# MINUTES OF THE MEETING
# OF THE
# ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

## Eighty-First Session
## April 26, 2021

The Committee on Commerce and Labor was called to order by Chair Sandra Jauregui at 1:31 p.m. on Monday, April 26, 2021, Online and in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

**COMMITTEE MEMBERS PRESENT:**

Assemblywoman Sandra Jauregui, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Jill Dickman
Assemblywoman Bea Duran
Assemblyman Edgar Flores
Assemblyman Jason Frierson
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Elaine Marzola
Assemblyman P.K. O'Neill
Assemblywoman Jill Tolles

**COMMITTEE MEMBERS ABSENT:**

Assemblywoman Venicia Considine (excused)
Assemblywoman Susie Martinez (excused)

**GUEST LEGISLATORS PRESENT:**

Senator Julia Ratti, Senate District No. 13
Senator Ira Hansen, Senate District No. 14
Senator James A. Settelmeyer, Senate District No. 17

**STAFF MEMBERS PRESENT:**

Marjorie Paslov-Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel
Terri McBride, Committee Manager
Louis Magriel, Committee Secretary
Cheryl Williams, Committee Assistant

**OTHERS PRESENT:**

Beth Slamowitz, Senior Physician and Senior Policy Advisor on Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services
Adam Porath, Director at Large, Nevada Society of Health-System Pharmacists
Dave Wuest, R.Ph., Executive Secretary, State Board of Pharmacy
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Paul J. Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber
Vasudha Gupta, President-Elect, Nevada Pharmacy Alliance
Krystal Riccio, Private Citizen, Henderson, Nevada
Amy Hale, Director-At-Large, Nevada Pharmacy Alliance
Ken Kunke, Executive Secretary, Nevada Pharmacy Alliance
Elliott Asarch, Private Citizen, Pahrump, Nevada
Richard Tomasso, Member, State Board of Pharmacy
Daniel Pierrott, representing Fingerprinting Express

**Chair Jauregui:**
[Roll was called. Committee protocol and rules were discussed.] We have three bills up for hearing today. I will be taking them out of order. Senator Ratti, we will have you go first. With that, I will open the hearing on Senate Bill 229 (1st Reprint), which revises provisions relating to the practice of pharmacy.

**Senate Bill 229 (1st Reprint): Revises provisions relating to the practice of pharmacy. (BDR 54-823)**

**Senator Julia Ratti, Senate District No. 13:**
I am very excited to be here with you today to present Senate Bill 229 (1st Reprint), which is all about access to health care. I just want to express my gratitude to the Committee for allowing us to go first because my copresenter is Dr. Beth Slamowitz, who is with the Department of Health and Human Services and heads up all of their pharmaceutical work. She is significantly and incredibly smarter than I am, and we really do need the benefit of her in the Committee. She is helping to present in another committee, so thank you for that indulgence.

First of all, I wanted to say that S.B. 229 (R1) is about access to health care. For many of us who have been working for many sessions to make sure that we are using all types of practitioners and health professionals to the top of their scope of practice—because we know that for the state of Nevada, almost every portion of the state is a health provider shortage area—we cannot afford not to use all of our health professionals to the best of their abilities. What I would like to say is that existing law allows for what are known as collaborative practice agreements, so we are not creating anything new here. These are agreements where a practitioner, such as a doctor, will partner with a pharmacist, and working together they will put together a group of protocols.

We will just take, as an example, a heart practice that would look at the disease of high blood pressure. They would put together a series of protocols that would allow for that practitioner to work with that pharmacist. That pharmacist, if they followed the specific protocols and rules, would be allowed, for example, to adjust a person's medication. I have family members who have high blood pressure. Many of you know that medication often has to be adjusted a little bit up or a little bit down. This allows for the pharmacist to do that within the series of protocols that were agreed upon between that physician and that practitioner, which is all laid out in this collaborative agreement. This exists today.

What I am happy to report, with only five weeks left in the session, is that this is not a scope-of-practice bill. There is no fight here about scope of practice. In the bill, a pharmacist is explicitly prohibited from working outside of their scope of practice. So that is not what this is about. During the pandemic, we learned the hard way that the way we have collaborative practice agreements set up in the *Nevada Revised Statutes* (NRS) puts significant barriers in place for these collaborative practice agreements to be implemented and effective.

The pandemic brought to light, in unfortunately not such great ways, how we could have used pharmacists quickly and readily to help with testing, immunizations, and all of the steps we needed in the pandemic. We actually could not get there with the way that collaborative practice agreements are set up in our law today. Instead, we had to use emergency orders to be able to get to the top of their training and scope of practice in the use of our pharmacists.

This bill makes a series of tweaks to collaborative practice agreements so that these can be used going forward, and it would not require an emergency declaration to do so. To give an example, in the law as currently written, collaborative practice agreements have always had to happen in a medical facility. It does not necessarily always need to happen in a medical facility; I think the pandemic has shone a light on situations where it is completely appropriate for things not to happen in a medical facility.

That is just one example of the barriers to collaborative practice that we are removing. Again, staying at the highest level, this is not a scope-of-practice bill. The pharmacists' scope of practice remains exactly the same. It is a bill that strengthens our collaborative practice agreement framework.

We talked about the heart specialist who would be working, perhaps, with a pharmacist who is right there in their practice. Let us talk about a different example, influenza. Right now we have a readily available lab test: if you can get to that lab test, you can take the test, it can be read, and we will know whether or not you have the flu. If those two things have happened, you have 48 hours to get a prescription for an antiviral medication. If you do not start taking that antiviral within 48 hours, it is not effective. A collaborative practice agreement could be set up whereby a physician, working with a pharmacist, could say, We agree within this collaborative practice agreement and under these protocols, the pharmacist can give this test, look at this test, and distribute this pharmaceutical; that would bring down the incidence of flu.

Before COVID-19, you may all remember that the spread of flu was one of our most significant public health issues. We do these huge vaccination campaigns and all of these things. If we can stop the flu sooner with more people, then we stop the spread. As an access-to-health-care issue, a lot of folks would just never get to the doctor. They definitely were not going to get to the doctor within 48 hours to get that sort of an issue resolved.

That is the idea. It can be used in a wide variety of settings. The law was so prescriptive that it did not allow for that variety of settings to be facilitated. What this bill does is walk back some of the prescriptive nature of the NRS and allows for that to be in the specific practice agreement instead, which that practitioner and pharmacist would sign off on.

There is still a very strong framework with some guidelines. It is just not the same level of detail. With that, I am going to turn it over to Dr. Slamowitz, who is a pharmacist and who can talk in more detail about what this bill does.

**Beth Slamowitz, Senior Physician and Senior Policy Advisor on Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services:**
[Ms. Slamowitz read from written testimony submitted to the Committee, Exhibit C.] I am going to give a brief overview of collaborative practice agreements and S.B. 229 (R1), and then go into the different sections of the bill and what they address in terms of amended language for collaborative practice agreements.

Collaborative practice agreements create a formal practice relationship between pharmacists and other health care providers, whereby the pharmacist assumes responsibility for specific patient care functions. The extent of the services authorized under the collaborative practice agreement depends on the state's statutory and regulatory provisions for that authority, as well as the terms of the specific agreement between the pharmacist and the health care practitioner.

In a 2015 paper, "The Expanding Role of Pharmacists in a Transformed Health Care System," the National Governors Association presented the following state policy considerations in regard to collaborative practice provisions: The first was to enact broad collaborative practice provisions that allow for specific provider functions to be determined

at the provider level rather than set in statute or through regulation. The second was to evaluate the practice setting and drug therapy restrictions to determine whether pharmacists and providers face disincentives that unnecessarily discourage collaborative arrangements.

Rapid innovations in education, training, technology, and evidence-based guidelines necessitate a collaborative practice framework that is both flexible and facilitates innovation in care delivery. Health care workforce is a critical component for a healthy Nevada.

The intent of S.B. 229 (R1) is to remove current collaborative practice authority barriers that exist and increase flexibility by defining elements that are more appropriately determined by the parties at the practice level who voluntarily enter into these agreements. It is in the interest of the state to encourage the use of these collaborative arrangements between pharmacists and practitioners to expand and provide access to care and improve the state's health care provider infrastructure, especially in Nevada's rural regions.

Section 1, subsection 8, of the bill amends NRS 639.0124 to remove the requirement that the development of written guidelines and protocols, in collaboration with a practitioner, "are intended for a patient in a licensed medical facility or in a setting that is affiliated with a medical facility where the patient is receiving care." A pharmacist's practice setting or a patient's relationship with a medical facility should not be a barrier to the pharmacists' and practitioners' ability to enter into a collaborative practice agreement.

