NEVADA STATE BOARD OF MEDICAL EXAMINERS
1105 Terminal Way, Suite 301
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Board President

Edward O. Cousineau, J.D.
Executive Director

MINUTES

OPEN SESSION R100-17 SUBCOMMITTEE MEETING

Held in the Conference Room at the Offices of the
Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301, Reno, Nevada 89502

and videoconferenced to

the Conference Room at the Offices of the Nevada State Board of
Medical Examiners/Nevada State Board of Dental Examiners
6010 S. Rainbow Boulevard, Building A, Suite 1, Las Vegas, Nevada 89118

WEDNESDAY, FEBRUARY 28, 2018 – 2:00 P.M.

Subcommittee Members Present at Board Office in Reno
Paul Edwards, J.D.
Karen Massey, MHA, FACMPE, CPMSM
Michael Salas, M.D.
Dave Wuest, R.Ph.
Wayne Hardwick, M.D.

Subcommittee Members Present at Board Office in Las Vegas
Victor M. Muro, M.D., Chair
Daniel Burkhead, M.D.
Senator Joseph P. Hardy, M.D.
Rudy Manthei, D.O.
Ms. April Mastroluca
Crane Pomerantz, J.D.
Robert Pretzlaff, M.D.
Faisal Suba, M.D.
Catherine O'Mara, J.D.

Subcommittee Members Absent
Michael C. Edwards, M.D., FACS
Rupesh Parikh, M.D.
Ms. Karen Rubel
Erin Russell, Ph.D.

Staff/Others Present at Board Office in Reno
Edward O. Cousineau, J.D., Executive Director
Laurie L. Munson, Chief of Administration and Information Systems
Brenda Riviera, Finance Assistant
Greg D. Ott, J.D., Senior Deputy Attorney General

Staff/Others Present at Board Office in Las Vegas
Jasmine K. Mehta, J.D., Deputy Executive Director

Agenda Item 1
CALL TO ORDER AND ANNOUNCEMENTS
- Roll Call/Quorum

The meeting was called to order by Dr. Muro at 2:00 p.m.

Ms. Mehta took roll call of the Subcommittee members. Not present were Michael C. Edwards, M.D., Rupesh Parikh, M.D., Erin Russell, Ph.D. and Ms. Karen Rubel. Ms. Mehta announced there was a quorum.

Ms. Mehta stated that Clevis Parker, M.D. was present on behalf of Ms. Rubel and Mary Ann Allison, M.D. was present on behalf of Dr. Parikh, and although they were not voting members, their participation was welcome.

Agenda Item 2
PUBLIC COMMENT

Dr. Muro asked whether there was anyone in attendance who would like to present public comment.

Kelle Brogan, M.D., Section Chief for Hospice and Palliative Medicine at Renown Health, said she knew there were a lot of issues the Subcommittee would be addressing, but she wanted to focus on the hospice patient and the homebound hospice patient. She stated there are several issues regarding the requirement of establishing a relationship with a patient prior to prescribing an opioid. She explained there are different sizes of hospices – small, medium and large – and that Renown is fortunate enough to have telehealth; however, many of the smaller home-grown hospices do not. She then reviewed several areas she said put the hospice patient population at extreme risk. She said hospice patients come to them either in a pain crisis or actively dying, and that even in a close geographic location, such as the Reno or Carson City area, there is often a great deal of difficulty for the medical director, who may have multiple patients coming on, multiple patients dying, and other jobs to do, to physically establish a relationship with a patient in a timely fashion, putting the patient at considerable risk for increased pain and suffering at the end of life. So you have the patient in a pain crisis, the patient actively dying, and you also have the rural patients, which makes it almost impossible to get to. Some of the local hospices don't have access

to telehealth, and some do not have wireless, so even if they had telehealth, they couldn't establish a connection or a relationship because of the absence of wireless availability, again putting those patients at considerable risk at the end of life for pain and suffering.

Dr. Brogan said there is also a large majority of patients who come on hospice with non-cancer-related diagnoses, such as COPD or heart failure, and they may be on hospice for several months and never require any of the Morphine or Oxycodone they have on hand until the very last couple of days of their life. So it makes no sense for the doctor to run out there and establish a relationship when the patient is not going to be using those opioids for months down the road, if ever.

