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Selecting an Official Testing Laboratory: Value is Not the Low-Cost Option

MODERATOR:
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SPEAKERS:
Dr. Dionne Benson: Executive Director and COO, Racing Medication and Testing Consortium
Dr. Mary Scollay: Equine Medical Director, Kentucky Horse Racing Commission

Ms. Wendy Davis: All right. Even though we're not quite done next door, we're gonna go ahead and get started.

Steve said he looked around, and I think all the important people are here, so we're just gonna go ahead and get going.

I think this is gonna be a really interesting panel.

It's one that was suggested to us, and we thought it was definitely the right way to go.

I think you know everybody up here, but just briefly I'd like to thank our panelists and Steve Koch. Now we can start. Alex is here, we're good.

[Laughing]

I can quit hemming and hawing. Steve, thank you so very much for moderating this panel, and thank you Dionne and Mary for being on it. Hopefully we'll get a few more people coming in. I'm gonna turn it over to Steve now.

Mr. Steve Koch: Good afternoon. I'm glad to be with you today to share our message at the NTRA regarding the Safety and Integrity Alliance.

More important than that, we're here to discuss what it means to assemble an effective drug testing program that delivers best value to your drug testing dollar.

I'll open with how the NTRA Safety and Integrity Alliance are making a positive impact on our horse racing.

I'll finish with an announcement and an explanation of our latest update to the code of safety and integrity standards that's very relevant to the laboratory's topic that's in front of us today.

Then following my discussion we're gonna turn it over to Dr. Dionne Benson. She's going to explain the role of the RMTC as an expert resource as establishing drug and medication testing standards.

She'll detail for us some pitfalls that are possible as a regulatory body shot for and sign operating agreements with her official testing laboratories. Then we're gonna turn it over to Doctor Mary Scollay.

Dr. Scollay is the Equine Medical Director for the Kentucky Horse Racing Commission. Dr. Scollay is long experienced as a veterinarian, and most importantly as a regulator means she can talk about the very complicated and typically conflicting realities our regulators face as they shop for official drug and medication testing services.

Indulge me for a couple minutes. I'll give you a quick history, how or more why did the Alliance form?

In the mid-2000s racing may have been at its low point. Barbaro breaks down in the Preakness; Eight Belles is second in the Kentucky Derby, euthanized right on the racetrack.

Big Brown admits he's on a regular rotation of anabolic steroids. Congress comes knocking on our door, and knowing the industry is really well organized to answer their questions. We were making the front page of the national newspapers, and for all the very wrong reasons.

By 2009 the Safety and Integrity Alliance, along with a host of other initiatives is in full gear to demonstrate to the industry, to government, to our horsemen, our stakeholders that horse racing really can reform itself.

Our mission, the health and safety of our human and equine athletes and the integrity of our sport are horse racing's top priorities.

The Alliance promotes national uniform high standards for safety and integrity that are subsequently adopted at the tracks across the nation in pursuit of that gold standard that we call an accredited race track.

Application for accreditation occurs every two years, and tracks not meeting those standards, health and safety code of standards can lose their accreditation.

This industry of self-regulation approach, it's not unlike the Joint Commissioners International that is used in the healthcare industry.

This map details our current list of 23 accredited racetracks. These tracks stretch across North America. They host 90 percent of our graded stakes, 70 percent of North American wagering.

They are each to be congratulated for their emphasis on safety and integrity, and they're rightfully proud to be on board with us. The code of standards adopted by the Alliance is updated annually. Those updates are gleaned through the previous year from individuals, expert entities across the industry and it's heavily driven by the RCI model's rule process.

The updated Code of Standards must be approved each year with a board with numerous representatives from the industry, expert bodies that represent a very broad cross section of this industry.

By updating the code annually and by strictly adhering to that bi-annual reaccreditation process we can be sure that tracks are continuously improving.

The best practices that we see today should become the minimum standards of tomorrow. The idea is continuous improvement for the industry.

The Code of Standards that a track must achieve for accreditation is extensive and it covers six broad areas.

For today's purpose we're really gonna concentrate on section number three regarding medication and testing.

Today we're going to announce — we are announcing an update to the Safety and Integrity Alliance Code of Standards.

We are adding a subsection titled Laboratory Selection and Performance Standards. Before I go very far on that, quick background.

Most of us here are plenty familiar with the RMTC, and what is the laboratory accreditation program.

RMTC accredited laboratories have long been a stipulation of the Alliance Code of Standards.

In more recent history though, this year, we've experienced some industry missteps, where we have sometimes misunderstood the difference between laboratory accreditation and laboratory performance.

This September 2015 article from the Guardian explains it very well when it says "the success and rigor of each racing jurisdiction's drug testing program is dependent not necessarily upon the accreditation status of the laboratory, but on the particulars of the contract they, regulators, have with each laboratory."

