



New York State Senate

Senator Kemp Hannon

District Office: 595 Stewart Avenue, Suite 540, Garden City, NY 11530
Albany Office: 420 State Capitol Bldg., Albany, NY 12247

516.739.1700
518.455.2200

Website: www.KempHannon.com | E-mail: Hannon@nysenate.gov

THE PRESCRIPTION DRUG CRISIS IN NEW YORK STATE:

A COMPREHENSIVE APPROACH



SENATE STANDING COMMITTEE ON HEALTH
Senator Kemp Hannon, Chair

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
PRIME AREAS FOR ACTION	3
ACTION PLAN: A COMPREHENSIVE SOLUTION	4
I. Getting Drugs Off New York Streets.....	4
A. Strengthening Requirements for Certain Controlled Substances.....	5
B. Statewide Drug Take-Back Programs.....	7
II. Monitoring the Prescribing Process	8
A. Tracking Robberies & Protecting Pharmacies	9
B. Tracking Missing Prescription Pads	10
C. Prescription Monitoring Programs.....	11
III. Educating Practitioners & Citizens.....	13
A. Educating Practitioners	14
1. Coursework in Pain Management, Addiction, & Palliative Care	14
2. Developing Prescribing Standards for Acute Pain.....	16
3. Developing Standards for Chronic Pain Management.....	16
B. Educating Patients & the Public	17
IV. Prosecuting Dealers, Rehabilitating Addicts	18
A. Prosecuting “Licensed” Drug Dealers	19
B. Rehabilitating Addicts	20
1. Examine Detoxification & Rehabilitation in New York.....	21
2. Medicaid Recipient Restriction Program.....	22
3. Handling Overdoses.....	23
CONCLUSION	24

EXECUTIVE SUMMARY

Like the rest of the nation, New York State is in the midst of a public health crisis: prescription drug abuse. There are more prescription drugs on our streets and in our homes than ever before. The Federal Centers for Disease Control and Prevention (CDC) recently released data showing only marijuana is abused with more frequency than prescription narcotics and more Americans die of prescription drug overdoses than heroin and cocaine combined.¹ New York is experiencing the sudden and unprecedented fallout from prescription drug abuse, including a record number of overdoses, suicides, new addictions, and armed pharmacy robberies resulting in casualties. Understanding all aspects of the problem is the only path to the solutions. For this reason, the New York State Senate adopted a resolution declaring April 28, 2012 “Prescription Drug Take-Back Day,” the Senate Health Committee held two roundtables, and the Committee issued this white paper.²

The flaws in the current system help this crisis continue and grow. While there is a need for measures to remedy these flaws, we must also remain cognizant of the fact these medications relieve suffering, especially those treated by oncologists, orthopedists, and neurologists. Prescription pain medication is a hallmark of modern medical science. For the first time in human history, we can truly ease the patients’ suffering. We can prolong the lives of people with non-paralytic spinal injuries, nervous system disorders, cancer, and many other maladies. Doctors can perform miraculous procedures, and thanks to advances in medication science, they can prescribe painkillers to treat subsequent and often intense pain. At the same time, modern painkillers have the potential to swiftly addict users—in a fashion hardly seen before—and worse, oftentimes under the umbrella of legitimate prescriptions from licensed medical professionals. Accordingly, policy changes must strike a balance between our desire to minimize abuse and the need to ensure access to those legitimately needing these treatments. Meaning, first, we must recognize the system is broken, not useless. Second, we need to

¹ CDC, *Prescription Painkiller Overdoses Policy Impact Brief*, Dec. 19, 2011 (citing CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60: 1-6), <http://www.cdc.gov/homeandrecreationalafety/rxbrief/>.

² NYS SENATE STANDING COMMITTEE ON HEALTH, Roundtable on New York’s Prescription Drug Abuse Crisis (Feb. 13, 2012), <http://www.nysenate.gov/event/2012/feb/13/new-york-s-prescription-drug-abuse-crisis>; NYS SENATE STANDING COMMITTEE ON HEALTH, Roundtable Discussion on the Growing Problems of Prescription Drug Abuse and Diversion throughout New York State (Aug. 31, 2011), <http://www.nysenate.gov/event/2011/aug/31/roundtable-discussion-growing-problems-prescription-drug-abuse-and-diversion-thr-0>.

evaluate all potential solutions, selecting the ones effecting real change. In short, we must examine all tools at our disposal to create a system meeting the legitimate needs of all New Yorkers.

The Health Committee submits this paper, which takes into account all information presented to the committee through its two roundtables on the subject, independent research, and information from stakeholders throughout the state. We have tried to be all encompassing, but are under no illusions that this represents the final word in fighting this crisis. Therefore, we welcome comments and suggestions. Considerable credit should be given to staff members of the Health Committee for their work on this effort, including Roslyn Martorano, Alison Kane, and Kristin Sinclair.

PRIME AREAS FOR ACTION

- ✦ Insufficient safeguards for accessing painkillers (e.g. patients effectively receive 6-month supply of drugs from one office visit).
Solution: Eliminate the automatic 5-refills by elevating Hydrocodone to Schedule II, and add Tramadol to Schedule III, marking it a controlled substance.
- ✦ Medicine cabinets are flooded with leftover medication, and New Yorkers do not understand how to dispose of the excess pills.
Solution: New Yorkers must recognize the importance of shedding excess medication and have frequent, convenient opportunities to surrender it to law enforcement.
- ✦ Some pharmacies refuse to stock painkillers because armed violence against pharmacists is at an all time high.
Solution: Institute incentives for pharmacies to install protective measures like DNA tracking, bank-like glass counters, and time-release safes for painkillers.
- ✦ No one told the pharmacies when 1.4 million painkiller prescription pads were stolen.
Solution: Implement a secure e-prescribing program for all controlled substances.
- ✦ NY has an ineffective prescription monitoring program (PMP), and it has yet to join the 21-state coalition who share data to eliminate doctor shopping.
Solution: Strengthen NY's PMP using smart software, data-mining, and provider education, then share this model and its data with other states.
- ✦ Patient gets a tooth removed and leaves with 30 days of highly addictive pain medication.
Solution: Determine protocols to effectively treat acute pain, including limiting painkillers to 3-day supply for certain conditions.
- ✦ Extreme advances in medication science, but little-to-no education for practitioners about treating pain management, addiction, or palliative and end-of-life care.
Solution: Develop an education program for providers on pain management, addiction, and palliative and end-of-life care.
- ✦ Painkillers ease intense, chronic pain, but they are highly addictive and there are no standards for how doctors should manage chronic pain.
Solution: Create standards for chronic pain management care, including pain management plans, patient agreements, and unannounced pill counts.
- ✦ People share medication and believe painkillers must be safe if they are FDA-approved and prescribed by a doctor.
Solution: Teach people to respect painkillers and watch for signs of addiction.
- ✦ New York penal laws make it hard to prosecute pharmacists who act like drug dealers.
Solution: Create a criminal penalty for pharmacists clearly operating pill mills.
- ✦ Highly addictive opioids are the second-most abused drug after marijuana, and addiction, overdose, and suicide rates are at an all-time high.
Solution: Implement a culture of rehabilitation and access to care for addicts.

