ATTORNEY GENERAL RICHARD BLUMENTHAL

PRESCRIPTION DRUG ABUSE HEARING

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MR. BLUMENTHAL: If I may welcome everyone, these are familiar settings for many of you, and for the commissioner and myself having been in the legislature; but for those of you who are here for the first time, welcome to our Legislative Office Building and to these hearings on prescription drug abuse and measures that we can take against prescription drug abuse.

We have a broad cross-section, very impressive group of speakers this morning to address what has been a quiet, but consistently devastating problem over the years; prescription drug abuse has afflicted many of our citizens and communities with results that have been often devastating, debilitating, extremely costly to many of our citizens.

There has been a tendency to focus on OxyContin as the prescription drug abuse most fashionable, perhaps most troubling in its results at the moment, but it is indeed only at the moment that it seems to have attracted this kind of attention, and the problem really is a much broader, more far-reaching and

fundamental one having to do with abuse of powerful painkillers and other prescription drugs that potentially offer tremendous promise and benefits to people who suffer from severe chronic pain, but even as

they offer great promise, they also come with tremendous pitfalls and problems: abuse and addiction leading to criminal wrongdoing, doctors, diversion.

The question is who should receive these drugs, who benefits from them, and who should not, and what we can do to make sure that those who legitimately need and deserve these drugs continue to have them available, but at the same time stop abuse and addiction and the kind of criminal wrongdoing that all too often has flowed from them.

Other states have employed methods such as electronic prescription drug monitoring programs to combat abuse. These systems allow for review by state law enforcement officials of the prescription of controlled substances and would also allow physicians to determine whether their patients or prospective patients already are receiving prescription drugs from another physician. That proposal, along with others, will be reviewed in this hearing, and I hope that this hearing is simply a first step, perhaps only the first of a number of hearings, that will address a number of

these issues.

I want to thank Commissioner Fleming, who has been very interested and involved in this issue. I will be talking to him and others who are

represented from the state of Connecticut here today about those prospective solutions.

I also wellcome Cindy Denne and Sam Siegelman: Cindy Denne, who is the bureau chief at the Department of Public Health, and Sam Siegelman at DHMAS, I notice that we have been joined by Senator Edith Prague, and I welcome her.

I want to thank my staff, most particularly Richard Kehoe, Justin Kronholm -- Justin Kronholm is here, and many of you who dealt with him in the last few days; and also attorneys on my staff, Arnie Menchel, Michael Cole, and Ted Doolittle, assistant attorney generals who have been instrumental in organizing this hearing and in working on this problem.

With that, I would like to ask whether any of the other panelists this morning have any opening remarks. First Commissioner Fleming who has been a very strong and stalwart ally in this effort. Thank you, Commissioner Fleming.

COMMISSIONER FLEMING: Thank you, Mr.

Attorney General. It's also my pleasure being here this morning. Having spent a number of years here in the legislature, I understand what a public hearing is all about, and that is for us to listen to what really

an impressive list of experts I expect will have to say in the course of today.

I've also asked to sit in from my agency, from the Department of Consumer Protection's drug division, the chief of enforcement, Bill Ward, and Leo Roberge, who is the head of the drug division. They will be taking plenty of notes, looking for any ideas that will come out of this hearing.

We have been working as an agency over the last several months with the Attorney General's office and with other agencies that deal with the issue of prescription drugs and how prescriptions are written to prepare a proposal which we will present to the next session of the legislature dealing with electronic monitoring of drugs. That is still in draft form, and so any additional information that we might gather from this hearing today we would find very helpful, and I would hope sometime in the early winter when the legislature reconvenes that I will have an opportunity to be where you are, and that is to sit before a group of legislators and make the case for that proposal.

Thank you.

MR. BLUMENTHAL: Thank you, commissioner.

MS. DENNE: I just would like to thank

Attorney General Blumenthal for pulling together this very important hearing, and I expect to hear some expert testimony today that will be very helpful to the department as it formulates its policies in terms of the differentiation between medical need and abuse of prescription drugs. Thank you.

MR. SIEGELMAN: On behalf of the Department of Mental Health and Addiction Services, I also would like to thank the Attorney General. Although we work more on the demand reduction side of things, it's not unaffected by supply side issues, and we look forward to learning from the experts at this hearing as well.

MR. BLUMENTHAL: Thank you. I know that we've been joined, I've seen Representative Dickman and Representative Sawyer who have since joined us along with Senator Talgri (phon sp), and I thought I saw Deputy Commissioner Starkowski.

I apologize to anyone whom I've missed in the course of announcing those who are here.

We'd like to move right along and ask

the chief state's attorney, Jack Bailey, if he would please address us.

MR. BAILEY: Good morning.

MR. BLUMENTHAL: Good morning, sir.

MR. BAILEY: Good morning.

For the record, I'm John M. Bailey, Chief State's Attorney for the state of Connecticut.

I welcome the opportunity to be here this morning to address the very serious problem of prescription drug abuse. As Chief States Attorney, I serve as the chief law enforcement officer of the state of Connecticut. I'm responsible for the overall administration of the division of criminal justice.

As you know, Dick, under the constitution, I'm responsible for the investigation and prosecution of all criminal matters in the state of Connecticut. This includes illegal use of prescription drugs.

Let me begin by stressing the importance of keeping this issue in perspective. The misuse of prescription drugs is only one element of the substance abuse crisis that is facing the nation today. It is a crisis that touches all aspects of American life and as such is a crisis that requires a comprehensive approach. Yes, prescription drug abuse is a serious

problem, but there are those who would argue that illegal drugs such as heroin poses a far greater threat because of a far greater number involved. Again, my point is that we must keep this problem in

perspective. We must resist the temptation to follow the headlines and focus the bulk of our attention and resources on the drug of the day simply because the media chooses to do so.

If you could recall last winter, the talk of the town in Washington was the illegal club drug Ecstasy. By summer Washington had shifted its attention to the legal prescription drug OxyContin. Prosecuting cases involved both of these drugs.

One problem has not gone away because the media and Congress has chosen to focus on another drug. That is why it's so critical that we develop a comprehensive plan that addresses all components of the substance abuse crisis; a comprehensive plan that brings together all involved to work together towards one goal. If we simply choose to follow the headlines, we are doomed to failure. Yes, we might solve today's problem, but we won't prevent tomorrow's.

We also must resist the temptation to look for a simple solution. Some, for example, have suggested the way to stop abuse of a specific drug is

to ban the manufacture and sale of those drugs. Keep in mind those drugs are already strictly regulated. They are classified as Schedule II narcotics. And the reason they are classified that way is because they are

highly potential for abuse and addiction. A physician cannot phone in a prescription for a Schedule II drug, nor can he order an automatic refill. Nevertheless, despite the existing regulations, these drugs are being abused.

The question for policy makers becomes what we can do to stop the abuse while keeping these drugs available to those who are in need of them. And we cannot understate the fact that there are many people, as you said, Mr. Attorney General, who do need these medications and who do benefit from them. Many in the health care community consider OxyContin a milestone in the treatment of patients with chronic and extreme pain.

Just as important, though, is the fact that banning specific prescription drugs will simply not work. The same can be said for the glue that children use to make model airplanes or the various other legal household chemicals that have become the means of substance abuse. If we ban one prescription drug today, you can be sure that drug dealers will find

another prescription drug to peddle tomorrow. The criminals who are peddling drugs whether they are legal or illegal are making tremendous profits, and they are not about to look for a new line of work. That is why

it is so important that we develop a comprehensive plan toward dealing with substance abuse, whether the substance is legal, prescription drugs obtained through illegal means, or illegal drugs smuggled across the borders and sold on the streets.

So what does this comprehensive plan involve? It involves everyone at every level of government, from the police officer who makes an arrest to the prosecutor who makes the case in court and the legislators who make the laws and the judges who apply them. And they must be involved with the private sector. The drug manufacturer must be prepared to make their products less vulnerable to abuse. The health care community must be more diligent in reporting suspected abuse and doctors who recklessly and unethically prescribe drugs.

We have made significant progress in developing comprehensive plans. I commend Governor Rowland and the General Assembly for the actions they have taken in recent years, whether additional resources for drug treatment or tougher penalties for

drug dealers. Yet much work still lies before us.

In terms of today's topic, prescription drugs, the division of criminal justice supports the concept of a prescription-monitoring program. We

commend the Department of Consumer Protection, the Attorney General's Office, the Drug Enforcement Agency, and the National Alliance for Model State Drug Laws and all those who pursue the concept. A properly structured prescription monitoring program will be another step forward, but, again, keep in mind that it will only be one of many tools, and only one component of a very comprehensive plan.

We have, as you know, Commissioner Fleming and Attorney General, we have arrested Dr. Dudley Hall, mainly because it was reported that he was prescribing more of OxyContin than anyone else in the state of Connecticut. What we did was we put undercover officers as patients entering his office. We had to pay $150 for the first time in his office. After that, we had to pay $50, all cash, 100 percent cash, for him writing other prescriptions. And right now he's facing 300 to 838 years.

These are only allegations, but I think they're very important because I think monitoring prescriptions could be real progress for us in the

state of Connecticut. And we really don't have to change the law because 21a-274 -- excuse me. Cooperation between law enforcement, that means we can exchange information, if you get a call or Commissioner

Fleming gets a call, we can share that information with the division, and we can begin the administration.

MR. BLUMENTHAL: I want to thank you for your testimony, Chief State's Attorney Bailey, and for your work on this problem which will be excellent, along with, obviously, the State Police and your entire office, and I hope that you will be part of developing that kind of comprehensive plan which I think is so valuable.

In the Hall case, as I recall, there were hundreds of thousands of dollars in state money.

MR. BAILEY: Right.

MR. BLUMENTHAL: Which is one of the reasons for our interest, because state spending on OxyContin alone now is at the projected level of $7.4 million for this year alone, which has quadrupled in the last four years.

MR. BAILEY: I think, Mr. Attorney General, if we all get together and make a plan, I think it will work. Thank you.

MR. BLUMENTHAL: Thank you. I would

like to again thank you for being here today.

Captain Peter Warren, commanding officer of the State of Connecticut Statewide Narcotics Division.

CAPTAIN WARREN: Good morning.

MR. BLUMENTHAL: Good morning, captain.

CAPTAIN WARREN: My name is Captain Peter Warren, and I appreciate the opportunity to be here today. And I applaud all of you for your efforts to discuss the growing problems that are related to the use of OxyContin here in Connecticut.

For the past four years, I have served as the commanding officer of the Statewide Narcotics Task Force. From my position as the commanding officer of this task force, and also from my position as the national president of the National Alliance of State Drug Enforcement Agencies, an alliance of the nation's 50 state police and highway patrol departments that conduct narcotic enforcement in the United States, I am well aware of the problem that our nation faces from the abuse of prescription drugs, primarily these days from the abuse of OxyContin.

Today the abuse of OxyContin is one of the most significant concerns to law enforcement agencies across the country, especially to those of us

along the East Coast. Abuses of this legitimate drug are often caused by those individuals who are heroin addicts who seek out an over-the-counter prescription drug that closely mirrors heroin.

The OxyContin medication is well-known as a legal and effective painkiller for cancer patients and others. OxyContin should never be denied to those patients who need this powerful medication and who use it lawfully. However, the abuses of OxyContin and the crimes caused by the illegal use of OxyContin needs our immediate attention, especially here in Connecticut before the problem becomes far too significant, as it has in other states.

OxyContin is often obtained illegally by those addicts or those who profit from the high returns of illegally selling these pills on the street, by doctor shopping, from forging prescriptions, and through theft of OxyContin shipments that are destined for pharmacies here in Connecticut.

As Mr. Bailey just mentioned, detectives of the Statewide Narcotics Task Force and others recently arrested a doctor who was engaged in the distribution of OxyContin at an alarming rate. Patients easily received excessive numbers of prescriptions from this doctor for OxyContin. This

should show all of us the high demand for this drug when a trained medical doctor risks everything to turn a profit on illegally distributing this drug.

In another case, we recently arrested an

individual who was responsible for distributing air shipments of OxyContin to pharmacies. This individual was being paid to pilfer portions of OxyContin shipments that were destined to the pharmacies here in Connecticut so that an associate could sell these pills on the street. This also shows that people are willing to risk their jobs to steal this OxyContin for others.

It is not uncommon for OxyContin to be sold for as much as sixty-five to eighty-five dollars per pill, depending upon the dosage and the number of pills that are being sold and that have been stolen. This compares to approximately the $6 cost when the pills are sold legally over the counter. OxyContin is also commonly sold on the streets for roughly $1 per milligram, meaning that an 80-milligram dose of OxyContin can easily cost $80 on the street, a significant markup from its six- to eight-dollar over-the-counter cost.

Oftentimes OxyContin is sold on the streets by patients who legally obtain these pills but who sell a portion of their prescription on the

streets, as they are aware of the high demand for these pills and the high returns by selling these pills they can realize.

Last week I attended a national HIDTA

conference in Washington, D.C. HIDTA stands for high intensity drug trafficking area. In Connecticut we have three counties designated as HIDTA counties.

Generally the focus of HIDTA initiatives is cocaine, heroin, and methamphetamines. The same is true in Connecticut for the HIDTA initiatives that I manage for the Connecticut State Police Department. However, when the national HIDTA conference -- as does NASDEA, the alliance I serve as president of -- sets aside portions of our meetings to discuss the growing problems associated with OxyContin abuse, it should make all of us realize that OxyContin is a significant problem that is confronting us both at the national and at the state levels.

I strongly support the efforts being made here today to strengthen and enhance the prescription process here in Connecticut. The significant criminal problems that are directly related to OxyContin abuse are well documented from Maine to the Carolinas. This should make all of us realize that we need to closely monitor the prescription process for

OxyContin here in Connecticut.

This does not mean that I am recommending we monitor or second-guess the prescriptions written by doctors and filled by

pharmacists. What I am suggesting is that we consider having these prescriptions electronically filed by doctors to pharmacists to eliminate abuses of forged prescriptions of OxyContin.

I would also support Superior Court legislation that creates a statewide database for health care professionals to access so they can easily identify those individuals who have recently obtained OxyContin from other health care professionals already. This would reduce some of the abuses of OxyContin by those individuals who doctor shop to receive multiple prescriptions of OxyContin for either personal abuse of this drug or for personal profit.

I would also support new legislation for both OxyContin as well as for Ecstasy, another illegal drug problem that Connecticut and the nation is facing. I would support new legislation that prohibits the specific illegal possession, sale, use, or distribution of these two drugs. I would also suggest that new legislation aimed at these two drugs set penalties for both the total weight and the number of pills that an

individual or illegal drug organization is found in possession of. For these two drugs, the number of pills one is found in possession of should be the standard for the appropriate criminal penalty, not the

weight alone.

While I support new criminal legislation aimed at those who abuse these drugs, I would also support legislative language that mandates treatment for those abusers of both OxyContin and Ecstasy. Specific legislation aimed at abuses of OxyContin and Ecstasy would show the public that Connecticut has a clear interest in prohibiting the illegal use of these drugs and in protecting our children.

Again, I appreciate the invitation to be here today, and any time that I or the State Police or Statewide Narcotics Task Force can be of assistance, please call me.

MR. BLUMENTHAL: Thank you for being here and for that excellent, very balanced, and insightful testimony and the work that you've been doing over many years on this problem.

Could you tell us just the three counties in Connecticut that are designated as high usage or high level?

CAPTAIN WARREN: Yes. Those counties

are Fairfield County, New Haven County, and Hartford County.

MR. BLUMENTHAL: Thank you. Commissioner.

COMMISSIONER FLEMING: Captain, you mentioned the theft of shipments into Connecticut.

CAPTAIN WARREN: Yes.

COMMISSIONER FLEMING: Can you give me a little more detail on that, the extent of that problem as it comes into the state? How widespread is it, say, over the last five or six years of controlled substances?

CAPTAIN WARREN: It has not been a significant problem, but it has occurred on occasion, and the occasion I'm talking about is just a couple of months old. Excuse me for not getting into particulars, but it is still an active investigation. We have made an arrest on it. And we are working very closely with this freight company because they don't want this to be occurring from their employees or at their terminals.

So it's not a widespread problem, but it has occurred, and every time that we've been aware of it, we've made arrests on it. It would be foolish not to think that it's happening more often than we're

aware of, but we have an excellent working relationship based on our HIDTA initiatives with all the airfreight companies here in Connecticut. They have been great to work with, they've been very supportive of our efforts,

and I look forward to working with them in the future.

COMMISSIONER FLEMING: Thank you.

MR. BLUMENTHAL: Thank you, captain.

MS. DENNE: May I make one comment?

MR. BLUMENTHAL: Sure.

MS. DENNE: Captain, I just want to point out the importance, and I know we work closely with the State Police, of keeping the Department of Public Health in the loop when there is an arrest of a health care professional that we license because in turn we can protect the public health --

CAPTAIN WARREN: Certainly.

MS. DENNE: -- by taking an action against that license.

CAPTAIN WARREN: Certainly.

MS. DENNE: Thank you.

CAPTAIN WARREN: Thank you.

MR. BLUMENTHAL: Thank you, captain. Please convey our thanks also to the commissioner Spada.

CAPTAIN WARREN: I will.

MR. BLUMENTHAL: I should mention that the Connecticut Chiefs of Police Association will be submitting testimony. They could not be here today. The same is true of the Pharmaceutical Industrial

Association, and the National Alliance for Model State Drug Laws. They will all be participating by submitting testimony.

Commissioner Starkowski, Michael Starkowski.

COMMISSIONER STARKOWSKI: Good morning, Attorney General Blumenthal. For the record, my name is Michael Starkowski. I'm the Deputy Commissioner of the Department of Social Services. Thank you for inviting me here today at this important public hearing on the use and abuse of prescription drugs.

What I would like to do first is try to put some things in perspective, try to go over some of the national growth in expenditures on drugs, some of the expenditures of DSS, and an overview of our present systems and what we feel will have the capability to do in the future to avoid some of this fraud and abuse.

We acknowledge whole-heartedly that there is a problem in our pharmaceutical system. Unfortunately, state-funded programs are not exempt from fraud and abuse by either clients or providers.

We feel we are taking some positive steps in enhancing our systems in the future to avoid some of this fraud and abuse.

I have a presentation that I'd like to

just go over some of the high points of the presentation. Spending on retail prescription drugs nationally rose over 18.8 percent from 1999 to 2000 from $111 billion to $131 billion. It's the highest cost factor in the health care industry right now. The increase in prescription drugs accounted for 44 percent of the overall increase in health expenditures. Spending for physician and hospital services accounted for 32 percent and 21 percent respectively.

So as you can see, what we have to do, in addition to fighting fraud and abuse, is try to control the expenditures of this program.

In Medicaid nationally between 1990 and 2000, the cost of prescription drugs and the expenditures on prescription drugs went from $4.8 billion to over $17 billion. As we go into detail, we can show you in the state of Connecticut, our expenditures followed that trend pretty closely.

This year we're expecting to spend over $300 million on our pharmaceutical programs. In the Medicaid program alone we expect to spend over $237

million, and in the ConnPACE program we expect to spend somewhere in the neighborhood of $50 million going up to almost $75 million in the year 2003.

We do serve a number of Connecticut

residents, though. Counting our fee for service program, our managed care program, our ConnPACE program, our SAGA program, we serve well over 300,000 individuals in the state of Connecticut and either provide assistance or full coverage for purchase of pharmaceuticals.

Let me talk about some of the things that we have in place right now. As everyone knows, we have an automated system in place right now where we have a claims processing system, and our claims processing system, which processes somewhere in the range of 24 million claims per year, has a number of features in it which provide some capabilities to identify fraud and abuse.

We have prospective and retrospective drug utilization review. Prospective drug utilization review, for those people who aren't aware of what it is, actually, we look at early refills, we look at drug interaction, and we look at inappropriate dispensing based on the therapies that are provided for that particular diagnosis.

In retrospective drug utilization review, what we do is we look at patterns and abuses after the fact based on the claims after they're paid.

We have a lock-in program for abusers.

What we do is when we find a client who is abusing the system, what we do is we restrict that individual's freedom of choice, we provide a lock-in to a specific pharmacy, we agree with that pharmacy that the individual will be locked into that pharmacy, and right now we have about 240 individuals in our programs that are locked in to specific pharmacies for abuse.

We provide educational letters to providers and practitioners describing ways to avoid abuse and trying to train them on patterns of abuse by clients that may doctor shop.

In addition to that, we do some manual manipulation of information. We have a number of systems in the agency that gather information for us. We have the Medicaid Management Information System, as I said before, which processes about 24 million health-care claims a year.

We have a pharmacy point-of-sale claims transaction system. That is for people who go into a pharmacy and swipe a card, and that will capture all the information and identify them as eligible for our

programs.

We have a surveillance utilization review system, another independent system where we gather information from other systems and try to

manipulate that information, and we have the drug utilization review reporting system that reports on either the prospective and retrospective drug utilization review.

All of those systems right now require extensive manual manipulation in order to do comparisons to try to find out other information.

The constraints in the system right now. Timeliness. When we try to develop reports right now for those systems, because it requires significant manual manipulation, it requires a significant amount of time, sometimes months to get information.

Restraints again or constraints: The data. What we use right now is paid claims data. So when we do an analysis, the analysis is after the fact. When we try to compile the information and put the information together, the information may go back as far as 15 months in order to try to gather the information, put it in one environment that's workable.

The system is rigid. Right now it's a

hard-coded mainframe system, and what happens is DSS needs have to be subservient to what's ever coded in the software and what we can get out of the system.

There is a cost factor in the system

right now. Each report we try to access from the system has an identified cost for the number of hours it took for a programmer to write that report. And in addition to that, it's a relational database system. So we don't have the ability to cross fields, to cross vendors, and to try to compare usually unrelated data that may produce a trend in a particular -- with a particular provider or a particular client.

Having said all that, we have done some extensive reviews on OxyContin. What we have done is we have identified the volume paid by DSS, the volume of claims that have been paid, we have identified the highest prescribing practitioners, we have reviewed their diagnoses and frequency, we shared the findings with appropriate legal and law enforcement officers, we quantified the inappropriate prescribing and actually we focused some investigations.