In short, the RMTC laboratory accreditation ensures the official testing laboratory is capable of the industry's highest standards.

However, it is your regulator's signed operating agreement with that laboratory that dictates how the actual — the laboratory actually executes on your drug testing program.

Failures we've seen recently sometimes relate to the pitfalls of these misaligned laboratory services agreements. There's good news that the RMTC has existing resources to assist our racing commissions with their RFP and contracting processes.

This document pictured here is available on the RMTC website, and it's a critical resource for our racing commissions, and I anticipate that Doctor Benson will discuss this at length in just a couple minutes.

Now that we've got that foundation, I present our latest update to the Code of Standards.

In brief, we've added a section calling on our racetracks to renew their awareness and involvement in their local regulatory — regulators laboratory selection process.

It reads in brief as follows: Members shall insist that local regulatory authorities implement industry performance standards and quality control mechanisms consistent with RMTC's model request for proposals for equine drug testing laboratory and their official testing laboratory selection and performance criteria.

The Safety and Integrity Alliance is here to help.

We continuously provide effective advocacy resources, not just in our 23 accredited tracks, but in several additional jurisdictions working towards future accreditation status.

We frequently interface with various racing commissions, horsemen's group, lawmakers, so on, in order to educate about the industry's safety and integrity standards, and we do help reinforce steps to achieving these national standards.

We have access to expert resources that can offer advice on the set up design and contracting process for your local testing program and operating arrangements, so call us any time we are at your service.

For my part, I'm quite proud to be on board at the NTRA Safety and Integrity Alliance where daily we truly are a positive change agent for this industry.

I thank you today for sharing your time with us, allowing this opportunity to spread that important message that is the Safety and Integrity Alliance and for the Racing Medication and Testing Consortium.

That said, I'm gonna turn the podium over to Doctor Benson, and then Doctor Scollay will take over.

Dr. Dionne Benson: Just give 'em a minute to get my presentation up.

Good afternoon. Thank you for inviting me to speak on this issue.

I know there have been a lot of questions about — excuse me, about laboratory testing and proficiency in regards to the RMTC Program.

Good on the slide show. Go to the stop. Go to slide show, two over.

No, to the right, to the right. Go to the right. There. Then from beginning.

There you go.

Okay. Let's talk for a second about laboratory accreditation. Laboratory accreditation by the RMTC is one of the four parts of the National Uniform Medication Program. I've listed the other parts there.

I know many of you are very familiar with these, and as a whole it is a package that we have to move the industry forward and really bring us into the next level, while protecting the integrity of the sport and the health, welfare and safety of our participants, horses and humans alike.

The goal of the RMTC Accreditation Program, as Steve touched on is to ensure that laboratories can perform at the same high level of proficiency.

The good news is we have labs that have the capability to perform very well. We have an individual who reviews those, their applications.

She is a former chair of the Association of Racing Chemists International, so an international expert in laboratory horse race testing.

We have a separate individual that actually is from Europe who comes over and inspects every laboratory.

The third part of the Accreditation Program is the External Quality Assurance Program, which is really the bread and butter to ensure that the labs can say what they do — they can do what they say they can.

Additionally there's a commitment to research, ethics and information sharing. I think one of the frustrations we've seen is that we have 14 testing laboratories in the United States, and often times they'll all be working on the same thing.

The goal of this is to ensure that we're working together to perhaps get more — make more progress on a variety of fronts instead of everyone getting a test for the same drug.

I can tell you that laboratory accreditation in the U.S. has come a long way. When we started this program in 2006 there were three labs that had any accreditation whatsoever. They were accredited, so what's called the ISO 17025 Standard.

We had 18 labs doing horse racing testing at that time. Currently we have 14 labs that are doing horse race testing.

Of those 14 labs 11— actually 12 are accredited to the ISO 17025 Standard. We've come a long way.

Of those 12, which is a prerequisite for RMTC accreditation, we have 9 that have either applied for or received some kind of accreditation from RMTC.

If you look at where we were just — even, honestly three years ago when we didn't have a single RMTC lab accredited, we've come a long way. That's the good news.

The bad news is that RMTC lab accreditation doesn't guarantee that the testing performed for a commission will meet the RMTC standards for the controlled therapeutic substance list, for the TOBA testing list, for a number of things.

That's where the RFP Model rule comes in. Early on in this exercise the RMTC Board really recognized that there was a gap.

In other words there was a gap between what the RMTC accreditation standards required and what was necessarily being required by the jurisdiction contracts.

To ensure that we have the laboratories able to perform at a high level, and that they are performing at a high level, we felt it was necessary to take this next step.

