House Bill 2884

Sponsored by Representatives DEXTER, REYNOLDS, Senator JAMA, Representatives BYNUM, NELSON; Representatives HIEB, LEVY B, NERON, Senators PATTERSON, SOLLMAN (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Changes term "naloxone" to "short-acting opioid antagonist."

A BILL FOR AN ACT

Relating to short-acting opioid antagonists; amending ORS 339.867, 339.869, 339.871, 430.389, 431A.855, 431A.865, 689.681, 689.682, 689.684 and 689.686.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 689.681 is amended to read:

689.681. (1) As used in this section:

(a) "Kit" means a dose of [*naloxone*] **a short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

[*(b) "Opiate" means a narcotic drug that contains:*]

[*(A) Opium;*]

[*(B) Any chemical derivative of opium; or*]

[*(C) Any synthetic or semisynthetic drug with opium-like effects.*]

[*(c) "Opiate overdose" means a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function and the impairment of the vital functions as a result of ingesting opiates in an amount larger than can be physically tolerated.*]

(b) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(c) "Opioid overdose" means a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function and the impairment of vital functions as a result of ingesting opioids in an amount larger than can be physically tolerated.

(d) "Short-acting opioid antagonist" means any short-acting drug approved by the United States Food and Drug Administration for the complete or partial reversal of an opioid overdose.

(2) Notwithstanding any other provision of law, a pharmacy, a health care professional or a pharmacist with prescription and dispensing privileges or any other person designated by the State Board of Pharmacy by rule may distribute and administer [*naloxone*] **a short-acting opioid antagonist** and distribute the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**. The pharmacy, health care professional or pharmacist may also distribute multiple kits to social service agencies under ORS 689.684 or to other persons who work with individuals who

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

have experienced an [*opiate overdose*] **opioid overdose**. The social services agencies or other persons may redistribute the kits to individuals likely to experience an [*opiate overdose*] **opioid overdose** or to family members of the individuals.

(3) A person acting in good faith, if the act does not constitute wanton misconduct, is immune from civil liability for any act or omission of an act committed during the course of distributing and administering [*naloxone*] **a short-acting opioid antagonist** and distributing the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist** under this section.

SECTION 2. ORS 689.682 is amended to read:

689.682. **(1) As used in this section:**

(a) "Opioid" means a natural, synthetic or semisynthetic chemical that interacts with opioid receptors on nerve cells in the body and brain to reduce the intensity of pain signals and feelings of pain.

(b) "Opioid overdose" means a medical condition that causes depressed consciousness and mental functioning, decreased movement, depressed respiratory function and the impairment of vital functions as a result of ingesting opioids in an amount larger than can be physically tolerated.

(c) "Short-acting opioid antagonist" means any short-acting drug approved by the United States Food and Drug Administration for the complete or partial reversal of an opioid overdose.

[*(1)*] **(2)** In accordance with rules adopted by the State Board of Pharmacy under ORS 689.205, a pharmacist may prescribe [*naloxone*] **a short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

[*(2)*] **(3)** If a prescription is presented to a pharmacist for dispensing an opiate or opioid in excess of a morphine equivalent dose established by rule by the board, the pharmacist may offer to prescribe and provide, in addition to the prescribed opiate or opioid, a [*naloxone kit consisting of a dose of naloxone*] **short-acting opioid antagonist** and the necessary medical supplies to administer the [*naloxone*] **short-acting opioid antagonist**.

SECTION 3. ORS 689.684 is amended to read:

689.684. (1) For purposes of this section, "social services agency" includes, but is not limited to, homeless shelters and crisis centers.

(2) A person may administer to an individual [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** that was not distributed to the person if:

(a) The individual to whom the [*naloxone*] **short-acting opioid antagonist** is being administered appears to be experiencing an [*opiate overdose*] **opioid overdose** as defined in ORS 689.681; and

(b) The person who administers the [*naloxone*] **short-acting opioid antagonist** is an employee of a social services agency or is trained under rules adopted by the State Board of Education pursuant to ORS 339.869.