Section 2, subsection 2, amends and removes the barriers for a practitioner to enter into a collaborative practice agreement, which include the requirement for a patient referral by a practitioner to a pharmacist; the requirement for the practitioner to obtain informed, written consent from a patient who is referred; and the requirement that the practitioner practice his or her profession within 100 miles of the primary location where the collaborating pharmacist practices in this state.

Pharmacists and practitioners may specify the level of patient involvement in the collaborative agreement. Depending on the level of service, elements such as informed consent, written consent, or opt-out provisions may be appropriate, as determined by the parties to the agreement.

Section 2, subsection 3, adds amended language to include that a practitioner shall not enter into a collaborative practice agreement with a pharmacist if the geographic distance between the collaborators prevents or limits effective collaboration in the delivery of care or treatment of the patients.

Section 2, subsection 4, adds amended language that a practitioner shall not enter into an agreement that includes the diagnosis or initiating of treatment, unless the practitioner actively practices his or her profession in the state or provides those services using telehealth. The State Board of Pharmacy may also grant a written request for an exemption from the

requirements of this subsection if good cause is shown. Section 2, subsection 5, adds language that a collaborative practice agreement does not grant a pharmacist the authority to engage in any activity that is outside the scope of practice of the collaborating practitioner.

Section 2, subsection 6, maintains the current language that outlines the requirements of a pharmacist who engages in a collaborative practice agreement. These requirements include the documentation of any treatment or care; the documentation of any decision or action concerning the management of drug therapy; the maintenance of records concerning care or treatment provided for at least seven years; the requirement to comply with all the provisions of the Health Insurance Portability and Accountability Act of 1996; and the requirement to provide a patient with written notification of any test administered and the results, any drug or prescription filled and dispensed, and the contact information of the pharmacist.

Again, language removed from section 2 intends to remove the barriers of elements that may be determined at the practitioner level through the individual collaborative practice agreement. The language that was removed includes the requirement for a pharmacist to obtain the informed, written consent of a patient. This must include a statement that the pharmacist may initiate, modify, or discontinue the medication of a patient; is not a physician, osteopathic physician, advanced practice registered nurse (APRN) or physician assistant (PA); and may not diagnose.

All of those elements can be included within the collaborative practice agreement, as agreed upon between both of the voluntary parties who take place or who have agreed to that agreement. Lastly, the requirement that a practitioner may not enter into a collaborative practice agreement with a pharmacist for the management of controlled substances is removed. It is recommended that all prescription drugs, including controlled substances, be included within a pharmacist's collaborative practice authority.

The language in section 3, subsection 1, paragraphs (a) through (j), is maintained and defines what must be included in a collaborative practice agreement. These elements include a description of the types of decisions concerning the management of drug therapy; a detailed explanation of the procedures that the pharmacist must follow, including documentation, and a requirement to report such decisions to the practitioner and receive feedback; the procedure by which a pharmacist will notify the practitioner of an adverse event; the procedure by which a practitioner will provide the pharmacist with a diagnosis and any other medical information that is deemed necessary; a description of the means by which the practitioner will monitor clinical outcomes and intercede when necessary; authorization for the practitioner to override the agreement; authorization for either party to terminate the agreement; the effective date of the agreement; and the date by which a review must be conducted for the renewal of the agreement.

Section 3, subsection 1, paragraph (k), is removed, which required the inclusion in the agreement of the process by which the pharmacist will obtain informed consent. As stated before, the informed consent can be part of the requirement of the protocols within the agreement.

Section 4 amends NRS 639.2629 by removing section 4, subsection 1, paragraphs (a) through (c), and replacing them with language which defines what must be included within the written guidelines and protocols that are developed by a pharmacist in collaboration with a practitioner and which authorize collaborative drug therapy management. The amended language allows for provisions to be determined at the provider level, and allows for flexibility based on practice setting and drug therapy restriction.

The following is required to be included without limitation within the written guidelines and protocols: a description of the types of decisions that a pharmacist can make regarding the management of drug therapy, including the description of diseases, drugs, or drug classes to be covered within the protocol, and the types of decisions that the pharmacist can make regarding those diseases, drugs, or drug classes; the training the pharmacist is required to complete; the procedures the pharmacist is required to follow to make changes to drug therapy or other therapeutic decisions, including the criteria to make those decisions and the procedures for documenting and reporting those decisions to the practitioner; and the procedures for the practitioner to provide feedback to the pharmacist.

Section 4, subsection 2, is amended and states that the Board may adopt regulations which prescribe additional requirements for written guidelines and protocols pursuant to section 4. Section 5 amends NRS 441A.110 to include a pharmacist within the definition of "provider of health care." Section 6 amends NRS 453.026 and defines an "agent" as a pharmacist who cares for a patient of a prescribing practitioner, removing the language regarding "in a medical facility or in a setting that is affiliated with a medical facility."

Lastly, section 7, subsection 1, paragraph (l), amends NRS 453.375 and adds a registered pharmacist, pursuant to written guidelines and protocols developed within a collaborative practice agreement, to be able to possess and administer a controlled substance. That concludes my overview of Senate Bill 229 (1st Reprint). I will stop there to see if there are any questions.

**Senator Ratti:**
That is the end of our formal presentation. In terms of answering questions, we do have Adam Porath, who is a pharmacist in a hospital setting and a practitioner. He can give you a little bit more of the on-the-ground sense of it. We also have representation from the State Board of Pharmacy as well as the Retail Association of Nevada to represent more of the retail pharmacy setting. You have the scope of folks who might be implementing this type of a collaborative practice agreement to help answer questions. We stand ready to answer questions.

**Assemblywoman Carlton:**
I have two questions. With regard to distance as far as the collaboration goes, could you repeat that portion? There was something about having to be within a certain distance in order to make it work.

**Senator Ratti:**
The existing law says 100 miles. That 100 miles has become a barrier; let me try to give a concrete example of that. Go to the heart specialist example: you are a person in a rural community with a rare heart condition, and you may not have that heart specialist within 100 miles. However, that heart specialist could still enter into a collaborative practice agreement with a pharmacist in your community to get you better access to care.

The way the law is currently written, that 100 miles would be prohibitive to that arrangement. However, now the law says that it has to be within a distance that does not interfere with a good, collaborative, working agreement. That would be distinct, depending on what kind of collaborative agreement was entered into. Dr. Slamowitz, if you could help me with the page number, I would appreciate it.

**Beth Slamowitz:**
I believe it is on page 3, line 27 of the bill.

**Senator Ratti:**
That is the shift; the 100 miles as a very specific thing was taken out of section 2, subsection 2, paragraph (d), and "if the geographic distance between the practitioner and the collaborating pharmacist prevents or limits effective collaboration in the delivery of care or treatment to patients" was added in section 2, subsection 3.

**Assemblywoman Carlton:**
If I am remembering correctly, I believe the original legislation was started in 2017 [Senate Bill 260 of the 79th Session]. Or was there a portion earlier, and then we expanded it in 2017?

**Senator Ratti:**
I do not have that history. Dr. Slamowitz, do you?

**Beth Slamowitz:**
I think Adam Porath probably has more history with this than I do, as I know he has been involved in all of this. I do think there was original language and then there was some additional language in 2017, but I know Mr. Porath has more detail than I do.

**Adam Porath, Director at Large, Nevada Society of Health-System Pharmacists:**
I am the vice president of the pharmacy here at Renown Health. Collaborative practice in the state of Nevada really started back in 2011 [Assembly Bill 199 of the 76th Session]. That was the first time we saw pharmacists practicing in what we call "affiliated practice settings" with health systems. For my particular example, that is when we started to do this work at our Fernley facility rather than just in the four walls of the hospital here. You are correct.

**Assemblywoman Carlton:**
I thought so. I do remember some of the conversations, and it was centered around medical facilities in order to let the doctor and the pharmacist at that facility take care of patients at that facility, since they were working with the same population.

I understand where you are trying to go. The thing I am trying to wrap my brain around on this one is on page 4, starting on line 23. This, to me, was the crux of the patient being aware of the collaborative practice between the pharmacist and the doctor. What safeguards will be put in place to make sure that if the pharmacist makes adjustments, the patient understands that it is the pharmacist making the adjustment, not the doctor?

**Senator Ratti:**
It is a great question. Certainly, in the Senate, the longest conversation we had was about consent. I consider this to be a modernization of the language. As the medical system has become more comfortable with a variety of practitioners, whether they be an APRN or a PA or any number of others whom we have worked on, we have moved away from that consent piece and more towards badges and things that just label who they are.

This consent, then, if you think about the flu example, may not be as necessary because it is more of a transactional piece: here is my sample, here is your test, here is your antiviral. In that setting, layering on significantly more paperwork—where we are already in a place where access to care is challenging—would not be appropriate. Whereas, if you were talking about a transplant survivor or a heart practice or cancer practice, that consent would be at a significantly higher level.

