance,
4 that's very lucrative; they can get paid through a
5 state paid program, Medicaid in most cases; or
6 they can even be paid in cash. And so if we think
7 about that, this prescription is the cover, the
8 key to a transaction that if people did it hand to
9 hand in cash, you'd say why aren't the police
10 jumping on these people, but they have this piece
11 of paper and all of a sudden it becomes a
12 transaction that police aren't supposed to look at
13 at all.
14 The good faith actors, because the
15 problem with doctor shopping is not that everyone
16 is a bad faith actor, it's that most of the people
17 are presumably a good faith actor. The pharmacist
18 who's not participating in a scheme and a good
19 faith doctor who is trying to treat a patient in
20 front of them, currently they have very few tools
21 to break that chain. And here's the interesting
22 kicker from our perspective--if law enforcement is
23 able to break into that chain, each of the actors
24 have the ability to point to each other as a
25 person giving a veneer of legitimacy to the

2 transaction. If the transaction seems to point to
3 a doctor being a problem, all a doctor has to say
4 now is that the patient misrepresented their
5 medical history to them. And colloquially, who
6 are you going to believe, me in my white coat with
7 my diploma over my shoulder or the admitted drug
8 addict, who will admit, as they necessarily will,
9 to being willing to do almost anything to get
10 their addiction need filled. So that's the blame
11 the patient defense.
12 The pharmacy that thought something
13 was fishy and thought maybe they wouldn't fill
14 out--fill this prescription, can always blame the
15 doctor. Who are you going to believe? Who am I
16 supposed to rely on, this official New York State
17 prescription with a prescriber's signature or my
18 vague suspicion that someone is acting in bad
19 faith? I have occasionally had an opportunity to
20 talk to pharmacists and I was talking to a
21 pharmacist tech the other day and I couldn't
22 believe the example she'd give. I said, have
23 there been circumstances in which you've rejected
24 a controlled substance prescription and she
25 thought for a while and she said yes, and I said

2 what was the reason for that, she said it was
3 written in crayon. And unfortunately, I was not
4 taken aback by that. And then I said, well what
5 did you do, well the person who brought it in was
6 a 16-year old boy, so somehow that 16-year old boy
7 had gotten his hands on a blank prescription and
8 didn't realize that there was more to it than just
9 having that piece of paper, but on the other hand,
10 he had the right kind of piece of paper. So I
11 call that the blame the doctor defense.
12 And then finally, the drug abuser
13 can say that a real doctor issued the prescription
14 after a medical consultation and who is that
15 patient to say that my doctor should not have
16 prescribed this to me? How am I to say that my
17 doctor, in quotes, didn't know that I needed a 90
18 pill supply of 80 milligrams of oxycodone? Blame
19 the white--and how would I know that the
20 pharmacist should have stopped it? Blame the
21 white coats.
22 So from a criminal perspective,
23 it's almost a perfect crime, but from the public
24 health perspective, as this committee, as the
25 committee members laid out, it's almost a perfect

2 health care crisis as well. So the I-STOP
3 legislation, therefore, addresses all these
4 aspects of the chain simultaneously, trying not to
5 put too much of the burden on any one portion of
6 the chain. So the legislation gives the good
7 faith doctor the information about the patient's
8 controlled substance history in advance of writing
9 that prescription and the good faith doctor does
10 not need to rely on possible falsehoods from a
11 person with an abuse problem, they can give that
12 patient the right medical treatment. Maybe that
13 treatment involves a controlled substance, I'm not
14 the one to say, but at least that doctor will be
15 doing it with objective information about the
16 patient's history. And the bad faith doctor won't
17 have the defense of being able to say, you know,
18 who am I to believe, my patient or your data.
19 The good faith pharmacist has the
20 tools to inquire of the doctor who is issuing it,
21 and with the validation requirement, has the
22 physical defense to that script. The script
23 didn't go through, for some reason it's not
24 electronically valid, I don't have to believe the
25 scribbles, the crayons on this piece of paper.

2 And the bad faith pharmacist also can't deny that
3 they see a stream of prescriptions from the same
4 doctor who writes for people who for some reason
5 show up from all over the state to go to that
6 doctor and they don't have a defense to fail to
7 report those observations.
8 And then the good faith patient who
9 may nonetheless have a drug abuse problem, now has
10 a doctor who has full information and that doctor
11 can treat the patient appropriately, whatever that
12 appropriate treatment is, rather than compounding
13 the problem. I'll leave it to physicians to
14 explain how many different problems can be created
15 simply by drug interaction, let alone the actual
16 substance abuse problem itself.
17 So we think some of the alternative
18 proposals are incomplete solutions and that,
19 unless prescribers and pharmacists are part of the
20 chain, it's not going to solve the problem. So
21 very quickly, I'll end on a few misperceptions
22 that I've heard and would like to address. One
23 misperception is that I-STOP interferes with the
24 medical judgment of a doctor. Not at all, I-STOP
25 has absolutely no directive for a doctor to do

2 anything other than consult a database and report
3 what they prescribe.
4 I-STOP will not create any form of
5 traffic jam in an emergency room or a hospital.
6 All existing emergency medical situations existing
7 in today's law are carried over and all the rules
8 about dispensing in those circumstances are not
9 affected in the least and all institutional
10 dispensing, so inside a clinic, inside a hospital,
11 is exempt. This addresses the paper prescription
12 that walks out of an outpatient setting and goes
13 into a retail pharmacy setting.
14 I-STOP does not prevent--does not
15 require a doctor to interrupt patient care to
16 enter keystrokes in a computer. The requirements
17 are review before the prescription is written and
18 data entering after a prescription is written and
19 the data entry can be done by any reliable agent
20 of the doctor inside the doctor's office. So
21 there's no delay, nothing that would prevent a
22 prescription from being written with full
23 information.
24 Also, I-STOP will not prevent
25 doctors who are acting in good faith from writing