I think one of the previous speakers talked about Dr. Hall. We were part of that investigation. What we discovered in that, though, is we also discovered that a number of our clients were

also purchasing OxyContin on their own. So not only were they purchasing pharmaceuticals paid for by the Medicaid program, they also had available cash to go in, doctor shop, and then purchase the prescription

from either that pharmacy or another pharmacy and pay for the entire prescription and not get it entered into our system.

What we did to try to remedy the problem is, Governor Rowland last year recommended the installation of a decision support system, the legislature approved that through the appropriations act. We have approximately $2.5 million to go out and develop and implement a decision support system which is actually equivalent to a data warehouse that would give us the automated capability of grabbing data from multiple systems and then compare that data in those systems to try to combat some of this fraud and abuse.

As for timeliness, the queries can be developed by users once we put up a decision report system and reports can be received literally within hours. The data that we will use in that system will be real-time data, so there will be claims data that is submitted today will be batched at night and downloaded into a decision support system for manipulation through software.

Flexibility, we'll have ultimate flexibility in the system. It will be able to capture, it will be able to sort, it will be able to compare and report data from multiple fields and multiple systems.

The cost, as I said before, the cost in the existing system is we pay by report. In the system that we're designing and that we have going up and are keying on, the design and implementation and all the reporting will be included on the front end of the cost to the system.

And as far as relations, the system itself will have some built-in algorithms in order to try to compare some information, and it will have some funding logic in the system which will be inherent in the software, compare relations between therapy, diagnosis, quantity of drug prescribed or actually the prescription that's prescribed.

We feel that this system will improve detection and recovery of fraud, either be it provider or client fraud, increase overpayment protection, and actually we hope we can get out of the pay and chase since right now all our systems rely on old data and we end up paying the claim and months later we have to go after the provider or client who was fraudulent; we're in that situation where we have to pay and chase. We

think we will be able to identify abusers much more quickly on the front end, we will have prevention ability through the use of alerts or thresholds so the system will have some inherent logic in it that will

send an alert to either us or the pharmacist or our prior authorization advocate to alert us to the situation in real time where we think there may be fraud or abuse.

We think the cost effectiveness of the system will be greatly improved. We are estimating right now that in the first full year of operation we could probably save the state of Connecticut approximately $10 million in our Medicare program.

We will be able to do targeted monitoring and analysis. So in this particular situation, if it's OxyContin, we could target individuals that are receiving OxyContin through the automated system -- I don't mean target those individuals, but target the data that is all that we have on that individual, be it medical services or other services provided.

We think what it will provide some overall program integrity. We think we have program integrity now, but having the ability to do some real-time analysis and real-time monitoring really puts us

at an advantage.

At the end of my presentation, what I did was I included two charts that actually show that since 1998, our expenditures alone in the Department of

Social Services, OxyContin have increased over 446 percent. So we would appreciate any efforts that this panel or the legislature or Attorney General Blumenthal and Commissioner Fleming would recommend to try to help us.

MR. BLUMENTHAL: 446 percent over what time period?

COMMISSIONER STARKOWSKI: From June of 1998 to January of '01.

MR. BLUMENTHAL: And I assume that the system that you've outlined, which we welcome and commend you for instituting, would be easily integrated with an overall prescription drug-monitoring program for private payments as well as the kinds of data that you're collecting?

COMMISSIONER STARKOWSKI: Yes. We feel that the data warehouse or the decision support system will have the capability to act or interact with a number of systems. One of the basic tenets of the RFP will make sure that it has open architecture available and accessible to other systems to capture data and

move data.

MR. BLUMENTHAL: Your feeling is the system that you have instituted could save the state $10 million in either waste or unnecessary prescription

drugs?

COMMISSIONER STARKOWSKI: Yes. It's our estimate, based on national projections on what we've done with decision support systems, that in the first full year of operation, we would save $10 million.

MR. BLUMENTHAL: Well, we would want to talk to you further, commissioner, about some of the details of what you're doing and what could be done to strengthen overall state efforts in this area. I don't want to take too much of your time now because we have other witnesses. Thank you.

COMMISSIONER STARKOWSKI: Thank you.

COMMISSIONER FLEMING: Just one quick question, if I may.

You mentioned that you have locked in about 240 clients.

COMMISSIONER STARKOWSKI: Yes.

COMMISSIONER FLEMING: Looking at some of the stats that you gave us, it looks like we have got about 116,000 individuals between various state and federal programs that -- is the 240 a reflection of the

degree of abuse or just of the ability to track what's going on out there? Because 240 individuals being locked in, you feel you have a problem with them, versus 116,000 between Medicaid, the state programs,

ConnPACE and so forth, is a very small number.

My question is: It seems like you're doing a good job if you only have 240 people locked in. Is that an indication --

COMMISSIONER STARKOWSKI: I would go out on a limb and say it's probably a reflection of the constraints on our ability to identify additional abusers. And in addition to the 116,000 that is represented in the material I provided today, there is another 240,000 that are in a managed care system and Medicaid, so actually there's like 350,000 people who we have pharmaceutical responsibility for.

COMMISSIONER FLEMING: The second question: Do the federal regs allow you to lock in those clients that are utilizing federal funds or is that just -- I know we can do it with the state programs. Would the federal funds, if you find abuse, allow you to lock somebody in?

COMMISSIONER STARKOWSKI: Yes.

COMMISSIONER FLEMING: Thank you.

MR. SIEGELMAN: Just a question, deputy

commissioner.

In terms of the people that you do have locked in, are any other efforts made around disease management or referral for substance abuse treatment in

order to deal with the underlying problem in addition to just limiting access to the drugs?

COMMISSIONER STARKOWSKI: I wouldn't call it disease management because I think "disease management" is a buzz word that's been around for a while, and most people have a different interpretation of it.

MR. SIEGELMAN: Case management pieces for it for attempting to engage people over time in addition to limiting their options, trying to move them in more appropriate treatment.

COMMISSIONER STARKOWSKI: We do. We try to not only work with the client, but we also try to work with the prescribing practitioners to make sure that they understand what the issue is with that particular individual so that if we have a particular provider that's been providing services, or multiple providers, we try to get to those providers and make them aware of the situation so they can take some steps.

MR. BLUMENTHAL: Commissioner, I would

like to thank you again for being here and thank you for the work that you and your staff are doing with my office and others in this area. Thank you very much.

COMMISSIONER STARKOWSKI: Thank you.

MR. BLUMENTHAL: Dr. Russell Portenoy.

DR. PORTENOY: Thank you for inviting me to the hearings. My name is Dr. Russell Portenoy. I'm chairman of the Department of Pain Medicine and Palliative Care, Beth Israel Medical Center and Veterans Medical Center in New York City, professor of neurology at Albert Einstein College of Medicine. I'm a past president of the American Pain Society and current secretary of the International Association for the Study of Pain. I also serve on the board of directors of the American Pain Foundation, and I'm vice chairman of the American Board of Hospice and Palliative Medicine. I've been involved in this area for two decades dealing with patients with chronic pain, and I've had a special interest in the four international conferences on pain management and chemical dependency and a fifth conference coming up in June of this year.

My testimony today is focused on medical use and abuse of OxyContin. It's based on my experience as a clinician and my knowledge of pain

medicine and opioid therapy. As disclosure, I will state that I have accepted honoraria for participating in educational symposia sponsored by several corporations that manufacture opioid drugs, including

Purdue Pharma, and my department has received grants from these companies for projects involving professional education and research.

There's been intense media attention focused on OxyContin abuse. The published statistics and the poignant stories of people damaged by addiction have justifiably raised concerns about the dangers associated with this drug. In response, there's been a call from some quarters for increased regulation of this drug, or of opioid drugs in general. In some states, actions that increase monitoring or limit access for some patients already have been taken administratively and new laws have been proposed.

Specialists in pain management are concerned, however, about the potential -- we are concerned about the potential for abuse, but we are equally concerned about a backlash that could potentially increase the undertreatment of pain. We fear that overregulation, ill-conceived enforcement policies, and worsening social stigma as a result of media attention will reduce the appropriate prescribing

of these drugs and increase the suffering of patients who have unrelieved pain.

I wanted to frame the issue for you a little bit and talk specifically about OxyContin.

Since the 1980s, there has been a worldwide clinical consensus that opioid drugs are the first-line approach for treatment of severe pain and chronic pain related to cancer, AIDS, and other serious medical illnesses. Despite this consensus, there have been numerous studies showing undertreatment is persisting.

Cancer pain is undertreated to the tune of about 50 percent in a study that I did myself several years ago, showed that 82 percent of patients with severe AIDS-related pain were not receiving opioid drugs. So we have a major problem with under-treatment.

Undertreatment is a complex problem. In part, it's related to physicians' fear of regulation. This is a very real concern. In 1998, for example, I and colleagues collaborated with the Medical Society of New York to do a survey of 1300 New York State physicians, and we found that more than half reported themselves to be moderately to very concerned about regulatory oversight and that one-quarter to one-half admitted to changing the way they prescribe medicines

solely because of concern of regulatory scrutiny. One-third to one-quarter changed the way they prescribed not because of the medical issues, but whether they were going to prescribe a certain way that

would yield investigation and potential sanction by the state. So fear of regulatory oversight is a very real phenomenon.

Now, despite persistent undertreatment, it had been improving for use in cancer pain. It followed to some extent the release on the U.S. market of a long-acting morphine formulation called MS Contin which is manufactured by Purdue Pharma. The educational program that followed the launch of this drug sought to dispel deeply-held myths about opioid therapy, reverse misconceptions, and decrease stigma. The later release on the U.S. market of other long-acting opioid drugs by other corporations was accompanied by similar educational programs that were pursued by the companies that released these drugs that Purdue Pharma engaged in and was mostly focused on an effort to reduce stigma and reverse some of the myths and misconceptions that were viewed as barriers for appropriate prescribing.

Now, as opioid use increased in cancer pain, pain specialists began to rethink the traditional

prohibition about the use of these drugs for chronic nonmalignant pain. After more than a decade of debate, a 1997 consensus statement jointly issued by the American Pain Society and the American Academy of Pain

Medicine supported the use of opioid therapy for selected patients with chronic nonmalignant pain. Similar consensus statements followed from the American Society of Addiction Medicine and by the Canadian Pain Society. In response to this changing perspective about the role of these drugs, those in the regulatory, law enforcement communities, and many state legislatures had indeed tried to reassure physicians that appropriate prescribing for patients with any type of severe chronic pain, if done in the normal course of medical behavior, would not lead to risk of investigation or sanction. The Federation of State Boards of Medical Examiners issued model guidelines and a variety of states passed intractable pain treatment laws in an effort to reassure doctors.

Now, most pain specialists believe that opioids are still greatly underused in the management of chronic painful disease, cancer pain, and seriously ill patients who are close to death.

The studies are compelling, but we think that undertreatment of pain using opioid drugs in a

huge population of nonmalignant pain is ongoing. We have a huge population of chronic pain patients in this country, and most studies show that somewhere between 10 and 20 percent of the adult population have chronic

pain. At minimum that is 50 or 60 million. There is no possible way that pain specialists could take charge of that prescribing; the use of opioid therapy in an appropriate way has to be brought down to the level of primary care provider. Now, at the same time, pain specialists are expecting that chronic nonmalignant pain is going to increase exponentially during the next decade.

As the consensus statement begins to have some influence on prescribing practices, we also recognize that abuse is a major issue. In this context, I think it's very important that we understand the difference between abuse and diversion and the problem of addiction, which is a medical problem, which has a strong biologic basis -- studies suggest and most experts believe that no more than about 10 percent of adult patients have the capacity, genetically-determined capacity, to develop addictive disease. Notwithstanding that, it is clear that abuse is a major problem and efforts have to be made to manage it and prevent diversion.

Now, pain specialists believe that carefully selected patients can receive those drugs and have their drug-related behaviors monitored over time, and abuse and addiction can be treated. Indeed, people

like myself who specialize in this really believe the vast majority of patients who are addicts can be treated with opioids in an appropriately medically supervised way. So opioid therapy clearly has a role to play even in that subpopulation of patients who may be predisposed to addictive disease.

So what about oxycodone and OxyContin. The active ingredient in OxyContin is the opioid oxycodone, which has been commercially available for decades. It provides a convenient long-acting delivery system for a drug that is commonly adminstered in many short-acting proprietary and generic formulations, and that is also available in the market in a variety of formulations. There is no scientific evidence that oxycodone is any more addictive than morphine or any other drug. Meaning to say that patients who are biologically predisposed to the disease of addiction are no more likely to select oxycodone than any other other drug. Those biologically predisposed to the disease of addiction are no more likely to be converted to addicts by therapeutic exposure to oxycodone or

morphine or methadone or to any other neuragnistic drug used therapeutically. From the medical perspective, we know that patients vary dramatically in the way they respond from drug to drug. So we know, for example,

some patients therapeutically will do much better on oxycodone than other drugs.

Now, experience with OxyContin by pain specialists has confirmed what this would lead us to expect: That some patients do very well with OxyContin and some don't prefer it as compared to other long-acting opioid drugs like MS Contin or Cadian or Duragesic or methadone. Some prefer OxyContin; some prefer others.

When Purdue Pharma was developing OxyContin, it opted to study the drug in populations with chronic nonmalignant pain, low back pain and arthritis patients. The studies were positive. Recently I collaborated in a study of patients with painful diabetic neuropathy, and the study was again positive.

After the drug's launch, the company chose to market it to nonspecialists with a focus on chronic nonmalignant pain, and they were allowed to do that by the Food and Drug Administration. The type of marketing approach and educational approach that went

along with the marketing was very similar with what they had done 15 years ago with MS Contin being targeted to treatment of patients for cancer pain. It was an approach that marketing and education focused on

trying to dispel the myths and misconceptions that we know exist out there and are impediments to the appropriate prescribing.

Now presumably the combination of marketing and education of the primary care community, combined with the huge, unmet need that exists among the population with unrelieved pain led to a very rapid increase in OxyContin sales, and as sales increased, we had pockets of serious abuse develop in many states, mostly along the East Coast. Among those were people with known histories of substance abuse, but undoubtedly some patients who had not yet declared themselves as having the capacity to develop addiction used OxyContin as a so-called gateway drug; it may have been legitimately and may have been appropriately prescribed by the physician, but the patients lost control of it and developed the disease of addiction.

Many of these individuals were highlighted in the press. These were some of the most poignant and troubling stories that we have read about in the last year, patients who were not known to be

substance abusers. There is no way to know -- there is no evidence that the amount of abuse by known abusers or the use of the drug as a gateway drug is more than would be expected with any drug that has the kind of

sales that OxyContin showed. And we also don't know the extent to which the media may have been involved in generating interest in OxyContin within the community of substance abusers.

Now, having said that, however, it's a reasonable presumption that the OxyContin problem is greater than it would have been had the company and professional societies linked together and focused more attention on the risks of the drugs, on the risks of all opioid drugs. For 20 years we have received educational programming from the pharmaceutical industry and from professional societies, many of which I've been involved with, that tended to try to minimize risks because we were dealing with the problem of undertreatment as the overriding concern. So our educational programs minimized risk and sought to dispel misconceptions and thereby implicitly encouraged greater and greater use, perhaps increasing the possibility that some patients would develop addiction anew and reports that increased access to the drugs would increase the problem among known addicts.

So the approach to opioid drugs with legitimate medical purposes should really shift a bit now, and I can say that the professional societies have now begun to recognize this. A liaison group, for

example, has been formed among the Pain Society, the American Academy of Addiction Medicine, solely because of the need to change the approach to the way we've been thinking and promoting the use of these drugs in the professional community.

Now we know that the approach has to be a balanced perspective that recognizes the essential medical nature of these drugs and the fact that they are underused and thereby incorporates the expectation that use will increase, but at the same time recognizes that as use increases and as less-skilled physicians begin to use these drugs in primary care, we may also see an increase in abuse and diversion and addiction. We have to be able to increase appropriate therapeutic use and minimize the risk associated with increased use.

The Drug Enforcement Administration recognized the need for that balance and reached out to the medical community, and just several weeks ago, there was a joint release by the DEA with 21 professional societies of a consensus statement calling

for balance in the way that opioid drugs are used by both the professional community and also in the law enforcement and the regulatory community.

So we should move forward on this issue

of balance, highlighting several critical points. The first is a recognition by everybody that opioid therapy is essential for millions of patients with acute and chronic pain. There is an epidemic of undertreated pain. Driving up here, I heard on the radio about the epidemic of OxyContin abuse. Every time I hear about the epidemic of OxyContin, I think of controlled pain, the enormous cost of human suffering, health care utilization, and lost productivity that occurs as a result of people with chronic pain unable to get access to proper medication. So we have an epidemic of unrelieved pain.

Opioid drugs are not a panacea. I myself have considered -- I consider myself rather conservative in who I select for opioid therapy and who I tell doctors to treat. But I think a mainstream view at the present time is that they are clearly appropriate for a subgroup of patients with chronic nonmalignant pain. So that the increase in use of opioid drugs for the treatment of chronic nonmalignant pain means you will see more utilization. You will see

increased utilization by physicians and, of course, increased costs within that huge increase. You would expect it to grow, and that would be my view.

Second, decisions concerning regulation

of opioid drugs should be based on the evidence and not based on anecdotes, as poignant as they are in the press, some really horrible stories, that touch me as much as anybody else; but clearly we can't base policy and regulatory oversight on the story of someone who unfortunately used OxyContin as a gateway drug and then developed the devastation of addiction. We have to go by the evidence.

Third, we should recognize that there's a lot of complexity in responding to the abuse of legitimate drugs that are now underprescribed for therapeutic purposes. It is very important to recognize that regulatory actions that are intended to reduce abuse might have the unintentional consequence of reducing appropriate prescribing and thereby increase the problem of uncontrolled pain. For example, there are many actions the state could take to reduce OxyContin prescribing, to reduce access to the drug to pain specialists, to not pay for the drug to indigent populations; there are lots of actions that a state or a regulatory agency could do to reduce use of

an opioid drug. The question is whether or not reduced usage is showing reduced abuse or is actually increasing the problem of undertreatment.

It's very important to have some

evidence that as use is reduced through certain state actions, what one is doing is managing the problem of abuse and diversion and not contributing to under-treatment. This can be done by monitoring programs that incorporate some ongoing quality analysis, independent studies that can be done in the population, end user studies, specific prescriber studies, laws and regulations that have evaluated in an empirical way over time to determine whether or not what was intended actually happened.

Finally, it is also clear now that the professional societies and those in law enforcement and the regulatory communities have to get together and have a dialogue on an ongoing basis. That's why I was so pleased about this hearing, why I was very pleased to be invited to come and testify, why the actions of DEA were met with such a positive feeling on the part of the professional community, because reaching out by the DEA to sit on the same side of the table as the physicians has not happened before.

There has to be an ongoing dialogue so

we can understand what balance is. We have got to reduce abuse and diversion but at the same time improve pain management so we can design educational programs for physicians that are reassuring them that

investigation and sanction won't follow legitimate medical use.

I have to tell you that given the current climate among physicians, appearing at a hearing like this or reading that the state is not interested in stopping legitimate prescribing won't have any influence. Physicians are already frightened about regulatory oversight. And they need to have systems in place that they feel are protective, and they need to have an ongoing dialogue with the law enforcement and regulatory communities so that they know that the issue of balance is on the front burner.

The last comment, of course, relates to the need for treatment. We need much more treatment for patients who have addictive disease. I don't think we're ready to market these drugs directly to the public, as some people have said the trend is moving toward. I think that would be a mistake. We have a big problem with the disease of addiction. This is a highly prevalent disease, it is devastating, it has huge costs to society, and I think we have to be very

careful as this epidemic of uncontrolled pain is addressed with increasing prescribing that we are cautious of what we do to potentially increase addiction like direct marketing of abusable drugs to

the general public, some proportion of whom will have addictive disease even if not yet manifested.

Thank you.

MR. BLUMENTHAL: Thank you very much, Dr. Portenoy. I want to reassure you that our purpose is not, and I want to stress this point to you and to everyone, not to deny this drug or make it less accessible to people who suffer from severe chronic pain. The drug OxyContin and others like it have been a Godsend to those people, and there are probably many more who are part of a population that are undertreated in terms of pain, but I think that we would be irresponsible if we ignore the risks that you have highlighted so eloquently that there is for abuse and addiction; whether it's 10 percent or 20 percent or 5 percent, there is a part of the population that is at risk of addiction and now is addicted, and if we deny that the problem exists, we would be completely irresponsible and ultimately do great damage to the many people who benefit from this drug, because it would be subject to even stronger oversight.

So I agree with you that there is a need for balance and for concern, as to the people who need the drug, and I take it from your remarks that more physicians, primary care physicians, will be presumably

prescribing this drug and perhaps need more information, more education, more training in pain management.

DR. PORTENOY: Right. I think that's a very important point. The educational programming that has been out there for a quarter century really has not focused on those issues that interface between pain and chemical dependency. Now, that's getting redressed now, fortunately, but it is going to take years to get that education out. That's part of the solution, I think.

I think we actually are in extreme agreement, as somebody might say. We actually agree with each other, and I think the issue is just to keep all of those issues, the need for education, the need for treatment, the need for law enforcement and regulatory structures that are effective and prompt, the need for better management of pain with an expectation of increasing use over time, we have to keep all those things on the front burner at the same time and just maintain this dialogue.

Again, I would ask, I would suggest to you, the state of Connecticut is, talking about EDT systems and so forth, to think about collecting some empirical data that builds it into the system up

front. Most states that have EDT systems have no empirical data other than what the system provides them.

MR. BLUMENTHAL: Right.

DR. PORTENOY: Since those are sales data, people engaging in illicit acts, one doesn't get the big picture of what's happening in the population of chronic pain, primary care providers. You like to know you have a system that works and doesn't cause more damage in increasing undertreated pain.

MR. BLUMENTHAL: One of the purposes of the system, my own purpose in being here today is to increase the amount of data that is available so we can make more informed decisions, quite honestly, an increase in the dialogue between the law enforcement community and the professional community, which I think has been lacking in this area, at least in Connecticut, I think maybe even nationally. You know, when you look at other industries, whether it is securities or utilities, where there is loads of communication between the oversight body and the professionals, and

in this one there's a lot less. Thank you.