Key to this is ensuring that the laboratory contracts with each commission effectively, require their best testing. Now I know for the majority of you, you're not analytical chemists.

I'm not an analytic chemist, so this is not necessarily second nature, particularly for commissioners who it's their second job.

I also understand that there's always an internal struggle in state government between people who at the commission who know what they want to do and how they want to do it and getting services procured from a state government office and getting the contracts.

What we did was we reviewed a number of contracts. The majority of jurisdictions provided us with their contracts. We were able to review those. Some of the information was very interesting.

There are a number of jurisdictions that are doing great work. By contrast, there are some jurisdictions that don't even have a written contract.

I'm not sure exactly how you would specify what the requirements are if you're not writing something down. There was some variation in testing, preparation of samples and cost of sample testing.

Testing variation, to give you an idea, there are contracts that require everything from every sample must be run through instrumental screening.

That's your LCMS, MS to some groups where they only require ELISA testing on a portion of samples, and some are screened instrumentally.

There was a wide variation on what kind of testing was being done on an individual sample based upon the jurisdiction it was in. Some jurisdictions, a third of the samples were instrumentally screened.

A third was put through certain ELISA and a third was put through other ELISA testing.

Some of those testing — for example, if you're doing what's called rotating ELISA kits and what it'll basically say is something to the effect of the laboratory will choose a segment of ELISA kits that will be rotated on a regular basis.

ELISA kits are fine for finding many things. The issue however becomes you're losing the opportunity to find many other things because you're only testing for a limited number of things.

ELISA kits can test for — for example, they'll have an ELISA kit panel for corticosteroids. Well then you're missing muscle relaxants and nonsteroidals and all of those drugs while you're doing that testing.

Then there was a significant variation in cost. I think the low end, you're in the 60's and the high you're just under 200.

The way we went about the model, RFP was to look at some general areas. We looked at some commission and laboratory background information.

In other words, how many — Included in the RFP should be how many samples they want run, how many race days, information requesting the laboratory's qualifications, experience, facilities. That's pretty background boiler plate.

If you're using an RMTC accredited laboratory, the laboratory qualifications facilities and experience are going to be taken care of.

Then you go to scope of work. This is really the meat and potatoes of this document.

It talks about testing for post-race, TCO2, elective testing's, unknowns, etcetera. That is really where your RFP will make the difference in your testing.

Quality control, again, RMTC accredited labs are required to have the External Quality Assurance Program, so you're getting some of that. We recommend that commissions also require the lab to do internal quality control.

Communication turnaround time. That's your benefit and for your horseman's benefit, the faster the better.

That isn't dictated by the RMTC accreditation standards. It's something that the commissions have to specify.

Then cost, these things based upon what you request, the cost will differ.

I'm just gonna focus in on scope of work. Scope of work is crucial for testing. The way that the document is written, it requires that all testing must be LCMS, MS or instrumental, unless there's a justification for using something else.

There are a very few number of substances that cannot be found through LCMS testing, and must in fact use ELISA kits. That would obviously be a justification for that.

Again, use of ELISA kits should be limited, so in other words you're using the best technology. It's very akin to having a brand new Ferrari versus a five-year old Chevy. This is the difference in the testing is what you're looking at in those two methodologies.

The Chevy in some places is gonna be the only way that's gonna get you there, but it's also nice to have the Ferrari to find everything.

The best laboratories that we have that are using instrumental screening are able to test for 1800 substances in every sample.

Additionally, they require that the lab — it be able to reach certain sensitivities based on, not only the RMTC's controlled therapeutic substance list, but also the TOBA the testing list, so you're able to find substances at certain concentrations.

This means that in some circumstances the laboratory is going to have to have approved methodologies or validated methods that include extractions.

I was at a meeting a few months ago, and we were talking to four states that had the same laboratory.

They all had different extractions that were done, and essentially what an extraction is is if you think about it as an amplifier.

If you are looking for drugs that are basic and you are doing a test, you can do an extraction that will highlight the basic drugs, make them seem loud or seem bigger than they would be if you just did a neutral or a dilution of the sample in order to test for it.

We recommend that laboratories do an acid, a basic and a neutral extraction in both blood and urine. That would be reaching the sensitivities that are required in order to locate substances, identify them and quantify them.

They need to have validated methods.

In other words there has been significant data to support the fact that they can reach those concentrations. The scope of work specifically prohibits pooling of samples.

Then this scope of work essentially has two options. The top, the post-race testing, the first four points, regardless of which option you choose, that is the recommended way to go.

The lower cost option essentially allows the collection and retention of some samples that you don't actually run through testing.

You are collecting as many samples, testing fewer of those samples, but you're testing them better.

I don't know if Doctor Scollay plans to speak to her experience in Kentucky on this?

