MINUTES OF THE JOINT MEETING OF THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES AND THE ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Eighth Session
April 1, 2015

The joint meeting of the Senate Committee on Health and Human Services and the Assembly Committee on Health and Human Services was called to order by Chair Joe P. Hardy at 3:35 p.m. on Wednesday, April 1, 2015, in Room 1214 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.

SENATE COMMITTEE MEMBERS PRESENT:

Senator Joe P. Hardy, Chair
Senator Ben Kieckhefer, Vice Chair
Senator Mark Lipparelli
Senator Joyce Woodhouse
Senator Pat Spearman

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblyman James Oscarson, Chair
Assemblywoman Robin L. Titus, Vice Chair
Assemblyman Nelson Araujo
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Jill Dickman
Assemblyman David M. Gardner
Assemblyman John Hambrick
Assemblyman John Moore
Assemblywoman Ellen B. Spiegel
Assemblyman Michael C. Sprinkle
Assemblyman Tyrone Thompson
Assemblyman Glenn E. Trowbridge

ASSEMBLY COMMITTEE MEMBERS ABSENT:

Assemblywoman Amber Joiner (Excused)
Assemblyman Brent A. Jones (Excused)

GUEST LEGISLATORS PRESENT:

Senator Moises (Mo) Denis, Senatorial District No. 2

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Eric Robbins, Counsel
Kirsten Coulombe, Policy Analyst
Debra Carmichael, Committee Secretary

OTHERS PRESENT:

Michael J. Willden, Chief of Staff, Office of the Governor
Tracey D. Green, M.D., Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Linda Lang, Director, Nevada Statewide Coalition Partnership
Karla D. Wagner, Ph.D., Assistant Professor, School of Community Health Sciences, University of Nevada, Reno
Dorothy Nash Holmes, Municipal Judge, Department 3, City of Reno
Ken Ball, Chief, Police Department, Holly Springs, Georgia
Liz MacMenamin, Retail Association of Nevada
John T. Jones Jr., Nevada District Attorneys' Association
Joseph P. Iser, M.D., Dr.PH., M.Sc., Chief Health Officer, Southern Nevada Health District
Stacy Woodbury, M.P.A., Executive Director, Nevada State Medical Association
Kathy Bartosz, Executive Director, Partnership Carson City
Christie McGill, Healthy Communities Coalition
Curt Fonken, CADC, The Life Change Center
Ginger Paulsen
Joseph Livernois, Northern Nevada Hopes
Joseph Engle, There is No Hero in Heroin Foundation
Christine Chicoine

Rhonda Mattson

Chair Hardy:
I will open the hearing on Senate Bill (S.B.) 459. Before you is a comparison chart of the four bills we will be hearing today (Exhibit C). These bills are S.B. 309, S.B. 288 and Assembly Bill (A.B.) 279. Senate Bill 114, as amended, is similar to all the bills before this body (Exhibit D). It requires the State Board of Pharmacy to send a report regarding patients who are receiving large amounts of controlled substance prescriptions, identified by the prescription monitoring program (PMP) algorithm, to the professional licensing board with oversight of the prescribers identified, in addition to providing it to the prescribers of the drugs and the pharmacies filling the prescriptions. The second provision authorizes specific law enforcement personnel who are assigned on a full-time basis to investigate prescription drug abuse, or illegal activity involving prescription medications, to have direct access to the PMP database.

Senate Bill 114 provides valuable tools that will increase oversight and assist Nevada in its efforts to address the prescription drug addiction challenges in our State.

SENATE BILL 114: Makes changes relating to prescriptions for certain controlled substances. (BDR 40-239)

SENATE BILL 459: Establishes an opioid overdose prevention policy for Nevada. (BDR 40-1199)

SENATE BILL 309: Enacts the Good Samaritan Drug Overdose Act. (BDR 40-214)

SENATE BILL 288: Revises provisions relating to prescribing controlled substances. (BDR 40-889)

ASSEMBLY BILL 279: Revises provisions concerning controlled substances. (BDR 40-775)

Michael J. Willden (Chief of Staff, Office of the Governor):
In 2012, the National Governor's Association (NGA) launched a prescription drug abuse policy academy process. In 2014, the NGA opened up the

application process again for the second prescription drug abuse academy. Governor Brian Sandoval was named as the cochair for this policy academy along with Governor Peter Shumlin of Vermont. Nevada submitted a grant application and was selected along with Alabama, Arkansas, Colorado, Kentucky, New Mexico, Oregon and Virginia. The academy was kicked off at Lake Tahoe in September 2014. After the task force meeting, each state created their own policies. Our academy has been working on a number of recommendations and plans which you will hear today. The draft recommendations will be presented the first work week of May at conferences in Las Vegas and Carson City. Beyond the legislation talked about today the academy discussed, reviewed and planned the educational efforts to present to youths, parents of youth and practitioners; get more buy in on the issue through stakeholder conference and other educational information; looking at data systems for collaboration and consolidation; improve screening processes particularly for 12- to 25-year-old persons; looking at specific targeting strategies to help identify abusing populations and improve case management to these populations.There was criticism about who was and was not on the Nevada NGA task force. The task force needed to be lean to accomplish things. Specifically, NGA did not want it filled with lobbyists. The task force was the First Lady Kathleen Sandoval, representatives from the Children's Cabinet, Medicaid, substance abuse prevention treatment agency, pharmacy board, State medical officer, Governor's Office, Health and Human Services director's office, Nevada Statewide Coalition Partnership and Public and Behavioral Health. One of the task force goals was to move forward legislation to help fight prescription drug abuse. The task force feels there are four areas of focus are; a Good Samaritan law; Naloxone or Narcan programs and use; continuing education programs for prescribers and dispensers of controlled substances and putting information into and using the prescription drug monitoring program (PDMP).

Sections 1 and 2 of S.B. 459 add a new chapter to Title 40 of *Nevada Revised Statutes* (NRS). Title 40 is the public and safety title and the new chapter may be cited as the Good Samaritan Drug Overdose Act. Section 7 allows a health care professional to prescribe an opioid antagonist to a family member, friend or a person who is a position to assist someone who is at risk of overdosing. Prescribers would not be subject to liability or disciplinary action. Section 8 allows for storage and dispensing of Naloxone. Section 9 requires the pharmacist, before dispensing an opioid antagonist, to complete a training program on the use of opioid antagonists. Section 10 allows

the Department of Health and Human Services (DHHS) to engage in efforts to ascertain and document the number, trends, patterns and risk factors related to fatalities caused by unintentional opioid-related drug overdoses and other drug overdoses. Section 11 deals with DHHS education grants. Section 12 allows a person who, in good faith, seeks medical assistance for a person who is experiencing a drug or alcohol overdose may not be arrested, charged, prosecuted or convicted. Section 13 deals with dispensers of controlled substances to upload to the database within 24 hours after dispensing a controlled substance. Section 14 deals with training. Practitioners who are registered to dispense must receive at least 2 hours of training approved by the Board specific to the misuse and abuse of controlled substances. This area is subject to interpretation and amendment. The intent should be dispensers and prescribers should have the training and oversight by their appropriate licensing boards. Section 16 deals with the initiating practitioner's requirement to run a patient utilization report before initiating a prescription.

