



State Physician Health Programs: Coming of Age

Guest Author: Peter A. Mansky, MD

Over the past three decades state Physician Health Programs (PHPs) have gone through stages of development and growth especially in the areas of physicians suffering from alcoholism and other addictions. The programs have produced guidelines, sought well-trained medical directors, established the Federation of State Physician Health Programs (FSPHP) and have combined efforts with medical boards through the Federation of State Medical Boards (FSMB) to develop mutual guidelines for allowing physicians to be treated before their illness leads to patient harm and thus, to protect patients.

Early History

In the development of PHPs, each state followed a similar path described here but the states changed at different times. The large eastern state PHPs hired medical directors who were psychiatrists and addictionologists with an academic background in the early to mid-1990s. The Nevada state PHP and the Nevada State Board of Medical Examiners (NSBME) recruited a medical director with the same qualifications in 2004. Although states developed their programs at different rates, all moved in the direction of leadership by qualified medical professionals who in many cases could promote research and gather data systematically.

Much of the impetus of the early state PHPs derived from a reconsideration of *The Sick Physician Report* which published research gathered by the American Medical Association (AMA) and illustrated that physicians had the same psychiatric illnesses as the general population (JAMA, 1972). Later academic studies would indicate that physicians started their professional career healthier than controls but took less care of themselves during their practice years (Frank, 1996 & Vaillant, 1970).

The early PHPs were promoted by state medical societies and state medical boards. The medical directors at that time were often physicians recovering from alcoholism and drug addiction. The medical directors participated in mutual help programs themselves. These groups emphasized the value of helping others with addictive illness in order to maintain their own recovery. For the most part, they were not professionals trained in psychiatry, addiction or occupational health. At that time, there were no guidelines for evaluation and treatment of physicians with addiction and the medical directors followed their own pathway of recovery and promoted innovations to assist their fellow physicians with the same disease. These individuals were courageous in taking what they knew about recovery from Substance Use Disorders (SUD - the new official terminology now covering alcoholism and addictive diseases), applying it to ill physicians, and communicating with each other to help solve their mutual PHP problems.

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MISSION STATEMENT

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BOARD NEWS

Leading Policymakers, Stakeholders Underscore the Benefits of the Interstate Medical Licensure Compact to Patients, Nation at National Press Club Event

Following the enactment of the Interstate Medical Licensure Compact by nine states, leading federal and state policymakers and key stakeholders gathered in the nation's capital to examine the success of the recently established Interstate Medical Licensure Compact. Hosted by the Federation of State Medical Boards at the National Press Club, the morning event highlighted the Compact's beneficial impacts on the delivery of and access to high quality medical care for patients across the country. Edward O. Cousineau, Executive Director, Nevada State Board of Medical Examiners, along with representatives from several other states was in attendance for the event.

"The Interstate Compact will benefit rural America, especially in Wyoming," said U.S. Senator John Barrasso, MD (WY), whose state was the first in the nation to adopt the Compact. "States like ours, with patients who live in small, remote areas, need access to physicians who do not live here. I'm proud of Wyoming for leading the way to ensure that patients have access to the medical care they need."

The Interstate Medical Licensure Compact, which offers a new pathway for expedited medical licensure, is expected to significantly reduce barriers to the process of gaining licensure in multiple states, helping facilitate licensure portability and telemedicine while expanding access to healthcare by physicians, particularly in underserved areas of the nation.

"The Interstate Compact for Medical Licensure would help thousands of Utahns, especially those living in remote corners of the state," said Utah State Representative Raymond Ward, MD, sponsor of the Compact legislation in Utah. "This bill would increase access to healthcare services for our most vulnerable residents and I am proud that Utah has joined eight other states in supporting this bipartisan, states' driven effort."

Additional panelists at the National Press Club event, who also spoke to the beneficial impact of the newly enacted Compact, included representatives of state medical and osteopathic boards, the American Medical Association, Council of Medical Specialty Societies, Gundersen Health System, and the National Patient Safety Foundation.

The Compact drafting process was completed in September 2014. Since then, the Compact legislation has been enacted by nine states including Alabama, Idaho, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia and Wyoming and has been introduced in ten other state legislatures this year.

For more information about the Interstate Medical Licensure Compact, visit: <http://licenseportability.org/>

To read the Interstate Medical Licensure Compact legislation: [http://licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-\(FINAL\).pdf](http://licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-(FINAL).pdf)

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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure, and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

At the same time, in the late 1980s, treatment centers were being developed by recovering physicians who addressed SUDs in physicians and developed new treatment based on their experiences and the input of other clinicians. A center was developed in Atlanta which emphasized long-term treatment at rehabilitation centers for 90 days. The treatment centers of the late 1980s and early 1990s treated physicians who were advanced in their illness and, at that time, required extensive and intense treatment.

