MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
May 17, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:34 p.m. on Wednesday, May 17, 2017, in Room 2149 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 Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Martha Barnes, Committee Secretary

OTHERS PRESENT:

Michael J. Willden, Chief of Staff, Office of the Governor
Elyse Monroy, Health and Human Services Policy Analyst, Office of the Governor
John DiMuro, D.O., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Michael Hillerby, State Board of Nursing; State Board of Pharmacy
Elizabeth MacMenamin, Retail Association of Nevada
Catharine O'Mara, Nevada State Medical Association
Susan L. Fisher, State Board of Osteopathic Medicine
Kathleen Conaboy, Nevada Orthopaedic Society
George Ross, Comprehensive Cancer Centers of Nevada
Regan Comis, Nevada Association of Health Plans

Nick Vander Poel, Nevada Osteopathic Medical Association
Stephanie Woodard, Division of Public and Behavioral Health, Department of Health and Human Services

CHAIR SPEARMAN:
We will postpone the work session until tomorrow and begin the hearing on Assembly Bill (A.B.) 474.

ASSEMBLY BILL 474 (1st Reprint): Makes various changes relating to drug overdoses and prescribing and using drugs. (BDR 40-1102)

MICHAEL J. WILLDEN (Chief of Staff, Office of the Governor):
The Legislature and the Executive Branch have been working on the prescription drug reform issue for several years. We have been working hard at it since 2012 when we participated in the National Governors Association Policy Academy on Prescription Drug Abuse Prevention. There have been a couple academies, and Nevada participated in the second round. Starting in 2014, the Governor named a number of people to a work group which met several times during 2014 throughout the State. This resulted in S.B. No. 459 of the 78th Session. It was called the Good Samaritan Drug Overdose Act. The group addressed the Good Samaritan laws, the naloxone programs, continuing education for prescribers, dispensing issues and some modifications to the prescription drug monitoring program. This was a very successful piece of legislation last Session, and we have been working on implementing it. When I say we, I mean several of the boards and the Division of Health and Human Services (DHHS).

In the spring of 2016, northern Nevada had a very significant event involving a prescriber and law enforcement. Many issues occurred, causing the Governor to refocus on this issue. A planning group was created in June 2016 to reexamine the prescribing and opioid world and to review the implementation of S.B. No. 459 of the 78th Session.

The planning group was fairly large with a couple of Legislators, judges, and district attorneys. The outcome of the planning group was a summit that was held the last day of August and the first day of September 2016 with approximately 500 people attending. The planning summit was held at the MGM Grand Resort and Casino in Las Vegas. From this summit, a number of recommendations were made which resulted in A.B. 474.

ELYSE MONROY (Health and Human Services Policy Analyst, Office of the Governor):

Assembly Bill 474 is the Governor's Controlled Substance Abuse Prevention Act, and it is a priority bill for the Governor.

Opioid and prescription drug overdoses continue to be a growing problem in the State. The Governor's Office has provided a data sheet with facts (Exhibit C) for your review.

In response to a situation in 2016, the Governor held the State Summit on Prescription Drug Abuse to identify and highlight areas in which Nevada must improve efforts to reduce and eliminate prescription drug abuse and overdose. During the Summit and the planning meeting, we heard heartbreaking stories from people whose opioid addiction started with a legitimate pain prescription.

The Centers for Disease Control and Prevention tells us of the people who are most at risk for prescription drug abuse. Of this at-risk population, 15 percent report buying their prescriptions from a drug dealer; 27 percent reported receiving prescriptions from their own doctors; 26 percent report getting prescriptions for free from a friend or relative; and 23 percent report buying prescriptions from a friend or relative.

The abuse, misuse and diversion of prescription medications are real problems. The Governor's Controlled Substance Abuse Prevention Act before you today was developed through review of the Summit recommendations, literature, State best practices and lessons learned. The Act was developed in collaboration with the DHHS subject-matter experts, various stakeholder groups and the State's occupational licensing boards.