ACTION PLAN: A COMPREHENSIVE SOLUTION

Prescription medication can represent a marvel of modern medicine; it can also represent a slippery slope into addiction. Nearly one-third of Americans over the age of 12 reported their first experience with drug abuse involved the non-medical use of prescription drugs.³ Traditional policies created to fight the nation's War on Drugs (for such drugs as heroin, morphine, cocaine, and even marijuana) do not affect this current crisis because 70% of prescription painkiller abusers got their drugs from a family member or friend—only five percent from a drug dealer. This crisis touches all of us, and we cannot continue on the same course. New York State must take steps to stem the tide, and we must act quickly.

There are four global areas we can target to combat the crisis: getting drugs off the streets; monitoring prescriptions; educating providers and the public; and rehabilitating addiction, while prosecuting real offenders. Moreover, this problem requires more than a one-size-fits-all solution. Each global area requires multiple smaller alterations. Some are legislative or regulatory changes, and others require a sea change in professional practice or social attitudes. The most important aspect of combating this crisis is to act quickly, in ways creating actual, on-the-ground change for New York residents. The result will be a modern, comprehensive system providing New Yorkers with the best possible treatment and interaction with prescription pain medication, to usher in an era of effective and efficient treatment of chronic pain.

I. GETTING DRUGS OFF NEW YORK STREETS

Part of the growing public health crisis originates in the sheer volume of prescription pain medication consumed in the United States. In many cases, the United States accounts for more prescription painkiller consumption than any other Western nation.⁴ Specifically, the amount of prescription opioids—or controlled-substance pain medication—consumed in the United States continues to grow exponentially. According to a 2011 White House Report, the United States

³ EXEC. OFFICE OF THE PRES. OF THE US, EPIDEMIC: RESPONDING TO AMERICA'S PRESCRIPTION DRUG ABUSE CRISIS, at 1 [hereinafter WHITE HOUSE REPORT] (citing Results from the 2009 NAT'L SURVEY ON DRUG USE & HEALTH (NSDUH): NAT'L FINDINGS, SAMHSA (2010)).

⁴ INT'L NARCOTICS CONTROL BOARD (INCB), UNITED NATIONS, REPORT OF THE INCB ON THE AVAILABILITY OF INTERNATIONALLY CONTROLLED DRUGS: ENSURING ADEQUATE ACCESS FOR MEDICAL AND SCIENTIFIC PURPOSES (2011) http://www.incb.org/pdf/annual-report/2010/en/supp/AR10_Supp_E.pdf.

saw a 402% increase in the “milligram per person use of prescription opioids” between 1997 and 2007.⁵ In 2009 alone, there were 257 million opioid prescriptions dispensed nationally.⁶ In 2010, New York practitioners issued 22 million painkiller prescriptions—not including refills.⁷ Not only does this demonstrate a 40% increase in prescriptions over five years, but it also reveals the New York health system issued roughly two million more prescriptions for pain medication than there are citizens in this state.⁸ Access to these highly addictive painkillers is made even easier through multiple refills, leftover unused medication, and doctor shopping. The broad solution to this is simple: keep excess drugs off New York streets.

A. Strengthening Requirements for Certain Controlled Substances

Modern painkillers provide a lifeline for patients suffering chronic pain. The goal should not be to regulate them out of use, but instead, to safeguard and monitor that use through appropriate medical management plans (*see* page 10 for further elaboration). The initial steps toward this result requires altering the classifications for two common drugs: Tramadol and Hydrocodone. The federal Controlled Substances Act places various restrictions on drugs falling into certain schedules, which, generally, the NY schedules mirror. Tramadol is an opioid, which “works by changing the way the body senses pain,”⁹ and under current law, it is not a controlled substance. It is less addictive than Hydrocodone and Oxycodone, but prescriptions for it and patients seeking Tramadol-addiction treatment are on the rise.

Hydrocodone is an opioid compound more commonly known as Lortab, Norco, or Vicodin. It is highly addictive and portions of the chemical compound can be found in 20 different pain medications. Due to its “compound” nature, the federal government left certain forms of the highly addictive medication in Schedule III.¹⁰ This means a doctor may write one, 30-day prescription with five refills. Thus, the very first prescription yields six months of

⁵ WHITE HOUSE REPORT, *supra* note 3, at 1 (citing Manchikanti L, *et al.*, *Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective*, 13 PAIN PHYSICIAN 401-35 (2010)).

⁶ WHITE HOUSE REPORT, *supra* note 3, at 1 (citing SDI, *Vector One: National, Years 2000-2009*, (June 2010), <http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupportDrugsAdvisoryCommittee/UCM217510.pdf>).

⁷ Sen. Jack M. Martins, Op., *Martins: The New Face of Drug Abuse*, PORT WASHINGTON PATCH, Jan. 22, 2012, <http://portwashington.patch.com/articles/martins-the-new-face-of-drug-abuse-54dcb79e>.

⁸ *Id.*

⁹ US NAT'L LIBRARY OF MED., *Tramadol*, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000960/>.

¹⁰ Letter to Margaret Hamburg, Commissioner of Food & Drug Administration, American Society of Addiction Medicine, Sept. 6, 2011 [hereinafter Letter to FDA].

medication *before* a patient returns for a physical visit with the doctor. This can be useful and convenient for the appropriate patient, but all too often, it can domino into chemical dependency. According to numbers from New York's Bureau of Narcotics Enforcement (BNE), between 2008 and 2010, high-dosage prescribing of Hydrocodone increased dramatically. An average introductory dose of Hydrocodone is around 40 milligrams per day. In just two years, 236, 319 more New Yorkers received prescriptions for between 50 and 99 milligrams per day. The number of patients receiving over 100 milligrams per day rose by 29, 602.

There are three major benefits to elevating the controlled substance schedule of certain forms of Hydrocodone and treating them the same as Oxycodone.¹¹ First, it limits patient access to only enough pills for 30 days (and we discuss the "30 Day Rule" on page 11 of this white paper). This will decrease the practice of doctor shopping, wherein patients seek numerous doctors for the same prescription; thus enabling them to get numerous prescriptions for the same drugs. Rescheduling Hydrocodone drastically limits the number of pills a doctor-shopper can access. Instead of an automatic six-month supply of Hydrocodone from each of five doctors, the patient can only access less. This step is not enough to end doctor shopping, but as a first step, it will make a significant impact.

Second, the new 30-day supply limit also requires a physical visit between doctors and patients before dispensing additional medication. In cases of intermittent chronic pain, the patient will revisit the doctor much earlier in the medication cycle. This, combined with appropriate medical management standards, could wean people off addictive drugs sooner or avoid automatic re-prescriptions in uncalled for situations. For those who must continue on the medications for longer periods of time, it will enable doctors to see patients at more regular intervals. Hopefully, this will create an environment where drug-seeking behavior can be seen and caught much earlier.

Finally, changing the scheduling of these drugs enhances criminal penalties of possessing or selling large quantities of Hydrocodone; it closes a statutory loophole and enables the Special Prosecutor of New York City to prosecute drug offenses in boroughs other than Manhattan.¹²

¹¹ S. 5880-A (2012).

¹² Due to strictures on the office, the Special Prosecutor can only prosecute Schedule III narcotics in Manhattan, but not in outlying boroughs. Memorandum in Support, S. 5880-A (2012).

This change closes that loophole. Rescheduling these painkillers is not only necessary, but embraced by the medical community. In September 2011, the American Society of Addiction Medicine wrote the Commissioner of the FDA asking the administration to add Tramadol to Schedule III, and elevate Hydrocodone to Schedule II.¹³ Within New York, pharmacists, pain management associations, and law enforcement agencies support all these changes.

