My name is Dr Mark Gilbert. I live in West Linn, Oregon, and practice in the Portland Metro area. I believe SB136 will reduce the safety and increase the cost of health care in Oregon, and I would ask the legislature to reject it.

My education included five years for an undergraduate science degree from the University of California at Irvine; four more years in medical school at the Medical College of Wisconsin to earn my MD degree; and then another four years in internship and specialty residency at OHSU to become an anesthesiologist. After an additional year of clinical practice, continuing education and study I achieved Board Certification. I maintain a continuing educational commitment of fifty hours per year for licensure in Oregon. Anesthesia doctors make an annual commitment to fifty hours per year of ongoing education, on top of at least thirteen to fourteen years of education and training, because the state of Oregon, and the rest of the United States has accumulated data to show this is what is required for physicians to deliver safe and effective care of our citizens. We must not have non-physicians establish a less educated tier of training and prescribing privilege to deliver care to an Oregonian: How many would be harmed?

The broader type and amount of training and education that a doctor undertakes is what allows them to:

1) assess how medical co-morbidities like Obstructive Sleep Apnea will increase the dangers of prescribing;
2) avoid drug interactions, contraindications, and inappropriate prescribing
2) safely craft a plan tailored for each patient's condition; and
3) put it into action through acutely painful medical experiences like labor and delivery or surgery.

Five (5) weekdays of nine hours of education/day, which is the total number of hours proposed in SB136, is not the equivalent of the years doctors spend to prepare for this responsibility. The medical education required to prescribe is not just a week long course in pharmacology. American medical education integrates anatomy, physiology, biochemistry, genetics, pathology, immunology and microbiology into a comprehensive education needed for today's more potent modern pharmaceuticals. SB136 proposes to overturn the accumulated wisdom of requiring years of training and education by letting someone study for 45 hours, and unleash them to prescribe some of the most dangerous, destructive, addicting medications to unwary citizens.

CDC states the rate of deaths from prescription pain medications has tripled; Oregon is already in the top category of states with the highest percent of pain medication prescriptions by the pound (19-28) per ten thousand people. In 2010 enough pain meds were prescribed to keep every adult in American medicated around the clock for a month.

In addition, the prescription of chronic medication for pain relief requires another one to two years of fellowship pursuing study and training to safely guide chronic pain patients

through their prolonged life altering medical experience. No one is better prepared than a physician to help guide patients through conflicting advertisements, or conferences promising unsupported outcomes; only a doctor who has taken the years required to prepare themselves can chart a safe and appropriate course.

The Oregonian and other lay press have explored the depth and breadth of prescription narcotic addiction, crime, harm and death in Oregon and around the country. The medical community, payers and regulatory bodies are working to reduce and eliminate the inappropriate prescribing of these medication classes, and where possible, restrict them to pain management multidisciplinary teams with the expertise to appropriately treat Oregonians. SB136 will open a Pandora's Box upon unsuspecting residents by allowing non-physicians who by their current and proposed training lack the adequate experience, educational breadth and depth to prescribe.

Costs beyond those of lives impacted or lost have also been measured. No study has ever shown a cost reduction by allowing APN or CRNA prescribing privileges. However, US Census and CMS data show that states that allow independent APN practice do have higher expenses than those that allow some prescribing or no independent prescribing.

New Mexico allows APNs independent prescribing privileges; compare with neighboring Nevada, which does not:

State Chip Programs

2010 Data

Number of enrollees in NV: 31,600
Expenditures: $22,700,000
Expenditures per enrollee: $786

Number of enrollees in NM: 9,700
Expenditures: 230,000,000
Expenditures per enrollee: $23,773

Number of Enrollees in OR: 64,700
Expenditures: $86,000,000
Expenditures per enrollee $1329

http://www.census.gov/compendia/statab/2012/tables/12s0144.pdf

State Medicaid Programs

2009 Data

Number of beneficiaries in NV: 281,000
Payments: $1,196,000
Payment per beneficiary: $4.25

