HB No. 5250 AN ACT PROHIBITING REQUIREMENTS FOR PRESCRIBING CLININCALLY INAPPROPRIATE QUANITIES OF OUTPATIENT PSYCHOTROPIC DRUGS

INSURANCE AND REAL ESTATE COMMITTEE

Public Hearing: February 27, 2020

Testimony: **IN SUPPORT**

Co-Chairs Lesser and Scanlon, Vice Chairs Hartley and Datham, and Members of the Committee:

I am Sheryl LaCoursiere, PhD, PMHNP-BC, FNP-BC, APRN, a dual board certified Psychiatric-Mental Health Nurse Practitioner, and a Family Nurse Practitioner trained in Primary Care. I am a faculty member at Yale School of Medicine and CEO of Integral Psychiatric Services, based in Southbury, CT. My clinical psychiatric training included a number of venues including inpatient and outpatient care at the Institute of Living in Hartford, Yale-New Haven Hospital Crisis Intervention, and the Department of Veterans Affairs PTSD clinic. I have also had extensive training in suicidality.

Vice Chair Hartley, I have been a resident of your district in Waterbury for many years. Representative O'Neill, my practice, Integral Psychiatric Services, is located in the town of Southbury. Many of my patients hail from both of your constituencies, as well as those of Representative Poletta's from Woodbury and Watertown, and Senator Kelley's from Monroe.

I would like to make a number of points related to this bill:

(1) **Out of pocket**. I object to the current scenario where insurance companies are allowed to dictate the number of pills I must prescribe- or they will not cover them, leaving the only alternative for the patient to pay out of pocket. As it is, many pharmaceutical companies have "co-pay cards" that enable the patient to receive 30 days of prescribed medication for a lesser amount, such as $10. Compared to 90 days, this is a bit of a relief, but still a clinical problem for reasons described in #5 below.

(2). **Medication-Naïvete.** I am most concerned for those patients who are **"MEDICATION-NAÏVE."** These are patients who have not been prescribed on a psychotropic product before, and their reaction is unknown. They are at higher risk for suicide and require closer monitoring.

(3). **Dis-incentive and Diversion**. Once the patient has been given 90 days of a medication, there is a significant **DIS-INCENTIVE** for them to return to appointments. Even if they don't take the medication themselves, having a large quantity of medication promotes **DIVERSION** to family members, friends and significant others. For those who are not in stable home environments, these prescriptions can be used as currency for other medications. As the first location of my practice was near the green in downtown Waterbury I witnessed this first hand. Combined with our current worry about the opioid crisis, extra medication causes an unnecessary risk for poor health outcomes. I ask our legislators how can we be talking about the opioid crisis on one hand, while allowing access to medications affecting psychiatric functioning on the other hand?

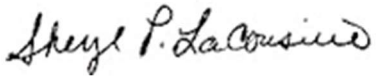
(4). **State Employee Plans.** Although there are several insurance companies that require 90 day prescriptions, a major user of this requirement that should also be mentioned is **STATE EMPLOYEE PLANS.** I have had a number of patients who would obtain 90 days of a medication, then cancel appointments until the bottle was about to run out. Thus, the patient was not being monitored at that time, putting the practitioner in a difficult position.

(5). **Role of Appointments, Titration and Cross-Titration**. It is these appointments in between the 90 days that are so very important. At the appointments, patients are assessed on their levels of anxiety, depression, suicidality, and homicidality, with medications adjusted as needed. Many of the prescriptions are antidepressants, which take two to four weeks to reach a steady state in the bloodstream. If the medication is **TITRATED** (adjusted) up or down, a new prescription is given. If the patient requires a different medication the old one must be **CROSS-TITRATED**, requiring multiple prescriptions of possibly several weeks each in decreasing doses so as not to destabilize the patient. Requiring 90 pills each time leaves the patient with stockpiles, which many of them **DO** have.

(6). **Impact on the Elderly**. I have numerous patients from Heritage Village, which as many of you know is an age 55+ retirement community in Southbury in Representative O'Neill's district. Senator Kelly, we had met last July 10 at the Western Connecticut Area Agency on Aging Elder Abuse Seminar in Litchfield, and I greatly admire your work on the Aging Committee. The elderly with mental health problems are disproportionately impacted by having extra medications. Problems occur because many times medication doses are lower because of potential lethal effects on the liver, kidneys and other organs. In addition, as individual age, they are typically on more medications, thus increasing the potential for confusion. They are also more likely to begin medications for cognitive decline. If the elderly person has assistance with the set-up of their medications, whether it be family members or home health caregivers, the potential for diversion again also increases.

Leadership and Members of the Committee, I urge your support of this bill, to tighten the controls on access to these important medications. Psychotropic medications need to be differentiated from other routine maintenance medications such as antihypertensives for blood pressures and statins for cholesterol, and be valued in their own unique role for the powerful uses they have in mental health. Please let me know if you have any questions.

Sincerely yours,



Sheryl LaCoursiere, PhD, PMHNP-BC, FNP-BC, APRN
Faculty, Yale School of Medicine
CEO, Integral Psychiatric Services
2 Pomperaug Office Park, Suite 105
Southbury, CT 06488
Email: sheryl.lacoursiere@yale.edu
(203) 597-8155