B. Statewide Drug Take-Back Programs

Many New Yorkers have unused medication in their homes and do not know how to properly dispose of them. The New York State Department of Environmental Conservation urges citizens not to flush their medications because it can pollute drinking water.¹⁴ The situation becomes even more confusing after a loved one passes away. Routinely, surviving family members are left with bags of medication—much of which are controlled substances—from the care of their deceased relatives. In an attempt to make sure controlled substances do not get into the wrong hands, federal DEA rules make it more difficult to return them. These drugs can only be surrendered to law enforcement agencies.¹⁵



Senator Hannon explaining what happens to surrendered medication.

For this reason, and like many other groups and associations, I hold “Shed the Meds” programs on Long Island,¹⁶ where we partner with law enforcement officials to provide a simple way for residents to dispose of old prescriptions. In Suffolk County, police agencies maintain round-the-clock “Shed the Meds” at police headquarters or precinct buildings.¹⁷ At each event, we collected more than 200 pounds of unused and unwanted

medication. This amounts to thousands of pills, which will not become part of an illegal drug

¹³ Letter to FDA, *supra* note 10, at 1.

¹⁴ NYS DEP’T ENVTL. CONSERVATION, *Drugs in New York’s Waters*, <http://www.dec.ny.gov/chemical/45083.html>.

¹⁵ US DRUG ENFORCEMENT ADMIN., *Got Drugs?: Prescription Drug Take-Back Program Q’s & A’s*, http://www.ojp.usdoj.gov/BJA/what/DEA_TakeBack_FAQ.pdf.

¹⁶ *Hannon Asks You to “Shed the Meds,”* GARDEN CITY NEWS, Sept. 16, 2011, http://www.gcnews.com/news/2011-09-16/Community/Hannon_Ask_You_To_Shed_The_Meds.html

¹⁷ NYS DEC, *Household Drug Collection Schedule*, <http://www.dec.ny.gov/chemical/63826.html>.

trade nor sit idle and available for dangerous misuse. Changing the prevailing attitude about prescription drugs is an important goal. Drugs in a medicine cabinet are not benign; they cause pollution, raise resistance to the benevolent actions of antibiotics, and can be addictive.

Currently, Long Island residents and other residents with robust take-back programs can participate in this solution, but it must be expanded to all areas of the state. We must encourage law enforcement to provide many opportunities for the public to properly dispose of controlled substances. There should also be a special emphasis on making it easier for hospice care workers, residential health care facilities, and surviving family members to return controlled substances in a safe and timely manner. Without expanding New York's take-back program, we will have no way to cut back on the millions of pills sitting, unused, in medicine cabinets throughout the state. As an immediate step, the Senate adopted a resolution declaring April 28, 2012 Prescription Drug Take-Back Day, in conjunction with National Prescription Drug Take-Back Day.

II. MONITORING THE PRESCRIBING PROCESS

According to reports, 30 armed pharmacy robberies occurred in New York in 2010; there were only four in 2006. In 2011, they turned deadly.¹⁸ In June, an opioid-addicted gunman entered a pharmacy in Medford, Long Island, where he shot and killed a pharmacist, his clerk, and two customers.¹⁹ The gunman then made off with 10,000 Hydrocodone pills.²⁰ In January 2012, an off-duty agent with the Bureau of Alcohol, Tobacco, Firearms and Explosives, was fatally shot after tackling a robber to the ground outside of a Seaport pharmacy.²¹ Furthermore, within the last three years, thieves stole as many as 1.4 million blank controlled substances

¹⁸ Chris Hawley, 'An Epidemic': Pharmacy Robberies Sweeping US, MSNBC, June 25, 2011, http://www.msnbc.msn.com/id/43536286/ns/us_news-crime_and_courts/t/epidemic-pharmacy-robberies-sweeping-us/#.Tw78QKWpkuc.

¹⁹ In four years before the shooting, the gunman and his wife filled prescriptions for almost 12,000 pain pills from dozens of doctors. John Valenti & Will Van Sant, *David Laffer Victim's Kin to Sue Doctor*, NEWSDAY, Feb. 9, 2012, <http://www.newsday.com/long-island/suffolk/breaking/david-laffer-victim-s-kin-to-sue-doctor-1.3516186>.

²⁰ Initial reaction to the large number of pills held in the pharmacy was that some nefarious practice was taking place. It turns out Hydrocodone is now a generic drug with a lower price and manufacturers often, to spur sales, offer margin-challenged independent pharmacists large discounts for bulk purchases.

²¹ Yancey Roy, *Report: Oxycodone Prescriptions Skyrocket*, NEWSDAY, Jan. 10, 2012, <http://www.newsday.com/news/health/report-oxycodone-prescriptions-skyrocket-1.3442993>.

prescription pads from New York City hospitals.²² This aggravates work for pharmacists because they cannot tell if prescriptions written on these pads are invalid. Each of the foregoing facts gives rise to a potential preventative step to illegal diversion.

A. Tracking Robberies & Protecting Pharmacies

After a rash of armed robberies across Long Island, local pharmacists found an interim solution. As a deterrent to future crime, some pharmacies now

post signs declaring they no longer carry Oxy- and Hydrocodone.²³ This may discourage violence, but it also prevents patients with legitimate medical needs from accessing this medication. Many of these patients are very ill, and the lack of medication requires them to travel even farther to fill prescriptions. It is not an ideal situation for anyone as it burdens both patients and local pharmacies. Solutions should curb violence and criminal diversion, but it should also help us effectively treat people suffering from chronic pain.

The County of Suffolk is proffering a rule for glass protected dispensing areas (like banks); other solutions exist using sophisticated scientific tracking devices. To stem violence against our pharmacists, we need to implement—in a reliable fashion—a method to track the flow of controlled substances in New York.²⁴ In addition, we can only stop the illegal diversion of controlled substances if we also track “in-transit losses.”²⁵ Current initiatives by the Office of the Medicaid Inspector General (OMIG) will balance the controlled-substance counts by focusing on pill counts and verifying controlled substance logs. For example, this new investigative tactic might involve evaluating Medicaid claims data for a given pharmacy, and then comparing this data to the records from the distribution chain.



Pharmacist Daryl Tomkin *no longer dispenses* Oxycodone products in his Hauppauge pharmacy.

²² Robert Lewis & Will Van Sant, *NY: Up to 1.4M Prescription Forms Stolen*, NEWSDAY, Oct. 22, 2011.

²³ Joye Brown, *Pharmacist Decries Easy Drug Availability*, NEWSDAY, June 22, 2011, <http://www.newsday.com/columnists/joye-brown/pharmacist-decries-easy-drug-availability-1.2977631>.

²⁴ System proposed by S. 5260-C (2012) for tracking non-controlled substances needs to be enacted to curtail the parallel systems used for controlled substances.

²⁵ Robert Lewis & Sandra Peddie, *NY Can't Tally Robberies*, NEWSDAY, Jan. 8, 2012.

Following Suffolk's lead, we must also institute incentives for pharmacies to install protective measures. We must strike a balance between the physical availability of pharmacists to counsel patients about treatments and safeguarding our pharmacists against physical violence. Pharmacy societies should adopt security measures that might prove most useful. These would include plant-based DNA signatures on pill bottles, bank-like glass counters, time-delayed safes holding controlled substances, separate accessible rooms for drugs with the highest street values, limiting the number of pills in a given store, or tamper-proof pills.