COMMISSIONER FLEMING: Good morning.

You raised, I think, probably the most important issue

for the state as they consider how to deal with this

issue, and that is, I'll call it the doctor fear factor, and that fear factor creating undertreatment of pain; and so as a regulator, as we are looking at putting together suggestions to the legislature in the next session, I'm going to need to answer some questions about that.

I also, as a human being, I'll bet you every person in this room has had a member of their family go through a situation -- I have -- go through a situation where they've been in tremendous pain, and it's an awful thing to watch. So I want to be sure that I'm balancing these things out.

In Connecticut, at the present time we do monitor prescription use of controlled substances, and we sort of do it the old-fashioned way, and there is a lot to be said for an old-fashioned way. We go to the pharmacies and we review records and every one of the agents that works for my agency is a trained pharmacist, and they make judgments about the patterns that they see. What we are thinking of proposing to the legislature is what other states have, which is an

electronic means by which we collect that data, it comes into my agency, and those same pharmacists look at that data and make those same types of judgments; and so what I would like to ask you, and I look at your

resume, it's really fantastic, but can you -- do you have any evidence, could you supply us any evidence that would compare a state like Connecticut that does this the old-fashioned way versus approximately 20 other states that now use this electronic system where that fear factor has increased, where the fact that you've put this electronic monitoring system in place, it has in fact caused doctors not to properly prescribe?

DR. PORTENOY: Unfortunately, I don't think those data exist, and I've asked for them myself, and I don't think they exist.

I also think it's complex in other states because of what's happening -- what the individual EDT systems look like. For example, in New York, we have a system that now still requires us to purchase special prescriptions. So that even though the hated triplicate is no longer there, the doctors still have a visible reminder that every time they pick up and write a prescription for a Schedule II drug, somebody is looking. So in New York my expectation

would be that the EDT system is not going to have the relief of the fear factor to the same extent that the systems in other states that are invisible to doctors do.

But the empirical data which people have called for for ten years just isn't there, unfortunately. I think that reflects the reality that the regulatory and the law enforcement community have focused on a problem and they view reducing use as a proxy for better control. Now only as we are coming into this century with this dialogue are people beginning to say maybe reducing use is adding to the clinical burden and is not actually what we want. We want reduced use among abusers and diverters. We don't want reduced use among primary care treaters treating elderly.

You are sitting in a position of being a demonstration state for the rest of the country because if you design your program in a smart way that keeps it as invisible to the prescribers as possible, you attach it to education and dialogue and you measure outcome empirically, maybe after a year, you could make a contribution to this whole area of drug regulation that hasn't been there.

MR. BLUMENTHAL: For some of the

prescribers, the system shouldn't be invisible. For some of the prescribers there should be some sense of oversight of somebody watching and caring if there is overuse or misuse, right?

DR. PORTENOY: If -- we're moving to the question of how one judges misuse and overuse. If in fact there is a legitimate concern that a prescriber lacks the skills and is unintentionally misusing or, even worse, is engaging in actions of profit or some other type of diversion, then there is no question that the state has a role to play and it should be there, and I would hope that it would -- it would target its response based on what the true need is and not to eliminate the license from someone who needs training and not to continue somebody's licensure if they're dishonest.

MR. BLUMENTHAL: Thank you.

COMMISSIONER FLEMING: One thing that we have done over the last year or so, my agency has been meeting with members of the industry, with law enforcement, with the professionals on the medical side to try to come up with a proposal that everybody would buy into. Now, I don't want to water it down to a point where it doesn't work, but I think what you're saying to me is you're a scientist and this is really

more of a political science problem. We need to try to balance those interests, and your recommendation, which I think is a good one, which I've not heard before, is that this process that we put together to develop this

legislation needs to continue after it goes onto the books.

DR. PORTENOY: Right.

COMMISSIONER FLEMING: So that all of the different parties, law enforcement, regulators, doctors, pharmacists, are talking on a regular basis so that whatever judgments we're making about prescriptions in the way it's occurring, that we take new technology, thoughts about management of pain into account. It's a hard thing to do, but I think that's sort of our challenge to put this legislation together.

DR. PORTENOY: That's right. Thank you.

MR. BLUMENTHAL: Thank very much. I hope you don't mind if we call on you again as we design this demonstration program. Thank you.

Kathleen Anderson.

MS. ANDERSON: Good morning.

MR. BLUMENTHAL: Good morning.

MS. ANDERSON: My name is Kathleen Anderson, and I'm the director of governmental affairs for the American Society for RSD-CRPS.

The American Society applauds the initiatives of Attorney General Blumenthal in addressing the issues of opioid drug abuse as well as the crisis in pain management. We appreciate his open-

door policy in encouraging those affected by the OxyContin controversy to step forward and voice their concerns.

The recent debate regarding OxyContin and the future of opioid analgesics is of great concern to the members of the American Society for RSD and the community of patients and caregivers we represent. Reflex sympathetic dystrophy is the worst imaginable pain known to man or women and rates a 42 out of 50 on the McGill Pain Index. Placing additional restrictions on opioid analgesics will prolong the suffering of RSD patients.

Presently pain management centers in Connecticut are limited. Treatments revolve around medications, physical, and psychological therapy, and invasive surgical procedures. It takes an average of two years to be diagnosed with RSD, and once diagnosed, most patients must see an average of 4.5 physicians before their pain is treated. How much longer will it take these patients to get relief if tighter restrictions are enforced? Will they live that long?

Suicide is one of the leading causes of death in RSD patients in the United States today. Until more facilities are established and HMO's cover their treatments, patients will continue to use primary care

physicians and a variety of specialists to obtain pain medications for pain relief. Knowing these facts, you cannot limit the dispensing of opioids to only pain specialists.

Research in the area of neuropathic pain and other chronic pain syndromes is just beginning to surface. If tighter restrictions are placed on the distribution of opioids, we will see less interest by pharmaceutical companies in researching pain mechanisms and developing effective drugs. The American Society for RSD supports the implementation of an electronic prescription monitoring program. It would be a more accurate and efficient method of tracking Schedule II, III, IV, and V controlled substances. It is imperative that physicians practicing proper pain management not be targeted as suspicious.

We would like to know how balance will be kept. Physicians need to be responsible for diagnosing patients and prescribing opioids conscientiously. Pharmacists must also be accountable for tracking and recognizing suspicious activities.

Pharmaceutical companies need to improve the structure of these medications to reduce abuse. The ability to disable a time-released formula by crushing it needs to be addressed. It is hazardous and life threatening to

both the pain patients and the drug addicts. Ultimately, it is the responsibility of state and federal law enforcement to curtail the illegal dispensing of drugs enforcing stricter consequences for those who abuse opioids.

I am a mother of an 18-year-old who has been suffering with RSD for over three years. Do I worry about the effects, the long-term effects of her medication and possible addiction? Yes. Of course I do. But I'll tell you my worries are secondary to the -- to the torture she endures. The pain is debilitating and relentless. It is inhumane.

Perhaps a plan to assist those suffering with this debilitating disease and other chronic pain ailments in Connecticut could be initiated and thus prove to be a more effective vehicle in curtailing opiate abuse:

One, establish multidisciplinary pain clinics; two, implement the electronic prescription plan; three, introduce legislation requiring certification in pain management for the medical

community; four, encourage pharmaceutical companies to earmark a percentage of their profits for these centers.

We feel addressing the issue in this

manner creates a win/win situation. A, patients will have the specialized care they need; B, prescriptions are monitored more effectively for abuse; C, physicians in the medical community are engaged in pain management, which will enable them to better identify abusers and refer them to drug rehabilitation; and, D, pharmaceutical companies would contribute back into a system that addresses the needs of the pain patients and substance abusers.

People in pain are a vulnerable population. We need to pursue education, awareness, and research in the area of chronic pain. Until pain is better understood, we need to place the burden on those responsible for drug abuse; not the victims themselves. The American Society for RSD-CRPS asks Attorney General Blumenthal to rethink his position of placing further restrictions on dispensing of opioid analgesics.

MR. BLUMENTHAL: Thank you for being here, Mrs. Anderson. As you know, a number of proposals you made are ones that I've advocated, and I

would agree with you that the restrictions should not be placed on the recipients, legitimate recipients, of these kind of painkillers because this drug OxyContin and others like it have been a Godsend for them. So I

welcome your being here today so we can develop some of the balance and measure and constructive kinds of proposals that you just suggested. Thank you.

MS. ANDERSON: Thank you.

MR. BLUMENTHAL: Nicholas Gugliotti.

MR. GUGLIOTTI: I'm married. I'm disabled with a liver disease and also chronic migraine headaches.

About three years ago, my physician recommended that I see a pain management specialist because I was suffering from chronic cluster migraines, and they were very, very difficult to live with. The pain management specialist put me on OxyContin, and it did help the headaches, but after about three or four months, I began to feel very lethargic and very dull in my activities, and I didn't like the way I felt, and I asked the doctor if there was anything more that I could do or anything different that I could do. The doctor suggested that I increase the dosage of the OxyContin, and so I did that.

About three more months went by, I tried

to give it as much time as I could to see what the outcome would be. I was in severe pain, so it was a help in that regard, but I began to feel depressed, I began to feel other side effects that were very

uncomfortable. So with my wife, I sought out another pain management specialist. I was referred to someone affiliated with Yale; the doctor there recommended that I continue with OxyContin, increase the dosage, and recommended that I take it morning and evening so that I would have it in my system 24 hours a day. I continued to feel relief from pain, but other side effects that are troubling; went back and saw the doctor a few times and told him I was very concerned about feeling depressed and didn't know if it was the result of the medication or not. He suggested that not alleviating the pain could create depression and could create some of the other symptoms that I was having. So he suggested that I continue to take the OxyContin, which I did.

At this point, it was about nine months or so I had been taking the medication, and my wife began to become concerned because I was having difficulty maintaining my grip, I guess. I was very, very troubled, I was emotionally upset, and I felt that I needed, at this point, I needed the medication; if I

didn't take it, I felt very uncomfortable. So we went to the emergency room. I was seen by a physician there. He seemed to agree with the other diagnoses that I should continue with the medication. They sent

me home. I continued to take the medication.

Two weeks later I had what I would consider something close to a nervous breakdown. I just couldn't do. I felt very much overwhelmed by the situation that I was in, back to the hospital, I was admitted to the hospital, and put in a psychiatric ward, which was very difficult for me. I was a businessman before I became disabled with illness. I was respected in my community, and it was a difficult thing for me. I stayed there for eight days and went through detox, which was horrible, probably the worst thing that I've ever experienced in my life.

I never took OxyContin that wasn't prescribed, I never took a dose more than I was told to take. In fact, I would cut pills in half and try to limit it because I didn't like some of the side effects, but I was continually told by people I thought were professionals and specialists that there was no harm, there was no danger of addiction, that pain medication, when administered where there is genuine pain, very rarely creates addiction. I definitely

22 became addicted to the medication.

23 I heard some testimony from Dr. Portenoy

24 that there is a certain percentage of people that are

25 perhaps predisposed. I didn't know that before. I

didn't even know that until today, to tell you the truth. No one ever told me that. No physician ever told me that. If that was the case, I'm just at this point very surprised that no one saw that that could have been a possibility for me.

After 50 years of living, after getting a Master's degree and being in business, never having a problem with addiction of any kind, having been given pain medicine along the way, my life, various operations, so forth, never had any reason to believe that this kind of problem would occur. I realize as I sit here that I am one of the anecdotal stories that the doctor referred to. And I realize that there is some very eloquent testimony about people in pain. Believe me, when I hear this lady speak about her daughter who is in pain, I would be the first person to say that I would want that young lady to receive the help. I'm not here to say that pain medication is bad. I'm not here to say that I know enough about OxyContin that I should tell you what to do. But I am here to tell you that I believe through no fault of my

own, I almost lost my marriage, I almost lost my family, and were it not for the fact that I had such a supportive family, I had a strong faith in God, I think I would have taken my life. I felt at a few points in

my life that it was not worth going on, and I believe it was directly related to the medication that I was taking.

MR. BLUMENTHAL: We want to thank you for being here and for sharing with us that story and sharing with us so eloquently because it adds a perspective, obviously, to the problem --

MR. GUGLIOTTI: Yes.

MR. BLUMENTHAL: -- that we see, and particularly, as I gather from you, the absence of disclosure to you about the potential pitfalls and problems that could accompany use of this drug at the time that you began using it.

MR. GUGLIOTTI: Yes, sir. Even when I went and asked for help because of side effects that were troubling, that I believe should have been at least a caution light that someone should have looked further, and all I was told was I should take more, and I feel in hindsight that was a mistake.

MR. BLUMENTHAL: Thank you. Thank you very much.

Is Mr. Joe Andrews here?

MR. ANDREWS: Good morning.

MR. BLUMENTHAL: Good morning.

MR. ANDREWS: My name is Joe Andrews,

and this is my father-in-law, Rheinhold Luther. And --

MR. BLUMENTHAL: I'm sorry, could you identify him? Could you speak up a little bit?

MR. ANDREWS: His name is Rheinhold Luther.

MR. BLUMENTHAL: Welcome to both of you. Thank you for being here.

MR. ANDREWS: I want to talk about my wife, who was under a doctor's care for OxyContin that she was taking, and living with her and her being a health care professional herself, she knew what the effects of the medication should be, what -- and took great care of herself, and she was a very intelligent person; and this medication, although she took it only under a year, I could see in her that it caused, at the beginning, it caused confusion, which even got worse, which I can't even describe, like the effects of that medication, the side effects -- I can't even begin to describe. But it's -- basically it would cause confusion, disillusionment and like that.

Although she was under the care of a

doctor, we had been to the hospital, we had been to the emergency room clinic, and no one -- no one got to the bottom of the problem, which was that drug itself, and that drug took her life, and it took her life because

no one -- I mean she -- she went -- let me back up a little bit.

She went from confusion and everything forward to addiction and -- and it took her life, and all that was because -- I believe in my opinion of what the time I shared with my wife and everything, that this medication should only be administered in a hospital setting with adequate hospital personnel who are adequately supervised, and it should not be administered through a physician or anybody else and given to people outside a hospital care setting, because there's no way that I believe -- experience when we went to the walk-in clinic, which I didn't know at the time, but there are people there that they're not even -- they're not physicians, so they don't know what to look for. They don't know what signs, danger signs, are or anything like that. And all these things revolve around the care of a person, and to get that adequate care, with this particular medication, I think should only be done in a hospital setting, and that's all I wanted to say.

MR. BLUMENTHAL: Thank you very much for those comments. Sir.

MR. LUTHER: My name is Rheinhold Luther.

COMMISSIONER FLEMING: See the button right in front of you, push that down. Now we will be able to hear you better.

MR. LUTHER: Okay. I'll repeat what I just said.

My name is Rheinhold Luther. I'm the father of Joe's wife Julie.

Julie developed severe migraine headaches as aftereffects of Lyme disease, and she was on various treatments and various doctors until she finally was given OxyContin. In the beginning, it looked like it was a wonder drug. She improved very quickly, she became much more involved in things, and she was becoming her natural self like she used to be. However, after a while, she started to become disoriented, she fell a couple of times, and this all happened -- well, she was treated for eight months totally, approximately, but in the last four weeks, these incidences of disorientation kept increasing, and finally one weekend it got to the point where we insisted that she seek immediate help, and this is

when she got the treatment that Joe referred to; they took x-rays, and even though she was totally incoherent, they sent her home. And she got home and later she was dead.

So Joe lost a wife; we lost our daughter. Not only that, but Joe was left financially devastated as far as the costs go.

MR. BLUMENTHAL: Thank you.

Just one question, Mr. Luther or Mr. Andrews. Was the prescription from a primary physician or from a specialist?

MR. LUTHER: It was from pain, Salvation Center.

MR. BLUMENTHAL: And did your daughter, your wife, go to a hospital? Is that what I heard you say?

MR. LUTHER: No. She went to a medical clinic.

MR. ANDREWS: I had also taken her to a -- I had also taken her to Bridgeport Hospital one time, where they had some idea what the problem was. They didn't -- they were reserved in treating her because they didn't know what -- they didn't know what the problems were, what the problem had to do with, the medication, and that's the whole problem. If whoever

is administering that medication needs -- needs to be the one taking care of that person. And they need to have that, the proper care. If they don't have that, then you lose the communication, you lose what the

problem is, and you lose a life.

MR. BLUMENTHAL: Well, for myself, I think for other members of the panel, we thank you for being here today and for sharing with us your story and your courage. I thank you.

We're going to hear from three panelists at once, but I think maybe before we do so, maybe we'll take a break. I don't know how our reporter is doing, but why don't we take a five-minute break and then come back with Dr. Li, Dr. Fallon, and Dr. Herzog.

(Recess: 10:40 to 11:02 a.m.)

MR. BLUMENTHAL: If I may call you back to order. We're going to hear from Dr. Charlene Li, Dr. Barbara Fallon, and Dr. Alfred Herzog.

And if you could just press the buttons in front of you, your mikes will turn on. Thank you all for being here today. Dr. Li.

DR. LI: Thank you, Attorney General Blumenthal and panel members. Good morning.

My name is Charlene Li, and I am the immediate past president of the Connecticut Academy of

Family Physicians. I am also an associate clinical professor at the University of Connecticut School of Medicine and a former member of the Commission on Education at the American Academy of Family

Physicians. I am currently in private practice in Windham, Connecticut. I would like to take this opportunity to speak to you on behalf of the Connecticut Academy concerning -- regarding their concerns about the abuse of prescription drugs and electronic surveillance of prescriptions.

We are all keenly aware of the benefits of controlled drugs, including narcotics for pain and drugs such as Ritalin for attention deficit disorder. However, we are also very aware of and concerned about the dangers of these prescription medications when they are used inappropriately and not in the manner that was originally intended. As family physicians, we are trained to look at the big picture and to approach problems not only looking at the problem itself, but also at all the associated possible contributing factors. Taking this approach, we feel there must be a multifaceted approach to curbing the use of appropriate medications.

First, patient education. When patients are prescribed medications that have an abusive or

addictive potential, they must, must be informed regarding this fact. All too often patients are not aware of the potential dangers of these medications and the dangers they can pose to themselves or others who

may use their medications inappropriately. The patient's physician should provide this information and education with additional information provided by the patient's pharmacist.

Second, physician education. Physicians should be aware of the addictive potential and abuse potential of all the medications that they prescribe. While all of us are aware of the addictive potential of narcotics, not all physicians may be aware of the modes of abuse of such medication such as Ritilin, OxyContin, or other such drugs. Physicians need to be educated about the current use on the street of legitimately prescribed medications. The state could assist physicians by providing such information. Physicians should also be reminded of the importance of accurately and consistently documenting the amount of controlled medication that they prescribe in a patient's chart. In this way, the physician has direct knowledge of the patient's drug use and can identify patterns of excessive or inappropriate use.

Third, the pharmaceutical industry's

responsibility. The pharmaceutical industry must take responsibility to inform physicians of the appropriate use of their medications and also potential abuse issues, if appropriate. In the case of narcotic

medication, it is critical that the information on the use of the medication, when to prescribe it, and for what type of patient and patient situation be based on appropriate clinical data and not on the desire to increase sales of the product.

Finally, electronic prescription surveillance. With the use of computers comes the abilities to monitor a patient's prescription drug use. In the case of the larger pharmacy chains, there is an ability to check a patient's prescription drug profile within the entire system. This ability can be helpful in identifying patients who may be receiving multiple prescriptions for the same medication from several different physicians. Certainly, I have had instances where a pharmacist has notified me that one of my patients is receiving a narcotic medication not only from me, but also from another physician in a different part of this state. If there were to be a larger, all-encompassing electronic system, this capability would be more comprehensive.

However, I think if we are to consider a

comprehensive electronic surveillance system for prescription medication, we must be sure that such a system has safeguards to assure that information obtained from the surveillance is used appropriately

and in a manner that assures privacy. Additionally, there must be special considerations in view of the upcoming implementation of the Health Insurance Portability and accountability Act, or HIPAA.

The concerns of the academy are the following: Number one, if it is found that a patient is receiving multiple controlled medication from different physicians, a method of informing physicians must be developed that does not compromise patient privacy or interfere with the doctor/patient relationship.

Two, if a patient is taking controlled medications on a regular basis, but in an appropriate amount for an appropriate reason, it is important that the information be kept confidential. Inappropriate release of this sort of information could negatively impact the patient's job, insurability, et cetera. Even if the use is inappropriate, this information should be used to educate and treat the patient in a manner consistent with patient confidentiality.

Three, if the physician is found to be

prescribing controlled medications in a pattern that is judged to be outside the norm, appropriate evaluation of the physician's practice type should be undertaken before any potentially negative actions are taken. For

instance, a physician who provides hospice care as a substantial part of his or her practice may prescribe a drug such as OxyContin frequently, but appropriately, whereas a dermatologist is unlikely to need to prescribe a medication like OxyContin with any frequency.

Information regarding individual physicians' prescribing patterns must not be made public in order to prevent inappropriate labeling of physicians. An example of how this type of release of raw information can have a negative impact on physician practices occurred about 12 years ago when Hartford Courant released cesarean section rates of obstetricians of Greater Hartford. One obstetrical group was reported as having cesarean rates significantly higher than that of any other group. The fact was that particular group performed cesarean sections for a group of family physicians and also a group of midwives, thus artificially increasing their numbers. Since the article did not explain this, but published only the raw numbers, their practice suffered

unwarranted negative publicity.

The Connecticut Academy of Family Physicians urges the state to consider the following:

One, urge pharmaceutical companies to

develop products that have decreased abuse potential and ensure that that marketing is appropriate; two, develop education programs for physicians and the public regarding the abuse potential of prescription medications; three, provide adequate programs and facilities to treat patients who may be abusing medications and also provide support to their families; four, develop safeguards for any electronic surveillance system that may be developed to protect the privacy of patients and physicians and to ensure the sanctity of the doctor-patient relationship.

Thank you.

MR. BLUMENTHAL: Thank you very much. Dr. Fallon.