Assembly Bill 474 is a comprehensive measure that addresses five main areas: prescriber education, prescribing practices, occupational licensing boards, data collection and the prescription drug monitoring program. The Governor's Office has provided the Committee with a section-by-section breakdown of A.B. 474 (Exhibit D).

Assembly Bill 474 makes the collection of data specific to overdose and suspected overdose permanent. *Nevada Revised Statutes* (NRS) 441A, Infectious Diseases; Toxic Agents, is used to capture diseases and illnesses that

are of public health importance. In the past, this has been typically related to communicable diseases and infections and illnesses stemming from biological, chemical and radiological events. As has been clearly shown, the opioid epidemic is of public health importance. The use of opioids is causing ongoing morbidity, addiction issues and death for our residents. The Division of Public and Behavioral Health (DPBH) already reviews suspected overdose data from hospital discharge billing forms, and some of the data is shown in the infographic you have been provided, Exhibit C. This is identifiable data, but there is such a delay that an immediate public health response is not possible. Assembly Bill 474 will allow for more immediate analysis, response and an ability to target interventions. Data will be reported directly to the State. Through regulation, DPBH will specify the methods of reporting, specify what will constitute a suspected overdose and specify the variables to be reported.

Assembly Bill 474 includes language requiring licensing boards to adopt mandatory continuing education requirements for prescribers of controlled substances, makes existing permissive language mandatory and increases the requirement to two hours of continuing education from one hour per license year. This request came from the prescriber community during the development of the protocols.

Assembly Bill 474 adds information to be included on the prescriptions for controlled substances. These changes are needed for the prescribing protocol initiative to be implemented. Pharmacies will need to collect additional data points including the specific number of days a prescription is to be used and the specific diagnosis codes. This bill also makes changes to the Prescription Drug Monitoring Program (PDMP).

Assembly Bill 474 clarifies that licensing boards have access to the PDMP for the purpose of investigations and administrative review of inappropriate prescribing. This bill clarifies that the State Board of Pharmacy can use the PDMP system to identify inappropriate prescribing and requires the Board to notify a licensing board when it has identified unusually high or otherwise inappropriate prescribing.

Assembly Bill 474 also requires prescribers to show proof of enrollment in the PDMP in order to renew or receive their controlled substance licenses. Since the passage of S.B. No. 459 of the 78th Session, the State Board of Pharmacy has seen a sharp increase in the number of prescribers enrolled in the system, going

from 16 percent of prescribers to 81 percent. There are still prescribers that are not using the system. By requiring proof of enrollment in the system before prescribers receive their controlled substance licenses, we can ensure that all prescribers have access to the system before being given permission to prescribe controlled substances.

Assembly Bill 474 requires occupational licensing boards to ensure that Nevada has a system for the identification and remedy of inappropriate prescribing. While inappropriate prescribing comes in many forms, generally, it is prescribing outside of the standard of care for a prescriber's practice, specialty or otherwise outside the medical need of the patient. Under this measure, licensing boards are now required to take action when they receive a report of potential inappropriate prescribing. This bill allows for the administrative review and dismissal of inappropriate prescribing notifications. Additionally, A.B. 474 will allow for the summary suspension of a controlled substance license if inappropriate prescribing is taking place and is deemed an immediate public health and safety risk.

With these changes, we are placing the responsibility of identifying inappropriate prescribing on the State's licensing boards. During the summit planning meeting, we in the Governor's Office were surprised to hear that while all occupational licensing boards have been receiving unsolicited reports on high or otherwise inappropriate prescribing, only some of the boards were taking action on these reports. We worked with the boards to understand their processes for communicating with their licensees and for their investigations. Allowing for the administrative review of controlled substance complaints makes the complaints actionable without complicating the investigation process.

We want to make sure the record reflects our appreciation for the licensing boards working with the Board in drafting A.B. 474.

This bill establishes mandatory prescribing protocols for prescribers that are treating pain with controlled substances: schedule II, III and IV drugs. These protocols are being proposed for NRS 639, the statute that governs the Board. Assembly Bill 474 requires all licensed prescribers to follow the prescribing protocol and requires all licensing boards to enforce the prescribing protocol established in NRS 639. This is the core of the Controlled Substance Abuse Prevention Act.