2 any medically necessary prescription. I've heard
3 a few doctors say that they would consider not
4 writing controlled substance prescriptions if they
5 had to go through this program. And at first,
6 that seems powerful, but when you disimpact it,
7 what it means is a doctor is saying that I would
8 believe that a prescription was medically
9 necessary, because that's the threshold to write
10 it in the first place, I believe it is medically
11 necessary to treat this patient but I'm not going
12 to do it because I have to turn to a computer and
13 enter a few keystrokes. Most doctors are
14 perfectly willing to do that when they're going to
15 get paid from an insurance program, they'll enter
16 those keystrokes. And we think that most of those
17 objections are not really based in a realistic
18 assessment of the burden and the medical necessity
19 and it's just an automatic resistance to doing any
20 additional work. But given the scope of problem,
21 as this Committee outlined, there's no problem at
22 all.
23 And so finally, I-STOP will not
24 write software that is burdensome or out of date.
25 I-STOP leaves the form of the software up to the

2 Commissioner of Health and contemplates an open
3 ended solution, all it says in substance is we
4 have to have this chain of review and report
5 before the pills go out on the street, because
6 when they're out on the street, there's no getting
7 them back.

8 So I'd like to thank the committee
9 for taking the time to hear Attorney General
10 Schneiderman's proposed solution on this, and if
11 the Committee has any questions, I'd be glad to
12 hear them.

13 CHAIRPERSON KOPPELL: Thank you.
14 Council Member Arroyo, why don't you go first?

15 CHAIRPERSON ARROYO: Thank you, Mr.
16 Chair. I guess my questions are more technical
17 coming from the health care administration field
18 and understanding the challenges that reporting
19 can present to professionals in the care of
20 patients. What is a health care provider seeing
21 differently in his or her office and--first, what
22 will I, as a doctor, be required to have in terms
23 of equipment, software, et cetera.

24 PAUL MAHONEY: Well the I-STOP
25 legislation does not write the hardware and

2 software needs. It's open-ended so that the
3 various groups that can participate--doctors and
4 pharmacies--who have already invest in technology,
5 it allows the chairman--I'm sorry, the
6 Commissioner of Health to prescribe multiple
7 routes of access to the data. We think of it as
8 an Internet-based solution because that's the most
9 common, simple solution there, but, for example,
10 on--if a doctor is part of a medical group that
11 heavily relies on electronic records and that
12 system is able to push out and receive data,
13 there's no obstacle to that in the legislation.
14 CHAIRPERSON ARROYO: And how long
15 would the pharmacy or doctor's office have to
16 implement or begin--'cause we're going to pass it
17 at the state, right, the Governor's going to sign
18 it, that what happens to Dr. Dunner on 149th
19 Street, when does he have to start reporting?
20 PAUL MAHONEY: Oh, the
21 implementation schedule? There's no specific
22 implementation schedule in the--
23 CHAIRPERSON ARROYO: Okay.
24 PAUL MAHONEY: --legislation
25 because the Department of Health will have to get

a functioning computer system. There are two routes to it, there is an existing prescription monitoring system that is a one-way data dump that has some ability to recapture data and there's nothing preventing--in the legislation that would prevent that system from being used, it may have to be significantly upgraded before that's functioning.

CHAIRPERSON ARROYO: Okay. And what's a capacity to identify who the bad faith actors are in the chain?

PAUL MAHONEY: Well that's exactly the problem and that's why this is an information-based solution that there is--the legislation does not say this person is good faith, this person is bad faith, what it says is that this pattern of activity occurred.

Now the biggest flag for that pattern of activity would be someone who wanted to avoid participating in the system whatsoever, that would be a very large red flag. The doctor who does not consult, the pharmacist who does not verify would be a very large red flag, but it would capture the fact that a patient might be at

2 Doctor A this morning, Doctor B late this morning,
3 and Doctor C early this afternoon--
4 CHAIRPERSON ARROYO: [Interposing]
5 Or last week.
6 PAUL MAHONEY: Or last week.
7 CHAIRPERSON ARROYO: So Dr. Dunner
8 does not--can Dr. Dunner see that pattern?
9 PAUL MAHONEY: Yes, once, you know,
10 on day one of the system, it will be incomplete
11 information, hopefully they will be able to import
12 the existing databases without much loss of data.
13 But certainly several weeks into the program,
14 several weeks of data will be available.
15 CHAIRPERSON ARROYO: Okay. And at
16 some point will he be able to identify that this
17 patient is not only going to him for a script, but
18 to Dr. John and Joe and Willie down in two other
19 boroughs?
20 PAUL MAHONEY: Yes, that would be,
21 I think, one of the key elements of information
22 that would now be available to a physician that
23 isn't available today.
24 CHAIRPERSON ARROYO: Okay. I have
25 a lot other questions, but I'm sure that my

2 colleagues also do. Just like anything else, you
3 know, but the government, and my name is second on
4 the resolution here, so wholeheartedly support it.
5 Implementation and impact on the system is always
6 a concern because I was one of those health care
7 administrators that criticized legislators for not
8 having a clue what the impact of legislation has
9 on the ground level when implementation is
10 required. So those details I think need to be
11 considered very seriously in the process.
12 PAUL MAHONEY: I would agree. One
13 of the elements that some people overlook in the
14 legislation is specific authority and a specific
15 requirement to the Commissioner of Health to have
16 a system for breakdowns in the system. And so,
17 for example, if there was a, let's call it, the
18 computer glitch that prevented data from being
19 transmitted and available, the commissioner under
20 the legislation will have to have an immediate--a
21 plan of immediate fallback.
22 CHAIRPERSON ARROYO: Okay.
23 PAUL MAHONEY: That can be both on
24 the system level and on the individual physician
25 level. The system does not fail simply because

2 one doctor doesn't get access on one day, the goal
3 is to get the maximum access and if some
4 alternative means of reporting by telephone or by
5 fax should be available so that the prescription
6 that is necessary can be written, but that the
7 data is nonetheless captured at some point in
8 time.
9 CHAIRPERSON ARROYO: Thank you,
10 thank you for your testimony, and, again, my
11 appreciation to the Attorney General for his
12 support of this becoming something that this state
13 does. I hate to be state number 48, that's the
14 other thing. Okay. Thank you.
15 PAUL MAHONEY: Thank you.
16 CHAIRPERSON KOPPELL: Councilman
17 Wills?
18 CHAIRPERSON WILLS: Good afternoon,
19 sir. I just have a couple of quick questions, one
20 of them was basically what Council Member Arroyo
21 already asked. The affordability, I know a lot of
22 physicians have been switching over to like a
23 electronic tablet type of device that recorded all
24 of the prescriptions and different things like
25 that, I know a lot of pharmacies already have