We have been working with the Board of Pharmacy on a friendly amendment for section 14, subsection 4 of S.B. 459 which deals with the continuing education requirement and the appropriate oversight boards for those continuing education requirements. We have worked with the Retail Association on a friendly amendment to section 13. Instead of a 24-hour reporting requirement, a next business day requirement to accommodate weekends and holidays is proposed.

Tracey D. Green, M.D. (Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services):

The misuse and abuse of prescription medications has taken a devastating toll on public health and safety across our Nation. We have seen a dramatic increase in substance abuse treatment admissions, emergency room (ER) visits and most disturbingly a dramatic increase in overdose deaths due to prescription drug abuse and misuse. The Centers for Disease Control and Prevention (CDC) has characterized prescription drug overdose as an epidemic. According to the CDC, overdose was the leading cause of injury death in the United States in 2012. In that same year, drug overdoses killed more people in the ages of 25 to 64 years of age than motor vehicle crashes. When people think about drug overdoses they typically think of street drugs like heroin. However, prescription drugs are a significant contributor to drug overdose in the United States. Of the 41,500 drug overdose deaths in 2012, 53 percent or 22,000 of these deaths were attributed to pharmaceutical drugs. Of the 22,000 deaths, 16,000 or

72 percent involved opioids. Fifty Americans die from prescription painkiller overdoses each day. Unfortunately, Nevada is amongst the highest prescribers and abusers in the nation. Nevada ranks in the top 10 percent of prescribers for Hydrocodone, Oxycodone, Methadone and Percocet. In 2009 and 2010, Washoe County School District conducted a survey of middle and high school students and found 9.8 percent of middle school students and 18.7 percent of high school students had used prescription drugs in the last 30 days to get high. Of the students surveyed, 23.7 percent and 21.9 percent of high school students think people are at no risk or slight risk of harming themselves if they use prescription drugs to get high. In 2013, 5.9 per 1,000 emergency department visits among Nevada residents were a result of heroin opioid dependence abuse or poisoning related emergencies. The highest rates, by county, were in Washoe County at 7.9 percent per 1,000 and Nye County at 12 per 1,000 prescription overdoses or emergencies related to pharmaceutical drugs. In 2011, the Clark County Office of the Coroner reported 551 deaths as a result of prescription drug overdoses, the majority of these being multiple drug overdoses. Prescription drug abuse and misuse overdose and death are statewide problems affecting almost all Nevadans in some way.

As part of the NGA policy academy, the Nevada team has taken on the task of significantly reducing prescription drug abuse and overdose. Prescription drug abuse and misuse policy varies from state to state. In 2013, Trust for America's Health identified 10 categories of evidence informed policies across the nation. They rated each state on the number of policies that existed in each state. Nevada received a 7 out of 10. Vermont, Nevada's cochair state, received a 10 out of 10. Nevada had a number of existing policies but lacked policies specifically in 3 areas. The areas are: prescriber education requirements, Good Samaritan immunity laws and laws for the use of Naloxone.

Before you are bills that include all three policy areas that have not been included previously in the policies surrounding prescription drug misuse and abuse in our State. In addition, we are strengthening our prescription drug monitoring program usage as the fourth area in the bills. The PDMPs are state-run electronic databases that are used to track the prescribing and dispensing of controlled prescription drugs to patients. Providers or pharmacists can use these monitoring systems to record and pull data on individuals' use of prescription drugs. The goal of PDMP is to quickly identify problem prescribers and individuals misusing drugs and to stop overt attempts at "doctor shopping."

It would also allow for better identification and treatment of individuals who are suffering from pain and drug dependence. The PDMP is in Nevada statute but the proposed bills aim to strengthen these legislations. While much of the prescription drug abuse problem is caused by illicit use, legitimate use of painkillers can lead to adverse consequences including addiction, unaccounted for misuse and death. When prescription drugs are over prescribed or improperly prescribed, it is important to recognize these untoward outcomes. In regards to prescriber education, it is important to educate providers about the risks of prescription drug misuse, abuse and also educate providers on the appropriate use of this category of medication. Currently, there is limited training in medical schools and the industry continues to grow and expand. Legislating to provider education insures a continued training for prescribers and providers. Good Samaritan laws are designed to encourage people to help those either in danger of overdose themselves or for friends or family they encounter that are at risk of or in the midst of overdose. These laws provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves and/or experiencing for or with a friend or family. Rescue drug use such as Naloxone or Narcan is an opioid antagonist. When taken, this medication temporarily reverses the effect of the opioid in the body. This medication unbinds the opioid the person has ingested. The drug is intended to reverse the effects of the opioid. It may be injected in a vein, under the skin or inhaled through the nose. It is a temporary drug that wears off in 20 to 90 minutes. Although Naloxone is a prescription drug, it is not a controlled substance and it has no abuse potential. In fact, if a person has not ingested an opioid or that class of medications, it has no effect. It is intended to be used after training. It is very important that training occurs because of the short duration of action of this medication. It must be included in a "system of care." It is very important that when Narcan or Naloxone use is indicated and used by any Nevadan that it is associated with immediate access to emergency services. In many instances, once the 90 minutes have passed the effects of the opioid can reoccur in the individual. This depends on the amount of drug taken and the specific drug taken. There are many different ways the categories of legislation can be brought forward and the bills presented today show the variations.

Senator Kieckhefer:
How broad are the immunity laws that other states have enacted?

Dr. Green:
It is the full spectrum including minimal immunity to immunity from murder.

Assemblywoman Titus:
Were there any practicing physicians on the task force?

Mr. Willden:
No, there were no practicing physicians on the task force. Three medical professionals were involved: Larry Pinson with the State Board of Pharmacy, Dr. Green and Mary Wherry with the Division of Public and Behavioral Health.

Assemblywoman Titus:
We had a severe shortage of Naloxone in our ER not long ago. It is a difficult drug to obtain and it is in limited supply. Will Naloxone be readily available for the "just in case" scenarios?

Dr. Green:
That is a real issue we need to address as we move forward. It is an element of looking where it is available in the larger ERs. We have not heard about shortages. Our first responders are not carrying Naloxone or Narcan. The level below the higher-level emergency medical technician is not authorized to carry Narcan. That can cause an issue for the rural communities.

Assemblywoman Titus:
The problem with an overdose is the person is given Naloxone and the person wakes up then in moments can be out again. Training is involved to understand that administering the drug is not something the average layperson can do.

Dr. Green:
While there were no practicing physicians on the task force, there are elements of the task force policy plan that include outreach to stakeholders, specifically the providers. There will be a full day in the north and south to engage other stakeholders.

Assemblyman Thompson:
Is the Good Samaritan law going to be included in the bill?