The concept in this bill is that it moves that consent to the collaborative practice agreement, where the practitioner, either the physician or the osteopathic physician, and the pharmacist agree that this is the level of consent that is appropriate for this collaborative practice agreement. This takes it out of the NRS and puts it into the collaborative practice agreement. There is also a piece in this bill that allows the State Board of Pharmacy to promulgate additional regulations, so there is an opportunity for greater clarity there.

**Assemblywoman Carlton:**
When do I as a patient know who is making my medical decisions?

**Senator Ratti:**
Dr. Porath or Dr. Slamowitz, do you want to try to take that one?

**Adam Porath:**
As it is in current Nevada law, it would be maintained in this. Anytime that a pharmacist makes a change in the patient's medication, they are required to provide that documentation to the patient. Anytime that a pharmacist performs a test on the patient, it is required that they provide the results of the test to the patient.

It is inherently clear when the patient presents to the pharmacist that they are seeing a pharmacist. We introduce ourselves as a pharmacist. The idea of consent and telling the patient anything other than that is duplicative.

**Assemblywoman Carlton:**
My questions are not really aimed at the consent part of it. If the medication was changed, how do I know if my doctor prescribed that or if the pharmacist took it upon himself to change it? How does the patient know who is managing their care if there is a change? Is that delineated? If the pharmacist makes a change, as a patient, do I have recourse to go to my doctor and ask him why my medication is being changed?

We have done everything in this building over years and years and years to make sure that things are patient centric. I just want to make sure that in this collaborative agreement, we are not making decisions for the patient and failing to keep them informed of what is going on. We want to make sure they have the opportunity to ask the question, Why would you have changed this, and to understand what their own medical care is. How would that work?

**Senator Ratti:**
Dr. Slamowitz, do you want to take that one?

**Beth Slamowitz:**
I think what might be helpful is to understand how these agreements work in a clinical setting. Mr. Porath might be able to walk you through what it is like for a patient who sees a pharmacist. It is no different than if they were seeing a physician, a nurse practitioner, or a PA.

Normally within these collaborative practice agreements in a clinical setting, patients have an appointment with the pharmacist and they are included in the pharmacist's care. They are going to have those conversations with their physician and with their pharmacist, and they are going to understand that the doctor, the physician, has referred them to a pharmacist for their medication management. That pharmacist is now going to do whatever they have been delineated to do within the protocol.

If that patient happens to be diabetic, the pharmacist is going to be checking blood samples to make sure their hemoglobin and A1c is in check, checking where their levels are, and seeing the patient on a regular basis to say, based on how the patient's labs came back, that they are going to make adjustments to the medication. That does not break or take away that relationship that patient has with their physician.

If the patient is not happy with the care they are receiving or they have questions about their medication, pharmacists are medication experts. I would hope that patient has that conversation with the pharmacist first. If they do not get the answers that they are seeking, they can certainly go back to their physician.

It is meant to be collaborative, as it says in the title. The hope is that the practitioner, the pharmacist, and the patient are all working collaboratively for the greater good of that patient's care and ultimately making sure their health, wants, and needs are taken into consideration. I do not think it is taking that consent away. It is making sure that everything is collaborative within that practice. Hopefully, that helps.

**Assemblywoman Carlton:**
When I see the lines through this language, it means the patient will no longer have to give consent to this. If they see a doctor, and that doctor has this collaborative practice, the patient is mandated to comply whether they agree or not. There is no opt-out for them.

**Senator Ratti:**
I would not present that bill. There is no mandate that they continue to see that pharmacist. There is no mandate that they do not have an appointment with their doctor. I just want to make sure, for the record, that is very clear.

**Assemblywoman Carlton:**
I apologize, Senator Ratti. I did not mean it that way. I just meant when we delete this language, how does the patient give their consent to participate in this practice model?

**Senator Ratti:**
I do not mean this to sound glib, but they show up for the appointment. In the clinical setting, they have met with their doctor.

**Assemblywoman Carlton:**
I guess I am not quite making my point, so thank you very much, I appreciate it.

**Senator Ratti:**
I apologize.

**Assemblywoman Marzola:**
Hopefully, my question will make sense. This is definitely a new space for me. In section 2, in what used to be subsection 5, it says, "A practitioner may not enter into a collaborative practice agreement with a pharmacist for the management of controlled substances," and you are deleting that subsection.

I am wondering, first, why it is being deleted, and second, are there any safeguards in place when it comes to this? When I think of controlled substances, I think of pain medication. Can you maybe give me an example of when a pharmacist would be able to change the amount of a pain pill for a patient?

**Senator Ratti:**
Again, we will turn it back over to the experts, but just generally, think of a patient who is going through a cancer diagnosis and who has significant pain management. We are talking about those kinds of situations.

You might have this cancer patient who is going to their clinical practice setting that includes their cancer doctor and their cancer pharmacist who are working in a collaborative agreement. If they need modifications to their pain management, again, under a very strict series of protocols which that doctor and pharmacist have agreed to, then that pharmacist who is the expert in medication in that relationship would be able to move those amounts up and down. If there is a drug that is not working, they can move through the process with the patient under the collaborative practice agreement with those protocols. That is an example.

I will be very explicit. There is nothing in this bill that removes any of the protections, reporting requirements, or all of the logging of information that we have been working on very heavily over the last sessions regarding pain management and pain medications. Those all still stand, and all that work still needs to be done. It is just that it would be the pharmacist who could move it up or down or perhaps recommend another drug. Dr. Slamowitz or Dr. Porath, do you have any additional comments to that?

**Beth Slamowitz:**
To follow up with what Senator Ratti said, when I was a student, I worked in a collaborative arrangement with a physician at an outpatient chemotherapy clinic. I did assist in the management of patients—not only their pain medications, but also their antinausea medications as well as medications for constipation, which is often caused with the use of pain medications. That is a really good example of where controlled substances would come in.

From a broader standpoint, pain medicines such as opioids or narcotics are the very first thing people think of when they think of controlled substances. However, there are many other medications that fall under the category of controlled substances. Some of those might be for the treatment of substance use disorders. Although they can sometimes be used to treat pain, they are also used to combat addiction to opioids or addiction to alcohol, and other items where it may be beneficial to have an agreement between a physician and a pharmacist to help assist those types of patients.

There are other medications that fall into other categories besides what we just consider to be a Schedule II controlled substance, things like benzodiazepines that treat anxiety or different psychiatric diagnoses. Controlled substances can be a very broad class of medications and are not just for pain.

**Chair Jauregui:**
Committee members, are there any other questions? [There were none.] I do have one. It was in the areas where we were deleting some of the language, specifically the language that deleted the approval of the State Board of Pharmacy for the agreements. Could you address why we were removing the requirement that the agreements have to be approved by the Board?

**Senator Ratti:**
Do we have the State Board of Pharmacy representative on to comment?

**Dave Wuest, R.Ph., Executive Secretary, State Board of Pharmacy:**
That was seen as potentially too restrictive to get some of these moving. We currently do review them. It is a policy decision by the Legislature. The Board is supportive of our not reviewing them. I will review them if you want us to, but I think we can trust the pharmacists and the physicians to work on the agreements.

**Chair Jauregui:**
Was there a delay in getting them approved?

**Dave Wuest:**
It takes review; under the new rule, they could just start implementing the agreements. For us, we have to review them and there is a lot of work that goes into making sure the guidelines are exactly what they are doing, so there is some delay in getting them approved, yes.

**Senator Ratti:**
The current language in the NRS is quite restrictive. We have not seen a significant number of collaborative practice agreements. The numbers right now are relatively small. The whole idea of this bill is to remove some of those barriers so there would be more opportunity to use pharmacists to the height of their education and scope of practice in order to increase access to care, knowing we have shortages throughout our state. The anticipation would be that the number would increase significantly, and that is where it becomes a barrier.

**Chair Jauregui:**
Committee members, this is the last call for questions.

**Assemblyman O'Neill:**
I am not sure who can answer this. I am going along with Assemblywoman Carlton's line of questioning. Because it is somewhat new, I want to make sure the patient is aware in this procedure that if a drug treatment or drug is changed, even if it goes to a generic drug for cost, the patient is aware of who made the change. That is what I read in here. I want to make sure that they understand it is a pharmacist who is not a doctor. Building upon that, does the doctor maintain final control over the patient's treatment?

**Senator Ratti:**
I think this is where there is a level of discomfort with the bill. I want to try to be as clear as possible in this. What would happen in the way the law is written is that the collaborative practice agreement and that level of detail would be left to that practitioner and pharmacist, because the level needed varies dramatically.