B. Tracking Missing Prescription Pads

New York State has a preeminent program for combating prescription theft and forgery. In the mid-1980s, the state instituted triplicate forms for controlled substances and saw a 54% decrease in forgeries.²⁶ Forge-proof prescription pads were introduced by 2006, it is a system that works through the joint-efforts of state government and private medical providers, but recent events might suggest the process is no longer as efficient as once hoped. On July 11, 2011, the Bureau of Narcotic Enforcement (BNE) sent an internal memo to the Department of Health. This memo confirmed 100 official controlled substance print-ready rolls of prescriptions were stolen from NYC hospitals and used to obtain drugs from in-state and mail order pharmacies. BNE estimated approximately 1.4 million official scripts had been stolen from NYC hospitals since 2008.

According to BNE, once the official scripts are delivered, it is up to the practitioner and facility to safeguard them. Therefore, BNE alleges these thefts occurred due to an apparent lack of adequate safeguards. As a result, in this memo, BNE recommended DOH take measures to raise awareness of the problem, improve safeguarding efforts, and require facilities implement safeguard mechanisms. On October 23, 2011, the New York Times published an article; titled *State Investigates Thefts of Prescription Pads at Hospitals*.²⁷ Four days after this publication, DOH, reportedly for the first time, issued a public statement to the pharmacy community advising them of the theft. Once DOH formally determines prescriptions are lost or stolen, they can be viewed on the agency's webpage for "Lost or Stolen New York State Prescriptions." This

²⁶ Robert T. Angarola & David E Joranson, *State Controlled-Substances Laws & Pain Control*, APS BULLETIN; 2(3):10-11, 15 (1992), <http://www.painpolicy.wisc.edu/publicat/92apssc.htm>.

²⁷ Thomas Kaplan, *State Investigates Theft of Prescription Pads at Hospitals*, N.Y. TIMES, Oct. 23, 2011, <http://www.nytimes.com/2011/10/24/nyregion/prescription-pads-stolen-from-new-york-city-hospitals.html>.

webpage is updated on a weekly basis. The DOH website also provides forms for the reporting of lost or stolen scripts. We need to pass and implement e-prescribing to combat theft; this should include instituting steps to proactively “hack” the electronic system to safeguard against future breaks.

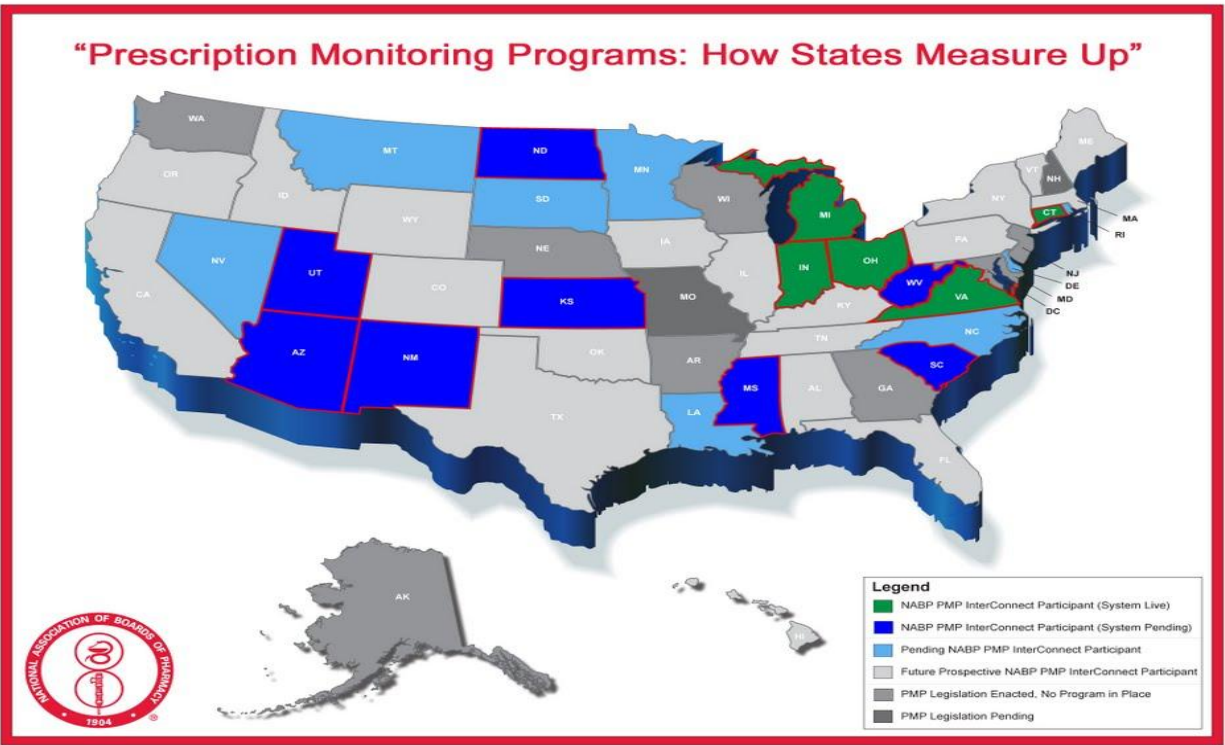
C. Prescription Monitoring Programs

The United States Department of Justice’s Drug Enforcement Administration (DEA) creates federal standards for dealing with controlled substances, but policies are administered at the state level. In 2011, the federal government began requiring Prescription Monitoring Programs (PMP)—electronic databases tracking prescribing habits. The DEA cited New York as one of three states with a lower rate of opioid prescribing and overdoses than other states with this electronic database.²⁹ Unfortunately, this does not translate into practical success; reports indicate New York’s PMP is very sluggish and very difficult to use. Criticism of the program includes lack of practitioner access, difficulty of use, a 30-day data lag, and

PMP STATE-BY-STATE COMPARISON²⁸		
STATE	DRUG CLASS	FREQUENCY
ALABAMA	C2 – C5	WEEKLY
ALASKA	C2 – C5	WEEKLY
ARIZONA	C2 – C4	WEEKLY
CALIFORNIA	C2 – C4	WEEKLY
COLORADO	C2 – C5	BI-MONTHLY
CONNECTICUT	C2 – C5	WEEKLY
FLORIDA	C2 – C4	WEEKLY
HAWAII	C2 – C5	WEEKLY
IDAHO	C2 – C5	WEEKLY
ILLINOIS	C2 – C5	WEEKLY
INDIANA	C2 – C5	WEEKLY
IOWA	C2 – C4	BI-MONTHLY
KANSAS	C2 – C4	WEEKLY
KENTUCKY	C2 – C5	WEEKLY
LOUISIANA	C2 – C5	WEEKLY
MAINE	C2 – C4	WEEKLY
MASSACHUSETTS	C2 – C5	WEEKLY
MICHIGAN	C2 – C5	WEEKLY
MINNESOTA	C2 – C4	DAILY
MISSISSIPPI	C2 – C5	WEEKLY
NEVADA	C2 – C4	WEEKLY
NEW JERSEY	C2 – C5	BI-MONTHLY
NEW MEXICO	C2 – C4	WEEKLY
NEW YORK	C2 – C5	MONTHLY
NORTH CAROLINA	C2 – C5	WEEKLY
NORTH DAKOTA	C2 – C5	DAILY/WEEKLY
OHIO	C2 – C5	WEEKLY
OKLAHOMA	C2 – C5	REAL TIME
OREGON	C2 – C4	WEEKLY
PENNSYLVANIA	C2	MONTHLY
RHODE ISLAND	C2, C3	MONTHLY
SOUTH CAROLINA	C2 – C4	MONTHLY
SOUTH DAKOTA	C2 – C4	WEEKLY
TENNESSEE	C2 – C5	BI-MONTHLY
TEXAS	C2 – C5	WEEKLY
UTAH	C2 – C5	WEEKLY
VERMONT	C2 – C4	WEEKLY
VIRGINIA	C2 – C4	WEEKLY
WASHINGTON	C2 – C5	WEEKLY
WEST VIRGINIA	C2 – C4	WEEKLY
WYOMING	C2 – C4	WEEKLY