DR. FALLON: Good morning. Good morning, Attorney General. My name is Barbara Fallon, and I am a physician and founding member of the Connecticut Cancer Pain Initiative, a voluntary, grass roots organization composed of physicians, nurses, pharmacists, internal medicine, medical oncology, pain management, and critical care. I have presented

written testimony which was presented and discussed with Attorney General Blumenthal and his staff in October. As a result of that meeting, I would like to emphasize the following points:

Patients with chronic pain, including patients with cancer, should have access to proper assessment and treatment of their pain. Mandates to curb diversion and use of opioids should be carefully drafted to prevent an adverse impact on patients, doctors, and pharmacists. Opioids are safe and effective in the treatment of pain. When used as prescribed, they rarely result in psychiatric and behavioral disease of addiction. Whereas over-the-counter analgesics such as acetaminophen or Tylenol, aspirin, can cause kidney failure, liver disease, and internal bleeding, especially in the elderly. Opioids do not pose such risks. Patients may receive the maximum dosage, mistakenly believing that more will be better -- it is not -- and that drugs must be safe because they're over the counter.

Opioids are dosed individually and are titrated to the relief of pain. There is no fixed dose. Thus, many patient's pain is controlled at the lower dosages, while some patients, especially patients with cancer, may need 10 to 15 times that amount.

MS Contin, long-acting medication such as those in pill form, provide patient dosages that are potent and can be given every 12 hours. If you needed 360 milligrams of long-acting oxycodone, would you

prefer to take two tablets or nine tablets at each dose?

Restricting the dosage amount could in fact have an adverse impact on patients because of the numbers of pills they would need to take, and pain medication is not the only medication that they take. Many are on complex regimens for bowel symptoms, sometimes nausea and vomiting, respiratory problems, a variety of things. So this is one thing we need to take into account if we are thinking about adjusting the dosages.

The only alternatives to these medications is invasive therapy, placing an intra-catheter device or catheter placement into the spine. These are much more restrictive to patients, more expensive, and more risky.

Along with measures to curb opioid abuse, CCPI strongly encourages the Attorney General to work with professional societies to establish minimum proficiency standards in treating pain. Education in pain is all but absent in medical schools and residency

training and continuing education is poorly attended because it is not required.

Education of health care providers about pain should be paired with a curriculum in chemical

dependency, as many doctors do not recognize substance abuse until very late in a patient's course, making treatment less successful. Providing information about proper prescribing for pain should reduce the vast number of patients needlessly in pain and provide earlier recognition and referral for treatment of substance abuse cases.

I would like to make a comment referable to the previous patients who provided testimony that depression and chronic pain certainly can coexist. The affect of acute pain is anxiety, but the affect of chronic pain is depression. Depression needs to be recognized and treated, as do any side effects of any medication that cause changes in a patient's mental status, and clearly that was not appropriately done, from what we've heard this morning.

I would also like to say that any competent prescriber would inform patients that they should never cut long-acting medications in order to reduce the dosage, as that would certainly allow an increased release of medication and possibly could

contribute to chemical dependency along the way. That's not my specialty. I would not want to testify to that as fact.

Finally, along with my colleagues from a

variety of disciplines here today, I would urge caution against overreaction and remind us that when college students overdose after binge drinking, we do not ban alcohol. OxyContin has a legitimate medical use, while alcohol does not. More medical expenditures, more suffering, more death occur from alcohol abuse than properly prescribed opioids. Don't get me started on tobacco. Thank you very much.

MR. BLUMENTHAL: I wish you would get started on tobacco. Dr. Herzog.

DR. HERZOG: Good morning, Attorney General Blumenthal, and members of the hearing panel. I am thankful to you all for having this hearing today.

I'm obviously here with my hat as president of the state medical society, also want you to know my real job, also, I still see patients in my practice, small as it, and a lot of them are pain patients. Again, thank you for giving me the opportunity to speak with you about this important problem.

Given the rapidly increasing number, strength and complexity of today's pharmaceuticals, the CSMS recognizes that the time has come to institute an appropriate system to monitor medical prescriptions,

though there is a need for strong pain medication for all kinds of patients, and we must put together an appropriate pain management program. We welcome the opportunity to really talk with you and develop such a program; one that does not inhibit the appropriate use of these medications, however strong they may be. All of these issues are important ones.

Physicians should not be limited to prescribing particular kinds of medications by the specialty they have. We should all be given access to prescribing these medications. My type of cases have been mentioned, depression, chronic pain often go together. Yes, anxiety too, sometimes all of the above in an individual. While certain specialties, such as oncology and pain management, may treat patients with larger needs for pain medication, may prescribe more frequently in higher amounts because of patient needs, all of us, whether we be internists, we should have available to us the ability to prescribe these medications appropriately for people who need them.

Now, having said that, we must

acknowledge there is a tremendous need for appropriate pain relief and acknowledge that there is a need to do it sensibly. However, limiting physician's abilities could have a negative impact for very good work done

today in Connecticut in providing adequate, good pain relief for our patients. While programs and coverage should certainly exist to cover issues like pain addiction, as we know, it is a possible side effect of these medications, we would suggest that companies, that is, pharmaceutical companies, should not be required to pay for such programs. Instead, what we would like is to have these pharmaceutical companies help develop an information program for physicians and education programs for patients who need the medications.

It takes time as a physician to treat patients like this, and that's something often that you can't do in seven minutes. You know the problems we have these days, managed care companies -- don't get me going on that -- don't like to pay for that. It's too much time. However, we need to do it right. We do feel and think that instead the companies should really help with these kinds of programs and pay for them.

Now, the other piece of the mix is addiction services; quite frankly, we need to make sure

our health insurance companies fund those addiction programs. It is rather difficult. So there is a need to deal with this problem.

Yes, an ongoing need exists to improve

education for both physicians and patients. They need to have their medications. Physicians must aggressively educate patients, given the appropriate time, given the appropriate information to educate them about the potential for addiction and potential for abuse. It is small, but it's real, but it can happen.

It reminds me of a particular patient of mine, not on OxyContin, but something like that, for the past ten years, never increased the dose. We have talked a lot about why that hasn't happened and what else we can do to make that not happen. So these are the type of issues that take time.

Now, there is no doubt that the physicians need to be educated more on this. We are hoping for that. We want that to happen. Hopefully we can develop that in the overall system. We need to work with one another to make it possible.

Existing and developing technology offers a great opportunity to assist in our efforts to prevent the inappropriate use of prescription drugs, really makes monitoring of this quite readily

available. Electronic monitoring is certainly a very sensible way to approach this problem, and we want to work with you in setting that up. However, we want you to consider at least three caveats that have been

voiced by my colleagues here, but I would like to emphasize them, setting up an appropriate electronic monitoring system, the right way to go, but also some caution in how you do that:

One, safeguards must be developed to ensure confidentiality. I can't emphasize that enough. It is so crucial for both the patients, physicians, pharmacists; and it can be done. I always tell my patients, look, there is a very simple way for us, there should only be one physician prescribing your medication. Pick your favorite pharmacy. Your choice, but pick a pharmacy. Even before setting it up, certainly can be done more appropriately once you set up the program. Accountability problem, we need to ensure the confidentiality; otherwise, the program doesn't fly.

Number two, appropriate people, such as treating physicians and pharmacists, should have accurate and rapid access to information. Methods to inform physicians without compromising privacy or the doctor-patient relationship must be part of the

program. It can be done. We know it can.

Number three, finally, the program should not interfere with the legitimate prescribing of controlled substances. You have previously, Dr.

Portenoy was asked is there evidence of decreased prescribing, I don't know about electronic monitoring, but I can tell you when New York instituted its triplicate form program, there was evidence that prescribing medications decreased; the more onerous the task becomes, the physicians give up. They will send the patients elsewhere. They won't say, "You don't need it." They will say, "I'm not into this anymore. See somebody else."

In fact, there was a decrease in prescribing. Please help us with that. We would like to work with you to make that happen. And it certainly has potential to decreasing misuse. You have a tremendous opportunity to benefit more of our citizens, and we're looking forward to helping you set that up. Thank you very much.

MR. BLUMENTHAL: Thank you. I would say that I am very sympathetic. I support the safeguards that you, Dr. Herzog, and Dr. Li both have mentioned, and I want to thank, really, all three of you for helping to educate me and my office. We've met before

and spoken, as I have with so many others who appeared today, and you have really performed an enormous service in providing us your insight and information. I thank you for being here today. Thank you.

Keith Macdonald. Good morning, and thank you very much for being here. I know you made probably the longest trip of anyone to join us, and I want to express my gratitude to you.

MR. MACDONALD: Thank you, Chairman Blumenthal. It's a project that the state of Nevada has been willing to travel to many states about. Our prescription monitoring programs, we think has been effective, and, in fact, the preceding witnesses were a good segue to essentially what Nevada does.

We sat through many hearings such as you're doing relative to what we should do in the state of Nevada. The information about prescription drug abuse, misuse, and correct use of was anecdotal at best. We kept hearing many concerns, we had reports from the medical examiner's offices and other information, but we did not know exactly what was happening. So approximately in 1995, we set about with our legislature to promulgate a project called the Controlled Substance Abuse Prevention Task Force, and that task force was made up of a group of people who

would include district attorneys, law enforcement officers, doctors, both on the regulatory side as far as association goes and other individuals to actually advise and set the policies of the program. The

legislative intent was, to be legal, which we believe it has under the HIPAA act as well as Whalen v. Roe, a Supreme Court ruling; we believed that it had to be confidential, and that was utmost in our mind because this information must be held in that respect for both patients and doctors. We wanted the program to be transparent so that it didn't affect doctors' practices or pharmacy practices. It has been alluded to here, indeed, that information is being collected, but it's being collected by drugstore chains and organizations for some commercial purposes, but it is not being collected between the chains. So the information we want to gather is for our entire state. And most importantly, we did not want to infringe upon the practice of medicine and particularly pain management because, as has been alluded to, there were some real concerns about people getting appropriate treatment, and that is absolutely the case.

We had some secondary concerns. We wanted it to be a prevention and intervention process rather than a law enforcement process. The reason

being it costs about five times the amount of money to place a person in the criminal justice system than it does to put them in drug treatment. So to arrest all the people -- I'll give you another figure here in a

minute -- was just not a possibility for our state. We do allow referral to the criminal justice system when we see a patient getting too many prescriptions in a month, we knew that they had been to Kinko's and had copied a good prescription and went all over the state with it. So there is referrals to the criminal justice system. Importantly, we did not want a chilling effect upon the industry of prescriptions in the state of Nevada because all of the issues occurred here, if you intervene in certain manners, it may cause the inability to give people appropriate treatment. And then, most of all, we want to involve all the stake-holders so there wasn't any contest. There was a lot of turf battles occurred on who should run a program, and so on, and I, with the Board of Pharmacy, am just one of the administrators of the program. There are other administrators, and, in fact, a task force made up of people I mentioned previously do set the policies for this organization and project.

We looked at being on line, rather than being retrospective. We are retrospective. We collect

the data, it's a month late; however, I can tell you that most drug abuse doesn't change within a month. It continues unabated. So the retrospective concept is all right. However, the online process would be much,

much more helpful to practitioners, except the cost goes up about five times. The processing of a POS, or point-of-sale prescription, is around 25 cents. We are operating our program at about four and a half cents per prescription. The project was to inform doctors about patients who were getting drugs.

The most common illegal act is doctor shopping or doctor hopping; the patient goes to this doctor, that doctor, and to 40 or 50. Our best patient had gone to 212 in a year's time. So our task force set up a threshold that when patients saw more than five practitioners or more than five pharmacies or more than 300 oral dosage units in 60 days, or two months, it would generate a document, a drug utilization review, which we euphemistically have called profiles, and we don't like to use that name because a drug profile connotes something bad today in terms of profiling, but we sent a drug utilization review document to the doctors.

Well, when we first -- before I talk about numbers, when we first identified the number of

people in our state that were going to more than five doctors and five pharmacies, it was 1700 people. Again, if you put those in the criminal justice system, that doubled the prison population in our state.

COMMISSIONER FLEMING: How many are there?

MR. MACDONALD: A million point seven when we started the program. It is now over 2 million people. So we raised the threshold to ten practitioners, ten pharmacies, and 500 oral dosage units in 60 days. When we raised that threshold, we had 4200 people, and a document that's been presented to you, although not titled, I guess I didn't want to claim ownership, does show that in the first year in 1997, legislation was '95, the first year we got the project under way was in 1997, and you'll see the patient profile activity, that the patients who exceeded the drug threshold were 4,179 people. That were individuals that had seen ten doctors, ten pharmacies, or over 500 oral dosage units in 60 days.

What we do then is send to the doctor with a cover letter saying this is information for the purposes of better treatment of the patient. It's not a threatening letter at all. It is just a document that suggests that this will help them better utilize

information for the care of their patient. They receive that document, and they can do a number of things. They can do something about the patient. Quite honestly, where insurance programs and HMO's and

others that limit doctor's time, they most often start from their practice. They often get the patient, the profile, and say, "I see what you're doing. You better do something about this, but you aren't going to do it here."

We would hope that they would refer to pain management doctors. Often the people call us, the controlled substances task force, and ask what to do. And we recommend, number one, that they see a doctor about pain management because invariably that's the most common concern that exists out there, they have unmitigated pain. Secondly, we talk to them if they don't have pain, but they've gotten into the use of drugs inappropriately, we talk to them about seeing an addictionalologist. Also, we have a list of drug treatment programs that we will provide them if they have a concern that they would like to get off the drug and so on. So we work this project through pharmacies and doctors.

We've had in four, actually five years now, because the year 2001 is almost over, we've had

one case of confidentiality destruction, and that was through a pharmacist that had given an employer the list of the drugs the patient was taking in the interests, in his thinking, of public safety. The

officer -- the person was an officer in the local law enforcement agency. He was charged by the state board of pharmacy and fined to the tune of around $2,000, and charged for the destruction of confidentiality. We hold this information to be absolutely confidential, and we don't like it to be disbursed anywhere.

We wondered what the outcomes of the program would be, and these are outcomes that we had looked for; that we would be able to advise pharmacists and patients -- excuse me -- pharmacists and practitioners, and that we would be able to counsel patients to pain management, appropriate pain management or addictionalologists or a drug treatment program. Also, as has been mentioned, if you see an outlier on a scale of people who are prescribing drugs, refer them to their licensing boards and let the licensing boards decide whether the treatment is appropriate or not. For the most part, people writing the program will not know. When we have a patient getting, we don't care if it's three wheelbarrows full of drugs if it is going to one doctor and one pharmacy

and that doctor is an oncologist or pain management doctor, they are wavered from our concerns, we don't care because that's probably in the best interest of the patient.

In the worst of cases we've referred to law enforcement. And occasionally we run across the case, but I can tell you in our state, as it is across the country, law enforcement has varied, and, frankly, our district attorneys and law enforcement people don't have a large interest in prescription drug law violations. So our referral system is quite small in total numbers.

Some of the concerns have been expressed here. People would like to have empirical analytical knowledge about what happens to patients after they've been identified. Well, that's very hard. You would have to almost have one-on-one interviews to get that, but it would be important if a state could afford that. Were they referred to drug treatment, did they drop off the program because they changed their name and address and are back somewhere else as another person, or did they leave the state. We don't have that information.

One of the features of the program, if you set it up, will be the fact that you will have much

more knowledge than you ever wanted, and it does become concerning because you will see how large this problem is, you will see what the cause of the problem is, and if I may be very offhanded, it isn't OxyContin, it's

hydrocodone. You're going to see there are other drugs that are much more involved in the abuse of prescription drugs than the drug du jour that you are looking at currently. The outcomes are listed on the document.

The people that we profiled, the average number of medical practitioner visits has dropped -- now, these are the people we sent out drug utilization reports on -- has dropped from 22 to 12, nearly a 50 percent increase; the average number of pharmacies that people are seeing have gone from 16 to 12; the average number of prescriptions has gone from 159 to 56; and average number of dosages, which was astronomical, has gone from 9,000, people who we first identified as exceeding the threshold, were getting 9,700 doses a year, and we have reduced that to around 3,300 doses. So we have been able to measure the outcomes.

Now, this is not empirical analysis because we didn't go out and interview the patients and find out where they may have ended up, and we do have some knowledge that they ended up in the coroner's

office and they overdosed and passed away, making their utilization suddenly drop to zero.

The doctors really like this program. We have a stack of letters, and we invite you or any

other state to contact the state medical association in Nevada, if you will, the State Board of Medical Examiners, or their counterparts in any licensing capacity, the dental board, the dental association, or any of the groups because they have found this has been an extremely helpful program for reaching those individuals.

This has been a very short review of what the Nevada program does. I'm trying to limit it because you have a number of speakers, but I would be happy to answer any questions at this time.

MR. BLUMENTHAL: Well, we hope that we can call on you in other settings by phone --

MR. MACDONALD: You may.

MR. BLUMENTHAL: -- for the benefit of your wisdom and experience, because it would be enormously helpful.

MR. MACDONALD: We would be happy to entertain your officers here, if you don't send them with too much gambling money.

COMMISSIONER FLEMING: They have it

here.

MR. BLUMENTHAL: We have an abundance of it here. Let me ask one quick question.

MR. MACDONALD: Sure.

MR. BLUMENTHAL: The four-and-a-half cent versus twenty-five-cent figures you mentioned, are those current or are they from 1997?

MR. MACDONALD: No. They are current. Our cost is approximately four and a half cents, I think it's about 4.6 cents is what we're operating under today. The point of sales, operating one, but the point of sales system cost around 25 cents a script to get the information transferred. Many of those are in operation for insurance companies, but they are online; online time is costly to monitor. That might be a different cost. It would be very effective if the persons who could access the information were limited, however, and there is a danger there because if you have any person can access this information, there are some that attempt to use it for inappropriate purposes.

I can give you examples. Law enforcement officers having, of course, a dispute with a spouse and he shows up in the office and attempts to give us a subpoena, and we don't allow subpoenas to obtain information, only court orders. He shows up

with a subpoena, he's actually trying to get information that the spouse used too many drugs so he could enhance his obtaining the children, keep her from having the child, that type of thing.

MR. BLUMENTHAL: But in many instances, that point-of-sale information has already been formed that it could be accessed, is it not?

MR. MACDONALD: That is true with a variety of companies, probably 150 companies that are doing that. How you would gather them together is -- is a question.

MR. BLUMENTHAL: But that could reduce the cost, couldn't it?

MR. MACDONALD: Yes, it could. Another thing is that -- each pharmacy, once a day, rather than having a point of sale, once a day could submit information. The chain stores usually do theirs in the middle of the night, they drop their information which they get to a marketing company called IMS --

MR. BLUMENTHAL: Right.

MR. MACDONALD: -- and/or have available for their own computers.

MR. BLUMENTHAL: A lot of that information is already submitted in almost immediately to IMS right now, is it not?

MR. MACDONALD: That's correct.

MR. BLUMENTHAL: Thank you very much.

MR. MACDONALD: All right. Thank you.

MR. BLUMENTHAL: I'm sorry.

MR. MACDONALD: Sure.

COMMISSIONER FLEMING: It is an old legislative habit. I would like to ask you a few questions in the hearing.

MR. MACDONALD: Yes.

COMMISSIONER FLEMING: The method by which Nevada pays for this, when this program was set up and you started in '95, it's been running since '97, how does the state pay for that? What does it cost you?

MR. MACDONALD: The first year we obtained grants and our legislation authorized that, the obtaining of grants and gifts, and we solicited two drug firms, and they were kind enough to provide us with substantial grants, and the State Board of Medical Examiners provided us with a sizable grant to start the program. We also raised in Nevada, we licensed the practitioners who have controlled substance authority with the controlled substance registration. That fee was $30 a buy number, which we equate to $10 a year. It helped run the program. Approximately now the

program runs $120,000 a year to operate. That's one and three-quarters person. Those persons also do some other things, but primarily they do the work of the task force.

COMMISSIONER FLEMING: So it's self-funded. The statistics that you've submitted between '97 and 2000, I don't need to know this now, but when you go back to Nevada, if you could tell me out of the types that you profile and found possible over-utilization, can you break that out by type of drug, say your top ten?

MR. MACDONALD: Yes. I have that information statistically in my briefcase. I would be happy to provide it to you. The top drug is hydrocodone; the second drug is Alprazolam. OxyContin is the fourth or fifth drug. The only other drug in Schedule II in the top ten is Methylphenidate. So there are only two Schedule II drugs in the top ten. The majority are the "pam" family, or diazepams.

COMMISSIONER FLEMING: The pharmacists that worked in my agency, they thought that would be the pattern, but if you have got some statistics on that, that would be very helpful.

One other stat, it's probably not under your jurisdiction, but we've had testimony here this

morning from our Department of Social Services about the amount of money that the state spends using state dollars and federal dollars to pay for these types of drugs. If you have any statistics from your, whatever

you call your Department of Social Services in Nevada that would show the costs before and after this program was implemented, that would be very helpful to us as well when we go before the legislature and they ask us questions about it may cost a little more to set something up and there may be a large savings down the road as well. That would be helpful if you have it now.

MR. MACDONALD: I am embarrassed to say it, but I like honesty. Nevada is the last state in the United States to obtain medical management information system in the Medicaid program. They don't have it operational yet. They are the 50th state, and it's not operational, so they have collected no data regarding the reduction of cost to Medicaid patients. Any other practices have not collected it either, to my knowledge, so we don't have a cost reduction knowledge that is accurate.

COMMISSIONER FLEMING: If you would like some help setting that up, you can talk to our people here.

MR. MACDONALD: Send some money.

COMMISSIONER FLEMING: Thank you very much.

MR. BLUMENTHAL: Thank you very much.

MR. MACDONALD: All right.

MR. BLUMENTHAL: Dr. David Haddox.

DR. HADDOX: Thank you very much for the opportunity to appear. For the record, I'm Dr. J. David Haddox, Senior Medical Director for Health Policy at Purdue Pharma, LP, in Stamford. I am past president of the American Academy of Pain Medicine. In my capacity as president of the American Academy of Pain Medicine before I worked for Purdue Pharma, I worked in the pain management that Dr. Portenoy referred to in his testimony, to study the interface of pain and addiction, to provide better education, clear definitions for physicians in both the field of addiction and pain. Incidentally, that initial meeting was funded by a grant from Purdue.