Nevada's approach to addressing the prescription drug abuse epidemic is to preserve individual patient treatment and recalibrate the standard of care for the treatment of pain and prescribing of controlled substances. These mandated protocols ensure patient safety and seek to end misuse, abuse and diversion of addictive prescribed controlled substances. These prescribing protocols place the responsibility of identifying patient misuse, abuse and diversion on the prescriber.

The prescribing protocols before you today are a product of months of hard work and complex conversations about prescribing, pain management, behavioral health, addiction and patient care with prescribers in Nevada. We appreciate the time that many prescribers and leaders of their trade associations took to help create prescribing protocols that are meaningful, reasonable and implementable. These protocols are accomplished through an initiative that we are calling Prescribe 365, which ensures no patient receives more than 365 days of controlled substances in a 365-day period.

There are two limits on prescriptions contained in this bill. They are the 365-day limit and a 14-day limit on initial prescriptions for acute pain. Many states have established limits for acute pain, and Nevada's limit will appear more liberal than the three-, five- or seven-day limits that other states have enacted. This is because we were sensitive to the State's access to care issues in our urban and rural areas. At this time, I will turn over the testimony to Dr. DiMuro to walk through the prescribing protocols.

JOHN DIMURO, D.O. (Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services):
In developing the prescriber protocols of A.B. 474, we recognize the importance of prioritizing patient safety while upholding the integrity of the patient-prescriber relationship. These protocols require prescribers to adhere to a standard of care which includes the application of clinical judgement in the use of controlled substances for the treatment of pain. Commonsense measures need to be developed that would account for the complexity of the management of pain across populations and minimize the risk associated with the use of controlled substances for the treatment of pain. We reviewed available research literature, evaluated consensus guidelines established by subject matter experts, assessed the impact of policy decisions in other states and engaged the provider community in extensive discussion.

Prescription misuse, abuse, diversion and risk for adverse events, including overdose, present unique challenges for prescribers and patients alike. The complexity of management of pain using controlled substances and the mitigation of risk from such medications require a multitude of evidence-based interventions. We must recognize the limitations of each intervention, acknowledging it is the cumulative impact of multiple efforts that have the best chance of keeping patients safe and empowering prescribers to practice within a standard of care.

The prescribing protocols in A.B. 474 establish standards of care from the initiation of a prescription of controlled substances for pain through ongoing prescribing for the long-term treatment of pain. Please refer to page 12 of Exhibit D which details the provider requirements in Prescribed 365.

Prior to an initial prescription, a provider must check the PDMP database to ensure they have a full record of the patient's current and past prescriptions for controlled substances. The PDMP review is a well-established clinical practice aimed at providing prescribers with some of the information they need in order to make prescribing decisions. Assembly Bill 474 closes a small but critical loophole that was left in S.B. No. 459 of the 78th Session by now mandating the PDMP checks all initial prescriptions regardless of duration. Previously, prescriptions of less than seven days did not require a review by the PDMP. This bill also limits initial prescriptions of a controlled substance for pain in both duration and dosage. Over the past year, nine states have enacted similar regulations and at least seven additional states have similar limits under consideration through legislation. Assembly Bill 474 limits initial prescriptions to 14 days and to no more than 90 morphine milligram equivalents daily. Unlike other states that limit initial prescriptions to 5 or 7 days, we chose a maximum of 14 days to account for known issues relating to access to care in Nevada. This is proactive in ensuring this limit would be reasonably implemented. If the controlled substance prescribed is an opioid, we establish maximum morphine milligram equivalence to 90 morphine milligram equivalents for patients who are not nor were recently issued an opioid prescription.

This standard of care allows for a continuity of care for patients who may be currently prescribed opioids while establishing a maximum daily dosage for opioid naïve patients. This maintains the prescriber's ability to prescribe based on individual patient history and in no way prohibits patients from receiving the care they require.

Identifying and mitigating risk is of utmost importance when evaluating factors that may compromise the patient's ability to safely and effectively use controlled substances for pain. In addition to the PDMP check, we believe it is important for prescribers to have the information they need to make clinical prescribing decisions. Prior to prescribing, A.B. 474 requires prescribers to assess the patient's risk factors through medical history, physical examination, and a good faith effort to obtain and review medical records in addition to the risk assessment measure.