²⁸ This chart illustrates the controlled substances monitored and the frequency that practitioners must submit data to the PMP. This information was provided in advance of the joint Health and Alcoholism and Drug Abuse Committee Roundtable held on February 13, 2012. For this and other materials, please see the online information about the Roundtable, <http://www.nysenate.gov/event/2012/feb/13/new-york-s-prescription-drug-abuse-crisis>.

²⁹ See discussion *infra* note 4.



The PMP InterConnect Program helps states link their information. This [chart](#) demonstrates New York enacted legislation creating a PMP, but it has made no efforts to share their information with other states.

inefficient filtering mechanisms.³⁰ These criticisms have merit, but they do not necessitate a wholesale elimination or replacement of the program. Ultimately, the most effective system will prove to be an amalgam of existing tools and ideas.

New York State is at the forefront of technology and has systems in place to tackle this challenge. Now is the time to upgrade the PMP, so it is the most effective and powerful tool available. Ideally, the greatest enhancement to PMPs would be the creation of a national database, which identifies patients with multiple prescriptions for controlled substances. Until that happens, New York must enhance its own PMP and explore the possibility of multi-state partnerships to strengthen monitoring. In recent months, more than seven states linked their PMPs, another 20 agreed to link their databases as well, but New York is not yet one of them.³¹ Short of a multi-state approach, New York must implement the best use of existing and newly developing databases (e.g. those owned by independent pharmacies, by larger chains, and the current PMP managed by BNE). New York must combine existing data in a manner that

³⁰ Participants offered these criticisms at the Senate Health Committee’s August 31, 2011 Roundtable. See note 2.

³¹ Nat’l Ass’n of Bds. of Pharm., *PMP Interconnect Map*, <http://www.nabp.net/programs/assets/PMPInterconnectMap.pdf>.

facilitates use, without burdening providers or government agencies with unnecessary costs. We should make clear who must have access to the database, including state agencies, doctors, pharmacists, and prescription benefit members.

In addition, we must conduct an external review of drug usage and drug prescribing patterns by a new regulatory authority using smart software. This software should apply functions much like the system OMIG uses to detect fraud in the Medicaid program (e.g. a smart system, which includes something akin to edits in eMedNY and alerts for practitioners about inconsistencies). The software should provide warnings to providers—automatically triggering additional action—and enable efficient filtering to drill down and explain what these usage and prescribing patterns indicate.³² No analysis or PMP, however, will function properly without a comprehensive review and understanding of new rules governing electronic prescribing and electronic medical records. Creating an effective PMP requires a delicate balance. New York needs to combat doctor shopping and recognize the practical realities of implementing change in the current economy. New York must appropriate the funds available to implement change, time constraints on already overworked doctors and pharmacists, confidentiality issues, constraints on compiling data, and the technical issues inhibiting necessary providers from accessing the PMP. This will perhaps prove to be the single most important tool in countering this public health crisis; New York must implement the correct solution. We must work to ensure the current system can be molded to include all of the most effective tools.

III. EDUCATING PRACTITIONERS & CITIZENS

Prescription medication can represent a marvel of modern medicine; it can also represent a slippery slope into addiction. Nearly one-third of Americans over the age of 12 reported their first experience with drug abuse involved the non-medical use of prescription drugs.³³ According to the CDC, one person in this country dies every 19 minutes through accidental

³² New York should explore a limitation CVS Caremark placed on certain physicians in Florida. In late 2011, as an internal compliance matter, CVS Caremark “informed a small number of Florida physicians that CVS/pharmacy will no longer fill the prescriptions they write for Schedule II narcotics.” Amy Pavuk, *CVS’ ‘Blacklist’ of Doctors Sparks Outcry*, ORLANDO SENTINEL, Jan. 25, 2012, <http://www.nashuatelegraph.com/newsworldnation/947665-227/cvs-blacklist-of-doctors-sparks-outcry.html>.

³³ WHITE HOUSE REPORT, *supra* note 3, at 1.

overdose or suicide as a result of prescription drug addiction.³⁴ Traditional policies created to fight the nation's War on Drugs do not affect this current crisis because 70% of prescription painkiller abusers got their drugs from a family member or friend—only five percent from a drug dealer.³⁵ This crisis touches all of us, and we cannot continue on the same course. Instead, we must spark a cultural transformation in this state by balancing the benefits and dangers of painkillers. We must instruct providers about when and how to prescribe these drugs, and teach the public to recognize the signs of abuse and addiction.

A. Educating Practitioners

Reports continue to surface about practitioners who prescribed woefully inadequate painkillers—literally aspirin for cancer—due to either ignorance or fear of medical disciplinary review. Conversely, there are many recent articles about practitioners who overprescribe pain medication. Medical practitioners work to find the best treatments, often without the time or information they would prefer. Pain exacerbates this situation. There are two primary targets for pain medication: acute and chronic pain. Treating acute pain involves patients recovering from surgical procedures, short-term trauma, or dental procedures; by definition, it is finite pain—with the exception of (often) terminal cancer pain. With chronic pain, the subjectivity of pain makes it all the more difficult to treat. In many cases, doctors cannot predict the intensity or length of a patient's pain. It does not help that few medical or pharmacy schools provide adequate coursework on either pain management or appropriate ways to handle with addiction. Moreover, as recommended, doctors must have access to, and use, the New York BNE expanded database to view a patient's current and prior painkiller use. Physicians must learn the proper methods for prescribing painkillers, and pharmacists must learn when they can refuse to fill controlled-substance prescriptions.

1. *Coursework in Pain Management, Addiction, & Palliative Care*

Currently, there is not a uniform method for preventing, assessing, treating, and understanding all manner of pain. Few states require coursework in pain management for medical or pharmacy degrees. Some states require doctors to complete continuing medical

³⁴ CDC GRAND ROUNDS, *Prescription Drug Overdoses—a US Epidemic*, 61(01);10-13 (Jan. 13, 2012), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>.

³⁵ See discussion *infra* note 3.

education courses in the areas of pain management and prescribing controlled substances. [Ohio has the strictest program; it mandates all doctors who meet certain qualifications complete continuing education. Affected doctors are those who work in clinics wherein 50% of the patients receive opioid treatment.³⁶] A 2011 report by the Institute of Medicine remarked on the lack of chronic-pain education: “there are strong indications that pain receives insufficient attention in virtually all phases of medical education--the lengthy continuum that includes medical school (undergraduate medical education), residency programs (graduate medical education), and courses taken by practicing physicians (continuing medical education [CME]).”³⁷

New York must engage its medical and pharmacy societies to initiate and create an education program on pain management, addiction, and palliative and end-of-life care. Pharmacy schools and boards should review current federal and state rules governing times when pharmacists may refuse to fill a prescription (e.g. if a patient exhibits drug seeking behavior or presents what appears to be a forged prescription). These must be distilled into protocols, which should be taught in schools and as continuing education. The boards should also explore appropriate education and protocols for assistants and other pharmacy employees. All pharmacy employees should understand their role in dispensing and safeguarding controlled substances.

