MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-ninth Session
March 17, 2017

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Kelvin Atkinson at 8:04 a.m. on Friday, March 17, 2017, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Kelvin Atkinson, Chair
Senator Pat Spearman, Vice Chair
Senator Nicole J. Cannizzaro
Senator Yvanna D. Cancela
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Heidi S. Gansert

GUEST LEGISLATORS PRESENT:

Senator Moises Denis, Senatorial District No. 2
Senator Becky Harris, Senatorial District No. 9

STAFF MEMBERS PRESENT:

Marji Paslov Thomas, Policy Analyst
Christine Miner, Committee Secretary

OTHERS PRESENT:

Marcus Conklin, Nevada Mortgage Lenders Association; Merscorp Holdings, Inc.
Liz MacMenamin, Retail Association of Nevada
Adam Porath, Pharm.D., Nevada Society of Health-System Pharmacists
Marie M. McCormack, M.D.
Michael Bloch, M.D.
Vasudha Gupta, Pharm.D.

Nikki Beck, Nevada Society of Health-System Pharmacists
Jay Parmer, Sierra Family Pharmacies
Catherine O'Mara, Executive Director, The Nevada State Medical Association
Kathleen Conaboy, Nevada Orthopaedic Society
Keith Lee, Nevada Association of Health Plans; Board of Medical Examiners
Michael Hillerby, State Board of Pharmacy
Rick Kuhlmey
Bill Powers
Bari Powers
John Yacenda, President, Nevada Silver Haired Legislative Forum
Suzanne Thomas
Kate Osti

CHAIR ATKINSON:
I will open the hearing on Senate Bill (S.B.) 238.

SENATE BILL 238: Makes certain changes relating to real property. (BDR 55-541)

SENATOR BECKY HARRIS (Senatorial District No. 9):
Senate Bill 238 contains technical corrections to the homeowners' association (HOA) notices for foreclosure liens to lenders. Section 1, subsection 1 adds "Each mortgagee or beneficiary of a deed of trust ... ". A mortgagee is an entity that lends money. The bill refers to financial institutions that lend money for mortgages. A beneficiary is someone who has the right to enforce a deed of trust. The bill clarifies companies like Merscorp Holdings, Inc., often designated as a beneficiary on deeds of trust in Nevada and throughout the U.S., be able to request notices when there is an HOA lien being filed. Because Merscorp is a central repository for mortgages and deeds of trust, it needs entitlement to notify for delinquency of HOA dues. The statute specifies a bank, a credit union, a savings bank, a savings and loan association, thrift company or other financial institution be entitled to this noticing, and it was unclear if Merscorp was included. Senate Bill 238 clarifies this provision.

MARCUS CONKLIN (Nevada Mortgage Lenders Association; Merscorp Holdings, Inc.):
Senate Bill 238 creates a clear understanding in statute which will result in less litigation. The information needed to create a notice of HOA lien foreclosure proceedings will be available to appropriate parties. I have written testimony

from William C. Hultman, representing Merscorp Holdings, outlining his support (Exhibit C).

CHAIR ATKINSON:
I will close the hearing on S.B. 238 and open the hearing on S.B. 260.

SENATE BILL 260: Establishes requirements for engaging in the collaborate practice of pharmacy. (BDR 54-973)

LIZ MACMENAMIN (Retail Association of Nevada):
Senate Bill 260 seeks to implement collaborative practice agreements (CPA) between a pharmacist and a doctor. Collaborative drug therapy management is a practice of the CPA between one or more providers and a pharmacist in which a qualified pharmacist works within the context of a defined protocol and is permitted to assume professional responsibility for performing patient assessments, counseling, referrals, ordering laboratory tests, administering drugs and selecting, initiating, monitoring and continuing and adjusting drug regimens.

In recent years, some states have modernized their laws to allow pharmacists to provide broader health care services under CPAs. Exhibit D provides more information on CPAs and pharmacists' patient care services in various states. In the states that allow CPAs, pharmacists work with physicians to help manage conditions like asthma, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, diabetes, congestive heart failure and other health care conditions. The dispensing of Naloxone is allowed in Nevada without a prescription. The CPAs in other states allow pharmacists to provide fluid strep screening and treatment services and other types of health care services according to the parameters outlined by the collaborating physician. Pharmacists do not diagnose patients. They are part of the functioning medical supply chain and pharmaceutical distribution center. Pharmacies serve as frontline resources for health care by providing public access to trained pharmacists.

The role of the pharmacist has expanded to include prevention activities such as immunization. Nevada ranks high in the immunization process due to forward thinking legislation. Pharmacists assist in response activities, not only through dispensing medications, but in disease surveillance, risk communication and community outreach.

The CPA is a private agreement with a pharmacist, pharmacy and a prescriber. Michigan and Wisconsin allow broad collaborative practices. They authorize physicians to delegate authority to pharmacists to perform any delegated patient care service. Idaho, Minnesota, Nebraska, Oregon, Tennessee, and Washington have modernized collaborative practices.

Massachusetts, Nevada and New York do not allow Clinical Laboratory Improvement Amendments (CLIA)-waived test practices. Forty-seven states allow pharmacies to perform CLIA-waived tests. The CPAs in Minnesota, Iowa and Nebraska allow a large breadth for testing and furnishing medications. The most common CLIA-waived tests provided under CPA agreements are rapid strep, rapid flu, blood glucose, hemoglobin A1c and cholesterol.