Dr. Brogan stated she was trying to represent hospice as a whole, and has several colleagues that feel the same way. Medicare already has regulations that require the medical director to review all of the records on each patient because they have to certify the patient has a potential prognosis of six months. Not only that, they have to look and see that the patient got appropriate medical care before coming on hospice. They not only do an extensive medical search, they have a time-honored, tested relationship between the physician and the physician's representative, which in this case is a hospice nurse. The hospice nurse goes to the patient's home, conducts an evaluation, calls the physician while at the patient's home, they have a conversation with the patient and review the details and the physician reviews the medical records. They often talk to the patients by speaker phone. They are not allowed to do a telephone view because it's not secure. So that relationship is there by telephone, and always has been; it has been a requirement all along. So it makes no sense to force medical directors for hospices to go out and see every patient before the patient gets opioids when that relationship has always been established to begin with. There are a lot of patients coming to hospice, a lot of patients dying, and only a handful of doctors to do all the work, so it's impossible to see that volume of patients in person.

Dr. Brogan said the other issue, that she believed the Subcommittee was already working on, is when she has a physician who is covering for her for the one week a year that she is gone, it doesn't make sense for that physician to have to reestablish a relationship with every patient he or she has to write an opioid for. He or she should, in the standard fashion, for all new patients, but not necessarily all old patients.

Dr. Brogan added that another issue is that some patients live longer than expected and do better than expected, and some improve, and they may be on opioids at that time for chronic pain or cancer-related pain, and hospice is required by Medicare to discharge those people. They do everything they possibly can to and set them up with a primary care provider, and give them a couple of weeks of medications, but the primary care provider will not write them a prescription for opioids because of the new law. And when they try to get them into a chronic pain doctor, there are an inadequate number of chronic pain physicians, and if the patient has Medicaid, they can't get them in to see anybody. So we have these people who require opioids, but have no place to go.

Dr. Hardwick asked what could be done to make the job of hospice physicians easier.

Dr. Brogan said she believes their system in hospice is not broken, and they have a well-established relationship requirement utilizing the nurse and physician by telephone, so to require the physician to actually see the patient and do the physical exam when they have a very well-qualified nurse doing the same thing and a dialogue occurring between them is inadequate and ridiculous.

Mr. Wuest asked where Dr. Brogan was getting the information that she has to see the patient in person because the law allows a nurse to be the liaison and for her to do it telephonically.

Dr. Brogan stated that was not their understanding; their understanding was that it has to be a nurse practitioner.

Mr. Wuest stated the hospice model they currently follow meets the criteria of the law. A bona fide relationship can be done via telephone; it doesn't have to be through WiFi or anything like that. Physicians are certainly allowed to use nurses. He stated he is the Deputy of the Board of Pharmacy and was putting it on the record that that model would work. The bona fide relationship came prior to this law, it has been in place for about 15 years or so, and it didn't get modified by this law. So that relationship has always been required. He said if the Pharmacy Board thought there was an issue with somebody having a bona fide relationship, they would have heard from the Pharmacy Board during those 15 years.

Dr. Salas stated that since January, patients have been showing up at his office that are being treated for active cancer pain and have been discharged by hospitals with three days or so of pain pills, and asked whether this was something hospice should be managing, or somebody else.

Dr. Muro stated the Subcommittee was deviating from the public comment portion of the meeting, and said that the Subcommittee was going to try to provide some clarity to both the hospice aspect and the transition from the facilities aspect, as there is a lot of confusion as to what is out there. He said if the Subcommittee could provide some clarity to the questions presented, it would eliminate some of the confusion as far as what's out there and the way people are interpreting and understanding it.

Agenda Item 3
APPROVAL OF MINUTES
- February 15, 2018 Subcommittee Meeting – Open Session

Senator Hardy moved that the Board approve the Minutes of the February 15, 2018 Subcommittee Meeting – Open Session. Ms. Mastroluca seconded the motion.

Dr. Burkhead stated it was not noted in the Minutes that the discussion regarding the Informed Consent at the last meeting was also applicable to the Medication Prescription Agreement, and that it should be noted in the Minutes.

Ms. Mehta stated it was her understanding that was not part of the motion, and that is why it wasn't included. Ms. Munson and Ms. Riviera listened to the recording in preparing the minutes, and asked them to speak up if she was misspeaking.

A vote was taken on the motion, and it passed unanimously.