Medical schools and boards must explore current basic training standards for pain management and addiction. Not all doctors prescribe controlled substances, but all doctors should have a basic idea of the potency and potential dangers of over-prescribing these medications. They should also have a basic understanding of the factors contributing to addiction. In addition, both the medical and pharmacy societies should develop protocols and standards for continuing education, which should track monitoring and prescribing trends for controlled substances.

³⁶ According to an American Medical News report, doctors working in pain management clinics must now complete 20 hours of continuing medical education every two years. Kevin B. O'Reilly, *States Try More Aggressive Rx Opioid Controls*, AM. MED. NEWS, Oct. 17, 2011, <http://www.ama-assn.org/amednews/m/2011/10/17/pl21017.htm>.

³⁷ INSTITUTE OF MEDICINE, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (June 29, 2011), <http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx>.

2. *Developing Prescribing Standards for Acute Pain*

Doctors prescribe painkillers in acute pain settings to help patients through short-term pain. Dr. Thomas Frieden, the current CDC Director and former New York City Commissioner of Health, recently argued for limited prescriptions to treat acute pain—three days of opioid medication—and using narcotics only as a last resort.³⁸ This does not reflect common prescribing practices. For example, if a patient has a tooth removed, he may receive pain medication to ease his suffering. In many present cases, this patient will receive one, 30-day prescription for pain medication and will not receive, either in writing or orally, advice as to the addictive nature of the drug, nor the proper way to dispose of unused pills. This is often far too much medication, simply because the pain abates and the patient does not use the remaining medication. In other instances, patients may suffer complications, but continue taking the pain medication instead of returning to the prescriber for further help.

Prescribing fewer pills can also lessen the potential for addiction. If the patient is still in pain after the shorter term, he may return to his doctor for additional treatment. New York pharmacy and medical societies should work together to determine what shorter terms of care for common acute pain settings maybe more appropriate. A treatment protocol for acute pain settings will be an invaluable tool in combating prescription drug abuse across New York. Moreover, insurers should not penalize those needing additional medication. To the extent a statute is necessary to regulate/require insurers to appropriately reimburse, then such a law must be actually pursued. We must ensure patients do not pay double co-pays for the same treatment over a short timeframe.

3. *Developing Standards for Chronic Pain Management Plans*

Dealing with chronic pain is often more complex. The CDC director cautions against using narcotics, except as a last resort to treat chronic pain;³⁹ however, practitioners and patients cannot and will not cease to use controlled substances. Although there is a crisis concerning abuse, we must not forget the many patients who suffer from intense and chronic pain. These people are in daily pain from cancer, AIDS, recent operations, and other illnesses. For these

³⁸ *Deaths from Painkiller Overdose Triple in Decade*, L.I. PRESS, Nov. 1, 2011, <http://www.longislandpress.com/2011/11/01/deaths-from-painkiller-overdose-triple-in-decade/>.

³⁹ *Id.*

patients, we must focus on managing their pain with appropriate treatment protocols. In light of these chronically ill patients, and the promise of even more potent painkillers on the horizon,⁴⁰ relevant practitioners and stakeholders need to collaborate and develop appropriate treatment practices, especially care management plans for patients using painkillers greater than an agreed-upon threshold or frequency. New York must have situation-adjusted protocols, specifically describing how providers should respond to patients requesting additional medication and the appropriate times to re-prescribe. Practitioners and medical societies should arrive at these protocols, which must have the input of specialists in oncology, neurology, and pain medicine. Most importantly, once determined, practitioners must apply these clinicians in practice.

Practitioners and professional societies support creating these protocols. To ensure their effectiveness, any protocols should include guidelines for pain-management education materials for patients, individual treatment plans, and creating pain management agreements between physicians and patients. Doctors should conduct unscheduled pill counts for patients. This helps doctors determine whether patients take the medication as directed. Due to dire financial circumstances, some patients sell their medications instead of taking them. This is illegal, and it prevents patients from receiving treatment they might need. A possible solution would require doctors to conduct urinalysis as part of the pain management plan. This additional tool will also help doctors see whether their patients took the prescribed medication. We should also explore requiring insurance companies to reimburse physicians who participate in chronic pain management plans; they will coordinate better care and, ultimately, prevent unnecessary prescribing.

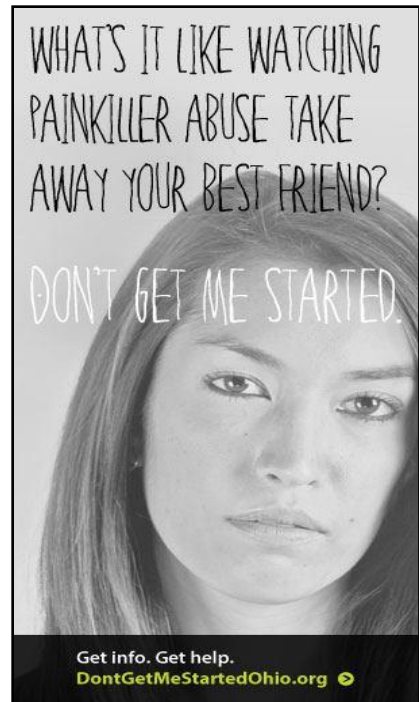
B. Educating Patients & the Public

Educating patients in the doctor's office is only the beginning. To make real change, we must correct two common, but inappropriate views about prescription painkillers. First, all too often, people share a portion of an old prescription with a son, wife, or roommate suffering from acute pain. A 2009 survey found 70% of prescription painkiller abusers got their drugs from a

⁴⁰ Joe Kemp & Tracy Connor, *New Super Painkiller Zohydro is More Dangerously Potent than Vicodin: Narcs & Docs*, NY DAILY NEWS, Jan. 7, 2012, http://articles.nydailynews.com/2012-01-07/news/30603028_1_oxycontin-prescription-drug-abuse-new-pain-pill.

family member or friend.⁴¹ This is made extremely easy because parents routinely lock up firearms and liquor cabinets, but leave potent, highly addictive drugs in the bathroom medicine cabinet.⁴² Patients must understand that doctors prescribe medication for a specific purpose. Drugs must be taken for that purpose, and in the manner advised by the physician and pharmacist. This seemingly innocent act of sharing medication can have dire consequences.

Second, many people believe that FDA-approval and a physician prescription mean narcotic painkillers are not every bit as serious and addictive as other street drugs. When used appropriately, these drugs work miracles, but like many other tools, they should be treated with respect. Parents and other family members need to understand the importance of watching for the signs of prescription drug abuse in the same way they would for heroin or cocaine abuse. In-state reports show two out of every five teens in Nassau and Suffolk counties have abused prescription drugs. In addition, the majority of teens report, “it’s easier to secure medication and believe that they are safer than illegal drugs.”⁴³ One of the most important tools to combat prescription drug abuse in this state is to change the social perception of medication. New York should consider a statewide media campaign to help citizens safeguard potent pharmaceuticals in the same way they protect against the hazards of underage or drunk driving.



Ohio began a statewide media campaign aimed at teenagers called “Don’t Get Me Started.”