Medicare is considering utilizing data from 2017 to impact the process with the CPA to slightly affect the star rating of a physician. There are fees included in CLIA-waived testing at the pharmacy. This is within the pharmacist's scope of practice in a CPA. The costs for the tests are minimal, often less expensive than doctor's office visits. Some insurance plans may cover these services. Nevada does not allow CLIA-waived tests by pharmacies. In a previous Session, similar legislation was introduced on CPAs and CLIA-waived tests without results.

There is an amendment (Exhibit E) to S.B. 260. More changes are needed on the language of the bill, and we will to work with the interested parties from the medical industry.

CHAIR ATKINSON:
Is the amendment insufficient?

MS. MACMENAMIN:
The amendment addresses the concerns of the retail chain drug members. It does not address the concerns of others in the industry opposed to the bill or those questioning content.

SENATOR HARDY:
What is done when a strep screen is positive?

MS. MACMENAMIN:
If there is a positive result on the strep screen, some states allow medication to be furnished, other states require a conference with a physician.

SENATOR HARDY:
It is necessary to document the condition of the patient's heart when they are diagnosed with strep. Different conditions can result when a person has strep throat which requires documentation. How much of a physical exam does the pharmacist perform? Is there diagnosis as well as treatment?

MS. MACMENAMIN:
The test is the diagnosis, which initiates a doctor referral or treatment. The authorizing state determines test procedures. In a CPA, the physician works with the pharmacist to set the criteria for various medical situations.

SENATOR HARDY:
I do not see a fiscal note on the bill. Are there costs to be incurred by the State or the patient?

MS. MACMENAMIN:
There is no fiscal note. The bill applies to people with health care plans. Due to large deductibles in the Affordable Care Act (ACA) and other health care plans, the CPA gives patients the option of starting treatment with the pharmacist which allows for decreased out-of-pocket expenses. There is no cost to the State.

SENATOR HARDY:
Is the bill changing the definition of a health care provider?

MS. MACMENAMIN:
The bill adds pharmacists in a collaborate practice with a physician. It does not change the definition of a health care provider.

SENATOR GANSERT:
The CPA would be helpful for chronic diseases like high blood pressure, diabetes and high cholesterol. Is the practice primarily around quick tests or around working with physicians with a contractual arrangement to try to best refine how types of medications are provided?

MS. MACMENAMIN:
Pharmacists practicing with a CPA are focused on chronic disease states. Scientific studies show positive outcomes with these practices. The chronic disease states are important areas influencing CPAs. Medication therapy

management improves patient outcome. Stabilizing someone with high blood pressure through this process is much quicker than the alternative route of seeing the physician for multiple visits. The physician and the pharmacist can work together to stabilize the patient to bring a positive outcome.

SENATOR CANCELA:
How does the process work for data sharing between the doctor and the pharmacist? How does the process ensure the patient receives the right treatment for the diagnosis?

MS. MACMENAMIN:
Within the agreement and the protocol, the physician and the pharmacist have access to patient files. It works well in the institutional setting which is a closed system. In the retail environment, sharing of records is an open system. Senate Bill 260 does not address this, and we will be discussing it with the medical providers to ensure the process meets their needs.

SENATOR SPEARMAN:
Will pharmacists be considered healthcare providers or what will they be called?

MS. MACMENAMIN:
Statute defines a health care provider. The definition of pharmacists has not been added. Most consider pharmacists health care providers. Statute does not clarify them as part of the health care provider network. It is assumed that pharmacists only count pills and distribute prescriptions. Pharmacists are highly educated and trained to manage patients for many diseased states.

SENATOR SPEARMAN:
I will read from the abstract of a study in SAGE Journals published February 8, 2017, "The Role of Pharmacy Through Collaborative Practice in an Ambulatory Care Clinic," by Jeany Kim Jun, Pharm.D.:

> Pharmacists have been practicing in ambulatory care environments managing patients with chronic illnesses since the 1970s. The U.S. Surgeon General and the Centers for Disease Control and Prevention support pharmacists working in collaboration with physicians to optimize medication outcomes, improve patient satisfaction, and lower health care costs. Through collaborative

> practice agreements, pharmacists are able to work as part of a health care team ... .

Instead of defining pharmacists as health care providers, based on the definition in this study, would it be suitable to define them as part of a health care team?

MS. MACMENAMIN:
The pharmacist is part of a health care team. I can discuss this for possible clarification in the bill.

SENATOR HARDY:
Does an advanced practice registered nurse (APRN) have a role in the CPA?

MS. MACMENAMIN:
The APRN does not have a role in the CPA.

SENATOR HARDY:
In the agreement between a physician's assistant and a physician, there is chart review and supervisory responsibilities and liabilities. Does the CPA propose there be some oversight or liability confluence between the pharmacist and physician?

MS. MACMENAMIN:
Liability is shared between the pharmacist and the pharmacy. There are chart reviews set up in the agreement. The bill language sets up the structure for the CPA. Oversight by the State Board of Pharmacy and language to keep the institutional practice agreements in place have not changed.