2 databases that can deal with conflicting
3 prescriptions so that if somebody comes in and
4 they see that they have a prescription from
5 somewhere else, they won't get sick or anything
6 like that, is there a way to tap in to that
7 database so that all of this information is
8 combined into one database?
9 PAUL MAHONEY: On the pharmacy
10 side, that is essentially already happening on a
11 one-way street to the Bureau of Narcotics
12 Enforcement. The pharmacists--and I don't believe
13 there's any pharmacy that's not highly automated
14 in the state anymore, but most of their systems,
15 as part of their data processing, will push that--
16 currently push the data to the Department of
17 Health. The current standard though could be as
18 late as 45 days after the prescription is written,
19 so the legislation calls for compressing that
20 timeframe. And as we found out from the
21 pharmacists' standpoint, you can really move that
22 back from 40--most of them are doing that on at
23 least a weekly basis, the technology is very
24 simple to move it up closer. We've learned that
25 real time in computer terms is not necessarily

2 necessary in human terms. One second is possible
3 in computer terms, but not necessarily easy, but
4 one minute in computer terms can be both very easy
5 and very achievable. So the precise number of
6 minutes, doesn't seem to be a problem from the
7 pharmacy side.
8 CHAIRPERSON WILLS: I know that you
9 had testified that there would be certain red
10 flags with doctors that might not have wanted to
11 participate in the program, but I'm sure that this
12 is not going to be so--it's not going to be
13 written in a way where sometimes we just have
14 elderly physicians, well they're older and they
15 might not be in tune with some of the newest
16 technologies, so I'm hoping that they won't be
17 someone that is pinpointed when we do the outreach
18 for this legislation. What would happen to
19 physicians--and this is one of the questions that
20 she was asking--how much of a--is it going to be
21 a--is it a software that they have to purchase to
22 be able to participate in this program and what is
23 the financial impact to the individual physicians?
24 PAUL MAHONEY: The legislation--and
25 this relates to Council Members Arroyo's question

2 as well--the same provision of the legislation
3 that relates to breakdowns in the system states
4 that the Commissioner of Health shall prescribe an
5 Internet-based or other electronic means of making
6 the report. So--
7 CHAIRPERSON WILLS: Okay. That's--
8 [Crosstalk]
9 PAUL MAHONEY: --although it
10 appears that virtually every physician in the
11 state is in a locality that has Internet access,
12 for that handful of people who may be an outlier
13 in that regard, it allows--it requires the
14 commissioner to have an alternative mechanism,
15 which we presume will be either telephonic or by
16 fax and we haven't identified any physician who
17 wouldn't have access to a telephone or a fax. In
18 fact, fax sort--
19 CHAIRPERSON WILLS: Okay. Right.
20 PAUL MAHONEY: --of sounds like
21 outdated technology--
22 CHAIRPERSON WILLS: Right.
23 PAUL MAHONEY: --today. And it
24 does not require any particular package to be
25 purchased. The goal of having an Internet-based,

2 the prime system to be Internet-based is because,
3 very much like perhaps you would do today to make
4 a purchase online, you no longer need desktop
5 software to do that--
6 CHAIRPERSON WILLS: Right.
7 PAUL MAHONEY: --you go to a
8 website and the access and the codes--
9 CHAIRPERSON WILLS: Okay.
10 PAUL MAHONEY: --are entered in
11 through a secured system, and that's what's
12 envisioned.
13 CHAIRPERSON WILLS: In 2009, we
14 know that there was approximately from the
15 research that it has 16 deaths from prescription
16 opiates and in 20--I mean, from heroin actually,
17 and on Staten Island, in 2009, there were 28 from
18 prescription drugs. So a lot of people have seen
19 Staten Island as a flashpoint for this
20 prescription drug abuse. How far ahead would this
21 legislation bring us as far as the impact that
22 we're having or we're seeing with these hot points
23 or flashpoints of the prescription drug abuse?
24 Like, how far will we be able to see that there's
25 a tangible result that we can start to stop this

2 or see or bring data to us, how fast would that
3 happen after implementation?
4 PAUL MAHONEY: That's a very good
5 question, I can't make a specific prediction, but
6 one of the ideas that--the thoughts we had with
7 discussing this with the Attorney General was that
8 there will be an immediate deterrent effect on
9 some of the casual--the doctors who are only
10 occasionally engaged in bad faith and it will
11 certainly--because we often that many of these
12 doctors who are engaged in this often have
13 substance abuse problems of their own, and so part
14 of the goal is to raise a stop sign in front of
15 these actors and say, it's not as easy as it used
16 to be, you have a real hurdle to--it's no longer
17 scribbling your name on a piece of paper, and we
18 think that will have an immediate deterrent
19 effect.
20 We also believe that because good
21 faith doctors will have--and most doctors are, of
22 course, good faith doctors--
23 CHAIRPERSON WILLS: Right.
24 PAUL MAHONEY: --they will have
25 immediate information available to say to their

2 patient, Patient, I hear what you're saying to me
3 about whatever they're articulating about their
4 need for medication, but I have to tell you, I see
5 a pattern of something else and I'd like to talk
6 to you about your substance use history, and we
7 believe that'll have an immediate positive effect
8 of getting people counseling towards substance
9 abuse. Substance abuse is not a light switch
10 that's easily turned on or off, it's something
11 that has to be addressed by the process, but we
12 think this'll--and this is what we hear from
13 doctors--it'll start a number of people on a
14 better pathway right away.
15 CHAIRPERSON WILLS: Well I applaud
16 the Attorney General and this legislation and I
17 yield the rest of my time, thank you.
18 CHAIRPERSON KOPPELL: Thank you.
19 I'm glad that Assemblyman Cusick is here because,
20 while I support the legislation and the idea, I
21 perceive significant problems in its
22 implementation, and I'm just going to raise a
23 couple because I think we have to think about this
24 as you implement this.
25 The idea here is you go to the

2 doctor and the doctor prescribes the oxycodone,
3 say, and gives you a prescription and then the
4 doctor has to enter it into the electronic system,
5 is that correct?