Agenda Item 4
COLLECTION OF MEMBER INPUT AND CONSIDERATION OF RECOMMENDATIONS REGARDING PROPOSED REGULATION R100-17 AND PROPOSED RECOMMENDATIONS TO CLARIFY IMPLEMENTATION OF ASSEMBLY BILL 474 (2017)

Ms. Mehta stated the meeting was agendized broadly to allow the Subcommittee to talk about multiple items that were outlined at the last meeting. At the last meeting, one of the votes was for counsel to provide draft language regarding the ability of practitioners within a practice

group to rely on the same informed consent. She said she believed that was what Dr. Burkhead was referring to – that it should apply to the prescription agreement as well.

Dr. Burkhead stated that was correct.

Ms. Mehta read Section 51 of AB 474 from the memorandum she had prepared and provided to the Subcommittee. She stated the language is pretty broad; it is not limited to being within the same practice group. She said at the last meeting, the Subcommittee also voted to make a recommendation as to the definition of course of treatment, which is defined as one diagnostic finding and assessment and anything secondary related to it. She said in taking those two things together, a regulatory definition regarding practice group may not be necessary, but for the comfort of the regulated community, she put together some proposed language for the Subcommittee's consideration. She then read the proposed language: "For the purpose of Section 51, an initial prescription does not include a prescription issued by a practitioner within the same practice group to continue a course of treatment for a patient of the practice group." She then stated she thought this language might address the medication agreement as well because it keys off the initial prescription.

Ms. O'Mara stated she did not disagree with the proposed language, but Ms. Mehta made a point of it being for the comfort of the licensees, and to her this is not going to clarify it for the licensees. The question for the licensees is if they can have one informed consent that everyone in their practice can be part of, and one contract that everyone in their practice can be part of. She thinks the two would go well together and thinks this could be good regulatory language to propose to the Board of Pharmacy, but she would also encourage the Board of Pharmacy to clarify that a practice group may use one informed consent and may use one pain medication agreement.

Ms. Mehta suggested that the Subcommittee walk through the actual language in Sections 52 through 58 of AB 474, because almost everything keys off this definition of initial prescription.

Mr. Edwards stated he agreed with Ms. Mehta that the proposed language is not necessary. He recalled from discussions, while they were drafting AB 474 regarding "initial prescription" and that qualifying language at the end, the express purpose of that was so if a patient is receiving pain medication from a general practitioner and moves to a pain management physician, or something like that, that prescription is not going to be treated as an initial prescription. The idea was to provide a continuity of care for patients as they flow from one practitioner to another, including outside the practice, so they don't have to start over, because if it's an initial prescription, you have to start over with the 14-day and other requirements. So while the suggested language is consistent with the statute, he doesn't think it is necessary, and he thinks the suggested language is more restrictive than what is already in the statute. The statute is broad enough to cover what is suggested.

Dr. Muro agreed, and suggested that going forward, the Subcommittee take what is already there and come to a consensus as to how the Subcommittee interprets its application and provide information and clarity to the physicians in the community.

Mr. Pomerantz said that AB 474 talks in terms of the "practitioner." In talking with Ms. Mehta, she appropriately pointed out that the Subcommittee is not really at liberty to expand the definition of "practitioner," which is an accepted definition under the Nevada Revised Statutes (NRS). The thing he heard from the physicians on the Subcommittee at the last meeting was the number one concern everyone had was whether other physicians in a group practice would need to get that informed consent. So the language Ms. Mehta has proposed is arguably "belt and

suspenders," but he agrees that it is very important to make that explicit without changing the definition of "practitioner" that appears in the NRS.

Ms. O'Mara stated she didn't believe the definition of "practitioner" needs to be changed. The ultimate objective is to clarify whether a group practice can share one informed consent. She thinks the Subcommittee could submit to the Board of Pharmacy that it wants clarity that multiple providers in a group practice can share one informed consent, and the Pharmacy Board can take it from there.

Dr. Muro said that was what the Subcommittee agreed to at the last meeting, but there was a question as to whether additional language is necessary, and that is what was currently being discussed. He proposed that the language, as it exists, suffices to allow the Subcommittee to work within an umbrella for consents and the pain agreements where the course of treatment is the same. And to get that across is where workshops and other educational scenarios come in.

Discussion ensued regarding the need for language to propose to the Board of Pharmacy defining the idea that a group practice can share these forms.