ADAM PORATH, PHARM.D. (Nevada Society of Health-System Pharmacists):
Nevada Society of Health-System Pharmacists (NVSHP) is the only active professional organization in Nevada representing the interests of pharmacists and pharmacy technicians and supports S.B. 260. We support access to health care in Nevada and want to see pharmacists outside of hospitals and health systems be able to enter into CPAs. We have a few minor issues with the language in the bill and will work with the bill sponsor to ensure Nevadans have access to pharmacist care through CPAs. Nevada is one of only four states west of the Mississippi that puts restrictions on where collaborative practices can be done. The other 20 states west of the Mississippi do not. Pharmacists working in collaboration with physicians have been shown to improve patient

outcomes and decrease costs of care in a variety of diseased states including high blood pressure and diabetes.

I am a practicing pharmacist in northern Nevada. I manage a team of 12 outpatient pharmacists deployed throughout the Renown Regional Medical Center System. I am involved in a variety of collaborative practice protocols. I have the opportunity to work side-by-side with physicians.

MARIE M. MCCORMACK, M.D.:
I am a family practice physician. I have a collaborative working agreement with Mr. Porath for chronic disease states. The CPA is a better way to provide care for our patients. Mr. Porath sees patients within our CPA, and when he sees a patient for anticoagulation and the patient's blood pressure is high, he can contact me to discuss changes and appropriate follow-up. An important part of a CPA is to access the same patient record. There is review from the supervisory position.

MICHAEL BLOCH, M.D.:
I am a vascular medicine physician and very involved in chronic disease management. I am vice president of the American Society of Hypertension. Many of the members are working to integrate more pharmacists into the health care delivery team. There is much data demonstrating the use of a pharmacist on the health care team in the field of hypertension which allows for better patient blood pressure control. In settings where we use the CPA system, we see blood pressure control rates increase. Kaiser Permanente makes extensive use of pharmacists in managing blood pressure and has some of the best hypertension control rates in the world. Kaiser control rates are 75 percent and up compared to 50 percent for the rest of the Country.

With the epidemic of cardiovascular disease nationwide, we need an all-hands-on-deck approach. I do not see anything in S.B. 260 that threatens my practice as a physician. My goal is to impact as many patients as possible. The CPA allows me to do so by expanding the team I work with in a very economical fashion. We are able to do this at Renown because we are an institution and are allowed to have pharmacists working under protocols with physician supervision. I can be involved in the care of thousands of patients per week instead of 100 patients per week. Studies have shown blood pressure and blood sugar can be managed quicker with a CPA. The bill will allow some of the other health care providers and federally sponsored clinics who take care of

some of our most vulnerable citizens to see patients for blood pressure, cholesterol and diabetes. Using the same framework Renown uses enables expanded care. I recently had a patient be helped by our pharmacist to manage confusion about blood pressure medications, and another patient came for an office visit who could have been helped by a pharmacist in an interim visit for a simple medication change. The patient was without medication for three months.

My team supports S.B. 260. The CPAs require considerable oversight by the State Board of Pharmacy, and we can work with them to be sure the collaborative agreements are put together in a way that protects patients, privacy and expands care.

DR. MCCORMICK:
I am concerned with the mileage restriction in S.B. 260. I practice in Fernley and Fallon, and there are many miles between providers in the rural setting. I would like the mileage circumference be changed to 100 miles.

SENATOR HARDY:
What are the studies mentioned to get blood sugar and blood pressure down quicker? How do you manage the CLIA-waived test and acute diseases? How do you keep track of 1,000 patients a week? What is the supervisory role and the oversight for the State Board of Pharmacy? Are there ongoing issues with communication between the Pharmacy Board and the Board of Medical Examiners? How do the two Boards communicate with each other for problems with the pharmacist?

DR. BLOCH:
The Pharmacy Board will bear the primary responsibility to ensure the collaborative arrangements are appropriate. The Medical Board does not lose the ability to sanction physicians who are not practicing according to our community standard. The Medical Board provides oversight for every physician practicing in Nevada.

Within the setting of Renown, we have set protocols for which patients come to me, the medical director, for review. Within these protocols some of the easier visits are taken care of by the pharmacist per the documentation of that patient. Protocol is spelled out for the more difficult visits as to what conditions need to be reviewed by the physician. For example, a patient who comes in for a new

anticoagulation visit is reviewed by the medical director. If necessary, we contact the referring provider. I review new patients starting on new blood pressure medications or new cholesterol medications. Our guidelines for the treatment of blood pressure require the patient's medicine be up titrated every four to six weeks. If I see a patient today, my next available appointment is in three and a half months. It is difficult for the patient to be seen and up titrated without the use of a large health care team. Usually, blood pressure patients are seen by the physician on their first and second visits, a treatment plan is initiated and other health care personnel including pharmacists take part in the follow-up visits. We have a workforce shortage. There are not enough physicians in Nevada to treat all of our patients with chronic disease.

MR. PORATH:
I have a separate license in Nevada as a point-of-care analyst to do finger stick and ProTime INR tests. The ability of these tests to be done in a pharmacy and to allow the pharmacy to be a CLIO-waived site for point-of-care testing requires a law change. I do not test for strep or influenza in my practice and cannot comment on how collaborative practice protocols work with that testing.

SENATOR HARDY:
Is there data sharing criteria in Michigan and other states allowing the CPAs? Does the pharmacist have access to the same patient medical record as the participating doctor? Is it complete sharing?