6 PAUL MAHONEY: Correct, with one
7 missing step. The missing step is before the
8 doctor issues that prescription--

9 CHAIRPERSON KOPPELL: Yes.

10 PAUL MAHONEY: --the doctor has to
11 look at that database to see the patient's
12 controlled substance filling history.

13 CHAIRPERSON KOPPELL: And what--

14 [Crosstalk]

15 CHAIRPERSON KOPPELL: --and
16 assuming there was no history.

17 PAUL MAHONEY: Yes, then--

18 CHAIRPERSON KOPPELL: What then?

19 PAUL MAHONEY: --then after writing
20 that prescription, the doctor has to have--the
21 doctor or the doctor's agent has to make an entry
22 in the database.

23 CHAIRPERSON KOPPELL: Yeah, and
24 what information does he put in the database to
25 alert a further doctor that this is now being

2 prescribed? What information has to go into the
3 database?
4 PAUL MAHONEY: I don't have all the
5 data points in my head, but it's essentially the
6 same key elements that the pharmacy already
7 reports, patient--
8 CHAIRPERSON KOPPELL: [Interposing]
9 Which are what?
10 PAUL MAHONEY: --patient name,
11 patient date of birth, substance being prescribed,
12 quantity prescribed, I believe patient address,
13 and the doctor's name, the doctor's contact
14 information, and the doctor's various DEA, Drug
15 Enforcement Administration.
16 CHAIRPERSON KOPPELL: What about
17 Social Security Number?
18 PAUL MAHONEY: I do not believe the
19 Social Security Number is required by the
20 legislation.
21 CHAIRPERSON KOPPELL: Yeah, so you
22 might have a big problem if the patient's name is
23 James Smith or Jose Rivera or Jun Kim and I
24 mention those names 'cause there are thousands of
25 people who have the same name and they move. So

if he looks up James Smith and the address, the James Smith who comes into the pharmacy gives him an address, you know, on Broadway, but, you know, he hadn't lived there before. The opportunities for confusion in the database which will cause the doctor not to prescribe are substantial. And then what you're saying is it goes in the database and before the pharmacy gives that patient the drug, they have to check to the database to see that the doctor did indeed prescribe that, right?

PAUL MAHONEY: I would agree with you on the second point. I think on the first half on the confusion side though, I think the potential is actually considerably less. We can always hypothesize that there is literally--and I hope there's no John Smith in the room--but a John Smith that has no other identifying information associated with them, but if we think about it, our core physician/patient interaction should be with an established patient, so--

CHAIRPERSON KOPPELL: [Interposing] Yeah, but what I'm saying is confusion of names. I don't want to debate it with you--

PAUL MAHONEY: Sure.

2 CHAIRPERSON KOPPELL: --let me just
3 raise it 'cause I want Assemblyman Cusick to think
4 about it a little bit. And before you say this is
5 a difficult hypothetical, in a much lesser--well I
6 don't know much lesser, but in a lesser area,
7 which is the area of checking people when they get
8 on planes, there have been enormous problems with
9 identiful names and people have been left because
10 they're on some terrorist list somewhere, they
11 can't get their flight, they've been held up for
12 days, and here you're talking about getting a
13 prescription. I think that the technological
14 obstacles here are very substantial and they're
15 going to have to be looked at very carefully.
16 Also, the idea that the doctor puts
17 the--I go to the doctor, I get a prescription, I
18 go down to the pharmacy five minutes later, that
19 has to be in there, right? Otherwise, the
20 pharmacy won't give me the drug.
21 PAUL MAHONEY: That's correct.
22 CHAIRPERSON KOPPELL: That's also
23 going to be a problem.
24 PAUL MAHONEY: Well in a sense,
25 yes, but if we recall that the sequence is what is

2 critical. And I can only give one simple
3 anecdote, and I know we're tight on time here, but
4 let's assume for the sake--again, going back to
5 the issue I said before about the medically
6 necessary prescription, if the doctor is writing a
7 medically necessary prescription for a patient,
8 the doctor has the freedom to decide whether that
9 prescription being filled in the next five
10 minutes, in your hypothetical, is so important
11 that the doctor should say to the doctor's clerk,
12 please enter this now. On the other hand, if the
13 doctor says, well, Mr. Smith, I see that you have
14 15 days left in your supply, so I'm going to issue
15 you a prescription, you should know you're not
16 going to be able to fill it in five minutes, my
17 clerk's going to do it in the next hour. But of
18 course if--
19 CHAIRPERSON KOPPELL: [Interposing]
20 Let me just say, I'm not going to debate it with
21 you, but I can see enormous problems with this.
22 It's going to be--I know technology has advanced a
23 long way, but enormous problems, tremendous
24 amounts of delays and frustrations and I just--I
25 support the legislation, but I'm going to ask the

2 Assemblyman to carefully discuss with the
3 technological people whether this is really
4 feasible in the real time.
5 PAUL MAHONEY: If I may just make
6 one final note on that, the legislation
7 anticipates that there are going to be many
8 different scenarios and so there is an advisory
9 committee set up through the legislation that the
10 commissioner is to consult from the beginning in
11 actually designing the implementation of this
12 process from various sectors of the health care
13 and patient care community so that these scenarios
14 can be gamed out before the computer is turned on.
15 CHAIRPERSON KOPPELL: Well I just
16 point out that it's going to be very difficult and
17 I leave it to the Assemblyman to work it out.
18 CHAIRPERSON ARROYO: No pressure.
19 CHAIRPERSON KOPPELL: Council
20 Member Arroyo.
21 CHAIRPERSON ARROYO: Thank you.
22 I'd like to acknowledge we've been joined by
23 Council Member Brewer, who's a member of the
24 Health Committee, I'm not sure if she's a member
25 of the Mental Health Committee--