If you are talking about the flu example, which is a one-time interaction, there is not an ongoing relationship with the physician and there is a whole different level of need there, versus a practice that, say, Dr. Porath is involved in, where it is an ongoing relationship in a heart clinic, cancer clinic, or a substance use disorder clinic. There, the physician is in

one office, the pharmacist is in another office, and the patient has an ongoing relationship with both the physician and the pharmacist. The level of communication and ongoing case management that happens in that kind of practice is significantly different.

For the broad range of examples of how a collaborative practice agreement could be used, what the bill calls for is that to be detailed in the confines of the collaborative practice agreement. For the heart practice, the heart doctor could say to the pharmacist that this is how we, in our practice, inform our patients. That is built into the model. That is versus the retail pharmacy setting where it is just a flu piece, and there is really not a whole lot there except for a pharmacist providing an antiviral. Folks are happy to take that and be on their way. Rather than it being explicit in the NRS, it is explicit in the collaborative practice agreement how that practitioner is working with that pharmacist to make sure that patient is being taken care of.

If that is not sufficient, I am happy to take another crack at this. I will say that we worked pretty extensively with the osteopathic doctors and the medical doctors on the first version of the bill to get to a place where we had removed their concerns. However, if we are not removing the concerns of the Legislature, then clearly we have more work to do.

**Assemblyman O'Neill:**
I understand all of those serious issues as you were saying, such as the heart treatment. Here is another example: I am possibly under some treatment and the doctor has prescribed various medications. I deal with a local pharmacy with multiple pharmacists working there. Who would be the pharmacist the doctor would collaborate with?

**Senator Ratti:**
That is probably not an ideal situation for a collaborative practice agreement, and you would not see one. That is not the nature of how a collaborative practice agreement works. This is not the short-term medication for this thing you are working on right now. It kind of lives at both ends of the spectrum, if you will.

**Assemblyman O'Neill:**
I understand a little better now, thank you. That is what was confusing me when you were talking about the flu, which is very minor.

**Assemblywoman Tolles:**
I heard somebody make the comment that this is new. Is this something that is done in other states? Do we have examples of how something similar to this is done and how it has been successful?

**Beth Slamowitz:**
Collaborative practice agreements are definitely not new. As Dr. Porath mentioned earlier, in Nevada we have been working on this since 2011 [Assembly Bill 199 of the 76th Session]. Several other states already have collaborative practice arrangements in place. Nevada has some of the most restrictive requirements, but there are other states.

Collaborative practice authority exists in Idaho, Illinois, Minnesota, Michigan, Montana, Nebraska, New Mexico, North Dakota, South Dakota, Tennessee, Utah, and Vermont, just to name a few. Florida just recently passed a law allowing pharmacists to both test and treat for minor, nonchronic conditions—that includes strep and flu—under a protocol with a physician. That was Florida House Bill 389 that just passed in 2020, for reference. As well, Idaho and Kentucky approved what they call "statewide protocols" to also include strep and flu. It does occur in multiple states across the nation.

**Assemblywoman Tolles:**
Essentially, the problem we are solving is we have these restrictive barriers, and this would put us more in line with other states that have successfully implemented these collaborative practices, yes?

**Senator Ratti:**
Yes. What we have learned since 2011 is our law was written with a particularly restrictive nature which was amplified in a dramatic way with the pandemic. We were not able to quickly put our pharmacists to work, again, well within their scope of practice and education, because of the barriers. We did get there with an emergency order, but there are lots of things we could be doing.

The flu is a perfect example. We have this significant spread of flu that could be prevented if we could just move the process along a little more quickly for patients in a way that is completely appropriate and completely within the scope of practice. Right now, just that little piece about having to be in a medical facility would prohibit something like that from happening. This bill seeks to remove those restrictions.

**Chair Jauregui:**
At this time, we are now going to move to testimony in support. Is there anyone in Carson City wishing to testify in support of S.B. 229 (R1)? [There was no one.] Is there anyone on Zoom wishing to testify in support of S.B. 229 (R1)?

**Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:**
Thank you for allowing me to support, and thank you for bringing this bill forward. Senator Ratti and many in the coalition have worked together to try to get this bill to where it has feet and can actually do something. In 2017, as Assemblywoman Carlton mentioned, Senate Bill 260 of the 79th Session passed, and it was so very restrictive before that, as mentioned. We are coming before you now to talk about how the pharmacists can be providers here.

There are many times that a pharmacist is the first one to provide health care for people. I am very blessed right now, as many of us are, that I have health insurance. There was a time in my life when I did not have health insurance, and I did use my pharmacist. I utilized a pharmacist who worked next door to me, and he was my health care provider. He was the one I went to when I had questions.

As has been stated, many states have modernized their laws to allow the pharmacist to provide broader health care services. For many conditions such as asthma, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, diabetes, congestive heart failure, and other health conditions, pharmacists in other states are successfully able to help and treat through medication. They do medication management for these patients. As stated, the current pandemic showed us again how Nevada has a real lack of health care providers; pharmacists can fill that void.

Pharmacists are highly trained. Their training includes a four-year, doctoral-level degree with extensive coursework in pharmacology and other pharmacological areas. They have an unbelievable ability to manage your medication, whereas most other prescribers have very limited knowledge of pharmacology.

They are trained to assess and refer patients, but let me be clear with the Committee so there is a real understanding: A pharmacist does not and will not diagnose. They manage drug therapy. They do not prescribe, but they can initiate and modify the drug therapy. I just wanted that clear for the Committee members, so they understand that this is what this bill is. It is preparing the pharmacist to be able to do this.

It will also improve access to health care, expand available services to the patient, and increase efficiency and coordination of care. The Retail Association of Nevada urges the Committee to vote for passage of this much-needed change to Nevada laws, and bring this in line with other states that have already realized the importance of these professionals as health care providers in their states.

**Adam Porath:**
I have been a practicing pharmacist in Nevada since 2006. I am a board-certified pharmacotherapy specialist and a board-certified ambulatory care pharmacist. I have been working with physicians and other providers in collaborative practice models since 2010 in our state. Over the last decade, I have had the opportunity to come to the Legislature on multiple occasions to talk about the practice of pharmacy and the benefits of utilizing pharmacists in a team-based model to improve patient access and health-related outcomes.

At Renown Health, I have had the opportunity to create a number of collaborative practice agreements to help patients with a variety of disease states, including anemia, blood-thinner management, blood pressure, cholesterol, diabetes, heart failure, hepatitis C, polypharmacy—which is when patients are just taking a lot of different medications—and smoking cessation. The results have been consistent.

Pharmacist comanagement of patients improves outcomes. Our most recent evidence of this compared diabetic patients referred to a pharmacist at Renown to those receiving usual care. Patients seeing pharmacists had significantly greater reductions in their hemoglobin and A1c, which is a measure of their blood sugar control, and on average lost 20 pounds more than those patients receiving usual care. They were pretty amazing results.

In 2017, Senate Bill 260 of the 79th Session was passed, revising pharmacy collaborative practice law in our state. Unfortunately, as we have talked about today, given the rather restrictive language of the bill, we have not seen the significant growth in collaborative practice that we expected, especially in the community setting. Restricting referrals to a pharmacist to only the physicians and other providers who have physically signed on to the pharmacist's collaborative practice agreement simply does not work in the community pharmacy environment.

As was already mentioned, the current pandemic has had some silver lining in regard to patient care access. It forced us to move headlong into virtual care. As such, there have been some temporary allowances for pharmacists to provide care with virtual supervision. To date, this has been a successful experiment and has allowed for expanded collaboration between pharmacists and practitioners.

The Nevada Society of Health-System Pharmacists fully supports S.B. 229 (R1), and I, personally as a pharmacist, am excited to support the bill. I think it is a positive step forward for access to care in our state and addresses some of the frustrations we have seen since the law in 2017.

**Chair Jauregui:**
Can we please go to the telephone line for those wishing to testify in support?

**Paul J. Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber:**
The Vegas Chamber is in support of Senate Bill 229 (1st Reprint) and appreciates the bill's sponsor for bringing the bill forward today. As you heard, this bill would be another tool in expanding health care access and conveniency for Nevadans. As we work to address the doctor shortage in our state, this bill will help us address services in the short term for the benefit of patients. We also view this bill as allowing for greater efficiency within Nevada's health care delivery system.

**Vasudha Gupta, President-Elect, Nevada Pharmacy Alliance:**
I am an associate professor at the Roseman University of Health Sciences, College of Pharmacy, and a board-certified clinical pharmacist at a Federally Qualified Health Center in Henderson, Nevada. I am representing the Nevada Pharmacy Alliance, and we fully support Senate Bill 229 (1st Reprint).

As part of my clinical responsibilities at First Person Care Clinic, I provide direct patient care to a medically complex and underserved population. I optimize the use of medications for chronic diseases to ensure efficacy while limiting side effects and misuse in collaboration with primary care providers. The providers whom I work with will attest that I am a valuable part of the health care team, helping to improve care through medication management. This is especially true for diseases that are mostly managed through a complex group of medications and which require significant education; for example, diabetes.