MR. PORATH:
Medical record sharing is an important piece of a CPA. A pharmacist working in a community pharmacy would need access to the referring doctor's patient records before decisions could be made under those protocols. Any medication changes requires communication with the referring doctor. This requirement is not spelled out in the S.B. 260.

SENATOR HARDY:
How much of the patient's record is shared? A patient on psychiatric medication may not want this information available.

DR. BLOCH:
A pharmacist already knows many details about the patient's medical conditions. They have access to some of the records. Each of those collaborative arrangements should have patient record sharing included. It is

difficult to legislate the variety of settings and circumstances. Retail pharmacies in rural Nevada are under different sets of circumstances on how they communicate and review records than pharmacists working in large institutions. It is up to the Pharmacy and Medical Boards to ensure appropriate record sharing between providers.

VASUDHA GUPTA, Pharm.D.:
I am a pharmacist and an assistant professor of pharmacy practice at Roseman University of Health Sciences. After graduation from pharmacy school, I completed a one-year postgraduate residency in primary care where I practiced under a collaborative practice agreement in Rhode Island. I managed patients with many chronic disease states including hypertension, hyperlipidemia, diabetes and congestive heart failure. After residency, I practiced at a primary care clinic in Sacramento under a CPA. Pharmacists are considered one of the most underutilized health care providers. We have the knowledge and the skills to provide and improve patient care. There are many studies showing pharmacists improve outcomes, decrease hospitalizations and decrease health care costs.

Nevada is one for the few states in the Country with limitations on the implementation of the CPA. I will be practicing at a federally qualified health center (FQHC) and am not able to implement a CPA. I support S.B. 260 to allow me and other capable pharmacists across the State to practice autonomously to help increase access to care for patients, especially in areas where services may be limited due to a shortage of primary care providers. Pharmacists across Nevada can provide education regarding disease states and medication, improve medication adherence, modify pharmacologic therapy to help patients meet their therapeutic goals in a safe and effective manner and improve patient satisfaction with their health care.

SENATOR HARDY:
Are you interested in performing CLIA-waived tests in your practice?

MS. GUPTA:
I do not have much experience with CLIA-waived tests. I practice in a primary care clinic. All of the lab or associated tests go through the primary care provider.

NIKKI BECK (Nevada Society of Health-System Pharmacists):
I am a clinical pharmacist working for the underserved in a FQHC. Many of the patients have chronic diseases such as diabetes, hypertension and hyperlipidemia. I cannot work under a CPA because FQHCs are not considered medical facilities or affiliated with a medical facility. A CPA would help providers unable to see patients on a regular basis allow the pharmacist to oversee patients needing more consistent care. Senate Bill 260 would allow pharmacists the ability to work with a provider to ensure patients are under controlled care.

JAY PARMER (Sierra Family Pharmacies):
Sierra Family Pharmacies consist of a small chain of independent pharmacies operating in northern Nevada. Senate Bill 260 will allow a pathway for pharmacists to work collaboratively with physicians to monitor patients and allow early opportunities to initiate beneficial treatment changes. Patients in rural communities do not have immediate access to regular medical services. The independent pharmacies support S.B 260. They are located in Carson City, Winnemucca, Elko, Fernley, Fallon, Ely, Yerington, Dayton and throughout the Las Vegas, Reno and Sparks areas. We are uniquely positioned to help serve the one-third of Nevadans who live in the underserved rural areas. Bipartisan legislation is pending in the 115th U.S. Congress in the form of Senate Bill 109 and House Resolution 592, called the Pharmacy In Underserved Areas Enhancement Act. Senate Bill 260 is a timely bill for consideration in Nevada.

SENATOR HARDY:
Is it a federal mandate or is it just Nevada not allowing CPAs in FQHCs?

MS. BECK:
I only know of this in Nevada. Arizona allows CPAs in FQHCs. I do not know if this is true in other states.

SENATOR SETTELMEYER:
Many Nevadans living in rural areas are challenged by distances for travelling to the pharmacy and medical provider. Do you agree with the amendment, Exhibit E, to change the mileage restriction from 25 to 100 miles?

MR. PARMER:
Sierra Family Pharmacies recognize the challenges patients have in the rural areas not just by distance but also the ability to travel for health reasons. Many are unable to schedule regular doctor visits. Sierra Family Pharmacies can work

collaboratively with physicians to monitor patients' conditions and refer to the doctor to improve patient outcomes.

CATHERINE O'MARA (Executive Director, The Nevada State Medical Association): The Nevada State Medical Association is opposed to S.B. 260 and the proposed amendment. We would like to participate in the working group to address our concerns.

Delivery of patient health care services is top priority in policy making and patient safety. We question the scope of appropriate oversight for the State Board of Pharmacy and the Board of Medical Examiners. Access to patient health care records is important. My father has low blood pressure and if he had gone to the pharmacist to adjust his medication, his kidney issue and a hand infection may not have been found. The health care record is important so the pharmacist has a clear picture of the patient's conditions. Pharmacists have a great deal of information about patients, but it is limited to prescriptions. The CPA works well in health care centers because of the access to records. It is an important piece missing from S.B. 260. It should be a requirement in the agreement.