IV. PROSECUTING DEALERS, REHABILITATING ADDICTS

Changing attitudes toward prescription medication also requires changing our perception of addiction. Without proper treatment or oversight, patients can become addicted to

⁴¹ See discussion *infra* note 3.

⁴² WHITE HOUSE REPORT, *supra* note 3, at 2.

⁴³ Vilma Sceusa, *Your Teen’s Access to Illegal Drugs a Lot Closer than You Think*, GARDEN CITY PATCH, Sept. 23, 2011, <http://gardencity.patch.com/articles/your-teens-access-to-illegal-drugs-a-lot-closer-than-you-think>.

prescription narcotics in just seven days. That timeframe dwindles to just days if someone alters the drug into a form wherein he or she can snort or inject it. “People with addiction who could be perfectly good people will do all sorts of horrible things to maintain their supply,” said Dr. Andrew Kolodny, President of Physicians for Responsible Opioid Prescribing.⁴⁴ This desperation, coupled with an inability to perceive danger, makes this population even more susceptible.⁴⁵ These people do not always know where to turn for treatment, and unscrupulous doctors and pharmacists exploit this vulnerability. The best artillery against those addicted and the bad actors feeding these chemical dependencies is to strengthen compassionate reforms for addicts and heighten penalties for drug dealers.

A. Prosecuting “Licensed” Drug Dealers

Like many solutions, we must be cautious with criminal penalties for New York medical professionals. The vast majority work diligently to provide the best medical care possible; however, there are a few very bad actors who abuse their power. Traditionally, we think of drug dealers in terms of cinema clichés, but these dealers hold professional licenses, which give them access to powerful narcotics. A doctor illegally selling painkiller prescriptions received a six-month jail sentence after two of his patients fatally overdosed.⁴⁶ This penalty has not caught up with, nor does it line up offenses for merely possessing opiates—someone possessing heroin will be sentenced to years in prison.⁴⁷ If these professionals illegally sell prescriptions, they should be punished the same way as any other drug dealer.

One doctor, Stan Li, ran a pain clinic in Queens for two years, and during that time, patients would reportedly line up outside his practice.⁴⁸ Prosecutors allege he saw 120 patients per day. As many as nine people died as a result of Dr. Li’s illegal prescribing. He also

⁴⁴ Hawley, *supra* note 23, at 2.

⁴⁵ Delthia Ricks, *Narcotics Nation*, NEWSDAY, Jan 21, 2012, <http://www.newsday.com/news/health/un-u-s-consumes-80-of-world-s-oxycodone-1.3469762>.

⁴⁶ Edward Robinson, *Drug Doctor Sentenced: Saji Francis Gets 6 Months for Selling Oxycodone*, MASSAPEQUA PATCH, Oct. 7, 2010, <http://massapequa.patch.com/articles/drug-doctor-sentenced>.

⁴⁷ N.Y. Pen. Law §§ 70.70, 220.09(1).

⁴⁸ *Long Island Physician Indicted in Illegal Prescription Drug Case*, CBS NY, Dec. 21, 2011, <http://newyork.cbslocal.com/2011/12/21/physician-indicted-in-prescription-drug-case/>; Press Release, NYC Office of the Spec. Narc. Prosecutor, Doctor Arrested for Illegally Selling Prescriptions to Overdose Victim (Nov. 21, 2011), <http://www.nyc.gov/html/snp/downloads/pdf/pr-112111.pdf>; Robert Lewis, Sandra Peddie, & Will Van Sant, *Records Show Laffer Shopped for Doctors*, NEWSDAY, Nov. 18, 2011, <http://www.newsday.com/news/breaking/records-show-laffer-shopped-for-doctors-1.3330619>.

prescribed more than 2,500 pain pills to the gunman in the Medford, Long Island pharmacy shooting. [The gunman shot and killed four people, before making off with 10,000 Hydrocodone pills.] This example illustrates why some prosecutors question the comprehensiveness of current New York penal laws. “It is difficult to prosecute unscrupulous pharmacists under current New York law,” said Nassau County ADA Jane Zwirn-Turkin, Chief of the Pharmaceutical Diversion Unit. “The Nassau County’s Pharmaceutical Diversion Unit investigated a pharmacist who filled narcotic prescriptions for customers he knew were addicts, but we were unable to prosecute him until he sold controlled substances to customers without prescriptions.”⁴⁹

Current general statutory provisions prohibit the sale of narcotics. Other provisions specifically address the sale of prescription drugs by physicians. There are specific provisions to handle physicians who illegally prescribe—sell—controlled substances. There are not specific provisions addressing when pharmacists illegally dispense narcotics. We need statutes clarifying and ensuring *all* licensed medical professionals who illegally prescribe or dispense controlled substances will face criminal penalties. Future laws must focus on practitioners acting outside the scope of their professions, namely those who knowingly and illegally dispense controlled substances.⁵⁰ Further, changes to the scheduling of Tramadol and Hydrocodone will enhance the tools available to prosecutors. They will provide stiffer penalties for practitioners illegally peddling these medications.

B. Rehabilitating Addicts

Across the country, users of prescription pain medication suffer from addiction. However, there are not enough resources in place to help these patients transition out of addiction. “In 2006, 692,000 reported misusing prescription drugs for non-medical purposes,” but three years later, only 19,182 people entered rehabilitation programs for opioid addiction.⁵¹ In many cases, health insurance plans cover prescription pain medication, but it can be difficult access to adequate coverage for rehabilitative services stemming from a later addiction to those

⁴⁹ Press Release, Sen. Kemp Hannon, Illegal Dispensing of Controlled Substance Pain Medication to Be Criminalized (Nov. 30, 2011), <http://www.newsli.com/2011/11/30/illegal-dispensing-of-controlled-substance-pain-medication-to-be-criminalized/>.

⁵⁰ S. 6066 (2012).

⁵¹ Recovery Connection, *NY Drug Rehab. & Addiction Treatment*, <http://www.recoveryconnection.org/new-york-drug-rehab/>.

same medications. In order to eliminate and prevent addiction, plans should cover drug rehabilitation for prescription drugs.

According to a 2011 study by Columbia University, local, state, and federal governments spend almost \$500 billion on the effects of substance abuse.⁵² Between 1999 and 2009, New York treatment admission rates for prescription opioids rose 450%—20% more than the national average.⁵³ At first glance, this number would seem to indicate rehabilitation rates are steadily increasing, but it does not reflect the massive number of people who need, but still do not have access to this intervention. Nor do these statistics adequately illustrate the pain and terror families face when a loved one cannot find a safe place to go through detoxification.

1. *Examine Detoxification & Rehabilitation in New York*

According to recent information from the CDC, “for every unintentional overdose death related to an opioid analgesic, nine persons are admitted for substances abuse treatment, 35 visit emergency departments, 161 report drug abuse or dependence, and 461 report nonmedical uses of opioid analgesics.”⁵⁴ Each of these represents a population that has or will have need of either detoxification (detox) or rehabilitation services. Many of those working in these fields dedicate their lives to helping others. These services are important, but they are also expensive, and inpatient treatment can be difficult to access through insurance coverage. New York must develop a thorough and ongoing process to evaluate and supervise both detox and rehabilitation services.