2 [Crosstalk]
3 CHAIRPERSON ARROYO: Oh, so you get
4 double credit for today.
5 I know that in the community, often
6 pharmacists are not willing to dispense a refill
7 on medication if the patient--if their system
8 clearly indicates they have 15 more days worth of
9 medication, that's something that happens, I
10 think, out of practice probably to help them
11 preserve inventory, or I don't know if there's a
12 rule that requires them not to fill a prescription
13 until the active script is still in the case they
14 have some medication left, and that might be one
15 of the ways that that issue can maybe get
16 resolved.
17 You keep saying doctors, our health
18 care system has other types of health care
19 professionals, are we only concerned about
20 doctors?
21 PAUL MAHONEY: No, I've been using
22 doctors as shorthand because that's who most
23 people seem to think of when writing a
24 prescription, but there's actually several other
25 professional categories that can be licensed to

2 issue controlled substance--
3 CHAIRPERSON ARROYO: Right.
4 PAUL MAHONEY: --prescriptions,
5 that includes nurse practitioners--
6 CHAIRPERSON ARROYO: Right.
7 PAUL MAHONEY: --to some levels,
8 dentists, and other professionals.
9 CHAIRPERSON ARROYO: Okay. So this
10 is a health care professional issue, not
11 identifying only doctors in the health care
12 system.
13 PAUL MAHONEY: That's correct.
14 CHAIRPERSON ARROYO: Okay. Council
15 Member Koppell? Thank you.
16 PAUL MAHONEY: Thank you very much.
17 CHAIRPERSON KOPPELL: Yes, thank
18 you. And now we'll have the Assemblyman.
19 [Long pause]
20 ASSEMBLYMAN MICHAEL CUSICK: Thank
21 you. My name is Assemblyman Michael Cusick, I
22 represent the mid-island of Staten Island and I
23 want to thank the Committee for taking up this
24 issue and putting this resolution forward. I have
25 a testimony here, but it's very short, I'm not

2 going to read it, I think the Attorney General's
3 office and your opening statements went through a
4 lot of the points that are in the written
5 testimony and I know that there are quite a few
6 people who want to testify.
7 But first I want to thank the City
8 Council for joining this fight because in Albany,
9 as you know, we need all the help that we can get,
10 Councilman Koppell knows that firsthand. When we
11 have folks that support us on the city and
12 municipal level, it's very important and it's
13 helpful in legislation, so I want to thank you for
14 your efforts 'cause this resolution will be very
15 helpful in getting I-STOP passed in the assembly
16 and the senate because we have to show that this
17 is an epidemic that we're behind already on. That
18 it's not only New York City, it's not only Staten
19 Island, it is the entire state of New York that's
20 being affected by this issue and this epidemic of
21 prescription drug abuse.
22 We can go through the numbers, the
23 oxycodone prescriptions have gone up close to 66%
24 in two years. There is an epidemic there that we
25 all know about that's in our districts, in our

2 communities, but it's been there for years, and
3 it's been there because, as some of my colleagues
4 have mentioned before, it's a type of issue that
5 people don't think is that important or it's that
6 damaging because it's prescribed by a doctor. It
7 can't be that bad, it's in my grandmother's
8 medicine cabinet; it's in my--my parents use it
9 every day, it can't be that bad. And that's why
10 Staten Island, where I represent, has become the
11 Ground Zero of this epidemic, because it is an
12 issue that people have overlooked, it's an issue
13 that we haven't concentrated on. And I think
14 legislation is just one area that we can help.
15 There's not one solution for this,
16 I think that's got to be on the table right at the
17 beginning. We're not going to solve this problem
18 with one piece of legislation or one law making it
19 criminal or increasing criminal penalties or we're
20 not going to stop it by having more police at drug
21 stores or whatever situation people might want to
22 put out there. This is going to be a solution
23 that's going to have different parts and that's
24 why legislation is very important.
25 As the Attorney General's office

2 mentioned, New York State has an existing
3 database, which many of us probably did not even
4 know. And as stated before, it was a one-way
5 database basically--the pharmacists would send the
6 information to Department of Health and then it
7 would just stay there basically, nothing--there
8 was no communication back. So about two years
9 ago, when my office started researching this
10 issue, when we had many roundtables, many
11 discussions with pharmacists and doctors and
12 parents and kids who are hooked and what we found
13 out was there was no communication, there was no
14 communication with pharmacists and DOH, there was
15 no communication with doctors and DOH.
16 So our original legislation that we
17 put in before I-STOP was to bridge that gap.
18 Pharmacists that I spoke to in Staten Island and
19 throughout New York City, they want to communicate
20 with DOH, they want to be able--because if you
21 walked into your neighborhood pharmacy, which I
22 did many times before we put in any legislation,
23 many of the pharmacists were on the phone with the
24 pharmacist down the street acting like police
25 officers because they were being asked did you

have a suspicious person come in here an hour ago 'cause they were just in my place trying to get-- so they were doing the police work already.

So what we want to do with I-STOP is we want to take it out of their hands because they're already on the frontlines. And this is an issue that's not just, as I said, in New York City, Nassau County has had killings in pharmacies because they don't have the proper tools. Buffalo and Erie County has a major, major issue with prescription drug abuse. So this is something that has spread all throughout New York state, and I want to say throughout the country.