How payment is handled is not defined in the bill. Should there be a limit on the number of agreements a physician can enter into, and can the agreements be with any or all pharmacists? Should this be expanded to retail pharmacists or just FQHCs? We prefer a CPA be between a physician and a pharmacist, rather than a pharmacy. We want to avoid the corporate practice of medicine. If the agreement is between the pharmacy and the physician, there is an economic interest component in drug management for the pharmacy. This could lead to a major pharmacy providing primary care. We would like the shared liability issue in a CPA more clearly defined.

A medical facility is defined in the *Nevada Revised Statutes* (NRS) 449. The definition includes surgical centers, obstetric centers, independent centers for emergency care, agencies for nursing facility and intermediate care, facilities for skilled nursing, facilities for hospice care, hospitals and psychiatric hospitals, facilities for treatment of irreversible renal disease, rural clinics, nursing pools, facilities for modified medical detoxification, facilities for refractive surgery, mobile units and community triage centers. It is important to note that these are health care facilities with connection and oversight, with physicians nearby and

with integrated health care record systems. This should be considered when making policy.

Collaborative drug therapy management does not appear in the bill. This term means the initiating, monitoring, modifying and discontinuing of a patient's drug therapy by an authorized pharmacist under the supervision of a physician in accordance with the CPA. It clarifies if the pharmacist can diagnose. It is not within the practice of pharmacy for a pharmacist to diagnose. Including the definition in the bill will help clarify this issue.

Statute should clearly define what should be outlined in a CPA, including to identify the scope of practice for a supervising physician. The CPA should include a written referral of the identified patient from the supervising physician to the authorized pharmacist and include a written consent to the agreement by the patient. It is important to educate the patient on knowing who the pharmacist is that has the CPA with their physician. The definition of collaborative drug therapy management should include what authority a pharmacist has to substitute a drug without the physician having identified the drug. No substitution should be allowed other that what is defined in the CPA. The practitioner makes the diagnosis, and the pharmacist helps in medication management. There should be a description of the treatment protocol if the pharmacist or practitioner is unreachable. The patient should be notified of any termination of the CPA.

CHAIR ATKINSON:
Have you had a conversation with Ms. MacMenamin on your concerns? It seems there are issues to be worked out.

MS. O'MARA:
The Nevada State Medical Association was contacted prior to the drafting of the bill and was aware of the bill concepts. The Association was unable to agree to the bill provisions until the language was finalized. Concerns arose with the introduction of the language. The Association is working with the sponsors and committed to addressing all concerns.

CHAIR ATKINSON:
I was aware of a couple of concerns, but it seems there is much more.

MS. O'MARA:
I can supply the Committee with a punch list of the concerns.

SENATOR SPEARMAN:
A health care team includes the doctor, the nurse or physician's assistant and the pharmacist. A person is prescribed a medication by the doctor and that goes to the pharmacist. If the pharmacist is familiar with the patient, that pharmacist might notice if there could be complications between two of the medications the patient is taking which could lead to a bad interaction. If the doctor cannot be reached, what happens? The pharmacists act as intermediaries for medications and are responsible to ensure no medication conflicts. What is the difference between what is not being done on the pharmacy level and what you think should be done in a collaborative working relationship (CWR) and then the CPA?

MS. O'MARA:
The pharmacist is a highly-skilled professional and an important part of health care delivery to our population. An electronic prescription includes a notification clarifying what drugs are in conflict with the prescribed medication. The patient record available to the pharmacist includes the medication prescription record. This is why the inclusion of a patient's health care record is important to the CPA. A paper prescription to a pharmacy requires they contact the physician if there is a question of conflict with other medications

SENATOR SPEARMAN:
I was not suggesting there is no communication between the pharmacist and the physician. The person who stands between the patent and a dangerous drug combination is the pharmacist. Even though physicians have the entire health record, they may or may not recognize what they are prescribing could be lethal. The pharmacist catches that. The pharmacist is part of a health care team. If your concerns are satisfied for the CWR, to develop the CPA, what would be the difference from what is happening now?

Integration of telehealth might be an advantage for the rural medical practitioners and pharmacists. Could the CPA include the telehealth factor? Senate Bill 260 seeks to put the pharmacist officially on the health care team, not to supplant the primary physician, but to take a supporting role. The studies are calling this practice an extender and a force multiplier. How do we get from

the current practice of the pharmacist's duties and responsibilities to the CWR forming the memoranda of understanding, to get to the CPA?

MS. O'MARA:
A critical component is to ensure the CPA is narrowly tailored. The physician is undertaking the liability for delegating to the pharmacist. We should be protecting patients to be sure the agreements spell out exactly what the protocol is. The number of pharmacists a physician is collaborating with is an important component to consider. Inside of a health care facility, there is strong communication and access to the electronic medical records in addition to what is on the drug formulary. When making the leap from current standards to allowing a pharmacist to become a more active participant of the health care delivery system, physician led teams are the key component. How the physician puts the CPA together needs to be narrowly tailored to the scope of practice of that physician. The protocols must be clearly identified for the pharmacist. It is critical to notify a physician if a possible drug interaction is prescribed.

SENATOR SPEARMAN:
I am not suggesting a physician would allow a pharmacist to swap a medication without approval of the physician. To get to the CPA, the current best practice is to work through the CWR to develop the collaborative working relationship which is foundational, and it is in that phase of the process that protocols are established. It sounds similar to what is being done now. As a veteran, I might go to my regular doctor or sometimes to a specialist. I may fill my prescription at the military base or I may take it to another pharmacy. Can you codify this? Is it changing current procedure? If the pharmacist does not catch a conflicting prescription, is the physician liable? It could lead to litigation. Working through the CWR to get to the CPA should make it easier to form an agreement.