Dr. Dionne Benson: Okay. It is an option, and it certainly is — I guess in my personal opinion I feel that you're better off testing fewer samples very aggressively than testing a lot of samples, but only testing 'em for a third or half of the substances that you could.

The idea behind this model, RFP is to allow the commission to send out a proposal, which gives you an apples to apples comparison.

When you're looking at a contract proposal from one lab versus another, they are giving you the same level of testing.

To be frank, this will likely represent an increase in cost for some jurisdictions, especially if you intend to do the same number of samples.

The ultimate goal here is to protect the health and welfare of the horse and the integrity of the betting public.

Between the combination of the RMTC Accreditation and the model, RFP, will give you the best testing you can get.

Steve put this up on the website, but even though we have a new website, sometimes you can't find things.

If you are looking for the Model Request for Proposal, I've put our website plus the two tabs you need to find it under or the direct link to the Model RFP document.

The information on the Accreditation Program is also there, if you're interested to see what the laboratories go through and what their requirements are.

Their documents are about 70 pages, it'll make this one look a little more palatable. I think it's about 20. That's all I had, Mary.

Dr. Mary Scollay: I'm gonna come at this from the client's perspective. The laboratory is my service provider, and I'm the client and I have expectations that the laboratory will meet my needs.

The laboratory doesn't dictate what I get; I tell them what I want. I think that's an important dynamic to establish, as the regulator they are serving you. You are the client, so it's important, I think, dynamic to remember.

We're gonna start off with important reality, and that is that the majority of participants in our sport act in compliance. They follow the rules.

Second to that is that your stakeholders want you to enforce your rules, because they rely on you to protect them from those who had not followed the rules.

We talk an awful lot in horse racing about testing the cheaters. I think we also need to remember that we are supporting and protecting those who do follow the rules.

I'm gonna talk about some different potential vulnerabilities in different drug testing schemes for you to think about.

The first one I call is testing roulette, and I just want you all to ooh and awe a little bit over the roulette wheel cuz I worked really hard on putting that together.

The question is when is it okay to rotate tests and when is not? When it's okay to rotate test is if you're gathering intelligence. Okay. If you're trying to find out if a particular substance represents a threat in your jurisdiction.

Maybe you don't need to test every sample every day for that, but maybe 25 percent of your samples over the week.

There's a way to get information without draining your budget. Population surveys. Also, one off tests specifically in response to intelligence, to credible intelligence.

When is it not okay to rotate tests? Your controlled therapeutic medications, your substances with thresholds, there is no excuse for rotating tests there. You have drawn a bright line in the sand for your horsemen, it is your duty to enforce that bright line.

Believe me, the horsemen know when the line is not being enforced. If you've identified a substance through your intelligence gathering that is an ongoing threat, you do need to test all your samples for it.

I guess the bottom line I would say is that when testing rotation is implemented strictly as a cost cutting measure, that's not the right decision.

There are better ways to strategize on effective testing within your budget.

Turnaround time. I mentioned this briefly, just because I became aware of this for another jurisdiction. In their contract, the regulatory authority required a final report within three days of receipt of samples.

The laboratory director interpreted that, that if work was not completed by the end of three days he would report the samples as passed, and he did. Audible gasp, right?

That is not, I assure you, what the commission intended when they wrote their contract. One of my messages to you is be very careful with the language that you use, be precise.

This was a miscommunication, and it coulda been averted.

I'm gonna talk a little bit about ELISA testing, you hear the word an awful lot and I just wanna make sure you know what it is and where the potential vulnerabilities are.

There will be a quiz at the end, so pay attention.

ELISA stands for Enzyme-Linked Immunosorbent Assay. That will not be on the quiz.

What it means is that a specific antibody is developed for specific substance. Now that antibody can cross react with other similar molecules, but when it does there is decreased sensitivity.

The similar molecules must be present in much higher concentrations in order to get the same response as the targeted substance — I meant to say substance, I try to take drug outta here. Sorry.

The targeted substance would at a lower concentration. Okay, so there is vulnerability in multiple substance panels.

Okay. At the top, we have synthesized this antibody to be specific for this blue molecule below. This is a schematic, but I hope it helps you understand.

If you'll notice there's a hand and glove there, right? They fit very well together. That antibody is specific for that molecule.

Okay, so the target molecule is at the top, and you'll notice that we've got three others below, and they are similar, but also different.

Molecule two is missing some things here. Molecule three is missing some things here.

Molecule four is missing six things compared to the top molecule. Yet they are all similar. Here's our antibody, remember this guy? He's specific to the one at the top.

Let's see how he fits with everybody else. That's the target molecule, nice hand and glove fit.

