March 27, 2023

To: House Committee on Behavioral Health and Health Care

From: Paige Spence, Director of Government Relations, Oregon Nurses Association

Re: Opposition to HB 2642 as written

Dear Chair Nosse, Vice-Chairs Nelson and Goodwin, and Committee Members:

Nurse Practitioners have supported legislation that has built the Oregon Prescription Drug Monitoring Program (PDMP) into a tool for prescribing healthcare clinicians to provide the best and safest possible care for their patients. Currently individual APRN prescribers have the ability to practice prudent controlled substance prescribing practices in order to prevent misuse, abuse and diversion of these medications.

The PDMP has evolved into a powerful tool checked by the vast majority of prescribers in Oregon on a daily basis. Barriers to checking it have been reduced by both support staff having been delegated rights and being integrated into most electronic health record (EHR) systems. It is already in Oregon law that for each and every time a prescriber writes for a schedule II controlled substance, they must check the PDMP or clearly indicate why it was not possible. This does exempt patients receiving these medications in hospice, palliative, active oncologic, and sickle cell disease care, in addition to those in long term care. The recent 2022 CDC guidelines are also clear on when a prescriber should check the PDMP when prescribing opioids.

At the time of the creation of the PDMP, Oregon faced a nationally recognized challenge with the public health consequences of prescription opioid abuse and misuse. As the opioid crisis came into sharper focus, the state board of nursing and medicine worked in partnership to support the Oregon Health Authority and with the Legislature to enhance the PDMP to make it a more valuable tool. A few of those enhancements included:

- Delegating access to the database to members of the practice staff;
- More extensive and useful information reposted by the pharmacist into the PDMP;
- Required registration of prescribers; and
- Integration of the PDMP data into the electronic health record.

EHR integration has been the most supportive change for the prescribing clinicians. The integration allows for easier access, by relying on existing systems in use by prescribers and pharmacists, including electronic health information exchange efforts. This process allows for PDMP data to be seen by prescribers without a separate query into the PDMP itself. These past legislative efforts have paid off. Of the top 4000 prescribers, 98% are registered PDMP users and over 7 million integrated queries were sent to prescribers.

Given the Secretary of State audit and the Oregon Health Authority report we know some constraints still remain in Oregon's PDMP and APRN's want to support legislation that can address these constraints with changes to statute to meet the goal of continuing to reduce the misuse of opioids in our state. I'm thankful for the work legislators put forward this session but also believe some small changes are needed.

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HB 2642 requires a PDMP check every single time a provider refills a medication that is reportable to the PDMP, which is way beyond just schedule II medications. It is already best practice that any time a clinician initiates a class 3-4 controlled substance, they should check the PDMP and also do so at least yearly. The Oregon medical and nursing boards often will discipline providers who fail to do this. In addition, it is already a law that class 2 medications require a PDMP inquiry at every prescription occurrence. We place requirements of providers to ensure they practice safe prescribing. Yet we also do not want to dissuade providers from prescribing life saving medications such as buprenorphine (schedule III). If HB 2642 were enacted, the burden of checking the PDMP every single time a clinician prescribe buprenorphine for a patient who is at a high risk of returning to their opioid use disorder could discourage providers from offering these medications. In addition, buprenorphine has a much stronger safety profile than other opioids and has a significantly lower abuse potential than schedule II medications.

On a similar note, HB 3258 includes medications in class V, which includes Lyrica (a non-opioid used for many conditions, including diabetic neuropathy), cough syrups which contain codeine, and the anti-diarrheal drug Lomotil (also a non-opioid). As I re-read the SOS PDMP follow up report and the proposed legislation to address issues that came up, I am actually on call so it got me thinking on how this legislation may become complicated. While I plan my 24/7 call weekends I plan to stay home the entire weekend and be by my computer and if I step out to get some exercise I also bring my computer. However many practicing clinicians cover calls on a more regular basis. One could imagine a provider on call who is out with their family at dinner, who wants to call in an effective cough syrup for a patient who has called after hours. How would they check the PDMP in that case? (besides the fact that a single dose of codeine cough syrup contains less than 1 equivalent mg dose of morphine.) The same goes for a patient with debilitating diarrhea who has run out over the weekend. How are we keeping patients safe in these scenarios?

As currently written, I've heard from many in the clinician community concerned for implementation. Adding a PDMP requirement for every prescription of all meds will overburden prescribers and will also potentially delay the refilling of such a crucial pharmaceutical. I believe if some sideboards and exemptions are added the policy can become workable at the prescriber level and still allow for the intent of the policy and strengthen the value of the PDMP.

Possible amendment concepts include limiting queries to specific schedules of controlled substances, limits for the type of prescription (initial versus clinically appropriate refills consistent with clinical practice guidelines), and some exceptions for emergencies and other appropriate clinical situations such as a public health emergency.

A specific amendment that could serve as a protection to Oregonians would be to require a PDMP check initially when starting a patient on a schedule 3, 4 or 5 medication, and at least annually after that. This would not only help the medical and nursing boards in creating standards and expectations for providers, It would also help create clear, strong rules for clinicians to follow that do not create an undue burden on their practice.

Thank you for considering our concerns and suggestions.