No other health care providers receive four years of a doctorate education that is primarily focused on the management of diseases utilizing medication. I am knowledgeable about the 30 different types of insulin that are available on the market to treat diabetes, and oftentimes I am also aware of which of those are most likely to be covered by patients' insurance. However, most community health centers and primary care offices do not employ a clinical pharmacist to provide these services.

The majority of pharmacists are located in community pharmacies, and the current restrictions in implementing a collaborative practice agreement (CPA) in a pharmacy limit the provision of care and make it impossible for pharmacists to be able to provide these services. For example, if a patient is experiencing low blood sugar for diabetes, the community pharmacist without a doubt has the knowledge to determine which of the five diabetes medications the patient is taking is most likely to cause the low blood sugar. That can be addressed when the patient is picking up their medications rather than waiting three months to see their primary care provider.

Senate Bill 229 (1st Reprint) allows for appropriate loosening of those restrictions so that unnecessary requirements do not hinder pharmacists from using their medication expertise to expand access to health care for Nevadans. Nevada is ranked forty-eighth in the nation for primary care physician access. Allowing pharmacists to practice effectively within their scope of knowledge and abilities will increase access to care and ultimately reduce health care burdens and costs.

**Krystal Riccio, Private Citizen, Henderson, Nevada:**
I am a 22-year resident of Nevada, an associate professor of pharmacy practice with Roseman University of Health Sciences, and one of the very few primary care pharmacists in Nevada. Today, I am speaking personally in support of Senate Bill 229 (1st Reprint), which increases access to care for Nevadans in rural, frontier, and even urban communities.

Many of these residents live in a desert, both literally and figuratively. They live within a medical desert. Nevada has a disparate shortage of primary care physicians, and this bill is a step in the right direction to increasing access to medical care. Medical providers and the Centers for Medicare and Medicaid Services have long promoted the concept of team-based care, with pharmacists as an essential part of an effective care team.

Physicians are provided extensive education and training on physical assessment and diagnosis, while pharmacists receive years of education and training in providing medication therapy management. I have worked collaboratively within a physicians' group for over a decade to provide optimized care for patients as a significant part of our care team, providing extensive education and chronic disease management within the scope of my practice. I am board-certified as an ambulatory care pharmacist, and after thousands of hours of practice, I am also a certified diabetes care and education specialist.

Despite years of practice developing rapport and trust with physicians and patients alike, barriers in our path due to present legislation assuage my pursuit of a collaborative practice agreement. Unfortunately, practice without a CPA creates its own barriers, requiring physicians to be on-site during all of my patient encounters and requiring me to interrupt a physician's own practice day to get approval for any medication changes I recommend. Specifically, this has caused me to cancel patient appointments due to physician illness, off-site physician meetings, and last-minute physician schedule changes.

Despite these barriers, we avoid pursuing a formal CPA due to the cumbersome process required for initial approval, consistent amendments based on frequent guideline and medication changes, and an annual renewal process, all through the State Board of Pharmacy. This bill opens up an opportunity to streamline the process, and allows for trust between a pharmacist and a practitioner in collaboration to provide improved access to care for Nevadans.

**Chair Jauregui:**
Thank you so much for your testimony, Ms. Riccio. We do need to move on the next caller. It sounded like you were reading from a document; if you would please email that over to our committee manager, she can include it in the record and send it to all of the members on the Committee.

**Amy Hale, Director-At-Large, Nevada Pharmacy Alliance:**
I am a Doctor of Pharmacy and a clinical pharmacist for Optum Care Cancer Care in Las Vegas, Nevada. I would like to voice my support for Senate Bill 229 (1st Reprint). I previously worked under a collaborative practice agreement, but we let it lapse due to many difficulties we encountered, including delays in approval if we wanted to adjust the language or any of the pharmacist-provided services. I have the full support of all nine physicians with whom I work, and they all signed the previous collaborative practice agreement.

As medication experts, pharmacists have patients referred to us to manage their medication therapy after a provider makes a diagnosis. Our training is also similar to physicians. We have a significant number of clinical training hours, and many of us have also completed residencies and hold board certification.

Most physicians who trained with clinical pharmacists will speak to how they utilize pharmacists to make these patient care decisions. They still routinely consult pharmacists, recognizing us as critical members of an interdisciplinary health care team. I personally have a 97 percent acceptance rate for my interventions, and I directly caused the reduction of approximately $20,000 per month in unnecessary prescribing when we compared our provider's prescribing practices from before having a pharmacist to one year later.

One issue we encountered after the dissolution of my collaborative practice agreement was an increased burden on our providers. They had relied on me to make appropriate dosing adjustments, adjust supportive care and pain medications per peer-reviewed and evidence-based guidelines, interchange drug products per our internal formulary, and follow

up on tests and labs that are needed for specific medications. Now they must be repeatedly interrupted to implement these changes that they felt were well within the scope of practice of a trusted pharmacist, or they would not have signed the original agreement.

Removing barriers to collaborative practice agreements allows for more comprehensive health care teams and greater communication between providers, pharmacists, and patients. It can reduce delays in care by having a pharmacist immediately resolve issues with the medication instead of waiting for a patient to schedule again with a provider. It can augment the patient-provider relationship by having more trained eyes to evaluate a patient's therapy, which results in better controlled health care costs and improved outcomes for both advocacy and patient safety.

**Ken Kunke, Executive Secretary, Nevada Pharmacy Alliance:**
[Mr. Kunke read from written testimony submitted to the Committee, Exhibit D.] The Nevada Pharmacy Alliance represents pharmacists, technicians, and students throughout the whole state of Nevada. I am here to show our support of Senate Bill 229 (1st Reprint).

First, I want to say that currently, 48 states have collaborative practice laws. Some of those laws are very restrictive, like ours, but others are allowing pharmacists to truly use the skills that they learned in school to treat patients to the best of their ability. Another thing I want to point out is that the U.S Department of Veterans Affairs system uses these in all 50 states because they can supersede state law.

I want to point to some documents that I uploaded for your exhibits under S.B. 229 (R1): the collaborative practice agreements workshop report [Exhibit E] and the team-based collaborative practice agreements guide [Exhibit F]. Those are two documents that have been worked on with groups such as the Centers for Disease Control and Prevention, the American Association of Nurse Practitioners, and the American Medical Association.

Regarding some of the questions and concerns that you had earlier, I would direct you to scan through those documents so you can get your concerns answered. I would just say thank you so much for considering this. Opening up these collaborative practice agreements is something Nevada desperately needs. I am asking you to show support of S.B. 229 (R1).

**Elliott Asarch, Private Citizen, Pahrump, Nevada:**
I am a board-certified pharmacist who works as the Director of Pharmacy for Desert View Hospital, a critical access hospital in Pahrump, Nevada. Today, I am speaking personally in support of Senate Bill 229 (1st Reprint). Nevada has a significant shortage of primary care providers, which particularly affects rural areas like Pahrump in Nye County. The patients we provide care for at our critical access hospital in Pahrump often do not have regular access to health care providers for their medication management.

Unfortunately, we often seen patients hospitalized and then re-hospitalized for preventable events. These include taking conflicting medications; not being able to titrate or adjust their medications on a week-to-week basis, such as with diabetes medications; and oftentimes taking medications from multiple prescribers—polypharmacy—that have not been adjusted due to long months in between primary care provider visits.

I believe that by providing pharmacy services at a critical access hospital, I am able to see firsthand the effects of the provider shortage and that pharmacists can be an important solution to the provider shortage. The pharmacists we work with are highly educated and qualified to provide medication management, but unfortunately, they are underutilized.

Senate Bill 229 (1st Reprint) would remove barriers to setting up these collaborative practice agreements. I believe more patients in our rural community would get access to the high-quality care that pharmacists provide and, hopefully, it would minimize the adverse events that we see from patients who do not have access to care and who are showing up to the hospital. [Mr. Asarch also submitted a letter in support of S.B. 229 (R1), Exhibit G.]

[Exhibit H is an additional letter in support of Senate Bill 229 (1st Reprint) that was submitted but not discussed and is included as an exhibit of the hearing.]

**Chair Jauregui:**
Is there anyone here in Carson City wishing to testify in opposition to S.B. 229 (R1)? [There was no one.] Is there anyone on Zoom wishing to testify in opposition to S.R. 229 (R1)? [There was no one.] Can we go to the telephone line? [There was no one.]

Is there anyone in Carson City wishing to testify in the neutral position? [There was no one.] Is there anyone on Zoom wishing to testify in the neutral position? [There was no one.] Could we please check the telephone line for anyone wishing to testify in neutral to Senate Bill 229 (1st Reprint)? [There was no one.] Senator Ratti, would you like to give any closing remarks?