I'm a physician, I'm board certified in pain medicine, general psychiatry, addiction psychiatry; I also have completed a residency in anesthesiology, and I have a dental degree. My complete CV is attached to my testimony.

With me today is Howard R. Udell,

executive vice president and general counsel of Purdue Pharma. I have provided additional information about Purdue Pharma in my file testimony.

For now let me state Purdue Pharma was

founded by and is managed by physicians. We are a research-oriented pharmaceutical company which seeks to provide a benefit to patients through new and improved treatments for disases and for people in pain.

Purdue Pharma is a Connecticut company. We moved our headquarters from Yonkers, New York, in 1973, bringing 150 jobs to Norwalk. For 27 years we expanded in Norwalk, and when we outgrew our facility there, we stayed in Connecticut and established new headquarters in Stamford. Since moving to Connecticut, we have added 817 jobs to the state's economy. We now employ 967 people in Connecticut, a total of 3,071 nationwide. Purdue Pharma has been a success story and at the very core a Connecticut success story. We obviously had a special interest in being here.

The availability of OxyContin is critical for millions of patients who are suffering from moderate to severe pain where a continuous around-the-clock analgesic is needed for an extended period of time. Unfortunately for those people, many of whom I have personally treated, concern generated by the

criminal use of OxyContin has significantly increased in some locations, with the result that some patients are asking for their doctors to switch them to less effective medications, and some pharmacies are no

longer willing to carry OxyContin. Purdue Pharma receives alarming reports like this every day.

At the same time, naive teenagers and others are abusing OxyContin and other prescription drugs. For some, the consequences are tragic. They do not understand that the abuse of prescription medication can be as lethal as the abuse of illicit drugs. Abuse of prescription medication is a public health problem for this country that we must all join together to address. This hearing is therefore both important and timely.

I appear today because we want to continue our collaborative relationship with you, Mr. Attorney General, to stop the abuse and diversion of our product by criminals and, as you do, we also want to make sure it remains available to meet the needs of persons in pain.

I also have a deep and personal reason for appearing here today. Before joining Purdue Pharma, I practiced and taught medicine for 20 years. For 11 of those years I specialized in the relatively

new field of pain medicine. When I attended medical school, I received less classroom instruction in the assessment and management of pain than it takes me to drive from Stamford to Hartford and back, even on a

good traffic day. In this regard, however, my medical school is not unique. We were no different than other medical schools even today. It is fair to say most doctors are trained to treat a patient's disease, not to treat their pain.

I grew up among on the mining communities of West Virginia. I did not have to go to medical school to learn about pain. I've seen the effects of pain on injured miners and their families since I was a young boy. Because I spent a lifetime seeing and treating pain, I welcome the chance to address the critical comment of use and abuse.

While all the voices in this debate are important, we must be especially careful to listen to patients who, without medicines like OxyContin, would be left in pain. We urge you to talk directly to some of those patients. They are not addicts. They are not criminals. They are people who, because of cancer, sickle cell anemia, nerve injuries, low back pain, or some other physical insult or disease that had the quality of their lives taken away from them by

unrelieved pain.

Today's testimony bears on a significant question of health policy: How to address the problems of abuse and diversion which accompany the sale of a

controlled drug like OxyContin without restricting its availability to meet the needs of doctors and patients to the effective management of pain. It's a question of balance.

This question, however, is neither new nor unique to OxyContin, as you heard. It has existed as long as controlled substances have been available. It is a critical question. We are confident that Purdue has devoted more resources and efforts than has any pharmaceutical company to seeking the answers.

Amidst all the publicity and controversy you heard this morning, a few facts stand out. First, the problem of chronic pain in this country is enormous and expensive. According to organizations like the American Pain Foundation, an estimated 50 million Americans suffer from chronic pain, with a cost approximating $100 billion a year in lost work days, excessive or unnecessary hospitalizations, unnecessary surgical procedures, and inappropriate medications and the patient-incurred expenses of self-treatment.

But even that staggering number fails to

capture the essence of chronic pain in America. Moderate to severe pain cannot be adequately expressed merely by numbers. It is individual and it is personal. It is intense. It is debilitating. It

destroys the capacity to perform life's simplest functions, and could even destroy the will to live. I have certainly seen this in my practice. Anyone who has cared for a loved one in pain knows more about the impact of pain than I could ever hope to describe. For those fortunate not to have experienced significant pain for themselves or to have cared for someone, let me ask you to imagine a life where you can't get out of bed, you can't go to work, you can't take a walk, you can't hug your child, you can't hug your spouse, or even kneel in prayer. That can be and often is the life of a patient with chronic pain.

Second, chronic pain has been historically undertreated. Only in the past decade has public and medical opinion swung decisively in the other direction, based on the proven effectiveness of individualized therapy, including opioids, in treating pain and the startling improvement in quality of life such therapy offers to patients.

The United States Drug Enforcement Administration itself acknowledges that for many

patients opioid analgesics are the most appropriate way to treat pain.

Third, OxyContin is widely recognized as a highly effective treatment for pain. When used under

the supervision of a physician, it's also an extremely safe medication. Its 12-hour controlled release mechanism affords an extended dose of pain medication, allowing patients to sleep through the night or to go to work, and avoiding wide fluctuations or changes in blood levels which can cause side effects. Many patients have told their doctors, have told our company, and have told me personally that OxyContin gave them their life back. I can't tell you the number of times in my practice I heard that almost exact phrase from patients.

Purdue shares all of your commitments, Mr. Attorney General and commissioners, to fighting abuse and diversion of controlled medicines. Abuse and diversion harms patients with pain, it harms the abusers, and it harms the cause of pain sufferers and those who treat them, and it harms Purdue and its products. Importantly, abuse and diversion threatens sound health policy, whose course should be driven by the health needs of millions of patients, not by the actions of relatively few criminal diverters.

Purdue has taken a leadership role and has provided and continues to provide assistance to law enforcement communities in preventing the illegal importation of OxyContin from Mexico and Canada.

Purdue has also changed the tablet markings on OxyContin exported for sale to Mexico and Canada to assist law enforcement in determining country of origin in drug seizures to frustrate smugglers and make it easier for law enforcement to identify illegally imported medications.

To more than 7,000 officers nationwide, we have provided placebos to law enforcement for use in reverse sting or controlled buy undercover operations, we voluntarily worked with the FDA to change the warnings in our package inserts, and we're educating youngsters about the dangers of prescription drug abuse, a program that is not replicated anywhere in the United States presently, even including the Bayer curriculum.

In our view, prescription monitoring programs, or PMP's, can be a good tool. The PMP's in Kentucky, the one you heard about in Nevada can serve as very useful models. PMP's can reduce doctor shopping and diversion from good medical practices to identify persons who are receiving controlled

substances from other doctors. Purdue supports the adoption by all states of well designed PMP's and urges that care be taken to provide uniform standards for collection, storage, and retrieval of data.

Purdue has also worked with Congress to develop legislation to provide states with incentives to adopt PMP's that meet minimum federal requirements.

We are here today to support your efforts in Connecticut to develop your own PMP. We are eager to work with groups represented here to design and support such legislation. In addition, we are prepared to utilize our resources to explain the benefits of an appropriately designed system to physicians and other members of the health care community to gain support for such legislation.

We have also seen a draft proposal made by the Department of Consumer Protection. The draft in our view contains many of what we consider to be the most important attributes of the ideal prescription monitoring program, and laudable attributes of an ideal prescription monitoring program in that this maximizes the benefit to the public health; it provides useful information to clinical management to authorized health care professionals; it assists in the detection of prescription fraud and doctor shopping; it allows for

case management interventions, based on pharmaceutical usage and, while fulfilling these objectives, will protect patient privacy and create little or no intrusion burden into or additional burden on the

practices of prescribers and dispensers.

Our largest area of concern, however, is that any PMP be designed primarily to benefit physicians and pharmacists in patient medical care. Purdue Pharma hopes to be able to work with your office, Mr. Attorney General, with the commissioners and their staffs, with Connecticut's law enforcement authorities to draft additional bill provisions to protect patient needs, to prevent abuse, and to save the state valuable health care dollars lost to fraud. Ultimately solving the problem of prescription drug abuse requires the cooperation of many elements in our communities, law enforcement, schools, religious leaders, parents, family, the courts, the medical community, the press, and federal and state legislatures, government agencies, social service providers, and the pharmaceutical industry. Purdue is helping through our specific programs and our cooperation with the other elements in the community.

As noted, we think appropriately designed PMP's would also be a step in the right

direction. What is needed, above, beyond, and in conjunction with all of these measures is cooperation and common purpose among all parties essential to solving the problem of prescription drug abuse. This

is a long-standing societal problem that requires a reasoned solution. We are committed to partnering with all involved.

Management of pain is critical in this country. OxyContin has proved itself an effective weapon in the fight against pain, returning many patients to their families, to their work, and to their enjoyment of life. This advance should not be stunted or reversed because of the illegal activities of a small percentage of people who divert and abuse the drug. The answer to the problem of prescription drug abuse lies in education, information, enforcement, and cooperation, not restrictions that would deny patients effective treatment or therapy.

Thank you very much.

MR. BLUMENTHAL: Thank you. And I might just say we welcome your cooperation being here today, and I know my office and I have met with representatives of Purdue Pharma on a number of occasions, three or more, as have my colleagues around the country from other states in working with them, as

you know, in a multi-state task force, and we had an opportunity as recently as last Thursday to talk about this problem and some of the steps that Purdue Pharma has taken and hopefully will take.

I noted in your description of those steps, unless I missed it, you didn't mention the changes in marketing, promotion, advertising. I wonder if you could discuss some of those and maybe some of the others that you have planned.

DR. HADDOX: Well, one thing that we're doing as far as educational activities is we are spending a great deal of time now, in cooperation with law enforcement, educating physicians and pharmacists, nurses on how to spot drug abuse, because that's an area that is typically poorly taught in medical school as well and also how to do things to prevent diversion, because a lot of physicians don't realize they are being taken by the criminal element from time to time.

We are also developing an entire line of abuse-resistant analgesic medications. This is a very significant technical challenge, as you are aware from your meetings with us; but we do believe we can overcome some of these challenges. In fact, we have been working on this since before OxyContin was marketed. The technical obstacles are substantial, but

we do think we can bring gradually to the market a line of drugs that will be less desirable to abusers and yet fully effective for patients with legitimate need.

MR. BLUMENTHAL: I wonder, without

asking you to divulge any confidential information, whether you could elaborate a little bit more on what the timing may be on some of those disabling resistant kind of drugs using alexon or naloxone, which I understand actually have been reported publicly, so I don't know that it's even confidential.

DR. HADDOX: That's correct. Yes. One of the theories involves different ways of compounding narcotic antagonists, the drugs that will neutralize or reverse the effect of the medication in a way such that the patient will get the full effect of the medication but that an abuser would neutralize that and not get any effect of it; therefore, it would not be desirable to them. We hope to be submitting clinical trials evidence on the first of those compounds to the FDA next year.

MR. BLUMENTHAL: Thank you. Thank you very much.

DR. HADDOX: Thank you, sir.

MR. BLUMENTHAL: We hope to continue to be in consultation with you in the future, and thank

you and Mr. Udell for being here.

DR. HADDOX: I will look forward to it.

Thank you.

MR. BLUMENTHAL: Karen Weingrod and Dr.

James Duffy.

MS. WEINGROD: Good morning, and thank you for the opportunity to speak today. My name is Karen Weingrod. I'm director of the Connecticut Coalition to Improve End-of-Life Care, a statewide organization comprised of providers, government and community agencies, and individuals committed to improving end-of-life care across the continuum of health care services.

My testimony today does not reflect the coalition's official position as our bylaws and operating procedures prohibit lobbying and advocacy and policy provisions. However, based on my experience with end-of-life care issues, I would like to make several comments regarding the critical importance of treatment of pain for dying patients.

Pain control is the integral component of passionate quality end-of-life care. A study by the American Health Decisions, a national coalition of citizen groups concerned about ethical issues and health care, many Americans are more fearful of how

they will die rather than of death itself. They want their pain to be managed, regardless of the possible risks of addiction or hastening death, and they prefer to die as naturally as possible in familiar

surroundings with loved ones.

Pain management is one of the most important things the health care system can do for those who are terminally ill. As one man in Idaho stated, "I think that pain is one of the worst things. A person needs whatever is available to stop the pain. You have got to help them stop the pain."

One of the greatest fears voiced by participants in these focus groups is that they or their loved ones will die in extreme pain. This tremendous concern was also evident in focus groups convened over the past two years across the state of Connecticut to discuss end-of-life issues. Recognizing that we must work to end the abuse of narcotic analgesics by individuals misusing these medications, it is essential to appropriate treatment for pain.

Consideration of the following two points is key to the delicate balancing approach: Patients must be able to freely express their degree of pain with the expectation that it will be treated appropriately and in confidence and that there will be

no stigma attached to their need for and receipt of a narcotic pain medication prescribed for their condition.

Recent studies indicate that under-

treatment of pain is a serious problem in the United States, even for critically or terminally ill patients, given the insurance companies' insurance practices. Narcotic abuse should not further restrict access to care by imposing an unintended chilling effect on level of treatment necessary to effectively manage severe pain.

Thank you for the opportunity to address these issues.

We must pursue a balanced approach that focuses on protecting and serving patients in need of pain control medication with safeguards to prevent abuse. It would be an immeasurable disservice to enact policies that compromise patient care at the end of life.

MR. BLUMENTHAL: Thank you.

DR. DUFFY: Good morning, Chairman Blumenthal, members of the committee. My name is James Duffy. I'm an associate professor of psychiatry at the University of Connecticut. I'm board certified in psychiatry, palliative care and hospice medicine. I am

also the chairman of the steering committee of the Connecticut Coalition to Improve End-of-Life Care, and I thank you for this opportunity.

My comments on the issue of the use and

abuse of prescription medications, particularly opiate medications, are as follows:

First, and most importantly, we must distinguish between the goal of assuring effective pain treatment versus the goal of enforcing the law. Effective, compassionate pain relief of those of us who are suffering should not be contaminated with the goal of apprehending criminals.

Opiate medications are an effective, vital, and irreplaceable part of our therapeutic armamentarium. Furthermore, recent advances in medications such as OxyContin offer significant clinical advantages that enable us to more effectively manage the pain of our patients. The fact that some individuals choose to abuse these drugs should not impinge upon what I believe are the civil rights, the civil rights of law abiding citizens, to receive the most effective pain relief available to them. Indeed, as you will hear shortly, an objective review of the research indicates that the problem is not that opiates are being abused, rather, they're being underprescribed

by people like us to those who need them.

So I believe the goal of any legislation addressing issues of prescription drug use and abuse should first focus on assuring that Connecticut

residents receive optimum pain relief. In this regard, I believe modern medicine has been remarkably effective with these pain treatments; however, the American and Connecticut public continues to experience unnecessary pain.

To this end, I would like to share with you some of the results of the recent study funded by the Hartford-based Donaghue Foundation and carried out by the American Society of Law, Medicine and Ethics published in December of 2000. The findings of the study are disturbing and are an indictment of our health care community. These findings include, first:

Less than one-third of the patients in the state with chronic pain consider their pain to be under adequate control.

Despite the fact that 70 percent of patients with chronic pain described their physicians as understanding and supportive, only 22 percent of these patients said their physicians had actually helped them a lot or controlled the pain.

It's disturbing that 43 percent of

cancer patients continue to experience significant pain relief and only 22 percent of patients with RSD experienced significant pain relief.

It's also concerning that patients who

are referred by their physicians to experts in pain control in the state typically receive no additional extra relief from their symptoms.

The study also reports that physicians and nurses attending our two medical schools are currently receiving inadequate training in pain management.

Connecticut physicians, the study reports, are ignorant about the federal and state laws concerning these drugs and are therefore paranoid and concerned about being prosecuted. It seems to me that we have another crisis of not only OxyContin and prescription, but also a crisis in health care.

The Connecticut Coalition to Improve End-of-Life Care, Robert Wood Johnson, has recently completed a number of focus groups trying to understand what Connecticut residents experience and feel about end-of-life care in our state. As always, they provide us with wisdom and insight as to what actually is going on. Some of the findings of these focus groups are as follows:

Connecticut health care providers, according to our focus groups, lack sufficient knowledge of pain and palliative care.

Connecticut health care providers,

according to their patients, are often ignorant about the resources available to them and their patients who are experiencing terminal painful illness.

Connecticut families and patients do not feel educated about their options when it comes to pain and symptom control, and they feel that their health care institutions have not developed effective mechanisms for treating pain in end-of-life issues.

Finally, they all feel that the reimbursement through the experience of palliative care and pain control by third-party payers, excluding Medicare, is totally inadequate.

So based on these research findings, it must be concluded that we as a society are failing to respond to the needs of our fellow citizens when it comes to their pain and their symptoms at the end of their lives.

I do believe, however, something can be done to improve this state of affairs, and I would suggest consideration of the following measures:

I think first we need to educate

physicians and health care providers on pain management and also on palliative care issues. Pain management should be a core skill set of all physicians who care for patients, not just experts. Despite the fact that

these skills are quite simple to acquire, physicians continue to display ignorance in this area. So in this regard, I must begrudgingly support a mandatory educational requirement in pain management as part of physician licensing. This training should include not just medical, but also legal aspects of pain management. I believe these educational initiatives should be funded by the state and funded by cooperation between the state medical society, our two medical schools, and our Connecticut Department of Public Health.

I would suggest that we need to educate our public about their options and rights when it comes to pain management and end-of-life care. All of our residents should be informed that they have a right to expect that their pain be managed at the end of their life. This should be, a great belief, a matter of civil rights and not just health care.

I would urge you to consider acquiring health care reimbursement for palliative care of all third-party payers, which is not currently the case in

this state. I would suggest instituting laws, regulations, or guidelines that protect physicians from sanctions for providing what is actually an adequate pain relief in certain groups of patients.

Finally, we need to assure that patients with pain continue to have access to the most effective analgesics available today. In this regard, OxyContin should not be singled out for particular mandatory regulatory restriction. As we have heard, this is actually just one of many drugs that have the capacity to be abused. OxyContin is an effective medication. It has brought relief to so many patients suffering from severe pain.

Finally, just the thought that although in recent years we have witnessed a remarkable, almost tidal wave of technological advances in medicine, it is regrettable that we have managed to transplant the human heart, but we cannot respond compassionately to the suffering of those not in need of one. Thank you.

COMMISSIONER FLEMING: Thank you very much. Any questions?

MS. DENNE: No.

COMMISSIONER FLEMING: Thank you. Mark Cooney and John Parisi.

MR. COONEY: Good morning. I'm here to

talk a little bit about --

COMMISSIONER FLEMING: Just for the record, state your name.

MR. COONEY: My name is Mark Cooney. I

represent the Chain Association, it is a Connecticut association of drugstore chains. I'm here to talk a little bit about the monitoring of the drug substances.

Currently we have stores that we represent in New York and Massachusetts for our company, and they currently are monitoring prescriptions that are Schedule II, and the idea of monitoring in all the classes to us just seems to be a large amount of information, and these classes were designed based off the addiction rates, and having the Schedule II's monitored seems to be the best route to go to try to look more along the classes for addiction rates.

One thing we try to do is, as a company and as an association, is to decrease the workloads for our pharmacists. In today's day and age, to try to decrease prescription errors and the amount of work pharmacists have to do, concentrate on filling prescriptions correctly and getting information to the customers, the counseling to our patients, is becoming

our major focus, and creating any more work to our pharmacists in these situations just seems to be going the opposite direction of what we're looking for.

We are in favor, obviously, of

controlling prescriptions that have a high potential for abuse and everything else. One thing we've looked at in the other two states is the amount of prescriptions that are sent in for the amount of controls --

MR. BLUMENTHAL: The other two states being?

MR. COONEY: New York and Massachusetts.

MR. BLUMENTHAL: I'm sorry?

MR. COONEY: New York and Massachusetts.

The information is sent in to these states, and once it does, a fair amount of it is coming back rejected for missing parts of information from the prescription. At that point, this information has to be taken back down, broken up, given back to the stores, pharmacists have to go back through, research the information, add in whatever information is missing, that has to be sent back in to the corporate level, and that information is again sent back to the states. So, in other words, we're creating more work, you know, at the store levels, you know, for our

pharmacy, and we're trying to go the other way. We're trying to decrease the workloads of our pharmacists.

MR. BLUMENTHAL: Run through that again. What happens?

MR. COONEY: What happens is when prescriptions are filled, the information is electronically sent to these states once a month, and that information is processed by the states for monitoring controls, any prescriptions filled in the Schedule II classification. Of those prescriptions, there are a large amount that are being rejected for either missing information, bad data, something along that line, and what they're doing at that point is sending it back to the companies, they are breaking down that information, taking that information, sending it to the store level, and they have to again research what's missing, whether it's a serial number, whatever it may be, reprocess the information, and send it back.

We are, of course, in favor of monitoring Schedule II prescriptions. Again, those were designed for the degree of abuse. Now, spreading that out to drugs that are in classes, you know, III's, IV's, and V's just seems to be a lot of excess information. If there are prescriptions that are in those classes that are, you know, being abused, maybe

we should look at those medications and move those to a Schedule II classification.

MR. BLUMENTHAL: Let me just ask you, you're with Stop & Shop?

MR. COONEY: Yes.

MR. BLUMENTHAL: And where are you based?

MR. COONEY: I cover -- I'm the regional pharmacy manager. I cover our stores in Connecticut and New York.

MR. BLUMENTHAL: You don't cover Massachusetts?

MR. COONEY: I have in the past. But I am licensed in both Massachusetts and New York.

MR. BLUMENTHAL: And don't you now keep and compile information about prescriptions that are filled?

MR. COONEY: Yes.

MR. BLUMENTHAL: And don't you in fact transmit that information to IMS?

MR. COONEY: Yes. For Schedule II's in those two states.

MR. BLUMENTHAL: All right. And when IMS gets that information, does it send it back to you and create all the work that you referred to?

MR. COONEY: Right.

MR. BLUMENTHAL: IMS does?

MR. COONEY: Yes.