The FAA's Program for Pilots With SUDs: Increased Aviation Safety

Some of the medical directors of the early PHPs were contacted by the Federal Aviation Administration (FAA) to assist with teaching about alcoholism, addiction and other psychiatric illnesses to physicians who were aviation medical examiners while at the same time advising the FAA concerning addiction and alcoholism. The state PHP medical directors working with the FAA observed the development of a similar program by Dr. Bart Pakull, a psychiatrist working for the FAA. They found Dr. Pakull's work encouraging and fostered an interchange between the state PHPs and the FAA program which helped both to grow and develop successful programs.

The FAA approached the problem of SUDs in airline pilots by gaining the trust of pilots and guiding them through evaluation and treatment of their illness. The key was that the FAA preserved the pilots' careers by allowing them to resume flying after treatment and while being monitored. Before the program was developed, the SUDs in pilots were usually not recognized by the FAA until after the illness progressed to the degree that it led to a plane crash. The pilots knew if they were diagnosed with an SUD, such as alcoholism, their flying career was ended. So, they hid their drinking and the flight crews often protected them.

Once the FAA program was established by Dr. Pakull and allowed the airline pilots to seek treatment and return to flying, sometimes within as little as three months, the pilots began to realize that they could seek treatment and continue to work in their profession. Additionally, pilots knew if they continued drinking, they could be impaired in flight which would lead to an accident. As the FAA program developed and gained the trust of pilots, the FAA was able to intervene earlier in their SUD progression before any accidents resulted.

Airlines, pilots, and flight crews were educated concerning SUDs and the optimistic results of treatment. The pilots were often referred by the airlines or flight crew for treatment and monitoring by the FAA Behavioral Division. Accidents decreased and the SUD illness recovery rate for the pilots was reported to be 93% (Pakull, B., 2002).

This substantial recovery rate is similar for most state PHPs which have the same degree of success. Furthermore, with the identification of SUDs in the earlier stages of illness both by the FAA and by the PHPs, they both were able to be more flexible in treatment by matching the treatment to the stage of the disease so that fewer were required to undergo 90 days of residential treatment.

Upon the recent retirement of Dr. Pakull, who became the FAA's Chief Psychiatrist, the FAA noted that:

"It's difficult to think of any other single medical certification initiative we have taken that has had a more positive impact on aviation safety" than Dr. Pakull's program.

Federation of State Physician Health Programs (FSPHP)

In the early 1990s, the state PHPs realized a need to communicate with each other to improve the programs the FSPHP started but it was not until 1995 that a group of medical directors and other staff from PHPs attended a national meeting and developed bylaws. The first year of the annual meeting of the FSPHP consisted of 12 people around a conference table. During the past 15 years, the annual meetings have grown and now offer a scientific-based agenda with Continuing Medical Education (CME) and up to 250 attendees.

The FSPHP, the AMA, and the Canadian Medical Society have also established scientific meetings which assemble every two years to address academic and evidence-based issues in physician health.

There are now 46 states with functioning PHPs that are members of the FSPHP. Two states have a PHP but are not yet members of the FSPHP (FSPHP.org) and two states have no PHP. Since the FSPHP was formed to promote dialogue among PHPs and to set guidelines for program operation and functions, it not only provides a forum for the staff of PHPs in annual meetings but provides opportunities for discussion during the year including two email Listservs.

The FSPHP also continued the research impetus of the *Physician Health Research Conference* which recognized the need for evidence-based data concerning physician health. The conference met in 1996 to define problem areas and set standards for research (Dilts et al., 1999). The conference was promoted by the University of Colorado and many organizations were represented including the AMA, American Academy of Addiction Psychiatry, American Society of Addiction Medicine, and FSPHP, as well as centers that treat SUDs in physicians, groups of academic physicians and medical licensure boards. This promotion for solid research and outcome data has been continued by the research committee of the FSPHP.

During recent years, the FSPHP has worked with the AMA and the FSMB to develop guidelines for the evaluation and treatment of physicians suffering from alcoholism and chemical dependencies. This was approved by the FSMB House of Delegates as the *Policy on Physician Impairment** in 2011. It contains direct input from the FSPHP and also has a list of references to back up the policy.