MS. O'MARA:
There are differences. The bill seeks to expand current CPA procedures in a health care facility to the retail environment and to FQHCs. Collaborative practice agreements are not allowed in the retail setting. If the pharmacist notices a mistake on a prescription, the physician is notified. The CPA allows a patient an initial prescription and then to continue seeing the pharmacist for monitoring, and the pharmacist can make adjustments to the medication if that is the arrangement with the physician. It allows extended services and visits with the pharmacist without physician oversight. The goal is to help more patients without requiring a physician visit. It is also the difference between

what pharmacists are allowed to do now and what the bill is trying to accomplish.

SENATOR HARDY:
Are you in agreement with the bill if all of your concerns are addressed?

MS. O'MARA:
Our position is opposed. We would like to work to make this a better policy.

KATHLEEN CONABOY (Nevada Orthopaedic Society):
Nevada Orthopaedic Society has had several conversations with the sponsor of the bill about some of the issues raised today. Our physicians are surgeons who work within the hospital system and endorse the CPAs. They depend on the CPA in the hospital setting which allows shared access to patient information. The health care team needs to be expanded. Physicians and team members are trained in the institutional protocols in a hospital or an institutional system. More attention needs to be paid to the process when it is taken outside the institution to the retail environment. We will be participants in the working group on the bill.

KEITH LEE (Nevada Association of Health Plans; Board of Medical Examiners):
The Nevada Association of Health Plans (NAHP) supported S.B. 260. Testimony today has raised red flags for the health insurance industry. Members of NAHP write the most health insurance policies in Nevada. Mention of expanding the list of providers and health plans and payments triggers concern for the NAHP. The health insurance industry, by mandate or discretionary, needs to look at this issue for premium pricing and decide if they will stay in the underwriting market for these products. I will discuss the payment issue with Ms. MacMenamin. The Board of Medical Examiners and the other health care boards are required under NRS Title 54 to conduct formal meetings on a quarterly basis and informal meetings as needed. The Medical Board and the Pharmacy Board speak regularly on issues including the pharmacy drug-monitoring program. Communication between the Boards has improved.

MICHAEL HILLERBY (State Board of Pharmacy):
The State Board of Pharmacy enforces State policy. In 2011, law regarding the institutional pharmacies was enacted. There are 40 CPAs on file with the Pharmacy Board. How prevalent they become and how often the Board will need to review CPAs can become an issue. The applications can become

complicated and widespread. The proposed amendment to S.B. 260, Exhibit E, to add "if the subject matter covered by the CPA is within the practitioner's scope of practice and within the scope of usual practice in which that practitioner engages" is not applicable to the Pharmacy Board. The Pharmacy Board does not know of a physician's specialty. If the language is added to the written agreement and filed this way, it would require an audit function between the practitioner and the licensing board. A CPA with this language presents some challenges for the Pharmacy Board to know the scope of practice of the partnering practitioner.

We are concerned with deleting section 12 of the bill so that the bill would no longer repeal NRS 639.2809, the language on institutional pharmacies. We would recommend keeping the existing language giving the Board the authority to adopt regulations for the CPAs and for immunizations. We have hundreds of agreements with pharmacies, who are trained and practice under guidelines established by the Board and the Centers For Disease Control and Prevention to administer immunizations, which is an important part of the public health component. There is some utility in keeping the consistent language allowing the Board to establish regulations and also make the application process easier by keeping the boundaries in the CPA in line with the law. We will work with the sponsors on the bill regarding these issues.

SENATOR ATKINSON:
I will close the hearing on S.B. 260.

SENATOR ATKINSON:
I am requesting Committee introduction of Bill Draft Request (BDR) 22-482.

BILL DRAFT REQUEST 22-482: Revises provisions related to the installation of certain systems for obtaining wind energy. (Later introduced as Senate Bill 314.)

SENATOR SPEARMAN MOVED TO INTRODUCE BDR 22-482.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

SENATOR ATKINSON:
I will open the hearing on S.B. 131.

SENATE BILL 131: Requires certain pharmacies to provide a prescription reader upon request. (BDR 54-665)

SENATOR MOISES DENIS (Senatorial District No. 2):
I am presenting S.B. 131 which helps provide accessible prescription drug labels or devices at pharmacies that convey audible information contained on a prescription drug label for the visually impaired. This bill will help provide these devices to those needy individuals not covered by insurance or whose insurance company does not provide additional reimbursement to retail pharmacies for dispensing prescriptions with accessible labels. Medicaid and Medicare cover the devices.

SENATOR GANSERT:
Are you considering this for costs outside of Medicaid and Medicare programs?

SENATOR DENIS:
Yes, there is a gap for people who need these devices but cannot afford them.

SENATOR GANSERT:
Do private insurance companies typically cover these devices?

SENATOR DENIS:
Some do and some do not. We are still researching this.

SENATOR SETTELMEYER:
A rural pharmacy may not have access to this technology; are you requiring every pharmacy in Nevada have a reader on hand?