(3) For the purposes of protecting public health and safety, the Oregon Health Authority may adopt rules for the administration of [*naloxone*] **short-acting opioid antagonists** by employees of a social services agency under this section.

SECTION 4. ORS 689.686 is amended to read:

689.686. (1) A retail or hospital outpatient pharmacy shall provide written notice in a conspicuous manner that [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** and the necessary medical supplies to administer [*naloxone*] **the short-acting opioid antagonist** are available at the pharmacy.

(2) The State Board of Pharmacy may adopt rules to carry out this section.

SECTION 5. ORS 339.867 is amended to read:

339.867. As used in ORS 339.869 and 339.870:

(1) "Medication" means:

(a) Medication that is not injected;

(b) Premeasured doses of epinephrine that are injected;

(c) Medication that is available for treating adrenal insufficiency; and

(d) [*Naloxone or any similar medication*] **A short-acting opioid antagonist, as defined in ORS 689.681,** that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug.

(2) "Medication" does not include nonprescription sunscreen.

SECTION 6. ORS 339.869 is amended to read:

339.869. (1) The State Board of Education, in consultation with the Oregon Health Authority, the Oregon State Board of Nursing and the State Board of Pharmacy, shall adopt:

(a) Rules for the administration of prescription and nonprescription medication to students by trained school personnel and for student self-medication. The rules shall include age appropriate guidelines and training requirements for school personnel.

(b) Rules for the administration of premeasured doses of epinephrine by school personnel trained as provided by ORS 433.815 to any student or other individual on school premises who the personnel believe in good faith is experiencing a severe allergic reaction, regardless of whether the student or individual has a prescription for epinephrine.

(c)(A) Rules for the administration of medication that treats adrenal insufficiency by school personnel trained as provided by ORS 433.815 to any student on school premises whose parent or guardian has provided for the personnel the medication as described in ORS 433.825 (3) and who the personnel believe in good faith is experiencing an adrenal crisis, as defined in ORS 433.800.

(B) Rules adopted under this paragraph must:

(i) Include guidelines on the designation and training of school personnel who will be responsible for administering medication; and

(ii) Specify that a school district is only required to train school personnel when the school district has been notified by a parent or guardian that a student enrolled in a school of the school district has been diagnosed with adrenal insufficiency.

(d) Guidelines for the management of students with life-threatening food allergies and adrenal insufficiency, which must include:

(A) Standards for the education and training of school personnel to manage students with life-threatening allergies or adrenal insufficiency.

(B) Procedures for responding to life-threatening allergic reactions or an adrenal crisis, as defined in ORS 433.800.

(C) A process for the development of individualized health care and allergy or adrenal insufficiency plans for every student with a known life-threatening allergy or adrenal insufficiency.

(D) Protocols for preventing exposures to allergens.

(e) Rules for the administration of [*naloxone or any similar medication*] **a short-acting opioid antagonist** that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug by trained school personnel to any student or other individual on school premises who the personnel believe in good faith is experiencing an overdose of an opioid drug.

(2)(a) School district boards shall adopt policies and procedures that provide for:

(A) The administration of prescription and nonprescription medication to students by trained school personnel, including the administration of medications that treat adrenal insufficiency;

(B) Student self-medication; and

(C) The administration of premeasured doses of epinephrine to students and other individuals.

(b) Policies and procedures adopted under paragraph (a) of this subsection shall be consistent with the rules adopted by the State Board of Education under subsection (1) of this section. A school district board shall not require school personnel who have not received appropriate training to administer medication.

(3)(a) School district boards may adopt policies and procedures that provide for the administration of [*naloxone or any similar medication*] **a short-acting opioid antagonist** that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug.

(b) Policies and procedures adopted under paragraph (a) of this subsection shall be consistent with the rules adopted by the State Board of Education under subsection (1) of this section.