Number of beneficiaries in NM: 562,000
Payments: $2,913,000
Payment per beneficiary: $5.18

Number of Beneficiaries in OR: 564,000
Payments: $ 2,797,000
Payment per beneficiary: $4.96

http://www.census.gov/compendia/statab/2012/tables/12s0151.pdf

Personal Health Care Spending per Capita

	1998	2004	2009
New Mexico:	3,232	4,843	6,651
Nevada:	3,109	4,759	5,735

Oregon: 3,398 5,059 6,580

Avg annual growth rate in NM: 1998-2004, 7.0%. 2004-2009, 6.6%.

Avg annual growth rate in NV: 1998-2004, 7.4%. 2004-2009, 3.8%.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MMRR/Downloads/MMRR2011_001_04_A03-.pdf

Medicare personal health care spending

	1998	2004	2009
New Mexico:	4,032	5,656	8,120
Nevada:	4,876	7,125	9,692
Oregon:	**3,916**	**5,989**	**8,247**

Avg annual growth in per enrollee spending for NM: 1998-2004, 5.8%. 2004-2009, 7.5%.

Avg annual growth in per enrollee spending for NV: 1998-2004, 6.5%. 2004-2009, 6.3%.

Avg annual growth in per enrollee spending for OR: 1998-2004 6.1% 2004-2009, 6.6%

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MMRR/Downloads/MMRR2011_001_04_A03-.pdf

Medicaid personal health care spending

	1998	2004	2009
New Mexico:	3,715	4,975	6,409
Nevada:	5,230	5,713	6,003
Oregon:	**4,380**	**5,366**	**6,018**

Avg annual growth in per enrollee spending for NM: 1998-2004, 5.0%. 2004-2009, 5.2%.

Avg annual growth in per enrollee spending for NV: 1998-2004, 1.5%. 2004-2009, 1.0%.

Avg annual growth in per enrollee spending for OR: 1998-2004, 5.9% 2004-2009, 5.0%

https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MMRR/Downloads/MMRR2011_001_04_A03-.pdf

FROM CDC: In a period of nine months, a tiny Kentucky county of fewer than 12,000 people sees a 53-year-old mother, her 35-year-old son, and seven others die by overdosing on pain medications obtained from pain clinics in Florida.1 In Utah, a 13-year-old fatally overdoses on oxycodone pills taken from a friend's grandmother.2 A 20-year-old Boston man dies from an overdose of methadone, only a year after his friend also died from a prescription drug overdose.3