Dr. Green:
Absolutely, section 7, subsections 1 and 2 of S.B. 459 cover the civil and criminal level of prescribing and dispensing the opioid antagonist.

Assemblyman Thompson:
When and if this is enacted, the outreach component has to be strong, especially within the schools and higher learning. It is important that age group understands it is acceptable to intervene and help.

Dr. Green:
I support the outreach component. The most important arm of the Naloxone aspect of the bill will be the effective and efficient education of all age groups.

Assemblywoman Benitez-Thompson:
What is the intent with using "initiating" in section 16 of S.B. 459?

Dr. Green:
The original intent is any new opioid prescription written for an individual would require review in the PDMP prior to this. The Nevada State Medical Association has assisted the task force in improving and defining the term "initiating." Initiating means the origination of a new prescription for a new patient of the practitioner or beginning a new course of treatment for an existing patient of the practitioner, not including ongoing prescriptions written to continue a course of treatment for an existing patient.

Assemblywoman Benitez-Thompson:
For clarification, is it someone new to the practitioner?

Dr. Green:
Yes, it could be a new patient but it could also be an established patient, new to the opioid prescription. If there is a concern about a patient, there is always the opportunity to review the PDMP. The term "initiating" is specific to the start of a new opioid prescription whether it is for a new or established patient.

Linda Lang (Director, Nevada Statewide Coalition Partnership):
I have submitted my written testimony (Exhibit E). Evidence shows that one strategy alone will not affect change, but implementing "multiple strategies across multiple sectors" will produce long-term sustainable results. Coalitions

utilize evidence-based practices or evidence-informed policies when addressing any problem that affects their communities. Nevada's issues related to prescription drugs are no different. Nevada currently employs six of the approaches and the legislation proposed today addresses the four additional approaches needed to "move the needle" on effectively addressing the prescription drug issues in the state.

Karla D. Wagner, Ph.D. (Assistant Professor, School of Community Health Sciences, University of Nevada, Reno):

I have been conducting research on overdose prevention and Naloxone programs since 2006. I have submitted a detailed summary of much of the research that has been going on since 1996 (Exhibit F). Naloxone is a legal prescribed medication. It is not controlled; it is not scheduled. It is legal for a physician to prescribe Naloxone to a patient who is at risk of dying of an overdose. These bills before you today expand access to this life-saving medication in a number of different ways. Since 1996, there have been programs in this Country that educate people about overdose prevention and prescribe and dispense Naloxone to people who are at risk of dying of an overdose. Since that first program, 50,000 people have been trained in Naloxone administration. Those people have reported over 10,000 uses of Naloxone to reverse suspected opioid overdoses without any documented serious adverse events. Expanding the use of Naloxone by non-paramedic first responders, such as law enforcement officers and emergency medical technicians (EMTs), are also considered in this legislation. It is occurring in many states and is part of a comprehensive overdose death prevention effort. Currently, there is no evidence that the life-saving benefits of distributing Naloxone to laypeople can be achieved if Naloxone access is limited only to first responders. Available data suggests that expanding access to Naloxone for laypeople does not encourage drug use. In fact, it may be associated with increased uptake of drug treatment. In my own research in California and other studies from Chicago and New York, many participants who received overdose prevention training and prescriptions for Naloxone reported no changes or decrease in their drug use. In my study, 53 percent said 3 months after their training their drug use had gone down. In addition the percentage of individuals, in my study, who reported being enrolled in drug treatment increased. My research suggests that reversing overdoses in the community can be empowering for people and serve as a life-changing moment after which some make dramatic changes.

We know from many studies that individuals who witness overdoses in their communities are afraid to call 911 to summon medical assistance out of fear of legal repercussions. This is a significant barrier for people seeking medical help for friends and family members who are dying. The 911 Good Samaritan protections such as those contained in the bills before you today are critical to removing the perceived barriers to summoning medical assistance.

There are several provisions regarding the PDMPs which can be a part of this comprehensive solution to opioid overdose. To be most effective in reducing deaths, they need to be accompanied by the Naloxone access provisions and the 911 Good Samaritan provisions. Together, these bills provide a comprehensive and public health-minded approach to reducing overdose deaths that are consistent with the best practices across the Country.

Dorothy Nash Holmes (Municipal Court Judge, Department 3, City of Reno):
I have been in the law profession for 38 years. I was a federal drug prosecutor in the Organized Crime Drug Enforcement Task Force program that President Ronald Reagan set up to deal with international narcotics traffickers. We have not won that war on drugs. I was district attorney in Washoe County and prosecuted there for 5 years early in my career. I have been a state prosecutor of inmate drug crimes including gang related deaths in the prison system for the State. For 7 years, I worked with the Department of Corrections; during my last years there, I worked as deputy director of Corrections establishing correctional programming. I had to train myself about rehabilitation, because in two-thirds of my career as a prosecutor, I did not believe in rehabilitation. As a drug court judge, I know what is working and what does not. Throwing these people in prison is not working. I have a drug court with mentally ill addicts, homeless inebriated addicts and driving under the influence (DUI) offenders. I inherited a court of 100 people who were just DUIs, then I added drugs and 3 years later, we see over 300 people a year. We have an 85 percent success rate, but we have also seen 10 overdose deaths in the last 4 1/2 years. That is just in Reno Municipal Court. Some of them are old addicts or alcoholics who finally just burned out everything, others overdosed. Overdose is not just the heroin addicts. Many of my heroin addicts are middle-aged adults who started on prescription drugs after a surgery. When the doctor cuts them off, they go to the streets to buy heroin because it is cheap. It costs $5 in Las Vegas and $15 in Reno. High school and middle school kids know about heroin, which is scary.

Fifty years ago, my high school boyfriend who was a budding musician with a great band, took LSD (lysergic acid diethylamide), on a trip out of town. He came back with permanent brain damage. In high school, I had a friend, whose father was the biggest beer producer in the western United States, who died from a drug overdose because his friends dumped him on the steps of a hospital instead of taking him inside. Twenty years later, my own brother went to jail for a year because he had become a meth addict and lost his family and career. Thirty years later, a boy who was in my Cub Scout troop died when he was 18 years old of an overdose. After a high school drinking party, he came home and went to the medicine cabinet and took one of his mom's pills figuring if he slept soundly he would not have a hangover in the morning. He did not have a hangover because he did not wake up. So, 50 years later nothing has changed.