SECTION 7. ORS 339.871 is amended to read:

339.871. (1) A school administrator, school nurse, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of a student's self-administration of medication, as described in ORS 339.866, if the school administrator, school nurse, teacher or other school employee, in compliance with the instructions of the student's Oregon licensed health care professional, in good faith assists the student's self-administration of the medication, if the medication is available to the student pursuant to written permission and instructions of the student's parent, guardian or Oregon licensed health care professional.

(2) A school administrator, school nurse, teacher or other school employee designated by the school administrator is not liable in a criminal action or for civil damages as a result of the use of medication if the school administrator, school nurse, teacher or other school employee in good faith administers:

(a) Autoinjectable epinephrine to a student or other individual with a severe allergy who is unable to self-administer the medication, regardless of whether the student or individual has a prescription for epinephrine; or

(b) [*Naloxone or any similar medication*] **A short-acting opioid antagonist, as defined in ORS 689.681,** that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug to a student or other individual who the school administrator, school nurse, teacher or other school employee believes in good faith is experiencing an overdose of an opioid drug.

(3) A school district and the members of a school district board are not liable in a criminal action or for civil damages as a result of the use of medication if:

(a) Any person in good faith administers autoinjectable epinephrine to a student or other individual with a severe allergy who is unable to self-administer the medication, regardless of whether the student or individual has a prescription for epinephrine; and

(b) The person administered the autoinjectable epinephrine on school premises, including at a school, on school property under the jurisdiction of the district or at an activity under the jurisdiction of the school district.

(4) A school district and the members of a school district board are not liable in a criminal action or for civil damages as a result of the use of medication if:

(a) Any person in good faith administers [*naloxone or any similar medication*] **a short-acting opioid antagonist** that is in any form available for safe administration and that is designed to rapidly reverse an overdose of an opioid drug to a student or other individual who the person believes in good faith is experiencing an overdose of an opioid drug; and

(b) The person administered the [*naloxone or similar medication*] **short-acting opioid antagonist** on school premises, including at a school, on school property under the jurisdiction of the district or at an activity under the jurisdiction of the school district.

(5) The civil and criminal immunities imposed by this section do not apply to an act or omission amounting to gross negligence or willful and wanton misconduct.

SECTION 8. ORS 430.389 is amended to read:

430.389. (1) The Oversight and Accountability Council shall oversee and approve grants and funding to implement Behavioral Health Resource Networks and increase access to community care, as set forth below. A Behavioral Health Resource Network is an entity or collection of entities that individually or jointly provide some or all of the services described in subsection (2)(d) of this section.

(2)(a) The Oversight and Accountability Council, in consultation with the Oregon Health Authority, shall provide grants and funding to agencies or organizations, whether government or community based, to establish Behavioral Health Resource Networks for the purposes of immediately screening the acute needs of people who use drugs and assessing and addressing any ongoing needs through ongoing case management, harm reduction, treatment, housing and linkage to other care and services. Recipients of grants or funding to provide substance use disorder treatment or services must be licensed, certified or credentialed by the state, including certification under ORS 743A.168 (8), or meet criteria prescribed by rule by the Oversight and Accountability Council under ORS 430.390. A recipient of a grant or funding under this subsection may not use the grant or funding to supplant the recipient's existing funding.

(b) The council and the authority shall ensure that residents of each county have access to all of the services described in paragraph (d) of this subsection.

(c) Applicants for grants and funding may apply individually or jointly with other network participants to provide services in one or more counties.

(d) A network must have the capacity to provide the following services and any other services specified by the council by rule:

(A) Screening by certified addiction peer support or wellness specialists or other qualified persons designated by the council to determine a client's need for immediate medical or other treatment to determine what acute care is needed and where it can be best provided, identify other needs and link the client to other appropriate local or statewide services, including treatment for substance abuse and coexisting health problems, housing, employment, training and child care. Networks shall provide this service 24 hours a day, seven days a week, every calendar day of the year. Notwithstanding paragraph (b) of this subsection, only one grantee in each network within each county is required to provide the screenings described in this subparagraph.