SENATOR DENIS:
That is a challenge for a small or rural pharmacy, and we will consider this issue.

SENATOR SETTELMEYER:
What is the cost of a device?

SENATOR DENIS:
There are various types of readers ranging from $5 to $60.

SENATOR SETTELMEYER:
Is there an phone application for a reader?

SENATOR DENIS:
There is a phone application that can read some of the labels.

SENATOR HARDY:
If I take a picture of something with my phone, I can read it with the photo enlargement feature. Does the bill allow a free reader to anyone who asks for it?

SENATOR DENIS:
The bill allows anyone who needs a reader and requests it. A visually-impaired person would have difficulty taking a picture of the bottle with a smart phone. If they could take the picture and enlarge it, they may still not be able to see it. The legally blind person might be able to see it. Making the image bigger is not necessarily better.

SENATOR HARDY:
Does the bill preclude someone without a visual impairment from receiving a reader at the pharmacy upon request?

SENATOR DENIS:
We are still working on the bill, so we can look at that issue.

RICK KUHLMEY:
I have been legally blind since 1972 and work as an advocate for veterans and the disabled, especially the blind. I appreciate Senator Denis for bringing the bill to give attention to service provisions for the blind. I favor the bill including a provision for pharmacies to notify customers of available technology. Three federal laws provide guidelines on how the pharmacist complies with the law. The written testimony (Exhibit F) and (Exhibit G) contain well-rounded information on what will occur if S.B. 131 is implemented. The bill encompasses more than just handing out a prescription reader. The U.S. Access Board has developed a best practices list of delivery methods for providing accessible prescription drug containers. The pharmacist is mandated to meet with each customer to determine the best way to access prescription readers

from the various methods available. Not everyone can access a smart phone to take a picture and read the prescription. We look upon this bill as an opportunity for pharmacists to better understand the customers and enhance service delivery. The bill will prompt pharmacists to follow the laws that have been in effect for over 42 years. A blind person living alone who needs to take medication needs assistance. The bill attempts to alleviate the outcomes for those that misuse medication from no fault of their own, by not being able to read instructions.

BILL POWERS:
I have been legally blind my entire life. I had ten percent vision until two years ago. An eye stroke took another five percent of my vision. I cannot read a prescription bottle. I am unable to determine which medication is in which bottle. I will demonstrate the prescription reader I am holding in my hand and pictured in Exhibit G. I place this pill bottle on the unit. There is a magnetic reader strip on the bottom of the bottle, recorded with the information on the label of the bottle, and the device audibly reads the label. Included is the name of the patient, the medication, the dosage and frequency of use. This was a lifesaver when I was too ill to administer my own medication. My wife was able to assist in this. This and many other devices with various configurations work well and benefit those who have the need.

BARI POWERS:
In 2015, Bill was diagnosed with stenosis of the cervical spine. Prior to this he could not walk or stand without assistance. He could not navigate with his hands to access his medication. I used the ScripTalk Station to administer his medications. It was beneficial for our situation. I am totally blind with no vision. We need the readers. This is important for any patient to avoid mixing up their medications.

MR. POWERS:
The ScripTalk Station is only one type of reader. I have 10 to 11 prescriptions and this device is convenient. There are readers that attach to each prescription bottle similar to a device at Walgreens. That one is a good solution for those with few medications. Consulting with the pharmacist to decide the best route is advantageous for the customer. Benefits of individual devices vary per person.

SENATOR GANSERT:
Do the pharmacies automatically attach a radio-frequency identification (RFID) label for the readers, or do you have to request it?

MR. KUHLMEY:
The pharmacist will provide the RFID label when a reader is requested.

JOHN YACENDA (President, Nevada Silver Haired Legislative Forum):
I will read from my written testimony (Exhibit H). I am moved by the testimony of Mr. Powers and the challenges some people face. This is real life. I encourage the Committee to pass S.B. 131.

CHAIR ATKINSON:
Who offers the reader services now?

SENATOR DENIS:
The bigger pharmacies have these devices available, and many provide this service free. The smaller pharmacies may not provide them.

CHAIR ATKINSON:
Would S.B. 131 require all pharmacies to have readers available?

SENATOR DENIS:
Yes.

CHAIR ATKINSON:
Are the pharmacies required to provide the prescription readers free of charge?

SENATOR DENIS:
Yes.

CHAIR ATKINSON:
Who is going to pay for the free devices offered by a pharmacy?

SENATOR DENIS:
The pharmacy will pay for the devices.

SENATOR SETTELMEYER:
Is there at national program that might help incur some costs for the pharmacy having the requirement of the RFID chip and reader? There is a smart phone application that allows a person to take a picture and read anything, even translate text into 26 different languages. There is interesting technology including a Braille phone available. My concern is costs smaller rural pharmacies will incur to provide reader devices.

SENATOR DENIS:
We are considering the issues and concerns. In many cases, individuals do not have the funds to purchase a smart phone. The main concerns are to ensure an individual takes medications properly and our ability to assist in providing that.

MR. YACENDA:
The pharmaceutical companies could provide readers as part of their outreach and public relations.

SENATOR HARDY:
Has Easterseals contributed input for the bill?

SENATOR DENIS:
No, they have not.

SENATOR GANSERT:
Lions Club International and other nonprofit organizations may be interested in contributing to making these readers readily available. How is the gap determined for people with disabilities who are unable to afford the devices? Most people with those disabilities are in Medicare or Medicaid programs.