He still fits here because there's nothing obstructing that, so it's just an empty space.

That antibody still reacts with that molecule. Still reacts with this molecule, even though you see a number of discrepancies. It can still react.

You come down here to the one that was missing six things, still reacts.

This antibody, this ELISA test can detect all of these substances, it is gonna be best for detecting this one.

You're gonna have to have to an awful lot of this, an awful lot of this and an awful lot of this to generate a positive test.

What that means is while that ELISA test can detect molecules two, three and four, their detection by this test is not gonna support your drug testing regulations.

Because you have to have a bucket of stuff in there for the test to register a finding.

When a laboratory offers to detect hundreds and hundreds of substances with 30 to 45 ELISA tests, view that with askance. Okay?

Remember that those tests really only have relevant sensitivity for 30 to 45 of those substances.

650 is a fabulous number, and it's not a lie, but it's not an accurate representation of what you're gonna get from that drug testing.

I'm starting to sound like Sy Syms, an educated consumer is our best client, but it's true.

The more you know, the better you're gonna be at requiring the testing that you need.

Now we're gonna talk about instrumental screening because we talk an awful lot about that and sort of wave it around like it's a magic wand, and there are still vulnerabilities there.

The reality is that you can run, in this case, tapioca pudding through a mass spectrometer.

You can put anything through there, doesn't mean you're gonna get good results.

As Dionne mentioned, samples must be adequately prepared to actually detect the substances.

Those are the extractions she was talking about. Instrumental screening of inadequately prepared samples, you might as well be analyzing the pudding. Okay.

When you write your RFP, when you draft your contract, be sure to require the laboratory to specify how they're gonna prepare those samples, how many extractions you're gonna get.

Because if it's just dilute and shoot, it sounds really good, you got instrumental screening, but you got the tapioca pudding test.

However, instrumental screening is really good. It can do an awful lot of things for you outside of enforcing your regulations.

It's immensely useful for intelligence gathering, and I spent an awful lot of time with our instrumental screening results.

It can help you identify medication usage patterns per horse, per trainer, per racetrack or race meet. You can sort things by surface, class, distance, age, really anything you wanna look at.

We have gotten some incredibly interesting information as a result of that. Further, and as regulators, you may find this more important, you've got retention of data for retrospective analysis.

Once your ELISA test is run, it's done. You can't do any more with those results.

You've either got a finding or you don't, a screening finding or you don't.

With the instrumental screening, all the data that's generated is retained in a computer, a big fancy computer.

When a new substance is added to the mass spectral library, that computer can be required to perform a search and go back and see if any of your previous samples, that substance was present.

The finding out of New York for the synthetic opioid, I called Rick Samson, I said, "Is that in our library?" He said, "It is now." I said, "Well good. Take a good, hard look back."

He went back through nine months of our drug testing results and reported to me that there was no evidence for that molecule in any of our instrumental screens.

That was big news. It's in our library going forward, and every sample will be tested for that substance because it's included in our mass spectral library.

It was really huge to be able to go back and say Derby wasn't impacted by that substance, we're good.

The other thing that you can do with this retained data is that you can search it for unknown peaks that appear with unusual frequency.

We don't know what it is, but boy; it keeps showing up in the samples.

You can then identify something that you need to find out what it is.

Does it represent a threat?

Is it an innocuous benign supplement that's being used?

There's a lot of retained information that can help us be a lot smarter.

I'm gonna talk about pooling of samples, cuz you've heard that you shouldn't do it, and here's why in case you're uncertain.

The tube with the red, we're gonna say that that contains a prohibited substance, let's say EPO, just for grins, okay.

Pooling samples is when you take portions of multiple samples, mix them together and then run a single test.

The premise being that if that test is negative, you don't have to do individual tests on all those other samples.

If the test is positive then you need to go back and run individual tests on the samples that contributed to that pooled sample.

In theory it sounds like it works, it makes sense. If you look here on the top row, we've got the sample that contains the EPO.

We've got a sample that contains no EPO. You mix them together. You run that test. You've decreased your concentration of EPO by 50 percent.

You save some money, but you may have also taken this concentration, put it below the laboratory's level of sensitivity and these get called passed.

It gets augmented, the more samples you pool. See red to pink, red to really light pink.

What happens there when those samples get pooled and the commission gets report that the samples are passed?

The commission thinks everything is good.

When in fact, you may have an active threat in your population.

The pooling of samples puts you at risk. I hope that in understanding this you know that it is not a practice you want to engage in for support of your rules.

My take home message and it ends up being two slides cuz I ramble a bit.

Know what you want from your drug testing program.

I would say if you are unsure of what you want, the Model RFP is a good place to start, because in addition to telling you the things that you should require, it explains why you should require them, so you can have some confidence when you go to your procurement agency saying we have to do it this way, we really do it's important.