(B) Comprehensive behavioral health needs assessment, including a substance use disorder screening by a certified alcohol and drug counselor or other credentialed addiction treatment professional. The assessment shall prioritize the self-identified needs of a client.

(C) Individual intervention planning, case management and connection to services. If, after the completion of a screening, a client indicates a desire to address some or all of the identified needs, a case manager shall work with the client to design an individual intervention plan. The plan must

address the client's need for substance use disorder treatment, coexisting health problems, housing, employment and training, child care and other services.

(D) Ongoing peer counseling and support from screening and assessment through implementation of individual intervention plans as well as peer outreach workers to engage directly with marginalized community members who could potentially benefit from the network's services.

(E) Assessment of the need for, and provision of, mobile or virtual outreach services to:

(i) Reach clients who are unable to access the network; and

(ii) Increase public awareness of network services.

(F) Harm reduction services and information and education about harm reduction services.

(G) Low-barrier substance use disorder treatment.

(H) Transitional and supportive housing for individuals with substance use disorders.

(e) If an applicant for a grant or funding under this subsection is unable to provide all of the services described in paragraph (d) of this subsection, the applicant may identify how the applicant intends to partner with other entities to provide the services, and the Oregon Health Authority and the council may facilitate collaboration among applicants.

(f) All services provided through the networks must be evidence-informed, trauma-informed, culturally specific, linguistically responsive, person-centered and nonjudgmental. The goal shall be to address effectively the client's substance use and any other social determinants of health.

(g) The networks must be adequately staffed to address the needs of people with substance use disorders within their regions as prescribed by the council by rule, including, at a minimum, at least one person qualified by the Oregon Health Authority in each of the following categories:

(A) Certified alcohol and drug counselor or other credentialed addiction treatment professional;

(B) Case manager; and

(C) Certified addiction peer support or wellness specialist.

(h) Verification of a screening by a certified addiction peer support specialist, wellness specialist or other person in accordance with subsection (2)(d)(A) of this section shall promptly be provided to the client by the entity conducting the screening. If the client executes a valid release of information, the entity shall provide verification of the screening to the Oregon Health Authority or a contractor of the authority and the authority or the authority's contractor shall forward the verification to the court, in the manner prescribed by the Chief Justice of the Supreme Court, to satisfy the conditions for dismissal under ORS 153.062 or 475.237.

(3)(a) If moneys remain in the Drug Treatment and Recovery Services Fund after the council has committed grants and funding to establish behavioral health resource networks serving every county in this state, the council shall provide grants and funding to other agencies or organizations, whether government or community based, and to the nine federally recognized tribes in this state and service providers that are affiliated with the nine federally recognized tribes in this state to increase access to one or more of the following:

(A) Low-barrier substance use disorder treatment that is evidence-informed, trauma-informed, culturally specific, linguistically responsive, person-centered and nonjudgmental;

(B) Peer support and recovery services;

(C) Transitional, supportive and permanent housing for persons with substance use disorder;

(D) Harm reduction interventions including, but not limited to, overdose prevention education, access to [*naloxone hydrochloride*] **short-acting opioid antagonists, as defined in ORS 689.681,** and sterile syringes and stimulant-specific drug education and outreach; or

(E) Incentives and supports to expand the behavioral health workforce to support the services

delivered by behavioral health resource networks and entities receiving grants or funding under this subsection.

(b) A recipient of a grant or funding under this subsection may not use the grant or funding to supplant the recipient's existing funding.

(4) In awarding grants and funding under subsections (2) and (3) of this section, the council shall:

(a) Distribute grants and funding to ensure access to:

(A) Historically underserved populations; and

(B) Culturally specific and linguistically responsive services.

(b) Consider any inventories or surveys of currently available behavioral health services.

(c) Consider available regional data related to the substance use disorder treatment needs and the access to culturally specific and linguistically responsive services in communities in this state.