This is I-STOP, I believe, is very important in that Councilman Koppell had mentioned, there are glitches with anything, as you know, with any piece of legislation, and it was mentioned in original legislation and in I-STOP, we put in--and that's the one thing as legislators I think we can all agree on, we're not experts on everything, we try to work on every single issue whether it's health care, education, transportation, and we get bits and pieces, but we never professed to be professional. And in this

2 case I don't profess to be a professional and
3 that's why we put in an advisory committee to
4 address issues like you had mentioned, Councilman.
5 This advisory committee would be made up of
6 medical personnel, law enforcement, the gamut,
7 pharmacies, all the professionals that would be
8 involved in this process to report back to the
9 legislature to let us know what the problems may
10 be, what they may foresee, and how we can
11 ultimately get to real time.
12 This basically gets down to
13 allowing doctors and pharmacists access to a real
14 time system, and I believe that if I-STOP is
15 passed in the assembly and the senate and
16 ultimately signed into law, that this will be a
17 part of the solution, a major part of the solution
18 because it will give the tools that are necessary
19 for the people that are on the frontlines, and
20 that is our pharmacists and our doctors.
21 So I want to thank you for your
22 work today. If anybody's got a question.
23 CHAIRPERSON KOPPELL: Thank you
24 very much. Anybody? Yes? Go ahead, yes.
25 Council Member Arroyo, Arroyo.

2 CHAIRPERSON ARROYO: Okay. Thank
3 you, Assembly Member, and my apologies for
4 butchering your name, that's something that
5 usually--
6 [Crosstalk]
7 ASSEMBLYMAN CUSICK: [Interposing]
8 Oh, I've heard worse, Councilwoman--
9 CHAIRPERSON ARROYO: --and that's
10 usually--
11 ASSEMBLYMAN CUSICK: --don't worry
12 about it.
13 CHAIRPERSON ARROYO: --that usually
14 happens to my name, so I do apologize--
15 ASSEMBLYMAN CUSICK: That's fine.
16 CHAIRPERSON ARROYO: --for that.
17 And thank you for being here, for taking the time
18 to come to talk to us about this.
19 And while we, in spirit, support
20 the need for this legislation and this system to
21 happen, but we--from a basic local community
22 perspective and the impact on providers and the
23 businesses, is also something that we need to be
24 very mindful of and be sensitive to, and my hope
25 with the advisory committee is that those

2 individuals will help tweak the nuances that need
3 to be dealt with.
4 So in that regard, how does one get
5 appointed to this advisory committee, where
6 they're going to come from, who's going to
7 appoint, for how long, et cetera?
8 ASSEMBLYMAN CUSICK: Well we have
9 been fiddling with the membership of the advisory
10 committee with different drafts of the legislation
11 and we are--the majority of the committee members
12 would be from professional organizations, state
13 organizations, whether it's the medical society or
14 the law enforcement state organizations, but we
15 will contact Council Members as to when we do get
16 this legislation passed as to the appointment
17 process.
18 CHAIRPERSON ARROYO: Okay. Thank
19 you. And in the event your colleague, Assembly
20 Member Arroyo, is not signed on, let me know, and
21 I'll have a conversation--
22 [Laughter]
23 CHAIRPERSON ARROYO: Thank you,
24 mister--
25 [Pause]

2 ASSEMBLYMAN CUSICK: Thank you, I
3 may call you on that.
4 CHAIRPERSON KOPPELL: Gale Brewer.
5 COUNCIL MEMBER BREWER: Oh, thank
6 you very much, and congratulations on all the work
7 involved because, you know, some of us don't put
8 that kind of time in and that's how you develop
9 the best policy, so congratulations.
10 ASSEMBLYMAN CUSICK: Thank you.
11 COUNCIL MEMBER BREWER: My question
12 is just on the technology, obviously, this will--
13 real time means that the technology obviously has
14 to be fast and has to be something that people
15 could access quickly. Do you have a sense that in
16 the doctors' offices and the pharmacists that
17 exists? And then my second part of that is--I
18 should know this, but I know the electronic health
19 records for the doctors' perspective is something
20 that still, I would say, in transition, in the
21 pipeline, it's not as quick or as universal as I
22 think some people would like and we're always
23 concerned about privacy and security. So I just
24 was wondering on the technology, maybe on your
25 advisory board, you want to make sure there's

2 somebody there who has that kind of expertise.
3 But has that come up in any discussion from the
4 pharmacists or the health professionals?
5 ASSEMBLYMAN CUSICK: Well it is,
6 that discussion has come up, quite frankly, from
7 the doctors on, you know, my experience is it
8 comes more from the doctors than the pharmacists
9 because in a lot of doctors' offices, which many
10 of you know, it becomes very busy and they're
11 concerned about whether they would be liable if
12 they missed a report in, if they were so busy that
13 they couldn't. Our legislation, you know, we know
14 that doctors' offices are made up of more people
15 than just doctors, that assistants can fill out
16 this database paperwork--well not paperwork, but
17 the database information. We understand the
18 constraints on the doctors and their busy
19 schedules and the pharmacists, quite frankly, that
20 it may take time out of their busy day of treating
21 somebody or filling prescriptions at a busy
22 pharmacy. So there are mechanisms in place in
23 this legislation that allows them the time
24 necessary to fill this out and the agents
25 necessary in their office to fill it out, so it's

not specifically Dr. Jones who may be treating Mary Smith down the hall filling it out, that it's somebody in his office.

And the privacy issue is--that has come up, you know, when we started the talk of legislation, year and a half, two years ago. You know, my argument to that issue has been is that this is no different than any other medical reporting that goes on already, and that's, you know, the same constraints will be put on doctors and pharmacists in this case, as in any other case when it comes to reporting. Because doctors do Medicaid reporting online and they actually get incentives to do it electronically.

COUNCIL MEMBER BREWER: Well that's the electronic health records--

[Crosstalk]

ASSEMBLYMAN CUSICK: [Interposing] Right, right, so they actually do that already, so that issue is already out there, and what we say is that there'll be no difference in the reporting in this situation.

COUNCIL MEMBER BREWER: Right, I just throw out that when you have your advisory

2 group, you might want somebody who's tech savvy to
3 be on it because I believe, given my background,
4 that you're going to end up with some tech issues
5 would be my guess. Thank you.
6 ASSEMBLYMAN CUSICK: Thank you.
7 CHAIRPERSON KOPPELL: I certainly
8 second what she's saying as a tech and I raised
9 that in my questioning, the tech issues are
10 formidable, I think.
11 ASSEMBLYMAN CUSICK: Yes.
12 CHAIRPERSON KOPPELL: Not that they
13 shouldn't be addressed, but they're formidable.
14 Thank you very much.
15 ASSEMBLYMAN CUSICK: Thank you.
16 CHAIRPERSON KOPPELL: Thank you for
17 coming.
18 ASSEMBLYMAN CUSICK: Thank you so
19 much.
20 CHAIRPERSON KOSLOWITZ: Our next
21 witness is Tracy Pugh from the New York Academy of
22 Medicine. [Long pause] Good afternoon, I assume,
23 just--
24 TRACY PUGH: Good afternoon.
25 CHAIRPERSON KOPPELL: --state your

2 name and affiliation for the record.