Patients have a right to be active participants in determining the course of care. Written and informed consent provides the patients information needed to understand the risks and benefits associated with taking a controlled substance for pain, the proper use of their prescription, on alternative treatments for pain, on their plan of treatment, on risks of dependency, or addiction, overdose, safe storage and provider expectations.

Once treatment has been established and the patient and prescriber agree that pain management with controlled substances will exceed 30 days, a medication management agreement is required to be completed. Medication agreements go beyond the information contained in the written informed consent. The agreements delineate goals of the treatment, consent for testing to monitor compliance when medically necessary, requirements for information sharing between prescriber and patient and reasons when a practitioner may change or discontinue a course of treatment. Medication agreements must be updated annually or whenever there are changes made to the treatment plan. The intent of the changes to the medication agreements is to ensure they are updated with the goals of treatment or when the goals of treatment change. If changes to medications and goals of those changes are clearly detailed within the treatment plan, medication treatments do not need to be updated with every medication change. The intent behind requiring updates to the medication agreements is to ensure they are aligned with the treatment plans when the goals of treatment change.

Assembly Bill 474 establishes additional protocols prior to prescribing controlled substances for the treatment of pain of a patient who has a controlled substance for 90 consecutive days or more. The 90-day visit must be in person or through telehealth and include, at a minimum, an assessment of risk, a PDMP review, and a review of the treatment plan. The prescriber must also conduct an evaluation of the patient to determine an evidence-based diagnosis for the cause

of the pain prior to prescribing controlled substances for the pain beyond 90 days. This combined with our Prescribe 365 Program will help to best guide the prescriber-patient-prescription relationship. The treatment plan must then be updated annually or as previously stated, when there is a change in the course of the patient's care. These provisions taken together are a reasonable plan to improve Nevada's safety related to controlled substances.

SENATOR HARDY:
In section 7, subsection 1, paragraph (e), subparagraph (2), it states: "each state in which the patient to whom the controlled substance was prescribed." We do not have access to each state, but we do have access to each state which is on the PDMP.

The NRS 630, 632, 636, 635 have 60 days; NRS 631 and 633 have 180 days. Is there a reason for the difference?

MS. MONROY:
This is the language specific to the summary suspension, and we aligned the language in A.B. 474 with the existing procedures language within each chapter. Some of the boards had 60 days and some boards had 180 days.

SENATOR HARDY:
Do the optometrists in NRS 636 use controlled substances?

MS. MONROY:
Yes, the licensing boards have optometrist prescribers that have controlled substance licenses, but I do not know how many optometrists have controlled substance licenses.

SENATOR HARDY:
Regarding the new wording in section 51, the word "new" was confusing to me. The "initial prescription" means a prescription originated for a new patient of a practitioner and it goes on, "The term does not include any act concerning an ongoing prescription that is issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner."

MS. MONROY:
We established the definition in S.B. No. 459 of the 78th Session for "initial prescription," but as we were working through the creation of this policy, we

realized that there was an unintended gap when a patient had to transfer to a new prescriber. If a patient started a prescription for a controlled substance with his or her primary care provider and got to the 30 days supply, but the primary care provider felt the patient needed to be referred to a pain management specialist, it would then be an initial prescription with a 14-day limit with an ongoing course of treatment.

DR. DIMURO:
The idea is if you are a physician and you give a 90-day prescription, it could be considered a new prescription, but since you are the continued provider, it would not be a new prescription. Thus, the language does not include any act concerning an ongoing prescription.

SENATOR HARDY:
The language states new patient or a new or existing patient, it does not state new prescription. In one place it states it applies, and in the other it states it does not apply.

There are also not enough pain doctors under network that the primary care physicians can refer people to.

Section 60, subsection 1, paragraph (b), uses the word "the" controlled substance as opposed to "any." I understand it is the intent that we are not going to prescribe "any" controlled substance whatsoever, not just the one he or she was using, abusing or misusing.