Ms. Massey said she reads this as the informed consent attaches to the patient in the course of treatment. So presumably, members of a group practice have access to see that an informed consent has taken place. But anyone going along with continuum of care would be able to see it as well. So she thinks if the clarification focuses on the patient and the course of treatment, it is an easy jump for anyone to understand that members of a group practice can share it, as long as it is the same patient and the same course of treatment.

Discussion ensued regarding how to define a group practice, the intent of informed consents within a group practice, and whether it would be better to provide a broad recommendation to take to the Board of Medical Examiners to take to the Board of Pharmacy, or to provide concise recommended language to take to the Board of Pharmacy.

Discussion ensued regarding the purposes and objectives of the Subcommittee.

Ms. Mehta asked what would be most helpful to the Board of Pharmacy.

Mr. Wuest said the Subcommittee should do what it wants to do, and both would be fine. It doesn't matter what we give the LCB; they are going to do it in their language. They will look at the intent and such, but they are not going to let the Subcommittee change the definition of "practitioner." The Pharmacy Board has already talked to them about these concepts and they are open to the process, and the Subcommittee is giving the Board of Pharmacy recommendations every time it says something. He said he didn't want to derail the Subcommittee from regulations because that may be the best way to proceed. Defining "group practice" is important to him because there are a lot of different ways to define it, and the people in the Subcommittee are the experts, so he thinks they should go with what the Subcommittee says a group practice is.

Dr. Muro stated the input of the providers in the room was solicited to try and provide some clarity and practicality to what was implemented because, as it is, it is not feasible to practice in pain management, oncology or hospice if we interpret it in the manner some of us are taking it to be. It appears that wasn't the intent, but to err on the side of caution, that is what is happening. If the Subcommittee can come up with an interpretation of a group practice, and it seems to be in keeping with what the Board of Pharmacy's intent was, we can move on from there.

Mr. Wuest stated the Board of Pharmacy will have regulations in front of them at a workshop the following Wednesday. They have already publicly noticed the concept of group practice and informed consent, and he has to put language in front of the public at that time.

Senator Hardy said what he was hearing is that the Subcommittee members were all on the same page as far as what the intent is.

Ms. O'Mara moved that the Subcommittee formalize its intent to let the Board of Pharmacy know that it believes informed consents, prescription medication agreements and the ability to write prescriptions should apply to a group practice.

Ms. Mehta suggested that the Subcommittee walk through the language of the bill.

Ms. O'Mara withdrew her motion. She then moved that for initial prescriptions, it is the Subcommittee's intent that a group can be covered by that document. Dr. Hardy seconded the motion.

Ms. Massey asked whether the language needed clarification or if a group practice is already defined somewhere else. Discussion ensued regarding the definition of a group practice. Ms. Mehta stated there is a definition in NRS 439B.425(5)(a) that the Subcommittee can either take and modify or simply take because that definition applies to a different Chapter of the NRS.

Mr. Pomerantz said with the caveat that this definition of group practice was developed in the context of the Nevada Stark Law which prohibits self-referrals, and there is an exception in that law for referrals within a group practice, that statute defines group practice as the following: "'Group practice' means two or more practitioners who organized as a business entity in accordance with the laws of this state to provide services related to health care." He said there are a bunch of subparagraphs which don't appear to apply to our situation, but it seems to him that Section 5(a), "two or more practitioners who organized as a business entity in accordance with the laws of this state to provide services related to health care" captures exactly what the Subcommittee was trying to say a couple of weeks ago.

Discussion ensued regarding the definition in NRS 439B.425(5)(a), and how it might apply to various types of business entities and on-call coverage.

Ms. O'Mara amended her motion to state it is the intent of the Subcommittee that informed consents can apply to groups where it is a business entity or for circumstances where people are on call for one another. Dr. Hardwick seconded the motion.

Discussion ensued regarding the motion. Ms. O'Mara explained it is just saying an informed consent can be crafted to include group members or people who are on call, but it doesn't have to.

A vote was taken on the motion, and it passed unanimously.

Discussion ensued regarding how the informed consent would apply to doctors who are on call for others.

Mr. Wuest stated he wanted to put it on the record that as far as the Board of Pharmacy and its staff goes, people that have legitimate pain and need a pain med, and pain meds are good for people in certain circumstances, they should have the pain med, and also that there are still options for people on the weekends to prescribe schedule II drugs if it is appropriate for the patient.