I started working on S.B. 309 because I met a women 2 months after her 27-year-old son died of a heroin overdose. He had been clean for 3 years and he used one time. He did not know that he could lose his tolerance when clean for that long and he died. When I met her I started researching overdose prevention the next day and discovered Naloxone. I was not part of the Governor's Task Force or the Attorney General's Task Force. I just started working with a small group locally to put together language and we came up with S.B. 309. Thirty-one states have Naloxone and the Good Samaritan laws and have done it in various different ways. I have submitted a color wheel prepared by the Office of National Drug Control Policy in August 2014 showing the states that have that legislation (Exhibit G). Our group is focusing on Naloxone access. Senate Bill 309 and Senate Bill 459 provide that Naloxone must be obtained by prescription. There are not five doctors in the State who identify themselves as substance abuse specialists. We went through five psychiatric groups in northern Nevada trying to get someone to provide the medicine for bipolar and schizophrenia patients that are in my drug court program. I have the adult son of a doctor, the adult son of a policeman, sons of elected officials and sons and daughters of casino owners in my program. I have good people this is not supposed to happen to. It happens to everybody. Ninety percent of the people in our program turn out to be people with undiagnosed mental health issues who are self-medicating with drugs or alcohol. We do not let mentally ill people die because they are not capable of making a smart decision. We have a tool that should be used. I cannot bear to tell the parents of adult children who have died of drug abuse that this tool has been in effect for more than 40 years and Nevada has never used it. Fifteen other nations are doing this as well.

The federal government, the Substance Abuse and Mental Health Services Administration and the Department of Justice are providing Naloxone grants to help with funding. I have attended national training for the last 3 years with Justice Mark Gibbons from the Nevada Supreme Court. Every time we talk to members of the pharmaceutical corporations about giving us money to try the drugs, the money is an issue. Naloxone is cheap, $15 to $20 for an administration kit. Naloxone takes effect in 2 to 5 minutes and lasts approximately 20 minutes. It is enough time to save a life. Dr. Wagner's research shows that the layman can be trained to administer the drug. If my son was a heroin addict, I would want to know that this is in the house or the drug program has the drug. Doctors would prescribe Naloxone to people who are trained to administer the drug. Senate Bill 459 provides that the Pharmacy Board, working with other stakeholders, would set up a standard protocol and education program that must ensure people that administer this have been trained. The bill describes what to teach: what an overdose looks, sounds and feels like; what the reactions are to Naloxone; how to administer Naloxone, and that they must go for medical assistance afterwards. Seeking assistance is defined as: getting assistance, supplying Naloxone, helping someone use the drug, calling 911, taking them to a hospital and contacting the authorities in the hospital. No more dumping people on the steps of a hospital.

I know prosecutors have heartburn about letting people off for things. There is a law in NRS 453.3335, which puts an affirmative duty on the drug dealer to be a Good Samaritan and try to save the user's life if he or she is present when the user goes into overdose. We are one of the rare states that has that law. It is a very effective statute that allows for a double penalty if the person dies. In Nevada, providing drugs that kill someone is first degree murder.

Senate Bill 459 provides that anyone who is trained and gets a prescription can administer Naloxone. The medical society wants just EMTs to administer the drug. That is not what has been proved in best practices. The 31 states have shown what is best practices and let us use their research in our law.

The immunity section is broad. No one at the party where the person overdoses will be prosecuted for any drug crime if they call for help and try to save the person. We are willing to work with the district attorneys (DAs) to tighten this up. This will help people to not be afraid and dump people on the steps of hospitals and run. It will help prevent the inaction that has been going on for

50 years or more. Prosecutors do not like the statement: it is an affirmative defense to murder for the drug dealer. Our group would be willing to cut that statement. It is first degree murder if someone provides drugs and a person dies. Prosecutor do like the statement: it could be a mitigating sentence. If the person who overdosed dies, the person who tried to help will be tried for first degree murder for supplying drugs. It could be raised in sentencing that the person tried to save the person who overdosed by calling for help, administering Naloxone, taking the person to the hospital. Without that the person gets a double sentence. From a law enforcement standpoint, there is flexibility working with the DAs on the affirmative defense part of the sentencing. Our group would be fine if immunity for possession and use but not for manufacturing or trafficking was in the bill.

Nevada has little medical expertise on this subject. One day my doctor told me he has two sons who are heroin addicts. He could not get any psychiatrist in town to prescribe the medication that eases heroin addicts down from the effects of the drugs. My doctor cried and asked what could he do. He is a doctor and could not get them help. Drug court does work as they are supervised and drug tested twice a week. They see me for a week and we know this works. We need help from the medical community to save lives and get them into court. We are not asking for money from the State but are asking for doctors to start prescribing Naloxone.

Assemblywoman Benitez-Thompson:
Section 12, subsection 1 of S.B. 459 states, "Notwithstanding any other provision of law, a person who, in good faith, seeks medical assistance for a person who is experiencing a drug or alcohol overdose or other medical emergency or who seeks such assistance for himself or herself, or who is the subject of a good faith request for such assistance may not be arrested, charged, prosecuted or convicted ...." Does that mean a child welfare case would not be opened?

Judge Nash Holmes:
It says no criminal prosecution or consequences for violating a restraining order, which could be a Child Protective Services (CPS) order. It also says the person should not get their parole or probation revoked, if he or she tries to help. The point is if the person has acted in good faith with reasonable belief and has

been trained and obtained the drug legally, then the person should be able to use the drug and not be punished for trying to save someone's life.

Assemblywoman Benitez-Thompson:
There are instances where small children obtain mom or dad's drugs and I do not want the language in the bill to prevent a referral to CPS.

Judge Nash Holmes:
Overdose can happen in so many ways. Language can be added or deleted to the bill to ensure referrals to CPS happen.

Ken Ball (Chief, Police Department, Holly Springs, Georgia):
In the 1980s, we saw heroin as a cheap drug. It was only used by the homeless and low-income people. We have seen the drug transition and take a different turn in Georgia. Florida started pushing out the pill mills. When that happened, the pill mills moved to Georgia. Prescription drug bills were put into place and Georgia was able to shut down the pill mills, but we saw a major spike in heroin use and deaths. When the Georgia House Bill 965, also known as the 911 amnesty bill came along, there was pushback from the Georgia Association of Chiefs of Police because the argument was drug dealers and drug users were let go. It costs Georgia about $30,000 a year to house a prisoner. That does not include any medical treatment. If an addict is housed in jail, the cost is almost doubled. The cost of Narcan is $20, which is less than the cost of 1 day in jail for a prisoner. House Bill 965 was just the amnesty bill. The Georgia governor attached a Narcan bill to it. I gave some pushback on the bill because I was not familiar with it and I did not want to put needles in the hands of policemen or first responders. In Georgia, the police officers are the first on the scene. Sometimes, we have to wait 15 to 20 minutes for fire department personnel to arrive at the scene. The bill puts the ability to the police officer responding to the scene to administer Narcan. I had a problem with the needles. The officers went through a 4-hour training course for the Narcan nasal injectors. We have a population of approximately 11,000 people in our town and 225,000 people in the county. We have had seven reversals since July 1, 2014. Of those, two have been very successful and stayed off the drugs. On one occasion, we had two saves on the same individual. If one of the responding police officers misdiagnoses someone who appears to have overdosed and administers Narcan nasal injector, it will do no harm. I have seen that firsthand and have become convinced that it will work. We were the first

department in Georgia to put Narcan in the hands of first responders and within 3 days had our first save. I have submitted various documents covering the Holly Springs Police Department Operations Naloxone Program, law enforcement departments carrying Naloxone and Kennesaw University Police Naloxone program (Exhibit H).