(d) Consider the needs of residents of this state for services, supports and treatment at all ages.

(5) The council shall require any government entity that applies for a grant to specify in the application details regarding subgrantees and how the government entity will fund culturally specific organizations and culturally specific services. A government entity receiving a grant must make an explicit commitment not to supplant or decrease any existing funding used to provide services funded by the grant.

(6) In determining grants and funding to be awarded, the council may consult the comprehensive addiction, prevention, treatment and recovery plan established by the Alcohol and Drug Policy Commission under ORS 430.223 and the advice of any other group, agency, organization or individual that desires to provide advice to the council that is consistent with the terms of this section.

(7) Services provided by grantees, including services provided by a Behavioral Health Resource Network, shall be free of charge to the clients receiving the services. Grantees in each network shall seek reimbursement from insurance issuers, the medical assistance program or any other third party responsible for the cost of services provided to a client and grants and funding provided by the council or the authority under subsection (2) of this section may be used for copayments, deductibles or other out-of-pocket costs incurred by the client for the services.

(8) Subsection (7) of this section does not require the medical assistance program to reimburse the cost of services for which another third party is responsible in violation of 42 U.S.C. 1396a(25).

SECTION 9. ORS 431A.855 is amended to read:

431A.855. (1)(a) The Oregon Health Authority, in consultation with the Prescription Monitoring Program Advisory Commission, shall establish and maintain a prescription monitoring program for monitoring and reporting:

(A) Prescription drugs dispensed by pharmacies licensed by the State Board of Pharmacy that are classified in schedules II through IV under the federal Controlled Substances Act, 21 U.S.C. 811 and 812, as modified by the board by rule under ORS 475.035;

(B) Prescribed gabapentin and [*naloxone*] **short-acting opioid antagonists, as defined in ORS 689.681,** dispensed by pharmacies; and

(C) Other drugs identified by rules adopted by the authority.

(b)(A) To fulfill the requirements of this subsection, the authority shall establish, maintain and operate an electronic system to monitor and report drugs described in paragraph (a) of this subsection that are dispensed by prescription.

(B) The electronic system must:

(i) Operate and be accessible by practitioners and pharmacies 24 hours a day, seven days a

week; and

(ii) Allow practitioners to register as required under ORS 431A.877 and to apply for access to the electronic system in accordance with rules adopted by the authority under subsection (2) of this section.

(C) The authority may contract with a state agency or private entity to ensure the effective operation of the electronic system.

(2) In consultation with the commission, the authority shall adopt rules for the operation of the electronic prescription monitoring program established under subsection (1) of this section, including standards for:

(a) Reporting data;

(b) Providing maintenance, security and disclosure of data;

(c) Ensuring accuracy and completeness of data;

(d) Complying with the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and regulations adopted under that law, including 45 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality laws and regulations adopted under those laws, including 42 C.F.R. part 2, and state health and mental health confidentiality laws, including ORS 179.505, 192.517 and 192.553 to 192.581;

(e) Ensuring accurate identification of persons or entities requesting information from the database;

(f) Accepting printed or nonelectronic reports from pharmacies that do not have the capability to provide electronic reports;

(g) Notifying a patient, before or when a drug classified in schedules II through IV is dispensed to the patient, about the prescription monitoring program and the entry of the prescription in the electronic system; and

(h) Registering practitioners with the electronic system.

(3) The authority shall submit an annual report to the commission regarding the prescription monitoring program established under this section.

SECTION 10. ORS 431A.865 is amended to read:

431A.865. (1)(a) Except as provided under subsections (2) and (3) of this section, prescription monitoring information submitted under ORS 431A.860 to the prescription monitoring program established in ORS 431A.855:

(A) Is protected health information under ORS 192.553 to 192.581.

(B) Is confidential and not subject to disclosure under ORS 192.311 to 192.478.

(b) Except as provided under subsection (3)(a)(H) of this section, prescription monitoring information submitted under ORS 431A.860 to the prescription monitoring program may not be used to evaluate a practitioner's professional practice.