MR. BLUMENTHAL: But you do that

voluntarily?

MR. COONEY: It is a requirement in those two states.

MR. BLUMENTHAL: Sorry?

MR. COONEY: It is a requirement in those states.

MR. BLUMENTHAL: I'm talking about IMS, marketing services.

MR. COONEY: Yes.

MR. BLUMENTHAL: They don't send it back to you and say, "Give us all this additional information," do they, or do they?

MR. COONEY: That I don't know.

MR. BLUMENTHAL: But if this information were compiled correctly and completely in the first instance, it won't be sent back to you?

MR. COONEY: Correct.

MR. BLUMENTHAL: Mr. Parisi.

MR. PARISI: My name is John Parisi. I'm a pharmacist and owner of Ivery & Dudley Pharmacy and Health Education Center in Winsted. I am also

president of the Connecticut Pharmacists Association. My desire today is to bring you the point of view of the health professional that patients see most frequently and the professional with five to six years

of drug therapy education: a pharmacist. The pharmacist is also the gatekeeper of all prescription medications, and this point is one of significance.

The pharmacist shares the concerns of law enforcement regarding using the prescription medication. Our main goal is to make certain that every patient gets the proper medication for his or her medical condition and takes his or her medications properly. If any drug gets into the wrong hands or is abused, this is abuse. Every day, pharmacists across the state monitor thousands of prescriptions for proper drug, proper dosage, side effect profiles, and, most importantly, communicate with the patient about any concerns that they have about their drug therapy. Part of this monitoring is being sure the patients are not overusing or abusing medications. Routinely pharmacists call other pharmacists about possible pharmacy shopping by patients. Routinely pharmacists refuse to fill prescriptions from patients who are either unfamiliar to them or in situations where the prescription itself cannot be verified.

OxyContin is the new darling of the press, spotlighted in every Sunday edition early in 2001. Actually, you may notice that this has already been relegated to the back page. The question we are

facing is should we add another layer of regulation on top of what is already in place just because of press coverage? Is OxyContin being abused more than any other controlled substance or is it in vogue due to the publicity? Is OxyContin being abused more than other forms of oxycodone, the active ingredient in OxyContin?

As a community pharmacist involved with home-based hospice programs in our area, we dispense many different medications to patients faced with terminal illnesses. Pain medications are just part of hospice care, but a key part. One of the first things we tell our hospice patients is that we tell them we should be able to keep them pain free, carrying on normal life. This knowledge allows the patient to move on to other important areas of life without the fear of writhing in pain or being heavily sedated during their final days. A misconception is that hospice is only provided in hospitals. Actually, the majority of hospice patients are cared for in their homes with the support of hospice teams made up of nurses, physicians,

pharmacists, clergy, and others.

In our pharmacy practice, pain management is one of our specialties. We need all pain medications available to our patients when they need

them. This means if a physician needs to order a medication at 4:00 a.m., it happens many times, that medication must be available at 4:00 a.m., not five or six hours later. Any restrictions on where the medications can be obtained are unacceptable. Every licensed pharmacy must be able to dispense every medication that is needed by the public. Safeguards are already in place.

I did an analysis of all OxyContin prescriptions dispensed in my pharmacy in 2001 and have brought many interesting things into focus. Oncologists do not write most pain prescriptions because the most common form of chronic pain seems to be back pain. Limiting prescribing of OxyContin to oncologists would be a detriment to the majority of pain sufferers.

OxyContin prescriptions were a small percentage of all oxycodone prescriptions written. Actually about 6 percent were OxyContin 80-milligram. The majority of oxycodone prescriptions were for oxycodone and acetaminophen combinations (Percocet,

Tylox) or aspirin combinations such as Percodan. When looking at abuse, do not assume all oxycodone prescriptions are OxyContin. These other products have been on the market since the early 1960s. The cost of

OxyContin, however, was the highest of all oxycodone formulations. If the cost of OxyContin to the state of Connecticut is the issue, this should be addressed separately.

The Drug Control Division is recommending electronic monitoring of controlled substance prescriptions. The Connecticut Pharmacists Association is in support of this regulation as long as the individual pharmacies do not bear any additional cost. Computer programming is expensive and a pharmacy's margin is very small. There is no way that the increased cost, including even a 4 1/2 cent transmission fee, can be passed on, as pharmacies have no control over drug retail prices in up to 90 percent of the prescriptions dispensed.

Getting the right drug to the patient when the patient needs the drug is the foundation therapy is built upon. When a loved one is in pain, making a caregiver feel like a criminal to obtain the pain relieving medication is in itself a crime. Pharmacy has led the battle to get proper pain

medication prescribed to patients so that issues such as assisted suicide do not have to be discussed. Finally, physicians are more likely to order adequate doses of pain medications so patients can have quality

of life in their final months. Any talk about increased surveillance, increased paperwork, or increased certification will only decrease physicians' desire to prescribe proper dosages of pain medications to the terminally ill.

MR. BLUMENTHAL: Thank you, Mr. Parisi.

MR. PARISI: You're welcome.

MR. BLUMENTHAL: And thank you for being here today.

MR. PARISI: Thank you.

MR. BLUMENTHAL: Both of you, Mr. -- I understand if your main concern, if I may put it most simply, is that there shouldn't be a cost to the pharmacy of this monitoring program?

MR. PARISI: That is our main concern of the management program. I don't think we have any trouble. That certainly can be done, and we support anything that cuts down on abuse of medication. We have no trouble with that.

MR. BLUMENTHAL: So long as there were no restriction on the number or kind of pharmacies,

which is not part of this proposal, I want to assure you, you wouldn't have any objection to it?

MR. PARISI: No. We certainly want to see free access. We feel that's really important to

the patient.

MR. BLUMENTHAL: Thank you very much. Thank you.

Sherry Green of the National Alliance for Model State Drug Laws is not going to be with us as we announced earlier. So I'm going to ask Pat Good to please join us now.

MS. GOOD: Good afternoon.

MR. BLUMENTHAL: Thank you for being so patient.

MS. GOOD: Sure. No problem. My name is Pat Good, and I'm with the Drug Enforcement Administration. I'm in the Office of Diversion Control. That's an area that specializes in illicit drug and chemical activities, and I'm the chief of the liaison and policy section.

In that section, we have had a lot of involvement with prescription monitoring issues over the last 30 years, and we are sort of a federal ombudsman for the programs. I appreciate the opportunity to speak to you today regarding the abuse

of controlled substances and the role that electronic prescription monitoring programs can play in dealing with this problem. Certainly the recent problems with OxyContin have focused more attention on this issue,

but as we have heard many others say, this is obviously not the only issue.

As a little bit of background, legitimately manufactured controlled substances play an important role in our life. We all heard many people state that they're essential to the well-being of those in pain. DEA does not dispute that, in fact, has come out in favor of acknowledging that. However, the diversion of legitimately manufactured controlled substances is a major cause of drug-related dependencies, medical emergencies, and fatalities. The Substance Abuse and Mental Health Services Administration, or SAMHSA, which conducts the annual National Household Survey on Drug Abuse, estimated that in 1999, the last year for which it had a full report, 2.6 million people reported nonmedical use of prescription pain relievers. That's 2.6 million people. The DAWN network, Drug Abuse Early Warning network, also administered by SAMHSA, reported in 2000 that mentions for oxycodone were 108 percent higher than was reported in 1998. Again, that's the generic

oxycodone, encompassing all products with that ingredient. Also in the year 2000, 2 percent of all emergency room mentions were for oxycodone products. This doesn't make it the highest by any stretch, but it

certainly is a change from years past.

A little background in the federal law. The Controlled Substances Act was enacted in 1970, and it set up a closed distribution system for controlled substances. And this is important here because many drugs are abused by drug abusers, many of them licit, but the illicit drugs are set up in a framework where they all originate from some licit source. All of those sources have certain legal requirements and recordkeeping requirements, registrants deal with registrants, and sales must be made only to other people that are properly licensed, unless they're being delivered to a patient by a legitimate doctor. All the parties to the transaction have to keep records, so ostensibly we should be able to go back and track everything from the time it's manufactured to the time it's delivered to a patient.

As a supplement to this, DEA has a system called ARCOS which captures reports of drugs distributed to the wholesale level and down to the retail level of all opioids or all Schedule II drugs

and all opioids and Schedule III. That system called ARCOS is given to the states periodically at least once a year, and it can report consumption levels for any given class of drugs or particular drug product. It

can tell where your state ranks per capita on the consumption levels compared to the national averages. It can be imported down to the mid-purchaser. Those purchasers are generally pharmacies or hospitals. So with any given state, let's say Connecticut, we can tell you that X amount of a particular drug was supplied to the pharmacies in your state, and we can tell you which pharmacies bought the most, which ones bought the least, we can tell you how you stack up nationally, whether you're first, middle, low in consumption.

These figures don't mean a whole lot. Somebody's always going to be highest, and it could all be legitimate. Somebody is going to be lowest. The variance between the highest and the lowest may be very small.

The curious part, though, is it stops at the retail level. We can tell you that 20 pharmacies bought 80 percent of your OxyContin. We can't tell you what the 20 pharmacies did with it. That's where prescription monitoring systems come into play. When

there is a problem, the prescription monitoring systems can backtrack and see just what is going on. They can serve as a warning system; when complaints are generated, they can allow complaints to be resolved

more expeditiously than what would happen if we had to send teams of investigators running around to every pharmacy in town trying to backtrack specific doctor's prescriptions or specific patients' prescriptions.

When we have to go on site and do this tracking, we're creating an aura that perhaps we are investigating or checking on people. It becomes public knowledge because the pharmacist looks over our shoulders and knows who we are looking at. The monitoring system allows you to do this in the privacy of your office without infringing on anybody's freedoms or rights.

It also is an aid to prescribers who may suspect their patients are doctor shopping because in many states the doctors can contact the state agency and obtain from them information on any patients they suspect might be seeing multiple doctors.

This is all done within a strict framework of privacy. The data is never authorized to be given to anyone who does not already have the legal authority to see it. By that I mean agencies like DEA,

agencies like state boards of pharmacy, already have the legal authority to go into a pharmacy and review prescription records. So those same kinds of agencys would be granted legal authority through whatever

statutes enact a monitoring system to do just that with the proper limits on service.

They also, as we've seen from states like Nevada and many others, they've served as a way to deal with public health issues. They have helped people get into treatment, they have helped uncover outmoded practice standards or people that may be using drug therapies that are no longer in favor. So this is not only looked at a law enforcement measure. In fact, many states look at them as a public health measure. DEA has long supported states in their efforts to prevent and detect abuse and diversion of pharmaceutical controlled substances through the implementation of such programs. They consider these our primary ways of clamping down on doctor shopping and prescription mills because they raise the level of awareness and they enable investigations to be conducted swiftly and unobtrusively.

Some of the states that have problems with OxyContin make an interesting comparison, if you look at the states with monitoring versus those that do

not have it. OxyContin, as you know, was introduced back in '95 by Purdue Pharma. You have heard about the product itself, and you've heard also about the abuse issues that face us today. We looked at a number of

data sources, including medical examiner data, and as of November 1st, that data showed that there were 117 deaths verified as being OxyContin specific and another 179 nationwide possibly related to OxyContin.

We have also looked at data -- we have heard IMS mentioned. We have to purchase that data. It's restricted what we can do with it. We cannot access patient names, doctor names; we only can get aggregate data. But in getting that, we found that five states with the highest per capita rates of prescriptions for OxyContin were also five states that did not have a prescription monitoring portion, and they were the five states reporting the most abuse of the product. Those states were Alaska, West Virginia, Delaware, New Hampshire, and Florida.

Conversely, the states at the bottom of the lowest per capita rate of abuse all had long-standing prescription monitoring programs, and they report very few problems. Those states being New Mexico, which has since lost its monitoring program, Illinois, Texas, New York, and California.

Curiously, a sixth state does have a monitoring program. That state is Kentucky, and two things play here that I think are important to note. Having the system is only the beginning. What you do

with the information is very, very critical.

Kentucky's system is outstanding, it captures Schedule II, III, and IV drugs. It has a small staff of people monitoring it, and their resources are dedicated to responding to requests from physicians to make sure their patients are not doctor shopping. It was not particularly proactive in identifying potential problems. Once the problem is noted, however, it is a great resource to try to track down possible violators.

Also, a state like Kentucky has bordering states of Virginia, West Virginia, Ohio, all without monitoring programs, that did not have monitoring programs, so that abusers can avoid being monitored themselves.

The states with monitoring programs now number 15, and there are about 7 or 8 more that are like you trying to get legislation rolling. The start-up costs vary, and some good news I do have about costs that may spark some interest, the Congress of the United States was so impressed with the ability of

monitoring programs to deal with issues that have emerged before the publicity of OxyContin that the Senate Appropriations Committee put $2 million in a DEA budget for Byrne grants for states to start up

prescription monitoring programs. We shortly expect to have with BJA, the Bureau of Justice Assistance, some of the criteria established. So we expect to -- the states to use this as seed money to start programs of this type. Again, we offer whatever support we can provide.

We believe that the monitoring programs provide an excellent tool in monitoring diversion issues, and we also believe very strongly in the balanced approach to preventing diversion while assuring access to the patients who truly need controlled substances, whether they're opioids or other types.

I appreciate the opportunity to speak to you and would be happy to answer any questions.

MR. BLUMENTHAL: Thank you very much for being with us and making the trip.

I wasn't sure whether you made reference to it just now, but my understanding is that there is some grant money available to states who are seeking to establish this kind of program?

MS. GOOD: Yes. The budget that was recently signed has $2 million in it to be allocated to the states through the Bureau of Justice Assistance in the form of Byrne grants.

MR. BLUMENTHAL: Is that in the Department of Justice?

MS. GOOD: It's in the Department of Justice, and we will shortly have parameters and criteria, and we will make sure that state agencies engaged in this process are made aware of it.

MR. BLUMENTHAL: How soon do you think that money will be available?

MS. GOOD: I would say in the next couple of months.

MR. BLUMENTHAL: Thank you.

One other question. If you were -- and I don't mean to ask you an unfair question. If you were to pick a state or a couple of states whom you would recommend Connecticut should follow, in other words, the states that have the best so far of those monitoring programs, could you suggest one or two?

MS. GOOD: Well, there are some parameters that differ from one state to another.

No one likes the paper forms, I'll say that right up front, because they are not invisible to

the prescriber and they're somewhat of a pain in the neck. But they're really the only mechanism right now that can take away the possibility of someone issuing fraudulent prescriptions because you can have a fistful

of fake prescriptions and the pharmacist can dutifully submit them to the monitoring program and nobody will be the wiser. So there is a benefit with having the forms.

The states with the forms are New York, Texas, and I'm running out of -- I forget who. But those are -- I have one coming on.

Some other attributes that are very effective, Nevada is extremely effective in the way they use their data. They also capture all schedules, like Kentucky, which is a definite benefit in the sense that it is true that if you create a, quote, stigma, or reporting requirement around one group of drugs, that someone's going to be diverting that type of drug, they can move to another schedule. So there is a benefit to doing all schedules, especially in opioids, because so many combinations are in Schedule III. So for those I would recommend Nevada and Kentucky. There are similarities and differences.

DEA has a publication that will run through the way each state is set up. We would be

happy to provide that to you.

MR. BLUMENTHAL: That would be very useful if you could. Maybe my office could contact you.

MS. GOOD: Sure.

MR. BLUMENTHAL: Thank you.

COMMISSIONER FLEMING: Thank you again for being here now this afternoon. I would just like to thank you and the DEA for all the past help that you have been to my agency. I know we had had two very high-profile cases this year with diversion of controlled substances, but on a regular basis, what a lot of people don't see is the amount of interaction that goes on between DEA and the agents in the Department of Consumer Protection's drug abuse as well as the other law enforcement, and it seems to work very well.

MS. GOOD: I think you can thank one of the gentlemen in the back of the room for that, then.

MR. BLUMENTHAL: Who is that?

MS. GOOD: Steve Simes (phon sp) is our local supervisor, and he should be -- he was back there.

MR. BLUMENTHAL: Is he still? Thank you for your help.

COMMISSIONER FLEMING: I have spent a little bit of time in a surveillance van. It is not terribly comfortable. I know those guys have a tough job. But it's the day-to-day stuff that's extremely

helpful to us.

You did mention, I was aware that there was federal -- there is federal money available that my agency would qualify for. The only question I did have, for $2 million, in the scheme of things, is not a great deal of money, and the amount of grants would be how much, and for when you say start-up, how long would it be for?

MS. GOOD: I'm not sure we have the answers to that yet. We met with the senate appropriations staff last week to iron out what they envision the money to be for and what we thought would be realistic. I think we were somewhat apart.

They were looking to give small amounts to as many states as possible to get them off the ground, and we wanted to make sure the amounts given were meaningful enough to make sense. So we were looking at the fewer states, high amounts; they were looking at more states, lower amounts.

But in talking to some of the folks about how much it actually cost to get the technology

rolling, if the grants were 150 to 200,000, that seems to cover the technology piece. We were looking at up to 500,000 needed for the entire intrastructure set-up. So I don't think there has been a restriction set

yet. We are in the early stages of meeting with DJA to develop realistic cost assessment and standards.

We also right now only have the budget for one year. We have no guarantees it will be in next year's budget.

COMMISSIONER FLEMING: I understand that. Thank you. Thank you very much.

MR. BLUMENTHAL: Thank you very much.

COMMISSIONER FLEMING: Before you set those standards, if you want to give us about a quarter of that, fine.

MS. GOOD: I will put you on the list. No problem.

MR. BLUMENTHAL: Diana Norris.

MS. NORRIS: Good afternoon, Attorney General Blumenthal, Special Counsel Kehoe, and invited panel witnesses. Thank you for the opportunity to provide testimony on behalf of Connecticut Nurses' Association.

I am Diana Norris, an advanced practices nurse, and a member of the Connecticut Nurses'

Association Professional Practice Committee. I'm also assistant director for the Eastern Health System Network Hospitalist Program.

We would like to commend the Attorney

General for bringing together professionals with a variety of perspectives and expertise related to drug control, law enforcement, and health care before drafting legislation. Any successful prescription monitoring legislation must be designed and implemented with a balanced perspective containing appropriate checks and balances.

Prescription drug abuse affects millions of Americans. This number itself is not important. What is important is that a large number of people suffer from addiction to prescription drugs, resulting in families that are torn apart, lives that are destroyed, and people who die. A prescription monitoring system with a clear mission created by a group with a balanced perspective could assist in efforts to bring prescription drug abusers into treatment and recovery. This kind of system could also provide a mechanism for identifying illegal activity and ensure that the prescribing of legitimate, helpful medications continues for patients who need them.

This issue must be addressed with a

balanced approach because patients must receive medications that are needed, prescribers must not be reluctant to provide medications that will help their patients, especially now, when there is a threat of

malpractice if pain is not well managed, and non-punitive systems for treatment must be in place for individuals suffering from the disease of addiction.

The focus of any board developing a prescription monitoring system must include establishing a committee consisting of individuals who have a broad base of knowledge and perspectives of Connecticut issues and who would be affected by this kind of legislation. This committee should be empowered to determine the needs before any legislation is developed; determining the flow of prescription medications from production through dispensing and identifying gaps in accountability for the drugs produced; determining through a systematic process what monitoring systems are already in place and where gaps exist; establishing the extent of problems related to prescription abuse in Connecticut; identification of current drug treatment confidentiality issues and rights and developing legislation that would be consistent; determining what is the necessity of a prescription monitoring system, what needs to be

accomplished. Would we improve the system of identification of drug abusers in order to intervene in obtaining treatment, if this is a major problem, or would this be a system to catch individuals in criminal

behavior, which may not be a major problem? Would we add another layer of reporting and monitoring which would make it more difficult for prescribers and more costly? Would we design a program based on best practices?

Legislation for a prescription monitoring system needs to take into account the following: Defining the mission or missions for the program based on the identified needs; reflecting the latest research and trends about treatment (alternative programs versus a punitive system); considering the costs, given the extent of current competing interests; ensuring confidentiality for any data that is developed and that access to the data is based on a very selective need to know; ensuring that systems for identification and referrals for health care workers who have as an occupational hazard prescription drug abuse, and that the systems are used to intervene rather than using the criminal justice system.

Legislation of that nature is complex and should be based on a thorough review of needs.

Language needs to be carefully crafted by individuals without political agendas who have the knowledge and skills to determine Connecticut's needs.

In the 2001 legislative session, it was

clear during hearings before the Public Health Committee related to mental health issues that alternative programs for drug abuse and impairment are needed, not punitive systems and incarceration.

The Connecticut Nurses' Assciation's interest in developing legislation for prescription monitoring is multileveled and includes its interest and expertise in patient care, prescribing for any advanced practice nurses, impaired nurses and health care workers in their recovery and return to safe practice, confidentiality issues and the safety of the public health. We want to be included in developing any legislation that concerns prescription monitoring, and I thank you for the opportunity to address this important issue; and the Connecticut Nurses' Association looks forward to continued work together for a healthier Connecticut.

MR. BLUMENTHAL: Thank you very much.

We have a panel now involving Susan Richter, Dr. Ed Hargas, Jeffrey Mendenhall.

Thank, you Ms. Norris.

MS. NORRIS: Thank you.

MS. RICHTER: Good afternoon.

MR. BLUMENTHAL: Good afternoon.

MS. RICHTER: I appreciate the

opportunity to make some comments this afternoon. My name is Susan Richter, and I'm the vice president of Patient Support for the New England division of the American Cancer Society. My background is nursing, and I'm a charter member of the Connecticut Cancer Pain Initiative also.

As you have heard many times so far today, pain and its undertreatment is a major public health problem in this country. Today over 8 1/2 million persons in the United States have had cancer, and more than 70 percent of them experienced pain from the disease. Unrelieved pain causes needless suffering and destroys the quality of life at a time when nearly all cancer pain can be relieved.

There are many barriers to the management of pain that include inadequate training of health care professionals, poor communication between patient and health care professional, fear of regulatory scrutiny by the health care professional, and perhaps the top reason the cancer pain patients refuse treatment and health care providers undertreat

pain is the fear of addiction.