Assemblyman Oscarson:
How do you fund the Narcan doses?

Chief Ball:
It is funded from the surcharge on traffic tickets.

Assemblyman Sprinkle:
What kind of response did you get from your officers when they found out they would be administering Narcan? Were they supportive? Were they fearful? Now the program is in place, how do they feel about administering Narcan?

Chief Ball:
Typically, police officers are very resistant to change. This is not something where they had open arms. However, we had a lieutenant who worked in the department who lost her daughter to a heroin overdose. I know she sent her daughter to at least three rehabilitation programs and had arrested her daughter once. That made it a personal story internally. Once they attended the training and saw they cannot make a mistake or hurt anyone if they administer Narcan, they very much adopted the program. Out of the seven people saved, the officers expressed it as a euphoric feeling to have the ability and tool to save someone's life. It has been very well accepted in law enforcement in Georgia.

Assemblywoman Titus:
Do your officers carry Narcan with them?

Chief Ball:
Yes, they do carry it with them. It is on their gun belt.

Assemblywoman Titus:
Do you also have epinephrine in your cars?

Chief Ball:
No, we do not have epinephrine in our cars.

Assemblyman John Hambrick:
Is it a good idea to educate chaperones at high school proms?

Chief Ball:
We have a program in Georgia called Ghost Out. This program is presented a week before prom night. Police officers, fire fighters, EMTs, judges and prosecutors are involved in the presentation. We set up scenarios and teach the kids what to do, what not to do and what can prevent certain outcomes. We also teach chaperones what to look for, how to spot it and how to deal with it if it is seen.

Judge Nash Holmes:
Senate Bill 459 requires the Pharmacy Board to come up with standard protocols and procedures and to ensure the people who receive Narcan are educated in what is an overdose, what it looks like and what it sounds like. You will hear testimony later about a woman who lost a family member. The death could have been avoided, partly or entirely, if she had known what an overdose looked like. Middle school and high school children think heroin is not as bad as meth or cocaine. They know heroin is a shorter high. Any education would promote the possibility of saving lives. Assemblyman Sprinkle, there are 350 different police agencies that have authorized Narcan use for their officers.

Liz MacMenamin (Retail Association of Nevada):
The Retail Association of Nevada supports S.B. 459.

John T. Jones, Jr. (Nevada District Attorneys' Association):
The Nevada District Attorneys' Association supports S.B. 459. We had a conversation with Judge Nash Holmes regarding the affirmative defense to murder in section 12, subsection 2. The Association would like changes made to that section. Chapter 453 of NRS provides if a death occurs while someone is violating a section of NRS 453, that is defined as murder. The language needs to be tightened up in section 12, subsection 3. Assemblywoman Benitez-Thompson brought up a good point regarding child welfare cases. How are the officers going to deal with any children inside the home if responding to a 911 call? This is a needed discussion, especially when

the language "otherwise penalized for violating" is used. The paramount concern should be for children in that situation.

Judge Nash Holmes:
Chief Ball submitted a package of information including forms his department uses to enact the policy and training for Narcan administration so the Committee could see how another state handles it.

Chief Ball:
Our amnesty bill follows immunity up to 4 grams of heroin, which is in the guidelines of trafficking in the federal laws. We can take a child out of a home if drugs are involved.

Joseph P. Iser, M.D., Dr.PH., M.Sc. (Chief Health Officer, Southern Nevada Health District):
I was a health officer in California in a county that borders on Sacramento but is considered a rural county. There was a program for syringe exchange and a harm reduction Naloxone/Narcan program. In the rural county, we found great benefits that Dr. Wagner talked about in terms of accessing people and getting them into treatment programs earlier and having more success in people who left those programs and are staying away from drugs. We saw decreases in deaths relating to drug overdoses. I am sure some medical doctors would be hesitant to use their medical licenses on things they do not feel are important and I am in the same boat. I did use my medical license to prescribe these medications in California. I am in favor of whatever combination of bills the Committee comes up with that can address this problem.

Assemblywoman Titus
Did you see a decrease in overdoses?

Dr. Iser:
I am not sure we saw a decrease in overdoses but I will provide several reports to the Committee. The county is conservative and the program was dismantled a year or two after I left.

Stacy Woodbury, M.P.A. (Executive Director, Nevada State Medical Association):
Prescription drug abuse is an issue physicians take very seriously. The Nevada State Medical Association has a long history of working with the Attorney General's Task Force on substance abuse, the Prescription Drug Monitoring Program advisory panel and the industry coalition that met over the last 18 months. We support S.B. 114 and all the bills on the agenda today. We have met with the sponsors of the proposed bills and some have proposed amendments to them. We are in agreement with those amendments. We also met with the Governor's Office recently and discussed concerns of providers. We have submitted a proposed amendment (Exhibit I). It amends section 7 of S.B. 459 to provide that all first responders and law enforcement may carry an opioid antagonist and removes the authority for practitioners to prescribe an opioid antagonist. Physicians have expressed concern about prescribing medications to people who are not going to take them. We have had that uncomfortable feeling with epinephrine auto-injectors in the past. It amends section 16 of the bill to provide that practitioners in an emergency department of a hospital are exempted from mandatory check of the PDMP if the practitioner writes a prescription for less than 10 days' worth of a medication. That changes the response of practical concerns about time sensitivity in the emergency departments of hospitals. It would only give an exception for the practitioner who is writing a prescription for 10 days or less. We are aware of persons who shop emergency rooms for prescription drugs and are hopeful we can identify better ways of discouraging such behavior. We frequently have a shortage of beds for legitimate emergencies in our ERs across the State. Although an extra 5 minutes per patient may not seem like a long time, over the course of the day it has an impact of requiring patients who are in need of care having that care delayed and having to wait longer in the lobbies of ERs to process each patient. The exemption proposed in the amendment was crafted as narrowly as possible to allow flexibility in emergency cases without compromising the overall intent of the bill. We have provided a clarification of the word "initiating." Initiating would be when a provider gets a new patient and writes a new narcotic prescription or when the provider is treating an existing patient and changing the course by substituting a different narcotic than the patient may have had in the past. This is an important distinction for a physician if he or she is treating someone who has a chronic pain issue the physician cannot write a prescription for longer than 30 days. Every 30 days the physician would issue a prescription to the patient. Under the bill, as long as it

was the same prescription to the same patient, the physician would not have to check every 30 days.

Kathy Bartosz (Executive Director, Partnership Carson City):
I have submitted a statement in support of S.B. 459 by Municipal Judge John Tatro and Municipal Judge Thomas R. Armstrong (Exhibit J). I have also submitted written testimony from Sally Churchley in support of S.B. 459 (Exhibit K).

Christie McGill (Healthy Communities Coalition):
All these bills give locals more tools to support people in addiction and mental illness. As Nevadans, we can do better. In rural Nevada, we have a thin infrastructure of services and it is important for locals to have strategies that they can use on their own until they can get to the urban centers. The Healthy Communities Coalition supports all the bills here today.