Require the service provider to do the work. Make sure that your contract doesn't offer the opportunity for somebody to cut a corner.

Then be willing to pay fairly for it.

I wanted to have a slide of my 92-year old mother waving, because she's gotten much smarter as I've gotten older.

[Laughing]

She used to say if something looks too good to be true, it certainly has to be.

Remember that when you're looking at bid responses. Good testing costs good money, but it's worth it.

Bad testing wastes everybody's money.

Not just the racetracks, not just the horsemen who have invested in the care to get these horses to races, but the betters, everybody.

That's my sermon.

Happy to answer any questions or sit down with the panel and see what people would like to do.

Mr. Steve Koch: Yeah, thanks to Dr. Benson and Dr. Scollay.

I think that's very interesting for a bunch of us.

There were some surprising things in there for me, so I think I'm not alone probably, interesting things.

We've certainly got time. We've managed our time well.

I think we're happy to open the floor to some questions if anybody has something on their mind.

Audience Member: How do you manage your sampling and testing program in Kentucky?

Dr. Mary Scollay: Sure, the red/gold, yeah. Sure.

The question was can I please explain how we in Kentucky manage our sampling and testing program, we collect more samples than we test.

This is based on a recommendation from the 1990 McKenzie Report for the Jockey Club on developing a world class drug testing program; I think that's what it was called.

The idea is very simply that profiling works.

We identify our samples as red and gold.

The gold samples are derived from horses contributing a performance of interest, winning longshot, favor who runs up the track, a trainer with an unusual win percentage, the stewards may see unusual wagering patterns.

Gold samples are all tested. Gold samples are always tested, and they are subjected to the full scope of instrumental screening.

All of our samples are subjected to the same full scope of instrumental screening, so a $5,000.00 claimer at Ellis gets tested the same way the winner of the Derby does.

The red samples, 50 percent of the red samples are tested. That decision takes place at the laboratory, so it's randomized, but it is not a decision that we make on the racetrack end.

First of all, the trainer doesn't know whether or not he's a gold or red sample.

If he is a red sample, he's got a 50 percent chance this sample is gonna be tested. It sort of turns into a do you feel lucky kinda deal.

What we have found is that's resulted in some cost savings to the racetracks, cuz in Kentucky they're the ones who pay for the testing. It has not reduced the number of positive tests that we find.

What that says to me is that the stewards have been very good in identifying the right horses to test.

I will follow that by saying, because there was some confusion at the AAP when some remarks were made about our testing program, overall 2013 our post-race positive findings are almost double what we've had for 2015.

That is probably a consequence of the implementation of the controlled therapeutic substances list and the thresholds that shows we're actually — our horsemen are very compliant, have adapted very well and our medication violations have dropped.

When we first implemented the red/gold and were testing fewer samples, we were still getting the positive tests and didn't feel that we had compromised the integrity of our program by testing fewer horses.

Audience Member: Could you address the issue of threshold levels with respect to horses, like the outliers?

Dr. Mary Scollay: Sure. Is that Mike? It's Mike.

When the RMTC does administration studies, and I'll give you an example. God, I wish I had my laptop with me. That's okay. We do these administration studies, say 20 horses.

We will sample them aggressively.

For a 72-hour study we may end up getting 20 samples from each horse.

We have already had a philosophical conversation at the Scientific Advisory Committee level where we think we want to have a withdrawal guidance for this substance, when we would like to have somebody discontinue it.

Then we will look at the blood samples associated with that time. We'll look at the data and determine what the appropriate threshold needs to be.

Now, typically you will see a large cluster of numbers in one area over here. Then you'll see one horse over here.

You might wanna say that that's an outlier, this horse over here, but we don't draw that conclusion. We assume that that's a normal finding in that horse.

That data is included in the whole calculation.

We do what's called a 95/95 tolerance interval, and some of you may have heard that that represents the numbers derived from that represent a five percent risk of a positive test.

That's simply not the case.

I don't wanna walk you through it. I'm happy to do it afterwards.

I can write it down and draw it for you.

The thresholds that we have developed for the RMTC represent a minimum of 3.92 standard deviations from the mean, and as far as out 38 standard deviations from the mean. 3.7 —

Dr. Dionne Benson: its 3.72 is the minimum, is 1 in 10,000.

Dr. Mary Scollay: 3.72 standard deviations represent a risk of an event 1 in 10,000 times. We consider that horse that's way over here, consider him normal.

The thresholds that we derive end up out here. There is an enormous margin of safety on those thresholds. I think they readily encompass the outlier.

What they don't encompass is the horse that's in renal failure or liver failure and can't adequately metabolize the drug.