Recent news reports have focused primarily on addiction and abuse of pain relievers. These reports unfortunately contribute to the under-

treatment of pain by reinforcing myths and misconceptions and may harm the quality of life of cancer patients. Since addiction is such a common fear that patients hold, such fear may prevent them from taking their medications. It also encourages family members to urge them to hold off as long as possible.

The American Cancer Society has set ambitious goals for 50 percent reduction in cancer mortality, a 25 percent reduction in cancer incidents and measurable improvement in the quality of life by the year 2015. Pain is the most feared complication of cancer, and it is a major quality-of-life issue affecting those with cancer. Meeting these goals will require us to have new partnerships and will require a commitment from both the private and public sectors.

In the year 2000, Congress has designated this decade as the decade of pain. This is an opportune time for everyone concerned about this critical issue to step forward and offer to spread the facts about pain relief. We need survivors, family members, health care professionals, legislators,

educators, employers, researchers, and media professionals to continue to provide the dialogue that will help dispel the myths and misconceptions that currently limit the existing opportunity to have good

treatment. The American Cancer Society strongly supports statewide educational initiatives that address patient and provider fear of regulatory action in order to reduce barriers to appropriate pain medication.

Public and provider education is greatly needed to correct these widely held and false beliefs that create barriers for patients attempting to access the pain control that they needed. Cancer patients have the right to know that their pain can be relieved and that proper cancer pain management does not result in addiction. Physicians and other medical practitioners have the right to know that they will not be prosecuted for appropriately treating their patients.

And the American Cancer Society recognizes that there is an urgent need to improve the quality and availability of cancer pain treatment. The society also recognizes that there are strong societal interests in assuring the appropriate use of controlled substances. We believe that attention to the misuse of controlled substance has overshadowed and impeded

attempts to manage pain. Currently we have not found a proper balance between these two issues, and that has been a great cost at the expense of those who need to have their pain controlled. The society believes that

concern for pain management should receive equal footing and funding with other health initiatives from federal and state government and/or private agencies.

On a personal note, a little over a year ago, my brother, dying from advanced melanoma in a Connecticut hospital, faced his own struggle for pain relief. As his advocate, I attempted to overcome the huge obstacles that were before us without success. In the process, I was actually asked, "Are you trying to kill your brother?" I was so disappointed to learn that all our educational efforts had yet to change many attitudes, behaviors, and beliefs about cancer pain relief.

The American Cancer Society stands ready to work together with federal, state, and local officials to ensure that policies intended to curb abuse and diversion of pain medications have minimal impact on legitimate pain management for cancer patients and to ensure that consumers and providers receive the education needed to dispel misconceptions and relieve unnecessary suffering. Please help me in

creating a real sense of urgency for this critical issue. Let's help people with cancer understand their right to request and receive effective pain management. We do not believe that cancer care can be complete

until pain is under control. Thank you.

MR. BLUMENTHAL: Thank you. Which of you would like to go?

MR. MENDENHALL: Okay. My name is Jeffrey Mendenhall. I have several hats to wear. I am clinical supervisor of the Branford Home Care Office of The Connecticut Hospice, Inc., where as the chairman of the Pain Care Committee, I am also chairman of the Connecticut Cancer Initiative for this year and up through next year. I'm going to read some excerpts from my written testimony today.

MR. BLUMENTHAL: We will have your written testimony.

MR. MENDENHALL: I understand that.

MR. BLUMENTHAL: I can assure you that we will read it or have read it in most cases. So you can feel free to summarize.

MR. MENDENHALL: Yes, indeed.

During the past year local media and some politicians have tended to exaggerate and distort the nature and scope of drug-related criminal behavior

in our communities, even to warn of an impending epidemic of abuse. But the only real documented epidemic is the public health crisis caused by chronic pain. Based on 2000 census data, approximately 600 to

700,000 adults living in Connecticut are living in daily routine pain.

For many patients, families, and their physicians, their reasonable and proper caution has been turned into irrational fear; fear of the only class of drugs proven safe and effective in the treatment of moderate to severe pain. Opiophobia is a sadly common occurrence, both in the general and professional communities, and it is the single greatest barrier to effective pain management, here and throughout the world.

Clinical research and experience have shown roughly 90 percent of this pain can be substantially, if not completely, relieved using simple interventions, including the use of carefully managed opioid medications. I believe the failure to treat pain when we have the knowledge and resources to do so is morally and ethically equivalent to torture.

I also believe it is crucial to understand that pain is not just pain. Pain impacts all aspects of a person's life, and it can become soul

destroying. It can also be life-threatening, decreasing immune function; and when chronic pain persists, it can become a progressive crippling, disease; RSD referred to earlier.

While I am actively involved in pain management at the end of life, today I am more concerned about the vast majority of persons who suffer pain. Those with chronic nonmalignant pain. Chronic noncancer pain in adults who are not terminally ill is often viewed as malingering, as an annoyance, and, worst of all, drug seeking. Hospice patients mistakenly believe that it is, quote, foolish to worry about addiction in patients who are dying. Incorrect. To be correct, it is foolish and dangerous to worry about addiction as a precondition for treating pain.

We know that diversion and abuse of prescription drugs is an historic problem, as is the rate of substance abuse and addiction in our population. I don't know of any reliable evidence that the rate of abuse has increased. It's also well to remember that prescription drug abusers typically use several drugs together and cocktail often with alcohol. To blame one drug is not only unfair, it is inaccurate and inflammatory.

MR. BLUMENTHAL: You don't mean to

suggest that alcohol is prescribed?

MR. MENDENHALL: No, no, I do not. Of course not. But it is legal, of course. I'm only attempting to get across the point that people who

use -- misuse prescription drugs typically are misusing a number of drugs, and they often are using alcohol at the same time.

MR. BLUMENTHAL: I see. Okay. Maybe I misunderstood you.

You know, just to state the obvious, this hearing is not about whether there should be pain relief for people who suffer from -- I think I speak for this panel and for most people I know, to say that there should be increased availability and accessibility of these drugs for people who legitimately need and deserve them. I think I've referred to these drug as a Godsend.

MR. MENDENHALL: Yes.

MR. BLUMENTHAL: Our concern is not with trying to restrict the flow of any drug that can be useful in treating pain. I hope you haven't misunderstood our purpose here today.

MR. MENDENHALL: No. But as I said, we have seen great reluctance, we have seen people go from being normally cautious to being almost irrationally

afraid of using drugs, not only drugs that would be effective in controlling pain. It is the chilling effect that I think a lot of us are worried about. I was really heartened to hear about that joint statement

that came out of Washington, D.C., with the DEA administrator, Mr. Hutchinson; Dr. Portenoy was involved in the press conference. One of the things that I'm recommending is that we look at that statement here in Connecticut as something of a mission statement for a coalition that would help to guide us toward a more balanced and rational public policy.

My concern as I walked across the pedestrian bridge this morning and somebody said, "Oh, are you here for the OxyContin hearing?" I didn't know that it was about OxyContin. I knew it was about public health, public safety, and ultimately public policy. Obviously OxyContin has been the big drug news this year. But I've worked, you know, in oncology and hospice, and over the years, other opioid medications have been the drug of choice, the flavor of the month, as people have sometimes said. It's unfortunate that diversion and substance abuse occurs, but that's criminal behavior. We need to trust both the public health and the pain management issues in addition to the public safety on the criminal side of the question.

MR. BLUMENTHAL: Can you comment on the monitoring program? Would anyone like to comment on the monitoring program that's been suggested? Which, by the way, would not only cover OxyContin.

MR. MENDENHALL: I understand that. We had a presentation from Mr. Roberge at our most recent meeting last week. I think many of us were impressed with, were in accord with that sort of thing.

MR. BLUMENTHAL: Right.

MR. MENDENHALL: I moved from California a little over two years ago, so I am familiar with living in a state where there is monitoring and a triplicate program.

MR. BLUMENTHAL: Did that program have a chilling effect as one of the things you mentioned as one of your apprehensions?

MR. MENDENHALL: Well, what I would say, what they finally did in California in triplicates in treating people with terminal illness is to get an exemption for triplicate prescriptions for patients who are terminally ill. Doctors treating the terminally ill were able to write C2, Schedule II prescriptions, without prescriptions, they only had to write on the bottom of the prescription pad the number of the law, which I can't remember at the moment, it was a senate

bill, they would write the number and exempt, and they were able to write those kind of prescriptions.

But it did have a chilling effect in the sense that only about 30 percent of the doctors in

California had triplicate writing privileges. Which, depending upon how you look at it, is a good thing or a bad thing.

What tended to happen, and you may have heard about the Bergman case in California, where a man was seriously undertreated for his pain in part because his doctor did not have triplicate writing privileges. There were many other factors, the hospital that was involved should have gotten involved and been much more proactive. Hydrocodone is a C3 drug, this is California, the triplicate program, you don't have to have a triplicate to write for Vicodin. So many people write for Vicodin. And that is what -- one of the reasons this poor man got into so much trouble, his doctor kept writing more and more Vicodin prescriptions and not -- he wasn't able -- he should have referred him to somebody who could have written him triplicate for morphine.

DR. HARGUS: Can I just comment, just about that one point? I believe Dr. Portenoy commented about it. When they established the reporting format

in New York, which was triplicate, they -- there was a rapid decrease in the amount of those -- those narcotic drugs, and not just a decrease in these drugs, but a switch to other less, you know, effective medicines.

MR. BLUMENTHAL: Was that -- was that a temporary switch?

DR. HARGUS: Which? I will just make a little point about this in Connecticut. You seem to -- when we got this report justifying the electronic monitoring of controlled substances, everybody seemed to be proud to state that, oh, it hasn't affected, Massachusetts has gone up, Rhode Island is going up, New York is going up. Well, it's not cause and effect there. What has happened is I think docs are beginning to realize that patients are grossly being under-treated. It's not the fact that this provided them a safety network or some great assurance that they wouldn't be prosecuted. It's the fact that people are beginning to wake up, you know, Massachusetts, a lot of bright people, but they wake up late too.

MR. BLUMENTHAL: Let's turn to you, if you have --

DR. HARGUS: I didn't want to --

MR. BLUMENTHAL: Did you want to finish?

MR. MENDENHALL: If I could, just with a

22 couple of brief presentations.

23 MR. BLUMENTHAL: Sure.

24 MR. MENDENHALL: I won't say much more.

25 I believe that all parties involved in

this hearing should endorse the joint statement by the DEA administrator and pain management coalition that was part of that press release on October 23rd, and that is part of my statement.

Connecticut insurance companies should cover consultations at Association for the Society of Pain Management-approved comprehensive pain management centers in contiguous states because we do not have a comprehensive pain management center that meets the standards of this group in Connecticut. We had one at Yale. It has since been closed. So we are a state without that full multidisciplinary pain management center. We don't have that.

I personally took my wife to see Dr. Portenoy in New York City because we couldn't find a pain management specialist that was able to treat the problems that she has. We were fortunate that our insurance paid for that, but most people are not that fortunate. I strongly suggest that we look at requiring that kind of coverage until such time as we have a full-service facility.

I also think it's important that we consider the Medicaid side of the equation when it comes to hospice. Connecticut is one of very few states, I think less than ten now, that does not

provide a Medicaid hospice benefit. This adversely effects poor and disadvantaged persons at the end of life. We must implement this benefit which would provide the sort of comprehensive pain and inter-disciplinary pain management which I believe all parties agree is effective and the most cost effective. It is also simply an outrage, I think, since Connecticut is the home of the first hospice in America, that we do not provide that kind of care for all of our patients, all the people who live in the state.

And, finally, I think that all primary care providers, ranging from physicians, nurses, pharmacists, physician assistants, I've talked with physician assistant classes at a couple of universities in the southern part of the state, and they are not getting pain management training, I can tell you that. We need to require that all of these primary care providers have some continuing education, continuing medical education a minimum amount of time before their relicensure, and also that all of the clinical training

programs in the state provide education and pain management and end-of-life care that would also include substance abuse and addiction.

MR. BLUMENTHAL: Well, I thank you for

those very well-taken points. I agree with you, certainly, on the last point; and on the other two, which are a little bit beyond the purview of this hearing --

MR. MENDENHALL: I understand. I was trying to make a more systemic look at how we could work with some of these other issues.

MR. BLUMENTHAL: I would like to work with you on those points either as part of this process or separately.

MR. MENDENHALL: Yes.

MR. BLUMENTHAL: Certainly, you may know I have taken some fairly strong stands about insurance coverage and HMO coverage on some of these issues; and also with respect to Medicaid funding and hospice, I have also publicly been an advocate, but I would like to work with you on it. Thank you.

DR. HARGUS: I'm Dr. Ed Hargus. I am certified in hospice and palliative care medicine, pain management, through the American Board of Anesthesia, and pain management through the American Academy of

Pain Medicine, the board of pain medicine. I have been a practitioner in pain since about 1985, and I may be the oldest, oldest continuing care pain provider in the state of Connecticut. There may be a couple of guys

still alive. We've been doing this for quite a while, and I established a pain clinic at our local hospital in Southeastern Connecticut many years ago.

I submitted written testimony which can stand, but I would just like to make a few other points here that need to be stressed: One, Dr. Portenoy said the fear factor cut down the prescription usage or prescribers, a fourth to a half of prescribers changed their pattern of writing prescriptions. I think that is absolutely true in the state of Connecticut. I have seen patients almost on a daily basis who were referred because of what I perceive as the fear of the primary care practitioner to take care of the narcotic prescriptions of that patient.

I have seen patients, you know, the last few months when I was in practice, we had a couple of patients back to back, young people who suffered severe crush injuries to their legs and had ample reason to have lots of pain, and they both came in and they both had pain control, and I scratched my head, saying, "Well, that's great. What are you here to see me

for?" And they were here to see me because their regular doctors would not continue writing narcotic prescriptions for them. They had established pain control, but their primary doctors would not prescribe

narcotic medications for them.

And I don't think the doctors are bad people. I think, you know, there is a real fear, these are very difficult patients to take care of. They consume a lot of time, and a lot of paperwork, too, by the way, but they consume a lot of time, and you don't get reimbursed for patients who have terrible problems. You get reimbursed for patients who have five-minute problems. So reimbursement is a big issue regarding some of these things.

So it's a very real, real thing, and I think people don't really realize it. You think you're doing a great thing and a good thing. Well, you may be doing way more harm than good; to save $10 million or so, you may be causing a great deal of harm to people in the state of Connecticut who already can't get pain relief and pain care.

Whether you know it or not, Dr. Duffy mentioned the Donohue study, Connecticut statewide pain study. It took about two years to do. So this is no little ditzel study. This took quite a bit of time.

And it showed these patients, like you said, are grossly undertreated in the state of Connecticut. But it also showed, a point you should be very aware of, that there are few people certified in the state of

Connecticut, pain care, few are certified in hospice and palliative care medicine.

We are looked upon as the experts, yet there are very few of us, and the other docs would maybe like us to be taking care of lots and lots and lots of tons of patients; but you know what? There is only so many hours in a day that we have. So that's a key issue here.

You heard that Yale closed its pain clinic, UConn closed its pain clinic, the University of Massachusetts closed its pain clinic. They are not evil places, but it is tough to do this stuff.

And for the Attorney General, I think there are some legal aspects that no one has even broached here. There are contractual issues between hospitals and pain practitioners. For instance, most of the pain practitioners in the state of Connecticut are certified, I believe, through the American Board of Anesthesiology. Most hospitals you will find, I think, have contractual relationships, exclusive contracts which bar other practitioners from providing pain

services to patients in their communities and their areas. That is not a 100 percent number, but it is -- but it is a reality. And I think that it may be time that those kind of laws and that kind of contractual

relationship should not be allowed to exist in a state or in a part of the country where services are under-represented.

Well, the other thing that -- I don't want to say disturbs me, but the devil is always in the detail, always in the detail. When I read paragraph 5 here, the commissioner shall adopt regulations, blah, blah, blah, electronic monitoring, et cetera, the adoption of these regulations pursuant to the statutes may be initiated upon the passage of this bill, I got terribly worried because this was all great, and then all of a sudden the real details of this and how you -- if this is adopted, it will be the details that will destroy, harm patients, harm pain care or not.

So there was no apparent mention here of oversight, outcomes, who is going to -- who is going to do this, what groups are going to be represented, who aren't going to be represented, who is going to look over this whole process. I think that there is the real, real rub here.

If you establish this, you know, you

think that this will help pain practitioners, and I have to tell you that in the most idealistic world it would help me as a pain practitioner because I would have access to information that I sometimes can't get.

You know, I'll throw out at least one example of a patient I had come in that, you know, that I had a call on, it was a patient of mine for many years with a chronic pain problem on methadone, who seemed to me to be a model patient, and I got a call from someone outside, said, "Oh, he's selling these drugs." Click. I sort of have to worry about that, and I called up, I forget which office, and in the state of Connecticut you have about three offices I can get on the phone and say, hey -- maybe four, if I call the Attorney General.

COMMISSIONER FLEMING: That is almost as hard as trying to get through to a doctor.

DR. HARGUS: I got through that.

COMMISSIONER FLEMING: Because I've had trouble getting through to doctors, but I don't know what it is that you're referring to there. But my agency has not released any draft of any legislation. You're correct, the devil is in the details.

MR. BLUMENTHAL: What do you have there? I'm sorry.

DR. HARGUS: I have an act concerning --

COMMISSIONER FLEMING: I have no idea what that document is. There is an old expression in politics about sausage making and law making. It appears there always is a lot of work to be done, and

the devil is in the details, as you say. Oftentimes what the legislature will do is they'll ask a commissioner to adopt regulations so that individuals such as you will have an opportunity to come before the administrative agency to make sure that we get it right. I can assure you, if we go forward with this, that you will have input into that process.

But I think the other point that needs to be made here is that no one sitting up here is interested in trying to prevent somebody who is in need of this type of medication from being relieved of pain, and we can all tell a story about someone close to us that has experienced pain. I watched my sister die from cancer, so I can assure you, she received an award in this room from a previous governor for her courage from the Connecticut Cancer Association. So don't misinterpret some of the motives. But if you had an opportunity to see some of the things I've seen on the streets in the community where abuse of these substances can destroy a community, then you would understand why we're trying to balance these two needs.

My agency has responsibility to legitimately regulate the use of these drugs, and I've seen what good they can do in the case of my sister and I have also seen the terrible harm they can do in a

community in some of our urban areas when somebody does abuse it, in some case a doctor who has sworn to do no harm abuses. What we're trying to do is find that common ground and want to work with you to do that. So try to keep that in mind.

It's not an easy process. It won't be easy for the legislators that sit up here and will have to decide how best to do that and to the extent to give the commissioner the authority to adopt regulations to make it work.

DR. HARGUS: Well, I may be unduly paranoid, but I think with good cause. I had a complaint filed against me years ago by a patient stating I addicted that patient to narcotic medications. This is a patient with RSD, severe RSD. Eventually totally cured, eventually back to work, everything, who saw a psychiatrist, truly got a multi-disciplinary approach, who refused to go into a substance abuse counseling session. It took the Department of Consumer Protection, it took them 14 months to get an answer to me as a physician.

How do you think I felt for 13 months? How do you think other doctors, you know, we're human beings too, our profession depends upon our license, and if there's any -- any problem with our license,

whether it's true or not, you risk your livelihood. I think that's a very real threat to people. So you have to be extremely careful with your legislation.

MR. BLUMENTHAL: We want to thank you for being here today. We have other people who have waited for a while to talk to us, and we appreciate your talking to us. Thank you very much.

I'm going to go a little bit out of order. If James Giglio is here. Since you've come all the way from New York and we're running a little bit late, I'm going to go to your point on the schedule.

Thank you for joining us.

MR. GIGLIO: Thank you for inviting me. My name is James Giglio. I'm director of the New York State Bureau of Controlled Substances. Thank you for the opportunity to present New York State's experience in curtailing the trafficking and abuse of illicit and controlled substances. We are flattered that you would consider New York to share our program with you while you develop your own.

New York has found no problem, no

activity as effective dealing with this problem as our own prescription monitoring program. Our program currently exists of an official form and electronic monitoring. In New York State, regulation of illicit

controlled substances is the responsibility of the Bureau of Controlled Substances.

The bureau is located within the Department of Health and is charged with the administration and enforcement of the New York State Controlled Substances Act, those substances which are prescribed, administered, dispensed and are valuable in the treatment of illness and disease. As such, these medications must be accessible to those who need them. However, when abused or used improperly, the same medications also have a potential to cause drug dependency, personal injury, impairment, and even death. It is the bureau's responsibility to assure that these drugs are accessible for legitimate medical purposes while at the same time preventing diversion and abuse.

This is accomplished by monitoring and regulating illicit and controlled substances from the point of their manufacture and distribution, through prescribing and dispensing and ultimately patient use. The major focus about the bureau's activities and the

ones I've been invited to give testimony before this panel today is New York's official prescription program.

Since 1972 there's been required

prescription for Schedule II controlled substances in New York, be prescribed on an official New York State prescription form, and substances such as Valium, Librium, also be prescribed on the official forms. The prescription forms are issued to licensed practitioners in multiples of 25, imprinted with the practitioner's name, address, phone number, and a sequential serial number. With each prescription order, practitioners must indicate their specialty. This specialty is taken into consideration when evaluating an order.

Before issuing the forms, which cost practitioners $12.50 for a book of 25, the bureau verifies that the practitioner is currently licensed by the state and appropriately registered with the Drug Enforcement Administration, the DEA registered address. Registration information is updated quarterly with data supplied by DEA and the New York State Department of Health.

From 1972 to April of 2001, the bureau issued a three-part prescription consisting of an original and two carbon copies, commonly referred to as

a triplicate. The way that system would operate is this: The prescribing practitioner would complete the prescription and retain one copy for his or her records. The patient would then take the original and

one copy to the pharmacy to be filled. The pharmacy would mail the remaining paper copy to the department, where the prescription information would be stored and made accessible for monitoring and analysis.

On May 1st this year, pursuant to landmark controlled substances legislation which, significantly, addressed pain management needs, legislation went into effect in New York State for prescriptions on a single-part form. The new form has security features to deter scanning and photocopying. It has a heat-sensitive ink component. If an attempt is made to alter the prescription with water or chemical solvents, the word "void" appears in three different languages. It also has a rub-off feature on the front which the word "void" appears. Instead of the dispensing pharmacy having to mail in paper copies every month, the required prescription data can now be submitted to us electronically.