SENATOR DENIS:
Medicare and Medicaid covers the reader costs. It is important to ensure anyone not covered by insurance have the readers available to them. We are attempting to determine the gap numbers.

SUZANNE THOMAS:
I have been an Americans With Disabilities Act of 1990 (ADA) disabilities consultant and an independent consultant for 40 years. I ran the Las Vegas office of the Governor's Committee on Employment of the Handicapped for 27 years. The office was closed in 2000. When President George H. W. Bush

signed the ADA into law, he remarked, "Let the shameful wall of exclusion finally come tumbling down." Independence is a primary desire for those with disabilities. Availability to information is as important as accessibility. Senate Bill 131 reminds our pharmacies about three federal laws already in place. The ADA and Section 504 of the Rehabilitation Act of 1973 have provisions to claim undue burden if a pharmacy cannot supply the service. This may eliminate the requirement to provide a reader. The pharmacy could find a way to spend $60 for just one reader. Businesses must understand their obligations and their rights under the law. The patient has the option to choose a pharmacy that provides a reader.

It is not necessarily true that Medicare and Medicaid provide the readers. I fought for two years for a person to get a reader through Medicare and Medicaid and was unable to get payment for the reader through these services. The law is clear that a person must have an impairment of major life activity to be eligible for a reader. An able-bodied person could not apply for a device. Free trainings are available to pharmacies on how to implement the laws provided by the ADA national technical assistance centers. These trainings were set up by National Institute of Rehabilitation and Education and Research. Training is provided without cost on rights under the law and the undue burden policy. Avenues are available to pharmacies in preparing for vision-impaired customers and in better serving customers as a reasonable accommodation to the disabilities, even in rural areas.

I take over 45 pills with various dispensing times and amounts. As a sighted individual, it is a challenge. Without sight it would be very, very difficult. The availability of the reader is needed and providing services for the disabled has been law for 37 years. A pharmacy would not seek payment from the Lions Club to pay for a device. A pharmacy has the option by law to buy the devices or claim undue burden.

SENATOR SPEARMAN:
This is a relevant argument to expand, not eliminate, the ACA and Medicaid in Nevada because we ought to be paying for these devices for the visually impaired. We should seriously consider including this provision in a type of expansion of the ACA in Nevada.

KATE OSTI:
I have been a clinician and social worker for 20 years. For the last 14 years, I have been blind. It is important for people to understand the smart phone is not the answer for blind people. A touch screen is not making my life easier. The prescription reading machine is the answer.

MS. MACMENAMIN:
The Retail Association of Nevada opposes S.B. 131. We have had discussions with the sponsor of the bill and with Mr. Kuhlmey regarding some compromises and ways we can help to enable the needy individuals get help reading their prescriptions. One of our members, a large chain of drug stores in Nevada, has devices available to the visually impaired. Pharmacists meet and counsel their disabled customers. One of the first concerns a pharmacist has is to ensure the patient is compliant. We want to facilitate those in need without the statutory provision every pharmacy have a device. We can reach out to various organizations for help. The devices are free upon request by the patient in some of the larger pharmacies. Thirty-seven years ago the readers were not available. The cost of $60 is not the cost to the smaller pharmacies. Implementing these devices into their systems is dependent on vendor fees. Patient adherence to medication is a priority for a pharmacy. President Obama formed the U.S. Access Board, a federal agency to promote equality for people with disabilities and to look at best practice standards. There is no law specifically mandating the pharmacy provide audible prescription devices for free. We request the State adopt standards that are consistent with and no more burdensome to a pharmacy than are present under the federal standards.

MR. PARMER:
The larger pharmacies have a different revenue mix than the smaller rural pharmacies. The Sierra Family Pharmacies consist of four drug stores. They provide the ScriptTalk readers for free. The devices and the cost to provide these devices is $1,000 to set up the system and the RFID is $1.31 per unit. The typical dispensing fee received from commercial insurance services is between $1.25 and $1.75 per prescription. The pharmacies are unable to increase the dispensing fee to cover their costs. They would need to absorb these costs. The return on investment is dependent on the number of patients served.

SENATOR DENIS:
Senate Bill 131 has educated us as to the needs of the unfortunate. The needy want their independence but often find it difficult. We are working out the issues to alleviate any burden to a pharmacy yet achieve our goal of providing medicinal access to those in need.

Remainder of page intentionally left blank; signature page to follow.

SENATOR ATKINSON:
I will close the hearing on S.B. 131 and adjourn this meeting at 10:24 a.m.

RESPECTFULLY SUBMITTED:

Christine Miner,
Committee Secretary

APPROVED BY:

Senator Kelvin Atkinson, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	5		Attendance Roster
S.B. 238	C	1	Marcus Conklin / Merscorp	Written Testimony from William C. Hultman, Merscorp Holdings, Inc.
S.B. 260	D	8	Liz MacMenamin / Retail Association of Nevada	Presentation
S.B. 260	E	1	Liz MacMenamin / Retail Association of Nevada	Proposed Amendment
S.B. 131	F	4	Rick Kuhlmey	Written Testimony
S.B. 131	G	26	Rick Kuhlmey	Exhibits A – H
S.B. 131	H	2	John Yacenda	Written Testimony