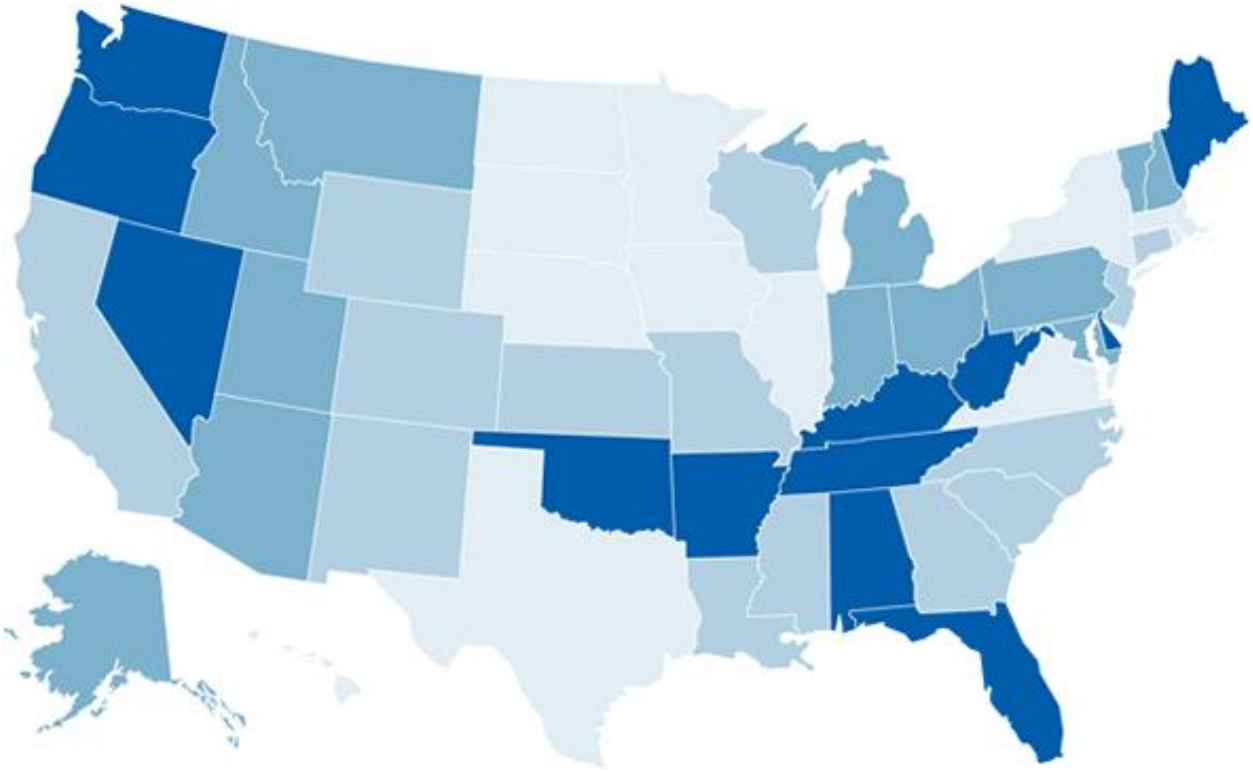
These are not isolated events. Drug overdose death rates in the United States have more than tripled since 1990 and have never been higher. In 2008, more than 36,000 people died from drug overdoses, and most of these deaths were caused by prescription drugs.4

The role of prescription painkillers

Although many types of prescription drugs are abused, there is currently a growing, deadly epidemic of prescription painkiller abuse. Nearly three out of four prescription drug overdoses are caused by prescription painkillers—also called opioid pain relievers. The unprecedented rise in overdose deaths in the US parallels a 300% increase since 1999 in the sale of these strong painkillers.4 These drugs were involved in 14,800 overdose deaths in 2008, more than cocaine and heroin combined.4

The misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.6

More than 12 million people reported using prescription painkillers nonmedically in 2010, that is, using them without a prescription or for the feeling they cause.7



The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices was 4 times larger in 2010 than in 1999. Enough prescription painkillers were prescribed in 2010 to medicate every American adult around-the-clock for one month. Oregon in dark blue sells 8.5-12.6 kg per 10K adults.

Who is most at risk:

Understanding the groups at highest risk for overdose can help states target interventions. Research shows that some groups are particularly vulnerable to prescription drug overdose:

People who obtain multiple controlled substance prescriptions from multiple providers—a practice known as "doctor shopping."14,15

People who take high daily dosages of prescription painkillers and those who misuse multiple abuse-prone prescription drugs.15,16,17,18,19

Low-income people and those living in rural areas.

People on Medicaid are prescribed painkillers at twice the rate of non-Medicaid patients and are at six times the risk of prescription painkillers overdose.20,21 One Washington State study found that 45% of people who died from prescription painkiller overdoses were Medicaid enrollees.20

People with mental illness and those with a history of substance abuse.19

1) Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60: 1-6
2) CDC. Warner M, Chen LH, Makuc DM. Increase in fatal poisonings involving opioid analgesics in the United States, 1999-2006. NCHS Data Brief;22 Sept 2009. Available from URL: http://www.cdc.gov/nchs/data/databriefs/db22.pdf .
3) Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA 2011;305(13):1315-1321.