To date, over 95 percent of New York pharmacies have been certified to submit prescription data electronically, either by tape, diskette, or

encrypted over the Internet to a secure Web site. Those pharmacies not submitting electronically are required to submit data manually on a form provided by the bureau.

We are currently nearing the end of a transition period during which both triplicate and single-part forms are valid for use. After December 31st, the triplicate will become invalid and all official prescriptions must be written on a single-part form.

The new system is already providing advantageous -- I'm sorry -- is already proving advantageous to the bureau in its prescription, dispensing, and diversion concerns. Under the old triplicate prescription system, prescription information from mail copies had to be data entered, which created backlog and put limits on accessibility. Now with the vast majority of prescription information being submitted electronically, prescribing and dispensing data can be accessed virtually on a real-time basis.

I was going to go through a couple of the programs or couple of reports that we can generate, but for time I'll just skip over that.

MR. BLUMENTHAL: Thank you.

MR. GIGLIO: It is sometimes argued that official prescription monitoring programs interfere with or inhibit the legitimate prescribing and dispensing of controlled substances to meet patients'

medical needs. Several years back, the bureau undertook a review of its official prescription data. We found from 1984 to 1994 that prescribing of Schedule II opioids, hydrocodone increased by 25 percent and morphine by 661 percent. This data led us to conclude that practitioners have prescribed and continue to prescribe controlled substances that are appropriate for their patients.

Confirming this is forms the bureau issues annually to practitioners. In 1989 when we placed benzodiazepines on the official form, we were issuing some 3.4 million forms per year. This year we anticipate issuing approximately 7 million. This demonstrates the effectiveness of New York's prescription monitoring program.

We recently received a report from the Drug Enforcement Administration regarding the consumption of OxyContin on both a state and national basis. Data reveals that in New York State OxyContin consumption per 100,000 population was below the U.S. average in both 1999 and 2000. Of the 54 U.S. states

and protectorates for which data was provided, New York ranked 50th in consumption for 1999 and 49th in consumption for 2000.

We believe that these facts are not a

coincidence. We believe that oversight afforded by our prescription monitoring program curtails the diversion not only of OxyContin in New York but also of the other drugs required on the official form.

Finally, I would like to commend this panel for recognizing the threat to public health and looking into ways by which it can be prevented. As both professionals and private citizens, we are all in this fight together. My hope is my presentation today of the success of New York's prescription monitoring program assisted the state of Connecticut in implementing one of its own. Thank you.

MR. BLUMENTHAL: You have definitely assisted us, sir, and thank you for being here. We would like to get back to you to learn more about your program as we move forward. Thank you.

MR. GIGLIO: By all means. Thank you.

MR. BLUMENTHAL: Lori Zehe.

MS. ZEHE: Hi.

MR. BLUMENTHAL: Good afternoon.

MS. ZEHE: Good afternoon. How are you?

Mr. Blumenthal and Commissioner Fleming and the other members of the panel: I'm pleased that I was invited to be here to speak with you today about the issue of prescription drug abuse.

For those of you I don't know, I do not know, my name is Lori Zehe, and I am the executive director of Capitol Area Substance Abuse Council which covers 16 towns west of the Connecticut River, including the city of Hartford. I've been working in the field of substance abuse for the last 12 years; 8 here in Connecticut and 5 in Ohio.

The issue of prescription drug abuse is not new. It's been a reality for a number of years, for many decades, as a matter of fact. However, the recent rash of deaths due to OxyContin abuse has pushed this issue to the public -- into into the public eye. As with many drugs of abuse, the ability to snort the drug of choice makes it much easier for an individual to use rather than to be selective or take the length of time that it takes to digest the drug. And this has resulted in a number of younger people experimenting with drugs such as OxyContin and other prescription drugs and becoming addicted to many of them.

As we move forward looking at public policy, we need to keep in mind that OxyContin is only

one of many prescriptions that are abused. We need to be measured in our approach to avoid throwing out the baby with the bath water. None of us are for that. These drugs are effective when used as prescribed.

OxyContin is considered a Godsend for many seriously ill individuals, especially end stage cancer patients for whom prescription drugs delivered on a four-hour schedule are not sufficient for pain management.

We must balance the need for pain management with the propensity for misuse and abuse. In speaking with my colleagues across the state, we are aware that young people are abuse -- well, young people and older people are abusing OxyContin and other pills and are paying for them in many ways: They are stealing them from parents' or relatives' medicine cabinets, they are buying them on the streets, they are writing prescriptions from a parent's prescription pad if there is a child of a doctor. They're also being prescribed often for teenagers who have had things such as knee surgery. I don't know how appropriate that is.

I also learned in the last few days that there is another way that young people are obtaining prescription drugs, and that is many of them are trying to get jobs as pharmacy technicians, because there is

no current regulation of pharmacy technicians, from my understanding, and it is very easy, if they are counting out drugs, instead of putting 60 in a bottle, pocketing a couple in their pocket. I did just learned

this from one of my staff members who works with the community and works with young people who are abusing drugs.

Frequently they divide the pill into quarters and take it with alcohol, creating a synergistic effect. More often the pills are crushed and inhaled, creating a quicker and more intense high.

Another source of prescription drug abuse that I don't know if anyone talked about today, it is well-known that many seniors have a tendency to share their prescriptions with others: "This worked for me, so, here, you should try this." In most cases, it's done innocently without malice, but totally unaware of the consequences of taking prescription drugs that have been prescribed for others.

What would a reasonable approach be to reduce prescription drug abuse? I brought you a few suggestions that I hope are helpful to this body.

First, effective prevention and education. We'll never end the abuse of drugs by eliminating them. The only way we will succeed in

reducing drug use is by reducing the demand for drugs. Effective substance abuse prevention and education programs are necessary. They're necessary to target specific populations of students, parents, teachers,

youth workers, social workers, and others.

Substantial research has been done on prevention programs in the last 10 to 15 years. We now know what works and what doesn't work. We also know that we must use multiple strategies and multiple domains with consistent booster sessions: Public awareness, information dissemination, education, capacity building within our communities and individuals, alternate activities, environmental and policy change, which is what you are looking at, and early intervention.

Unfortunately, prevention programs have been traditionally underfunded. Just as an example, my own organization, which is one of 13 regional action councils, was cut three times in the fiscal year '02 budget. Our core funding was a base funding of $75,000. That's now down to a little over $50,000. So we have to continue to look elsewhere for funding.

We also in the state of Connecticut have an excellent system of local regional -- whoops, I'm sorry -- local prevention councils in every state --

excuse me -- in every city and town in the state. And so no one else has that kind of infrastructure, but those local prevention councils that work in our town, town officials, residents, parents, and students are

also underfunded. They receive from 1800 to $10,000. They have not had an increase in ten years.

Public policy has to change to provide sufficient resources dedicated to prevention efforts if we're going to impact the issue of prescription drug abuse.

Second, we need to look at early warning symptoms -- systems. In Connecticut we need to establish an early warning system that alerts all parties to the latest drugs of abuse. Nationally the Drug Abuse Warning Network utilizes information submitted by hospital emergency rooms across the country. As far as I know, at this time there are no Connecticut hospitals in that network. Connecticut needs to establish some type of warning system for emergency rooms in order to spot trends in drug abuse as they emerge. This is not only true of prescription drug abuse, but it's true across the board.

I also do a lot of work with inhaling abuse. Again, the state of Connecticut has no reporting system. So we only find out about the

emergency room deaths and such through other sources.

Third, we need to look at regulation and enforcement. While we do not want to discourage physicians from prescribing drugs for the appropriate

patients or pharmacies from stocking them, there is a need for improved regulation. I would recommend five steps.

The first regulation should be tightening and enforcing what we have, those regulations on prescribing and dispensing prescription drugs that are already in place here in Connecticut.

The next step should be developing or enhancing a system of monitoring prescriptions by individuals and physicians.

In addition, physicians should be better educated on prescribing these drugs cautiously, as the earlier example I gave you of a young student who received OxyContin for knee surgery. I don't know if that was appropriate or not. Just need to hope that the doctor did do it appropriately.

Pharmacists must be thoroughly trained in identifying forged prescriptions, as well as improving the storage of those drugs subject to theft and misuse. With our new, modern technology, maybe the time has come to develop a new method of writing

prescriptions that make it less likely that they can be forged. This would also eliminate the errors in dispensing prescriptions that occur due to, not to insult any physicians, but the notorious handwriting of

physicians.

In addition, we should look also to those talking about pharmacies that this whole issue of pharmacy technicians, having kids who are already using drugs trying to get those jobs is a concern, and how can we tighten up that system.

The final step, manufacturers should review the composition of these drugs just to determine if there is a way to reformulate them to achieve the same results for the patient while making them less susceptible to abuse. This also includes manufacturers giving clear instructions to the physician, the pharmacist, and the patient.

Lastly, the fourth issue that we need to look at is treatment. Last, by no means least, is the availability of treatment services on demand. Those unfortunate individuals who succumb to the lure and addiction of drugs must be provided with treatment services at the appropriate level of care for their particular situation. When an addicted individual recognizes the need for treatment, he or she is

motivaed at that point. Telling somebody they've got to wait for two hours, two days, or two weeks, and many times more, is unacceptable because at the next craving, the addict will overcome his ability to resist

and a precious moment of opportunity is lost.

Here again, there is a lack of treatment services at all levels. Waiting lists are common. Efforts have been made to improve services in the state and in the Hartford area, but we continue to be unable to place individuals in treatment.

On the adolescent level, which really concerns me much, the picture is even bleaker. Adolescent drug abuse is not recognized by parents or teachers. Schools attempt to deal with the behavior problems that result but are hesitant to refer a child for a substance abuse assessment. It's my understanding if the school identifies the problem as substance abuse, they are then responsible for the cost of special education and treatment services. With school budgets as tight as they are, educators are extremely reluctant to incur those expenses.

Those are the recommendations that I bring before you that I tried to gather from my own work, my staff, and my colleagues across the state; and in conclusion, I would just like to applaud you, Mr.

Blumenthal, Commissioner Fleming, for making a priority of this issue of prescription drug abuse, and also after hearing some of testimonies today, I'm sure that you on the panel really need the wisdom of Solomon, and

I hope that you come close to achieving the right mix, and that you use every tool available to you to come to a reasoned approach to this issue.

MR. BLUMENTHAL: We want to thank you for being here. We will be sure to call on your wisdom again. Thank you.

MS. ZEHE: Thank you.

MR. BLUMENTHAL: Carl Mahler and Steven Levin, please.

MR. MAHLER: Hi.

MR. BLUMENTHAL: Thank you for being here.

MR. MAHLER: Good afternoon. I promise I will be brief.

My name is Carl Mahler. I'm a nurse. I am the vice president for the Hospice Council of Connecticut. It is called Hospice and Palliative Care of Connecticut. I represent the 27 Medicare certified programs that provide for over 8,000 patients who died in our hospice programs last year.

These terminally ill families and

patients choose hospice care because these programs offer excellent pain and symptom control, education and choices. They allow dignity and control over the quality of life time. The interdisciplinary team of

experts that provides this care includes the patient's primary physician, the nurse, the social workers, the home health aide, the trained volunteers, clergy and bereavement counselors. All these volunteers work together to palliate not only their physical symptoms that arise when a loved one is facing the end of life.

Pain can be the most disruptive symptom and yet the most treatable one as we've talked about today. There is an enormous amount of education that happens when patients are placed on a hospice program. There is a lot of education that families are fearful of addiction and of the very large doses of medication that are provided at the end of life to make those patients comfortable. There is a lot of education about the physicians, as you've heard today. Many physicians are very hesitant to order more pain medication because they are unfamiliar with the dosing requirements of the terminally ill patient in pain.

Whatever this legislation accomplishes, it must not negatively impact the hospice patients, as you have said. We agree with that. There is a

concern, however, that physicians must not become hesitant to properly prescribe or paranoid of the oversight the legislation may propose. They may be afraid to treat the patient appropriately.

Additional concerns that we would present for your consideration are: That when the legislation, if it is presented and approved, that the physicians have a lot of education around the details. Some physicians will just hear this new law and cringe. When the legislation is communicated, it should reassure the prescribers that pain management is not being targeted, that the targets of this legislation are the practitioners who sell for their own gain.

The other concerns that we have are about patient confidentiality, also about the monitoring, what type of ongoing monitoring will occur to assure that this legislation has no detrimental effects on patients' pain control. Will the monitoring body include experts in pain control to speak to adverse effects if and when they are identified?

Finally, we understand that prescriptions will not be monitored in hospitals. Will that in fact then encourage physicians to just admit patients to the hospital because there they won't be

afraid to prescribe the larger doses of medications? Is this, then, the best place to aggressively treat pain? Most hospice patients prefer to be at home and to live there until they die.

Thank you for this opportunity to voice our concerns. I think we all agree that the patient has to be our first consideration and their comfort and how this legislation may affect them.

MR. BLUMENTHAL: Thank you very much.

DR. LEVIN: Good afternoon. I admire your fortitude for plowing through all this.

MR. BLUMENTHAL: Thank you for your fortitude. I noticed both of you have been here most of the day. Thank you.

DR. LEVIN: My name is Dr. Steven Levin. I currently practice in New Haven, Connecticut.

I share of the views of the care providers that have testified today.

Since arriving in Connecticut in 1997, I have been actively involved in pain education and patient advocacy through my associations with the Yale University School of Medicine, the American Cancer Society, the Connecticut Cancer Pain Initiative, the Connecticut Hospice, and the American Society for Law, Medicine and Ethics as well as numerous national

societies that focus on improving treatment.

Despite the increasing awareness of the importance of properly evaluating and treating pain, efforts to provide sufficient medical resources have

been lacking. There are many barriers to the management of pain, including inadequate training of health care professionals, poor communication between patients and providers, the fear of regulatory scrutiny by health care providers. Perhaps the top reason that patients refuse treatment and are fearful of providing treatment is fear of addiction.

The medical community is slowly evolving understanding of the nature and magnitude of this epidemiological crisis that has led to incomplete treating of caregivers in general. The American Society for Law, Medicine and Ethics conducted a pain management study in Connecticut which presented the results of a public conference in December of 2000 at the Connecticut Hospital Association. This conference confirmed that most of the physicians feel equipped -- this survey confirmed that most physicians feel ill-equipped to offer pain management control to their patients. Meanwhile, the medical schools in Connecticut have felt compelled to reduce their commitment to clinical pain management services and

physician training, apparently because of financial concerns. Unfortunately, this reduction in academic pain management resources comes at a time when expansion of these resources is needed.

Many physicians report that they are aware of other physicians who have been subjected to disciplinary proceedings for prescribing opioid medications and this has made them more conservative in prescribing medications for their patients. Review from public records from 1980 has shown that only a handful of cases involving disciplinary action have occurred relating to the treatment of pain, contrary to the general perception of physicians. Assuming the public record is reflective of the actual number of proceedings against physicians for prescribing opioid medications to treat pain, we might conclude that the appearance of the regulatory oversight can have a chilling effect on treatment.

Recent news reports have focused primarily on addiction and abuse of pain relievers. These reports unfortunately contribute to the under-treatment of pain by reinforcing misconceptions and may harm the quality of life for patients. Since addiction is a common fear that patients hold, such a fear may prevent them from taking their prescribed medicine.

I've had examples of this within my own family. It may cause family members to encourage people to not seek treatment. Fear of addiction seems unfounded to this magnitude for patients with pain, as numerous studies

have shown that less than 1 percent of patients actually suffer addiction. And while we should not ignore the possibility of addiction, we should view these concerns in light of nearly 30 percent of our population that may suffer significant chronic pain symptoms. Evidence in support of appropriate pain treatment details improved quality of life for patients and decreased medical and disability costs for society.

As we attempt to resolve concerns over pain medications abuse and diversion, we must be careful to allow and promote access to appropriate medical care for legitimate patients. Basic fairness compels access -- to protect access to medical treatments to the many people who require them and not punish them for inappropriate or illegal misuse of these treatments by others. Our collective actions in this regard must be undertaken with the acknowledgment that chronic pain and cancer pain touch our lives, those of our friends, and those of our family.

The proposal for the electronic monitoring of controlled substances has several

theoretical advantages in helping patients to identify -- I'm sorry -- identify patients who may not be taking medications appropriately or in identifying physicians who require continuing medical education.

First, should real-time prescription information be made available to physicians attempting to monitor compliance in patients on opioid medications, and deviations from structured care plans could be detected earlier. Secondly, prescription patterns could be monitored regionally and information about high-risk areas could trigger more intensive surveillance in these high-risk areas. Thirdly, such a system could help to identify knowledge barriers that could trigger CME for care providers. Continuing medical education, that is.

However, the proposed electronic monitoring system raises concerns, not the least of which is a possible chilling effect on appropriate patient care if such is seen as a mechanism to promote disciplinary action against care providers. Also the system could create inadvertent barriers to patient care if it is overly burdensome. Therefore, the implementation of the system should come only after testing confirms that reporting is an efficient and economical process. Finally, the system that appears

to be proposed may not provide the rapid feedback that physicians could utilize in improving monitoring of compliance of patients.

I would reiterate that Congress has

designated this as the "Decade of Pain." This is an opportune time for everyone concerned about this privilege to step forward and offer to help spread the facts about pain relief.

There is a strong societal interest in assuring appropriate use of controlled substances. I believe that potential misuse of controlled substances has and will continue to overshadow and impede proper pain management if we're not careful. Efforts to improve public safety against misuse and diversion of opioid medications are important, but should not come at the expense of this continued challenge of continued treatment.

I thank the panel for its attention to this important issue and allowing me to share my thoughts on this issue. And in particular I would like to thank Attorney General Blumenthal for the actions that he has already taken on behalf of a number of my patients. I am happy to report to you that these actions have resulted in favorable outcomes and has in one instance saved a patient at risk of undergoing

potentially life-threatening treatments.

I'm happy to share these success stories with you. I look forward to working together and in ways we can share many other success stories together.

MR. BLUMENTHAL: Thank you very much for being here. I hope we will continue to have opportunities to work together and create more success stories. Thank you very much.

We are very sensitive to the concerns, as you gathered from sitting here, that both of you have raised so cogently today. Thank you.

Our last witness today is Jeffrey Casberg.

MR. CASBERG: Good afternoon.

MR. BLUMENTHAL: Good afternoon.

MR. CASBERG: Again, my name is Jeff Casberg, Director of Pharmacy Services, ConnectiCare.

I would like to thank you for allowing us to participate in this forum. Just a couple of brief points.

First I'm a licensed pharmacist in the state of Connecticut, practicing in the state of Connecticut for the last seven years. So I have some expertise in this in promoting appropriate use of medications for members.

I will make three brief points and keep it brief here. Number one is ConnectiCare's concerned about the appropriate use of controlled substances; number two, we're concerned that any legislation passed

would inhibit the access to needed pain medication at the point of sale; and, number three, we would like to offer continued assistance in developing any legislation in the future.

In the point of appropriate utilization, abuse of controlled substances is not new to health care professionals. It's been going on for years and years. As we have seen from other witnesses in other states, there are controls around the utilization of controlled substances in other states. So I am interested in participating in the development of this for the state of Connecticut.

I think the abuse of OxyContin in the last couple years has increased dramatically, which has brought us to this legislation right now. This topic, actually, we have a committee that meets quarterly of about 10 physicians from the state of Connecticut, some of the physicians may serve yourselves. We meet quarterly, we discuss their use of medications for all of our membership. There are 275,000 members in the state of Connecticut.

We met two months ago on this very issue. We discussed OxyContin, and we raised four proposals. I will tell you what they actually proposed. The first one we proposed was at the point

of sale to allow the initial prescription to come forward for 60 tablets or so, which allows them to walk out the door of the pharmacy with a prescription and at a later point request medical necessity criteria for continued use. That was the first.

The second one is continue what we have currently done for several years: Retrospectively look at prescriptions for our clients and develop thresholds as so much prescriptions per member per quarter, number of doctors they have seen, type of medication used, and then eliminate unnecessary reporting physicians through looking at other diagnosis criteria such as cancer or other things such as that. Then once we develop that, send that out to practitioners, describing to them which possible patients could be abusing the medications.

So we've been doing that on a quarterly basis for several years. That was probably number two, retrospective drug review.

Third was a similar non-physician focused education, but towards the member. It would be

a little softer. Basically running an electronic data, looking at members who basically are pharmacy shoppers, members who go to several pharmacies, getting different types of medications, trying to avoid edits at point of

sale, and sending members who do that educational points why it's best to use one pharmacy, why it is better to use one pharmacy rather than multiple pharmacies.

Number four is to do increased education to physicians.

After presenting these four proposals to our physicians on the committee, the final proposal was to stay with what we had currently been doing. Not to put point-of-sale edits in, but to remain with the retrospective drug utilization review with possible abuse potential with some of their patients. The committee decided they do not want their point-of-sale edits appropriate especially in the realm of pain where it is an acute need where they need the medications at that time. And after reviewing the number of patients on these medications, it was felt it was abuse, but the abuse is the exception rather than the rule, and that in our current situation with retrospective drug review that can address this, rather than putting additional stops at the point of sale or physicians or causing

increased paper hassle.

So that is a summary of why we decided to stay with what we are currently doing. And ConnectiCare is concerned about putting legislation

around electronic edits and would be more than willing to work with you on developing and providing our expertise in this area.

MR. BLUMENTHAL: Thank you very much.

I think we're done with the witnesses that we had scheduled. We may well want to schedule another such informational hearing, and I stress that it has been informational. It's provided a lot of very useful insight and data to us, and I hope to members of the public, and we want to thank everyone who has participated.

COMMISSIONER FLEMING: Also, I'd like to thank the Attorney General for organizing this. It's been very helpful to me. If my agency decides to go forward with legislation on this topic, much of what was said here today will help us to develop whatever the legislature decides they want to take up during the short session. So I appreciate everybody coming out and giving us your thoughts.

MR. BLUMENTHAL: Thank you all.

(Public Hearing adjourned at 1:53 p.m.)

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