3 TRACY PUGH: Good morning, my name
4 is Tracy Pugh, I'm a Policy Associate at the New
5 York Academy of Medicine.

6 CHAIRPERSON KOPPELL: Please, go
7 ahead.

8 TRACY PUGH: I am delivering this
9 testimony on behalf of Dr. Ruth Finkelstein, the
10 Senior Vice President for Policy and Platting at
11 the New York Academy of Medicine.

12 On behalf of the New York Academy
13 of Medicine, I would like to say thank you for
14 this opportunity to discuss the proposed
15 resolution regarding the Internet System for
16 Tracking Over-Prescribing, as well as discussing
17 this important issue of prescription use, abuse,
18 and misuse.

19 The academy is a leading non-
20 profit, independent institution that has been
21 working to improve urban health in both New York
22 and globally for over 160 years, through policy
23 leadership, research, community engagement,
24 education, and training.

25 I think we are all here today

2 'cause we all agree that the New York and the U.S.
3 in general is facing a critical public health
4 issue with the increasing rise of morbidity and
5 mortality relating to prescription use. This is
6 seen as, in the previously discussed increase in
7 unintentional poisoning deaths and it's also seen
8 in the increase in emergency department visits
9 relating to drugs. Opioid analgesic-related
10 emergency department visits in New York City have
11 more than doubled since 2004. Now as we already
12 seen, much of the attention surrounding this
13 increase in the harms and the deaths related to
14 prescription drugs has focused on the illegal
15 diversion of medications, but today in this
16 testimony I want to provide a closer look at the
17 complexities and the different kinds of problems
18 that appears to be driving this issue and suggest
19 that we consider a broader frame in developing a
20 solution or, as the Assembly Member noted
21 previously, that this probably will need multiple
22 solutions.
23 [Pause]
24 A frame that balances the need to
25 prevent prescription-related injury and death with

2 the imperative to ensure all New Yorkers have
3 access to needed medications is critical.
4 The first distinction that I think
5 is important to make is in drug-related emergency
6 visits, they have been driven by both the
7 legitimate medical use of prescription drug, as
8 well as the non-medical use, or as we--the misuse
9 or abuse of prescription drugs. Nationally,
10 almost half of drug-related emergency department
11 visits were for prescriptions that were used as
12 prescribed by a provider or medication
13 instructions. In New York City, that number is
14 39%. Patients are experiencing harm taking their
15 medications or over the counter medications, et
16 cetera, in compliance with providers or medication
17 instructions and without illicit drugs. This is
18 not a problem of diversion, but a problem of
19 inadequate patient and provider education,
20 problems in coordination of care, and problems in
21 recognition or referrals to treatment.
22 Prescription drug monitoring
23 programs have largely been used to identify
24 diversion and misuse, but they don't necessarily
25 capture and address this significant proportion of

2 the population of individuals with legitimate
3 medical needs who are being prescribed legitimate
4 medicines by providers in good faith. While
5 prescription monitoring programs can identify some
6 patients' medication history and instances of
7 over-prescribing, it does not provide sufficient
8 context regarding the patient's medical needs and
9 history or adequate guidance to the provider in
10 deciding appropriate care. Therefore, our
11 solutions must ensure that providers have a
12 thorough understanding of their patients' medical
13 history, while simultaneously mitigating the risk
14 of adverse drug reactions. Such strategy should
15 incorporate education, improvements in
16 coordination of care, as well as improved access
17 to Naloxone, which is a proven safe, lifesaving
18 prescription drug that prevents death in the event
19 of an overdose.
20 Now we also have to address the
21 misuse of prescription drugs whereby patients are
22 combining prescription drugs with illicit drugs.
23 Emergency department visits involving the use of
24 this combination has rose 97% between 2004 and
25 2009, and we also must consider the combination of

2 prescription drugs with alcohol, as well as the
3 injuries that's being derived from illicit drugs
4 alone.
5 Unfortunately, prescription drug
6 monitoring programs do not identify the use of or
7 a patient's addiction to illegal drugs or alcohol.
8 The persistent prevalence of harm relating to
9 illegal drug use, whether alone or in combination
10 with prescription drugs, should be addressed and
11 considered in this context. Again, strategies
12 should include improving access to Naloxone, as
13 well as ways to increase access and quality of
14 treatment services.
15 Finally, we must also address the
16 emergency room visits and injury related to
17 prescription misuse. So use of prescriptions
18 alone, non-compliant, or diverted drugs. Almost a
19 quarter of all drug-related emergency department
20 visits in the country have involved misuse of
21 prescription drugs. Prescription drug monitoring
22 programs may identify this kind of misuse through
23 doctor shopping or concurrent prescribing with
24 other providers, or over-prescribing. However,
25 national representative studies have shown that

nearly 71% of people have used opioid analgesics, or painkillers, for non-medical purposes from buying or getting them for free from family or friends. Moreover, in 80% of these cases where they were obtained for free from a friend or a relative or bought, the friend or relative received that drug from one doctor.

Prescription drug monitoring programs may not be sufficient to identify or prevent this kind of sharing or buying between friends and family of medications involving a single doctor. Taken together, the data we have suggests that harms and deaths associated with prescription medications come from different kinds of use for different reasons and, therefore, require different kinds of policy responses. At best, prescription monitoring systems can address only one small part of this issue at hand. We must weigh the potential benefits of a prescription monitoring program against its potential harms, such as deterring doctors from prescribing needed medications in the best interest of their patients.