**Senator Ratti:**
I do believe collaborative practice agreements have a significant ability to increase access to care and quality of care for Nevadans. The law that we have as written today is too restrictive, therefore reducing the number of these agreements, and therefore the benefit to Nevadans.

I would urge the Committee's support in this effort to strike the right balance between protecting patient safety and making sure that we have access to care. I did hear the concerns about consent and will work towards an amendment to address those concerns. Thank you so much for the opportunity to be here today and to present this bill.

**Chair Jauregui:**
With that, I will close the hearing on Senate Bill 229 (1st Reprint). Next up on our agenda is Senate Bill 112 (1st Reprint). I would invite Senator Hansen and Senator Settelmeyer to present. We are now opening the hearing on Senate Bill 112 (1st Reprint), which exempts certain products for the treatment of certain animals from regulation under state law.

**Senate Bill 112 (1st Reprint): Exempts certain products for the treatment of certain animals from regulation under state law. (BDR 54-821)**

**Senator Ira Hansen, Senate District No. 14:**
I represent Senate District No. 14, which is 38,000 square miles of Nevada. I represent most of Washoe County and all of Humboldt County, Lander County, Esmeralda County, Mineral County, Pershing County, and a big section of Nye County. Agricultural issues are very big there, needless to say.

While my name is on this bill, it is actually what happens when your leader has too many bill draft request commitments and needs an extra bill. Senate Bill 112 (1st Reprint) is on behalf of Senator Settelmeyer, which is why he is sitting up here. He is going to present the bill. I am fully supportive of it; it is a great idea. Frankly, it just brings Nevada law into compliance with federal law, but he will be able to answer the great details on it.

**Senator James A. Settelmeyer, Senate District No. 17:**
This bill goes back to the 1930s, when ranchers started to see a situation where, within their herds, they started to see loss. Specifically, the cows would miscarry in the beginning of the third trimester. I remember as a kid being 12 years old and walking out with my dad, asking him what was going on here. You would see a bunch of little fetuses out there with just the beginning of hair on them, and it was very sad and sickening. I do not know how to put it. In that respect, I asked my dad what was causing this. He said it is called "foothill abortion" and we really do not know more than that.

That dates to the 1930s when we started to see the loss. Some operations were seeing 90 percent loss. Traditionally, it was about 40 percent. Our herd was about 20 percent to 30 percent. When we lost our rangeland in California, we went down to about zero because it is related to the foothills, hence the term.

In that respect, it was interesting that the University of California, Davis (UC Davis) was looking at it and could not figure out what the problem was, but the University of Nevada, Reno (UNR) stepped in. They determined it was a deer tick that jumps off the deer and then jumps onto a cow, bites it, and causes this to occur.

They then started to work together to try to figure out, once they had an idea where it was coming from, how to figure it out. In the year 2000, they finally came out with molecular biology, which allowed them to figure it out. From that time frame to 2004, UNR worked in

collaboration with UC Davis and came up with a vaccine for this disease. It came out just recently. They finally figured out the disease and UNR was one of the predicators for figuring it out. That was fantastic.

Then, all of a sudden, the drug company that manufactured it ran into a snag. They determined that if they went through the State Board of Pharmacy, it would put them in violation of federal law because this is a biologic drug. It is only used on cattle. It is not a disease that crosses species; therefore, it is only to be regulated by the U.S. Department of Agriculture.

Well, this created a situation where we then had veterinarians—such as J. J. Goicoechea and my veterinarian, Randy Walstrom—driving to California to buy vaccines in California, to then truck it back to Nevada for a disease that Nevada actually figured out how to cure. That did not make a lot of sense.

I reached out to the State Board of Pharmacy. They worked on some emergency regulations, but agreed that we need to clarify this within statute so we would not necessarily have this problem again. However, they wanted to make it extremely narrowly tailored to come to that solution. If you look at the bill that is in front of you, S.B. 112 (R1), specifically within section 2.5, subsection 2, paragraph (a), it is only dealing with those things that are biologics that the Animal and Plant Health Inspection Service of the U.S. Department of Agriculture, pursuant to the Virus-Serum-Toxin Act, Title 21 of the U.S. Code (USC), has the ability to regulate.

Furthermore, we limited it to only livestock contained within the meaning prescribed in *Nevada Revised Statutes* (NRS) 571.022, subsections 1 and 3 through 6, inclusive, which is basically just cattle and goats. We made sure to leave out anything that could ever be developed within canine, feline, and even equine species, and things of that nature. We tried to tailor it very narrowly. With that, I do not want to eat up too much more of your time. That is the bill in a nutshell. I am ready whenever you are, Madam Chair.

**Chair Jauregui:**
Committee members, are there any questions?

**Assemblywoman Carlton:**
I followed you most of the way. I am trying to figure out how, currently, if I heard you correctly, this is encapsulated under our State Board of Pharmacy as far as distribution goes right now. What you are trying to propose and say is that this particular biologic, because it can only be used on cattle and goats, should be regulated under a federal USC chapter instead. Is this how other states have solved it?

**Senator Settelmeyer:**
In other states, they have grown a little bit larger than the state of Nevada, and so they do not necessarily have the pharmacy boards dealing with a lot of the agricultural stuff that is sometimes dealt with through their own departments of agriculture. In that respect, the other

states have decided, in my opinion rightly so, that since federal law precludes us from regulating these substances—because it is the exclusive jurisdiction and dominion of the U.S. Department of Agriculture per federal law—that there is no reason to get involved, since they cannot, in essence.

**Assemblywoman Carlton:**
Basically, our State Board of Pharmacy considers this under their jurisdiction, but in most states it is not under their jurisdictions. It is under the federal jurisdiction. Did I break it down?

**Senator Settelmeyer:**
Most other states have determined that since it is exclusive and can only be regulated, that yes, it is only to be regulated by the federal government. Our state had not necessarily come up with this discussion because most diseases within agriculture can be cross-species sometimes, as we have unfortunately just found out with COVID-19.

**Assemblywoman Carlton:**
That was leading towards my next question, that this would only apply to this particular biologic because it is only good for cattle and goats. We are not necessarily looking at others. I think that answers most of my questions.

I am just a little concerned that if the State Board of Pharmacy is regulating things that they really should not be because of the change, we should have a conversation about that. It seems as though, with this federal citation you have taken care of this one particular issue, so it looks like we are just going to have to take care of them one at a time as we move through this, Senator Settelmeyer.

**Senator Settelmeyer:**
Specifically, it states that for everything that falls under the categorization of the Virus-Serum-Toxin Act of 1913 and into the livestock that we have deemed not highly domestic, they would be considered outside of the scope of the Board. People do not have a ton of cows living in their house, and so there is no issue. They do not have a lot of goats necessarily living in their house. However, they may have felines and they may have canines.

We wanted to make sure it was narrowly tailored. However, if there are other biologics that fit within the U.S. Department of Agriculture, USC Title 21, the Virus-Serum-Toxin Act, they would also be considered to be outside of the scope and would not have to go through that. This is the first one we knew of, but let us say they come up with something else that, again, the federal government has dictated is only to be regulated by the federal government. The State of Nevada would not necessarily continue it in order to try to do this. However, we wanted to make sure we were not so wide and so broad that we would be giving up authority on things that somehow, someway could become domesticated or within one's home. That was our desire, and the desire within the definition of livestock in that categorization of NRS 571.022.

**Assemblywoman Carlton:**
Would this be administered by the rancher himself, or would this be administered by a veterinarian?

**Senator Settelmeyer:**
This particular one in question is actually much like the Pfizer COVID-19 vaccine. It has to be sustained in cold storage, liquid nitrogen, at minus 127 degrees. In general, it is something that is always done only by a veterinarian. It can only be purchased by a veterinarian.

It is just that the veterinarians in Nevada would appreciate purchasing it in Nevada rather than having to drive to California to get it. This is because traveling with liquid nitrogen in the vehicle is not real fun, whereas FedEx, UPS [United Parcel Service], and other carriers have figured out the storage and carrying of liquid nitrogen and are more accustomed to that.

Most veterinarians traditionally only transfer it from their house to the location when dealing with liquid nitrogen, which they deal with on a regular occurrence and are rather skilled at dealing with because they deal with it for everything from vaccines to semen and embryos. However, in this particular situation, they really did not like the idea of having to drive across the state line to do that.

**Chair Jauregui:**
I have a question for you, Senator Settelmeyer. You said that this would only apply to cattle.

**Senator Settelmeyer:**
I apologize, Madam Chair, I am furiously trying to look up the definition of livestock.

**Chair Jauregui:**
The definition under NRS 571.022 also includes birds, dogs, and cats.

**Senator Settelmeyer:**
It would be all cattle or animals of the bovine species; all horses, mules, burros, and asses or animals of the equine species; all swine or animals of the porcine species; it skips goats and sheep, but includes poultry; and that is it. It leaves out all dogs and cats and all alternative livestock.