There has been continuing discussion at the state and federal levels about decreasing the number of detox beds in New York because the service can often be conducted on an outpatient basis. We must require frank and full discussions about the appropriateness of this policy shift and explore alternate approaches. Many people suffer from a lack of detox beds; there have been reports of families across the state whose loved ones overdosed or committed suicide, and in some cases the reports indicate a link to an inability to access appropriate services. This is just one example of both the pain of addiction, and the necessity to clearly publicize how to access

⁵² Joseph A. Califano, Jr. & William J. Bennett, Op., *Do We Really Want a ‘Needle Park’ on American Soil?*, WSJ, July 1, 2011, <http://online.wsj.com/article/SB10001424052702304314404576411610933327334.html>.

⁵³ NYC DEP’T OF HEALTH & MENTAL HYGIENE, *Preventing Misuse of Prescription Opioid Drugs*, 30 CITY HEALTH INFORMATION 23, 23 (Dec. 2011), <http://www.nyc.gov/html/doh/downloads/pdf/chi/chi30-4.pdf>.

⁵⁴ CDC GRAND ROUNDS, *supra* note 32, at 1.

detox and support services. If we plan to change the way detox works in New York, the change must be comprehensive (i.e. it must be accompanied by educational materials about how to properly access new detox services).

Moreover, there are several models for outpatient, non-medical settings to help people through detox and rehabilitation from opioid and other addictions. Detox from opioid addiction may not be fatal, but “detoxing on the floor of your bathroom can be difficult to endure, frightening for family members and provides no link to treatment.”⁵⁵ We also need to consider continuity of care for those affected by addiction. New Yorkers must recognize the link between the medical and emotional aspects of addiction. Mental health and primary care must work together to treat patients. However, we must consider alternate models. We must explore providing for very short-term, residential, and non-medical supports—sometimes called hospital diversion programs—for those suffering from addiction. New York should conduct a demonstration for the establishment of diversion programs around the state to aid in ameliorating the effects of opioid addiction.

2. *Medicaid Recipient Restriction Program*

Reports from the Unified Court System recognize many of those in drug courts are also Medicaid recipients. Due to various socio-economic factors, many patients suffering chronic pain are also Medicaid recipients. According to reports, a “Medicaid patient with drug and alcohol problems costs \$5,000 to \$15,000 a year more in health-care costs than one without such problems. Most Medicaid hospital patients readmitted within 30 days are those with drug and alcohol problems.”⁵⁶ In 2010, the Senate Republican Task Force on Medicaid Fraud recognized the problems with doctor shopping “as a well documented form of Medicaid fraud.”⁵⁷ To combat this, the task force recommended requiring recipients to select one primary care physician and one pharmacy, which is similar to many managed care plan requirements.

OMIG implemented this recommendation through the Recipient Restriction Program, which uses a team of physicians, nurses, and pharmacists to determine whether a recipient

⁵⁵ Jeffrey L. Reynolds, *Finding Detox Options on Long Island Beyond NUMC*, LICADD, Jan. 23, 2012, <http://www.licadd.com/2012/01/23/finding-detox-options-on-long-island-beyond-numc/>.

⁵⁶ Califano, Jr. & Bennett, *supra* note 48, at 1.

⁵⁷ NYS SEN. REPUB. TASK FORCE ON MEDICAID FRAUD, *Combating Medicaid Fraud in New York State* at 7 (Mar. 2010), <http://www.nysenate.gov/files/pdfs/0317.Combating%20Medicaid%20Fraud%20in%20NYS.pdf>.

qualifies for the program. One investigative tool uses Salient data-mining technology to flag claims wherein a recipient receives a high-dose painkiller as their initial experience with the medication. From there, OMIG can research the patient file to determine whether the patient is doctor shopping or, perhaps, just needs better continuity of care. The local social service district will implement the restriction and help the recipient locate a convenient primary doctor and pharmacist. In 2010, OMIG conducted 5,864 reviews, leading to an average of 9,022 recipients restricted.⁵⁸ Not only did these recipients receive more coordinated care, but it also resulted in a cost-savings to the Medicaid program of over \$150 million.

3. *Handling Overdoses*

With prolonged, and often improper use, there is a high risk for overdose on opioid painkillers. Unlike some drugs, there are no maximum doses for opioids; however, higher doses can cause respiratory depression. In other words, the person's respiratory system stops working, and he or she will eventually die from oxygen deprivation. In 2009, DOH and the New York State Office of Alcoholism and Substance Abuse Services (OASAS) released a health advisory with recommendations for opioid overdose. These recommendations included: (a) recognizing previous overdoses(s) as a risk factor for a future overdose; (b) instructing individuals and their friends and family on how to recognize and respond to an overdose, including the use of rescue breathing and Naloxone; and (c) providing take-home Naloxone.⁵⁹ These provide a good foundation, but reports indicate emergency room visits for opioid misuse and abuse continue to rise.

Unlike other drug scenarios, those overdosing on opioids can be administered Naloxone. This medication counters the opioids' effects on the body, and some cities are exploring handing out doses to heroin addicts. Without Naloxone, opioid overdose can be fatal. To avoid fatalities, we must explore ways to get Naloxone to those who need it, without regard to their setting. While medical professionals can administer Naloxone—or its generic counterpart—we should explore whether this could be administered in a non-medical setting. In 2006, New York created

⁵⁸ 2010 NYS OMIG ANN. REP., at 12,

http://www.omig.ny.gov/data/images/stories/annual_report/annual_report_2010.pdf.

⁵⁹ NYS DOH, *Emergency Department Interventions to Prevent Opioid Overdose*, Sept. 4, 2009,

http://www.health.ny.gov/diseases/aids/harm_reduction/opioidprevention/health_advisory_interventions_preventing_overdose.htm.

a law creating Opioid Overdose Prevention Programs and allowing non-medical personnel to administer Naloxone.⁶⁰ The Health Department should report on the efficacy of this program, providing data on the number of programs and participants. As discussed above, if Naloxone were available for non-medical personnel, and outside the hospital setting, this could provide additional help for those needing detoxification services when beds are not available.

Moreover, we must foster an environment where those overdosing and those present while others overdose can call for medical attention without fear of prosecution. In 2011, New York took a step toward changing this attitude. A new law provides prosecutorial protection against a witness or victim of overdose.⁶¹ This law will not hinder efforts to weed out drug trafficking. Instead, it will encourage witnesses and victims to protect human life; it also impliedly recognizes these victims need rehabilitative help instead of criminal sentences.

CONCLUSION

As demonstrated in this paper, there is no “quick fix” for this crisis, but we must act to counter the terrors associated with prescription drug abuse. We must make prompt, but incremental change to correct flaws in the current system. Most importantly, we must require a sea change in the perception of this medication. We must continue to acknowledge the power painkillers have to relief suffering, and respect the dangers associated with their misuse. All practitioners should become familiar with appropriate prescribing practices and the signs of drug-seeking behavior. Patients and the public must become versed in the signs of addiction, and openly communicate with their doctors. As a society, we must alter the dialogue and make wholesale change, including educational initiatives, limiting access to certain drugs, tracking pills, punishing bad actors, and providing opportunities for rehabilitation. We can, and must, weave together a variety of solutions to strengthen the current system. New York is often at the forefront of innovation and change, there is no reason we cannot aim these powers at combating a present, and very real danger to our citizens.

⁶⁰ N.Y. PUB. HEALTH LAW § 3309; NYS DOH, *Opioid Overdose Prevention*, http://www.health.ny.gov/diseases/aids/harm_reduction/opioidprevention/index.htm.

⁶¹ N.Y. PEN. LAW § 220.78.