DR. DIMURO:
Yes. There could be multiple prescriptions for the same drug filled within days of each other. The intent of this section is to make sure that any prescriber who has not been prescribing the controlled substance checks the PDMP to see if the patient has been on that controlled substance. If the patient has been on that controlled substance, then the prescriber would not prescribe that particular controlled substance.

SENATOR HARDY:
Would prescribers be able to prescribe another controlled substance?

DR. DIMURO:
Yes, they would.

CHAIR SPEARMAN:
In section 60, subsection 1, paragraph (b), it states, "If the practitioner determines from the patient utilization report or from any other source that the patient has been issued such a prescription, the practitioner shall not prescribe the controlled substance." We spoke earlier concerning synthetics. Is it possible to look at what is being prescribed and if there were another drug that could be prescribed that would work as well, would the practitioners consider those?

DR. DIMURO:
We want to have the clinicians remain practicing medicine. There are many instances where multiple drugs from the same drug class are prescribed. We do not want to inhibit physicians from prescribing from multiple drug classes, especially when it comes to pain medicine. That is why the wording is specific about the prescribing of the drug and a specific drug that has already been prescribed.

SENATOR HARDY:
If I know that someone is using, abusing or overusing a narcotic of one kind, and I am interested in getting them off it without getting them in a withdrawal issue, then I may be interested in using a narcotic-related medicine that will get them off the narcotic that they are abusing. Does this make sense?

DR. DIMURO:
Yes.

MICHAEL HILLERBY (State Board of Nursing; State Board of Pharmacy):
We are in support of A.B. 474.

ELIZABETH MACMENAMIN (Retail Association of Nevada):
We are in support of A.B. 474.

CATHARINE O'MARA (Nevada State Medical Association):
We are in support of A.B. 474. We believe there is more work to do on this bill regarding regulations, and we want to be part of that.

SUSAN L. FISHER (State Board of Osteopathic Medicine):
We are in support of A.B. 474.

CHAIR SPEARMAN:
Ms. O'Mara, did you state there were some regulations that may be problematic, or is it that you want to make sure that you are working alongside the Governor's Office to address some of the issues?

MS. O'MARA:
There will be a few regulations that we anticipate will need to be promulgated during the regulatory period. We do not expect them to be issues. One example is the Pharmacy Board will be defining what inappropriate prescribing means. We look forward to being part of those discussions.

KATHLEEN CONABOY (Nevada Orthopaedic Society):
We are in support A.B. 474.

GEORGE ROSS (Comprehensive Cancer Centers of Nevada):
We are in support of A.B. 474.

REGAN COMIS (Nevada Association of Health Plans):
We are in support of A.B. 474.

NICK VANDER POEL (Nevada Osteopathic Medical Association):
We are in support of A.B. 474.

MS. MONROY:
May we clarify one of the questions from Senator Hardy, specific to section 51?

STEPHANIE WOODARD (Division of Public and Behavioral Health, Department of Health and Human Services):
I am the Co-Occurring Disorder Director for Rural Community Health Services. The way the initial prescription was written would create some unintended consequences. In section 51, language was added that states, "The term does not include any act concerning an ongoing prescription that is issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner." The language was added to the definition because of the way it had originally been defined. If you were being treated by a physician and that physician transferred care to another prescriber, under the original definition, the new prescriber would have been limited to only 14 days of a prescription. We are saying that if new prescribers were going to continue an existing course of treatment through the continuity of care, they would not be limited to the

14 days. They would be able to pick up that prescription and prescribe to the user as they saw fit.

SENATOR HARDY:
I understand it perfectly, but on paper, it is not as clear.

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CHAIR SPEARMAN:
I am closing the hearing on A.B. 474. There being no public comment or further business before this Committee, this meeting is adjourned at 4:18 p.m.

RESPECTFULLY SUBMITTED:

Tammy Lubich,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	3		Attendance Roster
A.B. 474	C	1	Elyse Monroy / Office of the Governor	Fact Sheet
A.B. 474	D	12	Elyse Monroy / Office of the Governor	Section by Section Breakdown