Curt Fonken, CADC (The Life Change Center):
I am a certified drug and alcohol counselor in the State. I work for an agency where the specialty is the treatment of opioid dependence, both prescription and heroin. Many of the people who come for treatment at our clinic are no longer getting high. The idea is to not abuse, it is to stay well. Some ask why can they just not quit opioids? Can they just stop? Opioid withdrawal is like the worst case of flu. Everything hurts, every orifice is leaking. There are situations where it feels like a dull knife is being dragged across that person's bones. The person does not sleep, there is anxiety and irritability. Oftentimes, the dependence keeps going because of these withdrawal symptoms. My colleague tells me drug addicts are better at getting medications than doctors are at identifying the intent. The prescription monitoring program allows doctors to see other prescriptions written for individuals, which can save lives. It may get people into treatment earlier. First responders cannot always get to a situation on time. If my family member was in respiratory arrest due to opioids, I would hope someone present had Narcan to keep that person alive until the first responder arrived.

I have a good friend who lost his son at a fraternity party in southern California because no one wanted to call for help. They did not want to risk getting into trouble. I fully support this bill. It can save lives.

Ginger Paulsen:
I support S.B. 309, S.B. 288 and S.B. 459. I am a native Nevadan and live in Reno with my husband. I have worked in the field of public health and wellness for the past 30 years. On September 16, 2009, around 7 p.m. there was a knock on our front door. It was a Washoe County Sheriff Deputy who told us our 24-year-old daughter Sabrina was found dead in a friend's apartment. I can assure you this is a parent's worst nightmare. Initially, her death was thought to be a homicide due to how and where she was found in the apartment. We later learned she died from an accidental overdose of prescription drugs and heroin. A 21-year-old male friend had provided the heroin to her to smoke for the first time. The prescription drugs came from another friend who had doctor shopped. She had gotten the prescription under false medical pretenses for a false medical condition. When Sabrina showed signs of breathing difficulties, the young man left. He did not call 911. Instead he left her alone only to return 3 hours later. When she would not wake up, he dragged her into the bathroom, put her in the bathtub and sprayed cold water on her attempting to revive her. He then panicked because he realized she was dead. He collected his drugs and paraphernalia and threw them away in the apartment complex dumpster. Finally, he called his father who pleaded with him to call 911, which he did. By the time the paramedics arrived, they could not revive her as she had been dead for several hours. The police officer told us that had 911 been called when she was first found unresponsive, she might have been saved by the use of Naloxone. This was the first time I heard of this drug and that it could be administered right after an overdose. This young man did not call 911 because he was afraid of being arrested for possession. To clear up any stereotypes of what many people think of those who use drugs or become addicted, Sabrina came from a loving two-parent, middle-class family. She was a kind, high achieving and well-adjusted student. She attended a local Catholic high school and the University of Nevada, Reno (UNR) where she was studying journalism. Sabrina had been a Girl Scout and was active in our church. She was an avid runner, played soccer and was a gifted and talented artist and writer. She should not have been using drugs but unfortunately she was. The drug use began her second year at UNR. We were blindsided as a family. I would like to remind you that each and every overdose is someone's son, daughter, sister, brother, grandchild, niece, nephew or friend—not just a faceless statistic on a piece of paper. To those who think this cannot happen to your family, it can, it did to ours. The death of one's child is as bad as life can ever get for anyone. Sabrina might have had a second chance had a comprehensive Good Samaritan law

been in effect and Naloxone been administered. I am putting my pain and my family's pain into purpose here today.

Joseph Livernois (Northern Nevada Hopes):
The first time I saw a vial of Naloxone it was given to me by an outreach worker at a syringe access program and drop-in center servicing Salinas, California. The worker behind the desk knew my girlfriend at the time had a problem with overdosing and suggested I take a vial just in case. So I did. That one vial was used four times and three lives were saved including mine. It did not fail the fourth time as it was twice on the same person. This is how I became aware of the lifesaving miracle that is Naloxone. It saved the life of my beloved sweetheart, my dear friend twice and my life. At the time I was given the vial, I was a homeless heroin addict and had convinced myself that I did not care whether I lived or died. I am really thankful for the outreach worker who cared enough about me when I did not care about myself. I am no longer a daily injector of heroin; I am no longer homeless. I choose life today and I am happy to be alive. I am vital. Dead people never get the opportunity to enjoy the kind of life I have today. Casualties of overdose never get to be the kind of person that I am, but what kind of person am I? I am a human with facets. I am a father, friend, a community activist and volunteer. In 2014, I was lucky to be given a chance and a job at Change Point, a program of Northern Nevada Hopes and Nevada's first and only syringe service program. Change Point is as successful a syringe exchange as I have ever seen. Lives are changed there on a daily basis. A harm reduction center with no overdose prevention program is like a mouth without teeth. It does not work that great. If S.B. 459 were to pass, Northern Nevada Hopes would finally have the legislation needed to support a thriving, effective, comprehensive and community-based overdose prevention program. Change Point would finally be the world-class center it has wanted to become since January 2014. Northern Nevada Hopes supports this bill and asks you to reject any compromise on provisions relating to Naloxone access and distribution. Due to third-party distribution policies in my home state, I am alive today. Now, I am that outreach worker who cares about the people who nobody cares for, the people who do not care for themselves. I would like nothing more than to place a vial of Naloxone in the hands of these stigmatized and forgotten human beings and to give them another chance at life as someone did for me years ago. Where life is concerned, chances should not be finite.

Assemblyman Thompson:
Do you think your girlfriend continued to overdose because she knew you had access to Naloxone?

Mr. Livernois:
The first three times she overdosed in my presence, we did not have Naloxone. She was lucky the first three times. When she went to the ER, I am certain they administered Naloxone. I do not believe she was aware of what they did to help her. She just knew they saved her. The time I administered Naloxone to her, she felt totally miserable. It put her in full-blown withdrawal symptoms right after administration. It is not for some time after being administered Naloxone that the thought of using drugs again even crosses your mind. After I administered Naloxone to her, she never overdosed again during the duration of our relationship. After Naloxone was administered to me, I felt like I never wanted to experience it again, because I felt horrible. I was more careful about the amounts of drugs used and the substances I mixed together. It was so scary to wake up and have no memory of what happened and everyone was freaked out. I did not want to put the people I cared about through that again. I did not want to again feel as miserable as I did. It affected me in the opposite way. I ended up using fewer drugs from that point forward.

Joseph Engle (There is No Hero in Heroin Foundation):
I support this bill. I am a father who lost my 19-year-old son as a result of a heroin overdose. In July 2011, I came home from work to find my son dead in the upstairs bedroom. He had been clean for 7 months and struggled with heroin and opioid addiction for over 4 years. These are our kids, they are not statistics. My life has been shattered and forever changed. Anything that will help change the public perception needs to proceed with change in the public policy. The public perception that the heroin user is a deadbeat-loser junkie needs to be changed. My son was full of life. I am a single father of four boys. Two years ago, I was sitting in my kitchen with four other people and we decided we wanted to help others. So far, the help has manifested into the foundation.