(2) The Oregon Health Authority may review the prescription monitoring information of an individual who dies from a drug overdose.

(3)(a) Except as provided in paragraph (c) of this subsection, the Oregon Health Authority shall disclose prescription monitoring information reported to the authority under ORS 431A.860:

(A) To a practitioner or pharmacist, or, if a practitioner or pharmacist authorizes the authority to disclose the information to a member of the practitioner's or pharmacist's staff, to a member of the practitioner's or pharmacist's staff. If a practitioner or pharmacist authorizes disclosing the information to a member of the practitioner's or pharmacist's staff under this subparagraph, the practitioner or pharmacist remains responsible for the use or misuse of the information by the staff

member. To receive information under this subparagraph, or to authorize the receipt of information by a staff member under this subparagraph, a practitioner or pharmacist must certify that the requested information is for the purpose of evaluating the need for or providing medical or pharmaceutical treatment for a patient to whom the practitioner or pharmacist anticipates providing, is providing or has provided care.

(B) To a dental director, medical director or pharmacy director, or, if a dental director, medical director or pharmacy director authorizes the authority to disclose the information to a member of the dental director's, medical director's or pharmacy director's staff, to a member of the dental director's, medical director's or pharmacy director's staff. If a dental director, medical director or pharmacy director authorizes disclosing the information to a member of the dental director's, medical director's or pharmacy director's staff under this subparagraph, the dental director, medical director or pharmacy director remains responsible for the use or misuse of the information by the staff member. To receive information under this subparagraph, or to authorize the receipt of information by a staff member under this subparagraph:

(i) A dental director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, dental clinic or office, or a system of dental clinics or offices, and ensuring the delivery of quality dental care within the coordinated care organization, clinic, office or system.

(ii) A medical director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, hospital, health care clinic or system of hospitals or health care clinics and ensuring the delivery of quality health care within the coordinated care organization, hospital, clinic or system.

(iii) A pharmacy director must certify that the requested information is for the purposes of overseeing the operations of a coordinated care organization, pharmacy or system of pharmacies and ensuring the delivery of quality pharmaceutical care within the coordinated care organization, pharmacy or system.

(C) In accordance with subparagraphs (A) and (B) of this paragraph, to an individual described in subparagraphs (A) and (B) of this paragraph through a health information technology system that is used by the individual to access information about patients if:

(i) The individual is authorized to access the information in the health information technology system;

(ii) The information is not permanently retained in the health information technology system, except for purposes of conducting audits and maintaining patient records; and

(iii) The health information technology system meets any privacy and security requirements and other criteria, including criteria required by the federal Health Insurance Portability and Accountability Act, established by the authority by rule.

(D) To a practitioner in a form that catalogs all prescription drugs prescribed by the practitioner according to the number assigned to the practitioner by the Drug Enforcement Administration of the United States Department of Justice.

(E) To the Chief Medical Examiner or designee of the Chief Medical Examiner, for the purpose of conducting a medicolegal investigation or autopsy.

(F) To designated representatives of the authority or any vendor or contractor with whom the authority has contracted to establish or maintain the electronic system established under ORS 431A.855.

(G) Pursuant to a valid court order based on probable cause and issued at the request of a

federal, state or local law enforcement agency engaged in an authorized drug-related investigation involving a person to whom the requested information pertains.

(H) To a health professional regulatory board that certifies in writing that the requested information is necessary for an investigation related to licensure, license renewal or disciplinary action involving the applicant, licensee or registrant to whom the requested information pertains.

(I) Pursuant to an agreement entered into under ORS 431A.869.

(b) The authority may disclose information from the prescription monitoring program that does not identify a patient, practitioner or drug outlet:

(A) For educational, research or public health purposes;

(B) For the purpose of educating practitioners about the prescribing of opioids and other controlled substances;

(C) To a health professional regulatory board;

(D) To a local public health authority, as defined in ORS 431.003; or

(E) To officials of the authority who are conducting special epidemiologic morbidity and mortality studies in accordance with ORS 413.196 and rules adopted under ORS 431.001 to 431.550 and 431.990.