In addition, at a time when health

2 information technology is rapidly growing, both in
3 utility and reach, we have an opportunity to go
4 beyond merely monitoring or of prescribing
5 practices to using health information technology
6 to improve care coordination and quality of care.
7 A patient's prescription history is only a
8 component of the patient's entire medical history.
9 Considering the expense of this system, we believe
10 that it will be better to invest increasing the
11 capacity of our health information system so that
12 we can develop a system that will flag medication
13 errors, improve interoperability of electronic
14 health records across patients, providers, and
15 pharmacists, and facilitate the adoption of e-
16 prescribing. An issue as complex as prescription
17 medication use requires an investment in a multi-
18 purpose system with multiple benefits.
19 Although we sincerely applaud
20 efforts by our government leaders to invest in
21 this critical issue, we urge you to make
22 investments wisely and develop systems that will
23 be effective in addressing the underlying causes
24 of this complex problem. We must take a step
25 back, clearly define the different kinds of issues

2 at play, and design a comprehensive approach to
3 addressing them. As I discussed previously in
4 this testimony, such an approach can include
5 education among pharmacists, providers, and
6 patients, improving access to Naloxone, improving
7 coordination of care, and improving incentives to
8 support a health information technology system.
9 This is no easy fix, but we can develop an
10 approach that reduces the harm of prescription
11 drugs, while ensuring that every New Yorker has
12 access to the medications he or she needs and
13 access to appropriate and quality care.
14 And with that, I would like to say
15 thank you and, again, I welcome any questions. I
16 do want to note, I am, again, speaking on behalf
17 Ruth Finkelstein, so if there are any questions I
18 may not be able to answer at this moment, I will
19 take them down and be sure to report back to you.
20 CHAIRPERSON KOPPELL: Thank you
21 very much for your statement. I might say I know
22 Council Member Arroyo has a question and I'll go
23 to her in a minute. I just want to say that you
24 did something that very few witnesses do and that
25 is that you summarized some portions of the

2 statement, making it somewhat more brief and
3 recognize that we can read. Most witnesses don't
4 do that and read every word that's in front of us,
5 rather than as sort of distilling out the essence
6 of what the statement says, which is what you did,
7 and I want to thank you for that.
8 Now--
9 TRACY PUGH: Thank you.
10 CHAIRPERSON KOPPELL: --Council
11 Member Arroyo.
12 CHAIRPERSON ARROYO: Thank you.
13 Okay. So you're here providing testimony and you
14 gave us a sense that this system may not be
15 enough, do you support the legislation that the
16 state is considering and our resolution asking the
17 state to pass and the Governor to sign this
18 legislation at the state?
19 TRACY PUGH: Again, I have to say
20 that NYAM does applaud the leadership that is seen
21 in this resolution and the actions that the
22 Assembly Members and the government is taking.
23 However, like I said before, what we're doing, we
24 recommend that rather considering the expense of
25 this system, it would be better to invest in

2 increasing the capacity of our health information
3 technology system, rather than this specific
4 portion of it, as well as increasing and investing
5 in a more comprehensive strategy. So I understand
6 your question--
7 CHAIRPERSON ARROYO: [Interposing]
8 It's a yes or no answer.
9 TRACY PUGH: I understand your
10 question, I'm not in a position to say whether
11 NYAM supports or is formally in favor or against,
12 we're just trying to broaden the discussion--
13 CHAIRPERSON ARROYO: Okay.
14 TRACY PUGH: --and shed more light
15 so that it could be a more dynamic discussion and-
16 -
17 CHAIRPERSON ARROYO: Okay.
18 TRACY PUGH: --recognize the
19 multiple dimensions of this issue.
20 CHAIRPERSON ARROYO: Okay. Thank
21 you. Thank you, Mr. Chair.
22 CHAIRPERSON KOPPELL: I would--in
23 going back to your principle, 'cause you were
24 speaking for someone else, and what I would say is
25 that sometimes--maybe it's a ill-advised

2 expression--sometimes you can kill, you know, two
3 birds with one stone, but sometimes it may require
4 more than one. And in this instance, while I
5 understand and I don't disagree, it would seem
6 certainly perfectly logical to recognize that
7 there are the multiple aspects of the problem,
8 including better education of doctors and use of
9 different remedies where there is an adverse
10 reaction. But the question is, and admittedly
11 there, there's expensive resource--resource
12 expenses is a factor, but in my view at least,
13 while this doesn't in any way address all of the
14 problems that you raised that relate to--it's an
15 important maybe you call it part of the solution.
16 And I'm surprised, frankly, that
17 the academy takes the position it seems to be
18 taking, which is that this is not important enough
19 to address without addressing some of these other
20 issues, but I hear what you're saying.
21 TRACY PUGH: Right, I mean, I just
22 want to reiter--what I said before is that we
23 think such a system only addresses a small part of
24 a solution and because so much of the attention
25 has been focused on diversion and enforcement,

2 that can kind of cloud and make the--or make
3 people not consider the larger picture. And so
4 with this we just want to recognize and have you
5 recognize what a small part of the problem this
6 is, and really try and get a discussion around a
7 more comprehensive strategy. Because we do want
8 to address the morbidity and the health of
9 prescription use, whether it's legitimate or not
10 legitimate. And, as you see in the testimony, we
11 do provide recommendations for what can be done.
12 And we do support sharing and
13 interoperability of electronic health records. We
14 think providing a more fulsome context will help
15 providers in making a very sound judgment without
16 them--and providing quality care. Whereas, a
17 medication history and accessing the medication
18 history has the potential harm of deterring
19 providers, as I think has brought up before, and
20 also not providing that needed context.
21 CHAIRPERSON KOPPELL: Well I
22 appreciate that point of view, I may disagree with
23 it, but I appreciate it. Thank you. [Pause] Do
24 we have anyone else who wishes to testify? There
25 being no other potential witnesses, hearing's

2 adjourned.

3 [Off mic]

4 CHAIRPERSON KOPPELL: Thank you.

C E R T I F I C A T E

I, Tammy Wittman certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature Tammy Wittman

Date __March 4, 2012_