My assertion would be that if a horse is on the transplant list, he probably shouldn't be racing.

Was that too snarky?

I'm sorry.

[Laughing]

Dr. Mary Scollay: It happens. Alex? I'm calling people, Steve.

Audience Member: Help us understand why you began the conversation talking about the accreditation standard for racetracks, but we spent our time talking about regulators and laboratories, what is the connection between the accreditation standards that you just announced, and what's happening at the labs?

How are the tracks supposed to be involved exactly?

Mr. Steve Koch: I'm glad you asked that, actually if I didn't draw that link clearly enough when I was speaking earlier.

The enormous power with the Safety and Integrity Alliance is that we can — as we travel to all these different racetracks and we see so many things, and we've got a very talented team of experience racing officials that come with us.

We're able to glean best practices and distribute those best practices to the racetrack.

When we're putting laboratory selection and performance standards into the Code of Standards what it means is when we're working with our racetracks on the accreditation process, we're going to ask you to — there's an application document — that was dramatic.

There's an application document that we did not bother putting up on the screen today, cuz that's very much for the racetrack's use.

In that document we're going to ask the racetracks, engage with your regulators.

Get a copy of that RFP and the services agreement from your local regulatory body and start asking questions about how your regulators went about contracting with that laboratory.

The Code of Standards update that we just did calls on the racetrack to actively engage with that process.

Historically I think too many of us racetrack operators, and forgive me, I was Vice-President at Woodbine, I would have been a racetrack operator in recent history.

Too often we just — the drug testing happens, we take for granted that it works well, and we're not asking enough questions to make sure that our drug testing dollar is going the farthest and we're getting true value for that dollar.

The point of baking that into the Code of Standards is so that the racetrack started asking us questions, get engaged and hopefully the regulators will engage back, and that way everybody can be very comfortable.

We're all paying into this.

Ultimately it's coming out of the horse racing to pay for these things, one way or another, whether it's directly from the track or through levy's or whatever it might be.

The point of this is to drive that engagement actually across the industry.

It's everyone including the horsemen, the racetrack operators and the regulators should be involved in this process.

Dr. Mary Scollay: I just add that a racetrack operator should be aware that poor drug testing impacts the quality and credibility of the product that you are promoting.

You do have a dog in the fight.

Bad drug testing is gonna cost you money at the bottom-line level.

Mr. Steve Koch: Yeah, absolutely. Thank you for adding that. Dan?

Audience Member: We, the RMTC and the Safety Integrity Alliance and our regulators, do we have standard operating procedures, protocols for the total operation of the test barn and how are we going to be enforcing that?

Mr. Steve Koch: That is baked into the existing Code of Standards.

There is a section on that one.

We write our reports.

A quarter of our team would actually go to a racetrack and inspect these racetracks. We're going to at least a dozen racetracks a year.

Part of that program is to make sure that our veterinary expert and our security consultant, and typically I will be sure to be there with them.

We go to that test barn.

We look at exactly how they draw samples, exactly how they split those samples, how is everything recorded.

The sign off for chain of custody is something that we're eyeballing carefully.

When we leave a racetrack we go home and we write, frankly a very dense and hard to read — long to read I should say, not hard to read, a long to read report.

That would be a chapter within that report. It's something we're paying attention to.

Again, that's that value of bringing these outside experts into the process and bringing those best practices across the country where they've seen other test barns do things.

We're able to pick up very quickly when we see someone draw a sample and they're not wearing latex gloves, something as simple as that or something more complicated with how they seal the samples or record the stuff.

Absolutely, that is a chapter in our Code of Standards.

Audience Member: Dr. Benson is there any plan to publicly call out the states that have locally inadequate testing, where we've been very quick to call out the states who — for whatever reason have adopted the thresholds in my opinion, this locally inadequate testing in some jurisdictions causes greater threat to our industry.

Dr. Dionne Benson: Well I think in part the Jockey Club has done some of that.

I think our goal at RMTC isn't to necessarily call those states out, but to help work with them to help improve their testing. That was part of the Model RFP.

I think that the jurisdictions that I've spoken with — so we finished the RFP about nine months ago.

Jurisdictions that have since renegotiated their contracts, I think we're seeing many of them use that.

Instead of shaming them, I think the goal is to get them to the next level and really work with them to do that.

In part, we continually publicize which laboratories are accredited, and I think that's an important part of that.

Audience Member: In which those ones are not?

Dr. Dionne Benson: Yeah, and those which are not, and have not made any progress.

That kind of information is helpful.

It's on our website in a map form, and you can find that.

The other thing is with those jurisdictions, it would be very difficult, especially when we have jurisdictions who don't have written contracts to know what they're doing.

Audience Member: Those might be the first that should be called out.