Christine Chicoine:
I support S.B. 459 and S.B. 309. I have two children in their early 20s who are in recovery from heroin addiction. They are at the greatest risk of overdose if they relapse. I would like access to Naloxone in my medicine cabinet. The first

time I heard of Naloxone was when my son overdosed after a 5-month drug absence. I found him in my backyard not breathing and blue. I did not know what was happening. I did rescue breathing for about 9 minutes. He did survive. I was asked by many friends in California why I did not have Naloxone. It was because I had never heard of it. I started researching about it. It is upsetting to know people in adjoining states have access to the drug. My children have known 17 people who have died from heroin and opioid overdoses. I believe these bills could have saved some of my children's friends. I know people who have been saved by Naloxone who are now an author and medical professionals. These lives matter. Having Naloxone available does not say it is okay to relapse, it is okay to use, it just says your life is valuable if you do use and let us give you another chance at recovery.

Rhonda Mattson:
I support the bills before you today. My mother overdosed from methadone opioid 13 years ago. My 12-year-old sister found her. It was too late for her. I have a son who is an opioid addict. My son and his girlfriend use drugs together and his girlfriend has a bad heart. They are clean right now, but it is scary to think what may have happened to them.

Senator Ben Kieckhefer (Senatorial District No. 16):
I am the sponsor of S.B. 309 which would enact the Good Samaritan Drug Overdose Act. Since S.B. 459 establishes an opioid prevention policy for Nevada and it contains everything in S.B. 309, I urge you to process S.B. 459, which I fully support.

Senator Moises (Mo) Denis (Senatorial District No. 2):
While working with interested parties, I have prepared a proposed amendment that substantially revises the provisions in S.B. 288. Because the amendment is significant, I will present the amendment (Exhibit L) instead of the bill. Senate Bill 288 attempts to decrease incidences of prescription drug abuse and misuse. Medical interventions, such as access to substance abuse treatment and opioid antagonists are a very important part of addressing the problem. Education regarding the safe and secure storage and disposal of prescription drugs is also an important step in addressing this challenge. We would be remiss if we did not take full advantage of the technology that is already in place to monitor the movement of prescription drugs in Nevada. The PMP in Nevada became operational in 1997. It was one of the oldest PMPs in the

Nation. The PMP uses Web-based technology to collect, monitor and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. Forty-nine states and one U.S. territory, Guam, currently have PMPs that are operational and collect data from dispensers and reports information from the database to authorized users. While Nevada has the oldest program, it has been updated several times. We fall short in Nevada of achieving the greatest benefit from the system because it is optional for prescribers to access and review the information in the system on a consistent basis. The State Board of Pharmacy currently licenses 9,150 controlled substances licensees, and 5,037 of these practitioners are registered to use the PMP. Each month, the PMP receives about 400,000 dispensed controlled substance prescriptions. Each month roughly 2,100 users access the PMP system, viewing about 50,000 patient reports. The system is underutilized by prescribers, and increased utilization and review on the part of prescribers will help improve the PMP's purpose of: supporting access to legitimate medical use of controlled substances; identifying and deterring or preventing drug abuse in diversion; facilitating and encouraging the identification, intervention and treatment of persons addicted to prescription drugs.

Senate Bill 288 as amended establishes requirements for practitioners who are authorized to prescribe and dispense controlled substances, to receive the necessary PMP-related training currently required by the Board of Pharmacy and to access the PMP. The measure requires that at least once every 6 months a practitioner access the database to verify that he or she continues to have access and that the information in the database concerning their related activities is correct. If the information is not correct, they are required to provide the necessary information to make it correct. To encourage compliance, the measure provides that practitioners who fail to receive the required training to access the PMP or fail to access it in a manner prescribed are subject to professional discipline.

I understand that complying with the provisions of this measure will take more time on the part of the practitioner. Ten years ago, it would have taken much longer to do and the system was much more clunky to use. Considering the enormity of the prescription drug abuse problem we have in the Country and State, I believe the extra time is justified.

Assemblywoman Benitez-Thompson:
Does your bill include all practitioners?

Senator Denis:
It includes anyone who is authorized to prescribe or dispense.

Assemblywoman Benitez-Thompson:
In S.B. 288, there are no exemptions for hospitals and child care facilities. In S.B. 459, there are exemptions. Why are there two different approaches?

Senator Denis:
If practitioners have the ability to prescribe, we want them to have access to the PMP. Part of the reason many practitioners did not use the PMP is because it was really difficult to use early on. If a practitioner wanted to look at a record, it had to be requested and then would take several days before the report was available. It was not very timely. Today the practitioner can request the information and get it immediately. I cannot answer for the sponsor of the other bill but we wanted to include everyone in S.B. 288.

Dr. Green:
That section in S.B. 459 is intended for inpatients, so it is specific to individuals who are in a hospital facility as an inpatient receiving a prescription for a narcotic. Those individual providers would not be required to access the PMP. In addition, children inpatient and residential treatment facilities would not be required to access the PMP. It refers to the inpatient status of the individual and the provider prescribing the prescriptions.

Assemblywoman Benitez-Thompson:
Emergency rooms are not exempt from this PMP requirement but once the patient is admitted, the hospital would be exempt from access to the PMP. Is that correct?

Dr. Green:
The clarification is in the amendment suggested by the Nevada State Medical Association in regard to exempting the ER individuals. Those are included in the original section of the bill.

Assemblywoman Benitez-Thompson:
Many individuals use ERs to access opioids. Is the reasoning behind exempting ERs because it is too onerous, it is too burdensome, it ties up things?

Dr. Green:
The Nevada State Medical Association suggested the exemption. The exemption is for a prescriber in an ER who writes a prescription for 10 days or less.

Senator Denis:
The reason the ER exemption is not included in S.B. 288 is because individuals know which ERs are in the system and shop different ones and end up with 15 to 20 days' worth of pills. Unless the ER prescribers check the PMP, they will not know this.

Assemblywoman Titus:
I wear many different hats. One hat I wear as chief of staff at our hospital and I work in the ER. Then I wear another hat as a family practice doctor in the rural area where I have been for 30 years. I have patients I have seen for 30-plus years who I have known forever. As a provider, I see abuse in the ERs, where a patient will shop, even in my rural hospital. Classic examples are a toothache or a backache. It is hard to diagnose someone's pain. Those two diagnoses are the ones you write for 5-day prescriptions. I do access the PMP and it immediately diffuses the issue when I see a patient come in with, for example, a toothache and see he has gone to five different ERs in the last 5 days. It gives me ammunition to refuse writing a prescription. Taking out the provision that the ER doctors do not have to check the PMP defeats the purpose of what is being done. On the other hand, in my practice I have little old ladies whom I have known for my entire life, who may have fallen down and now have compression fractures. I now have to put her in the system because it is a new prescription, even though she is a patient I have had forever. That is where I have concern. It is a burden on the provider to have to input the information on a patient. I see all sides, but the ER is where you would want the doctors to put the information into the PMP.