Ms. Mehta directed the Subcommittee to the excerpts of AB 474 that she had provided to the Subcommittee. She stated that Section 51 is the definition of "initial prescription," and that definition is very important because a lot of the rest of the requirements key off of that definition.

Ms. Mehta then read Section 52(1), 52(1)(a) and 52(1)(b), and said that this is really a documentation requirement. She then read Section 52(2), 52(2)(a) and the first sentence of Section 52(2)(b), and said this section is really talking about opioid-naïve patients. She said one of the items the Subcommittee discussed at the last meeting that needed to be clarified is the definition of "acute pain," and this is where the need for that definition arises, because this is the only section that really talks about acute pain.

Discussion ensued regarding whether the "initial prescription" provisions apply to patients who transfer from practitioner to practitioner or to hospice and are prescribed medications by the new practitioner or hospice that are part of an existing course of treatment for that patient. Ms. Mehta clarified that the term does not include ongoing prescriptions issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner. Mr. Edwards stated this allows a patient to continue to receive a continuity of care from one practitioner to another.

Ms. Mehta read the definition of acute pain contained in the 2017 *Guidelines for the Chronic Use of Opioid Analgesics*, adopted as policy by the Federation of State Medical Boards: "The normal, predictable, physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Acute pain generally is time limited, lasting six weeks or less." She stated Congress has just introduced a bill with another definition of acute pain.

Ms. O'Mara stated the bill was introduced this week, and read that definition: "The term acute pain means pain with abrupt onset and caused by an injury or other process that is not ongoing and does not include chronic pain, pain being treated as part of cancer care, hospice or other end-of-life care or pain being treated as part of palliative care." She stated it does not have a definition of time, but specifies "not ongoing."

Discussion ensued regarding which definition of "acute pain" should be recommended by the Subcommittee.

Ms. O'Mara said between the two, the Nevada State Medical Association would prefer the definition in the bill introduced by Congress.

Dr. Hardwick moved that the Subcommittee recommend use of the definition in the bill introduced by Congress. Senator Hardy seconded the motion.

Discussion ensued regarding whether the Subcommittee should recommend utilizing the definition in the bill introduced by Congress but add a time limit for clarification. Dr. Muro suggested the Subcommittee add a time constraint of six weeks.

Dr. Hardwick amended his motion to add the time constraint. Ms. O'Mara seconded the motion.

Further discussion ensued regarding whether the time constraint should be added to the definition.

A vote was taken on the motion, and it passed, with Dr. Salas opposed to the motion and all other Subcommittee members in favor of the motion.

Ms. Mehta asked whether there were any questions regarding the 14-day requirement or the 90-day MME requirement for opioid-naïve patients in Subsection 2 of Section 52, and none were raised.

Ms. Mehta read Section 53(1) through Section 53(1)(e)(3) of AB 474, and stated Section 53 is where the requirement for the written informed consent derives, and that it keys off the initial prescription for the treatment of pain. It doesn't require a written informed consent for an ongoing prescription to continue a course of treatment.

Ms. Mehta read Section 53(2), and said she had heard some confusion around this subsection.

Senator Hardy stated the confusion may stem from Section 60(1)(b).

Ms. Mehta read Section 60(1)(b), and stated it might be helpful for the Pharmacy Board to weigh in on this and how it dovetails with Section 53.

Mr. Edwards said this addresses "doctor shopping," and Dr. Muro stated this is where the PMP is really a valuable tool.

Discussion regarding the intent of Section 60, and the potential problems created by the language prohibiting prescription of a controlled substance to a patient who has already been prescribed that controlled substance by another physician.

Ms. Massey left the meeting at 3:58 p.m.

Dr. Pretzlaff asked whether, with respect to Section 53(2), there is a definition of telehealth in statute. Mr. Wuest stated there is one, and it is very broad. He stated that a telephonic conversation with a patient would qualify.

Weldon Havins, M.D., J.D., said he was substituting for Dr. Edwards. He stated telephonic communication is not telemedicine; telemedicine requires a computer screen, face-to-face, by law.

Mr. Wuest stated telehealth allows telephonic relationships; that is the definition that is in statute.

Ms. Mehta read the definition of telehealth contained in NRS 629.515(4)(c): "Telehealth means the delivery of services from a provider of healthcare to a patient at a different location through the use of information and audiovisual communication technology, not including a standard telephone, facsimile or electronic mail."