This was requested not only by the industry but also by the State Board of Pharmacy, who crafted these amendments to the bill to get us to this stage. This is where they felt the most comfortable. I was trying to make sure to follow their guidance, and, as we all know in the Legislature, to go the path of least resistance.

**Chair Jauregui:**
Senator Settelmeyer, if you could, show me where in the bill it exempts dogs, cats, and sheep.

**Senator Settelmeyer:**
If you look at page 2, lines 11 and 12, which would be section 2.5, section 2, paragraph (b), it says, "'Livestock' has the meaning ascribed to it in subsections 1 and 3 to 6, inclusive, of NRS 571.022." This would mean that it would only include NRS 571.022, subsection 1, which covers cattle and bovines; subsection 3, which covers swine and animals of porcine species; and then through to subsection 6, which would get you the goats, the sheep, and the poultry; but not subsections 7 and 8, which is dogs, cats, and all domesticated and alternative livestock.

**Chair Jauregui:**
Thank you so much, Senator Settelmeyer, I appreciate that. Committee members, are there any other questions for our presenter? [There were none.] Let us go ahead and move on to testimony in support. Is there anyone in Carson City wishing to testify in support? [There was no one.] Is there anyone on Zoom wishing to testify in support? [There was no one.] Could we check the telephone line for those wishing to testify in support of S.B. 112 (R1)? [There was no one.]

Is there anyone in Carson City wishing to testify in opposition? [There was no one.] Is there anyone on Zoom wishing to testify in opposition? [There was no one.] Could we check the telephone line for anyone wishing to testify in opposition to Senate Bill 112 (1st Reprint)? [There was no one.]

Is there anyone in Carson City wishing to testify in the neutral position? [There was no one.] Is there anyone on Zoom wishing to testify in the neutral position? [There was no one.] Could we check the telephone line to see if there is anyone wishing to testify in neutral? [There was no one.] Do you have any closing remarks, Senator Settelmeyer?

**Senator Settelmeyer:**
If anyone else on this Committee has any questions, please reach out to me and I will do my best to get them answered. Thank you all.

**Chair Jauregui:**
With that, I will close the hearing on Senate Bill 112 (1st Reprint). The last bill on our agenda today is Senate Bill 408 (1st Reprint). I will now open the hearing on Senate Bill 408 (1st Reprint), which revises provisions relating to the State Board of Pharmacy. I believe we have Mr. Wuest here to present the bill.

**Senate Bill 408 (1st Reprint): Revises provisions relating to the State Board of Pharmacy. (BDR 54-1098)**

**Dave Wuest, R.Ph., Executive Secretary, State Board of Pharmacy:**
Yes, I am here. Actually, I have Richard Tomasso, who is the State Board of Pharmacy's public member. He is going to make a statement first as he has some time constraints, and then I will run you through some sections and answer any questions.

**Richard Tomasso, Member, State Board of Pharmacy:**
I am the vice president of security, surveillance, and government affairs for Mesquite Gaming. About a year and a half ago, I was honored by Governor Steve Sisolak to be appointed to the State Board of Pharmacy as the public member.

Coincidentally, at that time the Division of Internal Audits of the Office of the Governor just completed a review of the State Board of Pharmacy. After that review they made five recommendations, four of which were already implemented and are part of our policies and procedures as we speak. The fifth recommendation, however, would take legislative action, and that is what is before you today in Senate Bill 408 (1st Reprint).

The bill requires national background checks on pharmacist applicants and pharmaceutical technician applicants. The Division of Internal Audits also happened to note that four of our surrounding states—Arizona, Oregon, Utah, and Washington—already require background checks on their pharmacists and pharmaceutical technicians. They also, interestingly, noted in their review that the State of Nevada required background checks for the Board of Medical Examiners, the State Board of Nursing, the Nevada Physical Therapy Board, and the Board of Dental Examiners of Nevada. And yet, there is no background check for pharmacists.

When you think about this, it is kind of shocking because all of the legal narcotics—I am talking about controlled substances—that come into the state of Nevada, all of them, fall under the dominion and control of your pharmacists and pharmaceutical technicians. It falls under their control for storage, inventory control, and dispensing.

Prior to my getting into the gaming industry, I spent 31 years as a special agent with the Federal Bureau of Investigation (FBI). My expertise and specialty was in federal narcotic investigations. In fact, I spent the last eight years of my Bureau career right here, working federal narcotic investigations in Nevada. The greatest tool I had for vetting the subjects of my investigations was the national background check. These background checks can tell you a lot about a subject's or an individual's character, their propensity to commit another crime, and their tendencies. You can read a lot into it.

I think that the State Board of Pharmacy needs this tool to vet those pharmacists and pharmaceutical technicians who are in control of all of the narcotics in the state. I think that the general public—of which, Assemblymen and Assemblywomen, you are a part—needs some assurance and comfort to know that when you go to the pharmacist and get your prescription bottle, what is in that bottle is what your doctor prescribed; it was not tampered with, exchanged, substituted, or diverted.

The State of Nevada needs to know that the drugs that come into the state, including all of the controlled substances, are not being illegally put out into the state and contributing to our opioid crisis. I think, Assemblymen and Assemblywomen, what the State Board of Pharmacy is asking you for is your help to help us help you.

**Dave Wuest:**
Thank you, Chair Jauregui and members of the Committee, for your consideration of S.B. 408 (R1). This bill clarifies and makes more consistent various provisions of existing law that govern how the Board operates. It implements recent recommendations that were made either by the Sunset Subcommittee of the Legislative Commission or by the Executive Branch auditors. It helps the Board protect the public to the greatest extent possible, assuring that we have reliable pharmaceutical care.

I will just run through the sections really quickly, being sensitive of your time. Section 2, subsection 3, removes a provision that clearly conflicts with the Open Meeting Law in statute. We are just blending that in to use more transparent language.

Section 3 clarifies the Board's authority to perform two essential functions. First, the Board routinely enters into agreements with local, state, and federal agencies to coordinate our efforts and better protect the public. Second, the Board has a State Board of Examiners-approved contract with Appriss Health to administer the Nevada Prescription Monitoring Program. The Board would like both of these functions to be clearly specified in the *Nevada Revised Statutes* (NRS).

Section 4 amends NRS 639.100 and simplifies the statute to clarify that it is unlawful to manufacture, wholesale, compound, sell, or dispense prescriptions in Nevada unless properly licensed. Sections 5 and 6 require the applicants to undergo criminal background checks to become registered pharmacists or pharmaceutical technicians. This recommendation was made by the Executive Branch audit.

Currently, the only people to whom background checks apply are operators of wholesalers. Many other states, as Mr. Tomasso said, have such a requirement. This is ultimately a policy decision that rests with you. It did come up, obviously, on the Senate side that this is moving forward, not going back and doing background checks on all the current licensees. This is as new people would apply. Section 11, which relates, makes conforming amendments to protect the criminal history, once the Board has it, from unauthorized use or disclosure, as required by the FBI.

Section 7 increases the statutory limits on the biennial fee to be licensed as a manufacturer or wholesaler from $500 to $1,000. This is the result of a Sunset Subcommittee recommendation to the Board to analyze its fee structures and revise fees to the extent necessary to support its operation. Currently, the Board cannot increase fees for manufacturers and wholesalers to cover the cost of regulating these activities because there is a statutory limit. This will remedy that.

Section 8 changes NRS 639.243, subsection 2, to conform with the 20-day period of filing and answering a Notice of Defense. It just tidies that up. Section 10 amends NRS 639.281 to clarify that it is unlawful to obtain a license from the Board under false pretenses or false representation of one's self as a holder of a license.

Section 13 repeals NRS 639.095, which requires that the Board provide free paper copies of their chapters in the *Nevada Administrative Code*. This requirement is outdated and unnecessary because the laws are accessible on the Board's website. I thank you for your consideration of this bill and can answer any questions.

**Assemblywoman Kasama:**
My question is in section 2, subsection 3, relating to where you deleted the line on administrative action. Could you give an example of the difference between administrative action—because you are removing that—and the administrative examinations that are closed to the public?

**Dave Wuest:**
The Board actually does all of these up in the public. The current statute would allow us to do those administrative actions in closed sessions, but the Board does not. When we are looking at the character or competency of an applicant, they can still request that it be in a closed session, and the Board votes to see if they are going to do that or not. However, 99 percent of the Board's activities at Board meetings are open to the public, and I think that is the way the Board likes it. That is why they are asking for this change.