Dr. Dionne Benson: Yeah.

Dr. Mary Scollay: I think it's important to recognize the potentially poor decisions that were made that got those jurisdictions into the jackpot with the testing that they got.

They were made out of ignorance. It wasn't a deliberate, malicious effort to undermine their testing or anything else.

My response would be let's try and help those folks do a better job, rather than shaming them for something that they probably, maybe didn't understand how they got there in the first place.

Mr. Steve Koch: Good. Anybody else? Eric?

Audience Member: Dr. Benson or — is that intended to be put forth to the model rules or is this just a standardized grouping that is along with the accreditation?

Dr. Dionne Benson: We've talked about how that would work, and it really would be difficult to make it into a model rule.

Because it would basically be that the commission would have to pass a rule that would determine how they behave or how they contract it.

It's better in our mind as an RFP and as a document that they can follow.

I think that as we go forward the more jurisdictions that are using this, I think they're finding it to be really helpful.

I think that they're finding it to be really comprehensive.

By the other risk that you always run with a model rule is that it can change significantly as we get through a model rule process.

I don't think that would be something we would be interested in.

Audience Member: Sometimes the executive director is put in a very difficult position because the legislature or the government or what has not provided adequate resources to conduct —

Some of those jurisdictions come under a tremendous amount of pressure and criticism.

What we really need to solve that problem is for the racing industry in those states to work with the commission and make sure that they get the resources they need to be able to do the kind of testing that Dr. Scollay recommends.

Dr. Mary Scollay: The other thing I'd remind you is that the RFP is a state government process, which means that it's a public document.

To your point about calling out those who aren't doing it well, if after the existence of this model RFP that provides good guidance, if somebody sends out an RFP that permits pooling, I think somebody probably oughtta spot it and ask some hard questions.

Audience Member: Is the Model RFP only shared with organizations like — and the racing commission level, or can it also be shared with the — group that represents the horsemen

Dr. Mary Scollay: It's on the website, it's a public document.

Dr. Dionne Benson: Ours is a public document, and I don't know if when you release an RFP if you put it on your website.

I think if you are requesting as a state testing services.

Dr. Mary Scollay: It is a public document. Anyone can see it and respond to it or just see it and not respond to it.

Audience Member: If it's not on our website you can make a public request.

Dr. Mary Scollay: Yeah.

Audience Member: Really, the Equine Drug Control Program starts with the selection of the horse and the collection of the sample and should be as well, Meaning collection and shipping —

Dr. Mary Scollay: Okay. Kentucky has actually got a post-race sampling and testing rule that describes the red/gold process.

That's available on our website if you're interested.

It would be a good idea to give guidance, and so we're asking people to spend more money on a per sample basis to show them how they can be more effective with the money they do have.

Dr. Dionne Benson: It might also be a good idea to follow up on Dan's point that the jurisdictions or the tracks that aren't covered by the Safety and Integrity Alliance, it might be good to have a document where they understand best practices for within the test barn.

Dr. Dionne Benson: I mean it may have for example, collect this, collect blood, collect urine.

I'm not sure it would have the nuts and bolts of you need to make sure things are sealed this way.

You need to make sure that you use gloves when collecting urine.

This is how samples should be stored; they should be spun after this many minutes.

I don't think that that type of information belongs in a model rule, but it would be helpful in a document.

Audience Member: — Protection is a matter of each jurisdiction, if you're sloppy in how you run your test barn it means that you will be successfully challenged on open terms with chain of custody matters given the way the appeals process works, that is all discoverable and so since we haven't had many instances where that's been overturned it might be isolated one every number of years with human error, but that is extremely rare —.

Dr. Mary Scollay: No, but I will tell you that that's where the aggressive challenges are coming.

They are looking in every nook and cranny with respect to chain of custody.

Because with the accreditation process the lab work is becoming more and more air tight.

The chain of custody is going to come under really aggressive scrutiny.

Dr. Dionne Benson: I will say that I had a call recently from a steward in the jurisdiction that had questions about how split samples were handled and how they were stored and sealed.

I think it's worth at least us going through the exercise of going through the information and whether a commission has a comparable policy, then they don't have to worry about it.

I think, especially as people go through and come and leave, they may not always understand why something is done the way it is.

Mr. Steve Koch: Okay, I think we've used up all of our time and then some.

Thanks to Doug Reed and Wendy, thank you for having us.

I know this is some dense content, but thanks for everybody participating. I'm very pleased to have Drs. Benson and Scollay here.

During the world tour, they've been in Vegas last couple days, at the AAEP, now they're here. Now they're going back.

I think Dr. Benson is even going onto Hong Kong from there, so if you call her at home and she doesn't answer, don't take it personally.

Thank you everyone.

[Applause]