Mr. Edwards read the definition of bona fide relationship contained in NRS 639.235(4), cited in AB 474: "For purposes of subsection 2, a bona fide relationship between the patient and the person prescribing a controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics, including, without limitation, through telehealth, within or outside this state or the United States by the person prescribing the controlled substance within the six months immediately preceding the date the prescription was issued."

Discussion regarding whether the definition of telehealth in Chapter NRS 629 or NRS 639 would be the applicable definition with respect to Section 53 of AB 474, and how the definition impacts both initial prescriptions and prescriptions to increase a dosage.

Dr. Muro said he thought the intent was to keep it broad to allow physicians to continue to care for patients.

Discussion ensued regarding the fact that this could only be changed by the Legislature.

Ms. Mehta read Section 54(1). She stated at the last meeting, there was significant discussion regarding the definition of a "good faith effort," and the Subcommittee voted that it was, at a minimum, to check the PMP. However, given the following language of this Section, "to obtain and review the medical records of the patient from any other provider of health care who has provided care to the patient," she thought it would be worth a revisit of the discussion by the Subcommittee members.

Dr. Muro stated that a good faith effort also depends on the environment. For example, what an emergency room physician can do versus a physician in an outpatient environment. So a good faith effort could be checking the PMP and reviewing whatever records they have available through their own EHR.

Ms. O'Mara stated the law already requires a check of the PMP, and suggested the Subcommittee could say that a "good faith effort" is a reasonable inquiry based on the physician's specialty.

Discussion ensued regarding what a "good faith effort" to obtain medical records should include.

Dr. Hardy stated there is a definition of "good faith" in law.

Further discussion ensued regarding how to define a "good faith effort" to obtain medical records.

Dr. Hardy said that licensees are scared of what will happen if we don't define it because if we don't define it, they will be at the discretion of whatever the Board decides to do. The Board's disciplinary regulation has scared everybody.

Ms. Mehta stated the disciplinary regulation hasn't yet been promulgated and doesn't have the force of law, and one of the purposes of this Subcommittee is to make recommendations to the Board on that disciplinary regulation. She understands there is a fear out there, but one of the purposes of this Subcommittee is to gather the stakeholder input on that regulation, and whatever recommendations the Subcommittee comes up with will go back to the Board and that will start the whole process all over again.

Further discussion ensued regarding how to define "good faith effort."

Mr. Wuest stated the Subcommittee can't change the law, but can define what good faith is. There is some value in doing it through the Board of Pharmacy because then all the prescribers have the same definition, but that may not be necessary. From his notes, he has that good faith takes into account the time necessary to provide care, it takes in the setting in which the prescriber is practicing in, and whether prescribing the medication outweighs the risk of not having all the

records at the time of prescribing. He thinks something like that may put people at ease, or may not.

Discussion ensued regarding what Mr. Wuest outlined. Ms. O'Mara asked if the Subcommittee needed to affirm what Mr. Wuest said. Ms. Mastroluca said she would want to see it first.

Ms. O'Mara suggested that the Subcommittee address at the next meeting whether it had the ability to define, and still be consistent with the law, if "good faith effort" is to include that the records are relevant to the prescription being written. Another thing is under subsection (d), the same question as it relates to assessing mental health and risk of abuse and whether mental health and risk of abuse are two things that go together or whether mental health and risk of abuse must each be assessed independently. There is no comma after mental health, so she thinks there is a reasonable argument that they are talking about mental health as it is related to risk of abuse, and she thinks it is very important to the people who are trying to figure out whether they are supposed to assess all mental health.

Dr. Muro stated there are validation tools available.

Ms. Mehta said she had provided to the Subcommittee all of the prescribed samples, which she thinks gets into that.

Ms. Mehta then said to close the loop on what Mr. Wuest proffered, she didn't know that a vote was appropriate at that time because people want to look at the language.

Agenda Item 5
PUBLIC COMMENT

Dr. Muro asked whether there was anyone in attendance who would like to present public comment. No public comment was received.

Agenda Item 6
ADJOURNMENT

Senator Hardy moved to adjourn the meeting. Ms. Mastroluca seconded the motion, and it passed unanimously. Dr. Muro adjourned the meeting at 4:35 p.m.

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