**Assemblywoman Carlton:**
Could you elaborate on the fee increase, please?

**Dave Wuest:**
During the Sunset Subcommittee review, it was found that we were very short in reserves. We were obligated to do a reserve policy which we did report back to the Sunset Subcommittee. We had no fee increases in the last 21 years at that time.

The Sunset Subcommittee made us take a hard look at the activities that we were doing and the fees we were charging. We did implement some increases to other fees that were within statutory guidelines or allowable dollar amounts, but we were way under what other states were doing for the wholesalers. That is not the reason to increase it, but as Mr. Tomasso said, we had to change how we were doing the wholesalers. We have had an increase in activities and are now doing a lot more with the background checks.

I want to be clear that this does not change the fee. This only changes the statutory limit of the fee. We would still need to change regulations and go in front of the Legislative Commission's Subcommittee to Review Regulations in order to change any fees.

**Assemblywoman Carlton:**
I understand that; you are raising the cap. Can you give me an approximation of what an investigation would normally cost you?

**Dave Wuest:**
If you are talking about the investigation of an applicant, we have to run the fingerprints, interact with the Food and Drug Administration to see if they are a licensed wholesaler,

interact with their current state to make sure they are in good standing, and do all of those kinds of things. That is what the fees go towards.

**Assemblywoman Carlton:**
I appreciate that. I have been working with these Boards for a very long time, so when I see that the investigation or issuance of the original license is up to a certain amount, but then I see the renewal is also up to that amount—realizing that yes, these are caps—I know the original investigations and issuance are always much more expensive than the renewals. The files have already been established and all the original documentation has already been collected.

It is just a matter of updating everything and making sure that everyone is still legitimate and has not gotten in trouble over the last couple of years. I was just wondering what the real cost of the investigations for the original license was versus what the actual time and effort was on the renewal because you are setting the cap at the same limit. That is where my question comes from.

**Dave Wuest:**
I am not sure, was there a follow-up question?

**Assemblywoman Carlton:**
It costs more to do the investigation. About how much does that cost, and how much does it cost to do the renewal? Why did you set the caps at the same amount?

**Dave Wuest:**
If you want the actual dollar amounts, I can definitely provide you that after this meeting. I understand your point that the upfront investigation is more expensive than the renewals potentially are. However, we are coming from a place where this was not something the Board even took into account. We had an incident where, certainly, the audit staff pointed out that there was a deficiency. It took a whole revamping of how we were doing that licensure for that category, and we have added people to do background checks. I can get you those dollar amounts after this meeting.

**Chair Jauregui:**
If you would provide those to the committee manager so she can share them with the entire Committee, that would be great, thank you. Committee members, any other questions?

**Assemblywoman Tolles:**
I have one question specific to the bill and another question that might be directed towards legal counsel. The first question is on the last page of the bill and the text of the repealed section. We are removing the requirement that the Board furnish free copies of the laws and regulations for applicants and registrants. I was just wondering if you could elaborate a little bit more. Is that because we are directing them to see that online? I was wondering what the reasoning was for repealing that section.

**Dave Wuest:**
That is an excellent question. Currently, the Board will print out a hard copy of the laws and send it to an applicant. That is generally related to them studying for the test or whatever, and in today's world, there are electronics. We do not get a lot of requests for the paper copies because people can get them themselves on their devices. We are just trying to remove that requirement of the paper copies.

**Assemblywoman Tolles:**
Again, this may be better suited for legal counsel and I may need to take it offline, but last session, this body passed Assembly Bill 319 of the 80th Session. It set up a process by which all Boards that conduct criminal investigation background checks for applicants must provide a process for an individual with a criminal history to be able to solicit an opinion from the Board if they were automatically disqualified before they began that process. For this example, you would have somebody who, perhaps, was just starting pharmacy school and wanted to see, before they even went down that path, if their criminal history would automatically disqualify them from being able to be licensed.

Would the provisions that we passed in all the applicable chapters from NRS Chapter 624 to Chapter 648—which I believe NRS Chapter 639 would then fall into—also carry over to this bill and this chapter? This may be a question for legal counsel because it is not actually written into this bill. Because the Board did not have background checks before, that is why it was not written into this chapter. But because we are now putting background checks in, would that take separate legislation, or would that automatically be conforming language?

**Chair Jauregui:**
We can go to Sam Quast. Mr. Quast, if you do not have the answer for us now, could you research it and get it to the Committee?

**Sam Quast, Committee Counsel:**
Yes, I will look into that and get it back to the Committee.

**Chair Jauregui:**
Committee members, are there any other questions? [There were none.] Mr. Wuest, I did have one. It is more of a process question. You are adding language in section 3, subsection 1, paragraph (r), that allows the Board to "Contract with a private entity to administer the database of the program established pursuant to NRS 453.162." How is that process currently handled? Who tracks that database or the information required under NRS 453.162?

**Dave Wuest:**
We currently follow the purchasing requirements of the state, so that contract and others would go to the State Board of Examiners. It is one of our bigger contracts for the State Board of Pharmacy, and so I think our attorney recommended we just put it in statute. I think we currently do it and we work through the Purchasing Division within the Department of Administration to follow all the rules for that.

**Chair Jauregui:**
Therefore, you will continue to work through the Purchasing Division; you are just adding this and putting it in statute.

**Dave Wuest:**
Yes.

**Chair Jauregui:**
Committee members, are there any other questions? [There were none.] We are going to move on to testimony in support of Senate Bill 408 (1st Reprint). Is there anyone in Carson City wishing to testify in support? [There was no one.] Is there anyone on Zoom wishing to testify in support? [There was no one.] Could we check the telephone line for anyone wishing to testify in support of Senate Bill 408 (1st Reprint)?

**Daniel Pierrott, representing Fingerprinting Express:**
Today, I am testifying in support of Senate Bill 408 (1st Reprint) on behalf of our client, Fingerprinting Express. We [unintelligible] in technology and fingerprint background checks in addition to a myriad of other services to ensure the safety and security of Nevadans.

Currently, there are over 80 industries in Nevada that are required by statute to receive fingerprint background checks. For that reason, we are in strong support of this legislation, particularly section 5, subsection 2, and section 6, subsection 4. We support the move to fingerprint our pharmacists and pharmaceutical technicians. Thank you for your time and consideration.

**Chair Jauregui:**
Is there anyone in Carson City wishing to testify in opposition to S.B. 408 (R1)? [There was no one.] Is there anyone on Zoom wishing to testify in opposition? [There was no one.] Could we check the telephone line for anyone wishing to testify in opposition to S.B. 408 (R1? [There was no one.]

Is there anyone in Carson City wishing to testify in the neutral position on S.B. 408 (R1)? [There was no one.] Is there anyone on Zoom wishing to testify in the neutral position? [There was no one.] Could we check the telephone line? [There was no one.] Mr. Wuest, would you like to give any closing remarks?

**Dave Wuest:**
I appreciate your time and I will get you the answer you asked for. Thank you.

**Chair Jauregui:**
With that, I will close the bill hearing on Senate Bill 408 (1st Reprint). Committee members, we have one last item left on our agenda today; it is public comment. [Protocol concerning public comment was discussed.] Is there anyone on the telephone line wishing to give public comment? [There was no one.] Is there anyone on Zoom? [There was no one.] Is there anyone in Carson City wishing to give public comment? [There was no one.]

With that, Committee, thank you so much. Our next meeting will be on Wednesday, April 28, 2021. Please be on the lookout for the agenda and please note the start time. It will be different than our normal start time. With that, we are adjourned [at 3:18 p.m.].

RESPECTFULLY SUBMITTED:

_____
Louis Magriel
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sandra Jauregui, Chair

DATE: _____

## EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony presented by Beth Slamowitz, Senior Physician and Senior Policy Advisor on Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services, regarding Senate Bill 229 (1st Reprint).

Exhibit D is written testimony presented by Ken Kunke, Executive Secretary, Nevada Pharmacy Alliance, in support of Senate Bill 229 (1st Reprint).

Exhibit E is a report titled "Pharmacist Collaborative Practice Agreements: Key Elements for Legislative and Regulatory Authority," presented by Ken Kunke, Executive Secretary, Nevada Pharmacy Alliance, regarding Senate Bill 229 (1st Reprint).

Exhibit F is a document titled "Advancing Team-Based Care Through Collaborative Practice Agreements," presented by Ken Kunke, Executive Secretary, Nevada Pharmacy Alliance, regarding Senate Bill 229 (1st Reprint).

Exhibit G is a letter dated April 26, 2021, submitted by Elliott Asarch, Private Citizen, Pahrump, Nevada, in support of Senate Bill 229 (1st Reprint).

Exhibit H is a letter dated April 26, 2021, submitted by Dana Mitchell, Private Citizen, Las Vegas, Nevada, in support of Senate Bill 229 (1st Reprint).