Senator Denis:
Senate Bill 288 does not require you to put them into the PMP. This bill only requires a provider to take the training and register to use the program. Many of

the doctors do not register. Requiring the providers to go into the program once every 6 months assures they are accessing the program.

Assemblywoman Titus:
One thing that happens is people steal prescriptions. Having the provider check once in a while to see who is using your name and Federal Drug Enforcement Administration number is not bad.

Dr. Green:
To clarify, S.B. 459 as written does include the ER requirement.

Assemblyman Michael C. Sprinkle (Assembly District No. 30):
My other full-time job is a paramedic firefighter. I have been doing that for more than 20 years. I have administered Narcan more than anybody in this room and I have seen the effects. Often, we have had success with this drug but sometimes the outcome was not good. I attest individually that this medication is valuable. It saves lives and the sooner we can give it the better. It takes me 3-7 minutes to respond from the fire station to someone's home.

Assembly Bill 279 is a holistic approach to an identified problem. Section 1 gives definition to practitioners. Section 2 requires those who dispense controlled substances to upload the required information to a database within the next business day and defines who is exempt from this provision. Section 2, subsection 1, paragraph (e) has been amended (Exhibit M). Section 2 also requires the Board of Pharmacy, the Investigation Division and pharmacists to report to the appropriate governing body or law enforcement any suspected fraudulent or illegal activity. If prescriptions are being filled and the dispensers are uploading the required information within a business day, they will see multiple prescriptions, even from the ERs. Because pharmacists see this on a daily basis, they should be mandated to report when they see something that seems fraudulent or illegal, without putting the burden of an investigation on them. In the course of their daily duties, if pharmacists see something that does not seem appropriate, they have an avenue to report to the governing body of the prescriber. It would be the governing body's responsibility to investigate it. Section 3 adds prescribers to those who are charged fees for participating in the PMP. I will be amending out section 3. Section 4 adds prescribers to those who are required to register with the PMP. Section 5 allows the Board to register prescribers and requires 2 hours each of continuing

education units (CEUs). Section 8 requires the Board of Pharmacy to prepare a report on incidents on abuse or misuse.

Getting back to the holistic approach, we do not feel this bill is the end-all to this. This is an amazing big step in trying to curb the problem of prescription and illicit drug abuse. It will not end with this bill. We want to gather the data and bring it back to the coalitions to see what we need to do in the future to protect our kids and future generations.

Assemblywoman Titus:
Can you clarify what you are eliminating in section 2 of A.B. 279?

Assemblyman Sprinkle:
I am adjusting the wording from 24 hours to the next business day because that was burdensome for those who do not work on the weekend. I am amending out the prescribers. There was a significant problem with the PMP if prescriber was added. The software cannot handle updating all that information. Fundamental software changes would have to occur and would add a fiscal note. By eliminating this, it removes the fiscal note.

Assemblywoman Titus:
Section 5, subsection 4 of A.B. 279 addresses the training requirement to be 2 hours of CEUs every year. Do you have any data that 2 hours training every year changes behavior?

Assemblyman Sprinkle:
No, I do not have any data. The amendment would place the requirement for 2 hours of CEUs in the chapter associated with the licensure of the individual licensing board.

Assemblywoman Titus:
Does the Governor's Task Force have any data that 2 hours of CEUs on prescriptions has changed behaviors? I am focusing on whether behaviors are changed. I believe the training requirement is an important element.

Mr. Willden:
I do not have the data with me. I will get back to you with the information.

Assemblywoman Titus:
It is important for practitioners to be educated on prescription drugs but I want to make sure that 2 hours every year changes behavior. Practitioners are very busy. I want to make sure that researchers have seen what it takes to change behaviors.

Mr. Willden:
According to research, many states have instituted the 2 hours of CEUs. We will do the homework and get back to the Committee.

Assemblyman Thompson:
This past summer, I worked with a group of students at the Summer Business Institute at the county. They are required to have a civil engagement project and one project was ensuring properly disposed of prescription drugs. There is a high cause of death from prescription drugs. Is there a preventative component in S.B. 288, S.B. 459 or A.B. 279? If not, I would suggest a friendly amendment. The bills address prevention and intervention but not a way to dispose of prescription drugs. There must be a way to incentivize individuals to turn in no-longer-needed prescription drugs. Many of the police stations have a place where individuals can properly dispose of prescription drugs.

Mr. Willden:
In my days as Health and Human Services Director, part of the substance abuse block grants that were issued contained prevention and treatment. Coalitions work on the take-back programs or turn in the drug programs. We continue to fund those programs. Specifically, section 11 of S.B. 459 addresses to the extent money is available through DHHS, education and training programs will be available concerning the containment and disposal of prescription drugs.

Assemblyman Sprinkle:
Our coalition discussed the take-back programs but there are many concerns about them. We thought about the different venues where it would make sense, even literally in the pharmacies where the drugs are dispensed. There are very significant safety concerns. It makes the most sense having the take-back programs in the law enforcement facilities. We will continue to work on it with community collaborations, but A.B. 279 does not address it now.

Senator Denis:
Senate Bill 288 does not address the take-back programs. We discussed the options but safety concerns prevented us from putting it in the bill.

Chair Hardy:
The Committees have received nine letters in support of S.B. 459, three in support of S.B. 309 and one in support of S.B. 288 and A.B. 279 (Exhibit N). Having no further business on the agenda and seeing no public comment, I adjourn the meeting at 6:18 p.m.

RESPECTFULLY SUBMITTED:

Debra Carmichael,
Committee Secretary

APPROVED BY:

Senator Joe P. Hardy, Chair

DATE:

Assemblyman James Oscarson, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit**		**Witness or Agency**	**Description**
	A	1		Agenda
	B	10		Attendance Roster
S.B. 459, S.B. 309, S.B. 288, A.B. 279	C	8	Senator Joe P. Hardy	Certain Prescription Monitoring and Drug Overdose Prevention Related Measures Comparison of Major Provisions
S.B. 114	D	2	Senator Joe. P. Hardy	Testimony
S.B. 459	E	7	Linda Lang	Testimony
S.B. 309, S.B. 459	F	8	Karla D. Wagner	Research statistics
S.B. 309	G	1	Dorothy Nash Holmes	Color wheel chart
S.B. 459	H	27	Ken Ball	Documents
S.B. 459	I	2	Stacy Woodbury	Proposed amendment
S.B. 459	J	1	Kathy Bartosz	Letter
S.B. 459	K	1	Kathy Bartosz	Testimony from Sally Churchley
S.B. 288	L	4	Senator Moises (Mo) Denis	Proposed amendment
S.B. 279	M	1	Assemblyman Michael C. Sprinkle	Proposed amendment
S.B. 459, S.B. 309, S.B. 288, A.B. 279	N	20	Senator Joe P. Hardy	Letters of support