(c) The authority may not disclose, except as provided in paragraph (b) of this subsection:

(A) Prescription drug monitoring information to the extent that the disclosure fails to comply with applicable provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and regulations adopted under that law, including 45 C.F.R. parts 160 and 164, federal alcohol and drug treatment confidentiality laws and regulations, including 42 C.F.R. part 2, and state health and mental health confidentiality laws, including ORS 179.505, 192.517 and 192.553 to 192.581.

(B) The sex of a patient for whom a drug was prescribed.

(C) The identity of a patient for whom [*naloxone*] **a short-acting opioid antagonist, as defined in ORS 689.681,** was prescribed.

(d) The authority shall disclose information relating to a patient maintained in the electronic system established under ORS 431A.855 to that patient at no cost to the patient within 10 business days after the authority receives a request from the patient for the information.

(e)(A) A patient may request the authority to correct any information related to the patient that is maintained in the electronic system established under ORS 431A.855 that is erroneous. The authority shall grant or deny a request to correct information within 10 business days after the authority receives the request. If a request to correct information cannot be granted because the error occurred at the pharmacy where the information was inputted, the authority shall inform the patient that the information cannot be corrected because the error occurred at the pharmacy.

(B) If the authority denies a patient's request to correct information under this paragraph, or fails to grant a patient's request to correct information under this paragraph within 10 business days after the authority receives the request, the patient may appeal the denial or failure to grant the request. Upon receiving notice of an appeal under this subparagraph, the authority shall conduct a contested case hearing as provided in ORS chapter 183. Notwithstanding ORS 183.450, the authority has the burden in the contested case hearing of establishing that the information is correct.

(f) The information in the prescription monitoring program may not be used for any commercial purpose.

(g) In accordance with ORS 192.553 to 192.581 and federal laws and regulations related to privacy, any person authorized to prescribe or dispense a prescription drug who is entitled to access

a patient's prescription monitoring information may discuss the information with or release the information to other health care providers involved with the patient's care for the purpose of providing safe and appropriate care coordination.

(4)(a) The authority shall maintain records of the information disclosed through the prescription monitoring program including:

(A) The identity of each person who requests or receives information from the program and any organization the person represents;

(B) The information released to each person or organization; and

(C) The date and time the information was requested and the date and time the information was provided.

(b) Records maintained as required by this subsection may be reviewed by the Prescription Monitoring Program Advisory Commission.

(5) Information in the prescription monitoring program that identifies an individual patient must be removed no later than three years from the date the information is entered into the program.

(6) The authority shall notify the Attorney General and each individual affected by an improper disclosure of information from the prescription monitoring program of the disclosure.

(7)(a) If the authority or a person or entity required to report or authorized to receive or release prescription information under this section violates this section or ORS 431A.860 or 431A.870, a person injured by the violation may bring a civil action against the authority, person or entity and may recover damages in the amount of $1,000 or actual damages, whichever is greater.

(b) Notwithstanding paragraph (a) of this subsection, the authority and a person or entity required to report or authorized to receive or release prescription information under this section are immune from civil liability for violations of this section or ORS 431A.860 or 431A.870 unless the authority, person or entity acts with malice, criminal intent, gross negligence, recklessness or willful intent.

(8) Nothing in ORS 431A.855 to 431A.900 requires a practitioner or pharmacist who prescribes or dispenses a prescription drug to obtain information about a patient from the prescription monitoring program. A practitioner or pharmacist who prescribes or dispenses a prescription drug may not be held liable for damages in any civil action on the basis that the practitioner or pharmacist did or did not request or obtain information from the prescription monitoring program.

(9) The authority shall, at regular intervals, ensure compliance of a health information technology system described in subsection (3) of this section with the privacy and security requirements and other criteria established by the authority under subsection (3) of this section.
