March 19, 2024

To the members of the State and Local Government Committee for the State of Minnesota:

Thank you for allowing me to submit this written testimony. I do apologize for my absence at today's hearing, I am a nurse practitioner and am in clinic all today today. So, as to not disrupt care I wanted to provide you this written testimony.

The use of prescription medications is on the rise, over 5 billion are filled annually in the USA with over 66% of the US population using at least one prescription medication. While they come with great benefit to quality of life when used correctly, when used incorrectly they end up being the cause nearly 10% of all deaths in this country. Medications are complex, with multiple names (brand and generic), complex instructions, indications, side effects – and with the average medical literacy of the general popiulation (only 35% having basic health literacy), we need to do a better job making prescription medications safer.

This bill is designed to improve the safety and efficacy of prescription medications by making clearer the "What" and "Why" of a prescription medication.

The first issue addressed is to confirm that the patient understands "what" medication they are taking. Currently, there is no state mandate to even include the full generic name on a prescription bottle label. This is in opposition to the USP General Chapter 17 which states the standard for the drug name "spelled out full generic and brand name" on the medication bottle label. Personally, after surgery I was prescribed a combination narcotic medication (Norco – Hydrocodone-acetaminophen); yet the bottle label from a chain pharmacy read "Hydrocodone-ACET". What does "ACET" mean? That isn't even an accepted abbreviation of acetaminophen (Tylenol) which would be APAP. As a healthcare provider, I could deduce the meaning – but what about everyone else? Could this lead to unintentional acetaminophen overdose? Yes, of course it could. Therefore, the first issue addressed is to ensure that the full, unabbreviated generic medication name is included on the patient's bottle label.

The second issue addressed is to confirm that the patient understands "why" they are taking a certain prescription medication. Current MN law is, again, in opposition to USP General Chapter 17 standards stating that inclusion of "purpose-for-use language in clear simple terms" is evidence-based and should be included on the patient's bottle label. Instead of using medical jargon – such as you are taking "Furosemide as a diuretic" – the prescriber will include the language used with the patient when prescribing the drug "furosemdie is your water pill"; this will be printed on the bottle label. Customizing this language to be specific to that patient-provider relationship will help to improve patient's understanding, confidence, and compliance with medication regimens.

As a healthcare provider, I know all too well the complexities of medication management that plague our patients. Every day patients come into my office having limited understanding (or no understanding) of their current medication regimen. How can we expect them to get it right when we don't even provide them the basic information? In providing a clear and concise "What" and "Why" – this bill turns USP standards into MN state law requirements and, most importantly, promotes safe and effective prescription medication practices for our patients.

Thank you. Robert Anderson APRN, DNP, CNP