*(http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/grpol_policy-on-physician-impairment.pdf)

Safer Patient Care

The goal of a state PHP is to promote physician health which then leads to better and safer patient care. Evidence supports the fact that as the SUD progresses, impairment at the worksite occurs last in the disease process (Centrella, M.C., 1994). If a state PHP helps one doctor to recover from illness before the progression of illness is to the point of impairment at the work site, then the PHP has protected many patients.

This result is an important aspect for those who work in PHPs. It is what motivates us to serve the physicians of our state. If the state PHPs did not exist, then a clinician's illness may not likely be recognized until impairment at the work site and/or patient harm exists. A physician who is ill or severely stressed may not be providing the best care he or she can, but also may not be at a level of impairment until the illness or stress progresses. Again, each physician a program assists in health or wellness helps many patients.

Functional Aspects of State PHPs

State PHPs have developed five basic functions similar to the FAA program:

1. *Primary Prevention*
2. *Case Identification*
3. *Guidance Through Evaluation and Treatment*
4. *After Care Monitoring and Support*
5. *Advocacy with Clinical, Local, State and Federal Entities.*



Primary Prevention

State PHPs provide primary prevention through education and through the PHP partisans who are, or have been, participants in the PHPs. The PHPs provide presentations at hospital staff meetings, to hospital medical executive committees, hospital medical staff personnel, medical schools, residency programs, group practices, the public and malpractice carriers as well as to managed-care and insurance entities. Additionally, physicians who are participants in a PHP or have completed participation, recognize SUDs in their patients and also end up prescribing addictive medication more judiciously and help prevent over-prescribing of addictive substances.

Case Identification and Referrals to PHPs

The primary prevention activities lead to referrals earlier in the stage of the SUD illness. In doing this, PHPs are able to recommend several levels of treatment from individual treatment and attendance at mutual help groups to residential treatment at rehabs.

Referral to state PHPs emanates from multiple sources which include family, hospitals, colleagues, medical boards, medical schools, residency training programs, group practices and an occasional self-referral especially after attending a presentation of the state PHP describing how the PHP can be helpful to clinicians in addressing an addictive illness. Most of the participants in state PHP are voluntary and confidential. They may have been pressured by family, colleagues, practices, or hospitals but they entered early enough in their illness to prevent patient harm. The minority of participants are referred by medical boards often in lieu of discipline. Participants in PHPs, former participants, and those who have seen the change in the recovering physicians also add to referrals.

Guidance Through Evaluation and Treatment

Several clinical centers that specialize in treating physicians may be available locally. If not, there are national programs dedicated to the treatment of health care professionals. National centers provide increased confidentiality and increased objectivity that decrease the effects upon the physician's local reputation and professional relationships especially in a city with a small population. These centers are experienced in working with a PHP and in joining the PHP in advocating for the physician with medical boards, other regulatory agencies, hospitals, managed care and physician-employers.

Some physicians, however, may respond better to local outpatient evaluation and treatment and with clinicians approved by the state PHP in their ability to obtain objectivity while working with PHPs. Again, it takes a great deal of therapeutic skill for a treating clinician to be able to maintain the trust of the physician as a patient, provide effective treatment and to still be able to report the physician's progress but also to notify the PHP if there are problem areas that may affect the physician's ability to practice safely. The therapist must be willing to work with the physician and the PHP in promoting recovery. The clinician must have the ability to keep personal issues confidential and to allow the physician to respond to therapy with openness and honesty in spite of reporting duties. Most reporting is of attendance, willingness to work on issues, openness and progression of recovery (Fayne and Silvan, 1999).

As the result of earlier recognition of the disease and referrals from multiple sources along with the input of medical directors who were psychiatrists and addictionologists, PHPs have become more flexible over the years and more evidence-based in their recommendations.

Flexibility in recommended evaluation and treatment takes into account the placement criteria recently published by the *American Society of Addiction Medicine*. In addition to standard placement criteria, the most recent addition offers a section on *Safety Sensitive Positions* which applies to health care professionals, including physicians.

Physicians may be offered evaluations that require several days and involve a multidisciplinary Independent Medical Evaluation (IME). To prevent the appearance of the IME providing a diagnosis to promote treatment at its own evaluating center, after the IME, all physicians are given a choice of several treatment centers and the opportunity to discuss the PHP with friends and family.

Physicians recovering from SUDs and returning to practice tend to do best with abstinence-based treatment (Centrella, 1994).

Initial assessment by a PHP or utilizing a multidisciplinary IME usually reveals the presence of a SUD because of prescreening by the PHP but occasionally may reveal other disease processes. Three salient examples seen in the two PHPs I have directed are Huntington's chorea, early senile dementia, and a brain tumor.

Monitoring and Support

It seems obvious that a physician's motivation to maintain his or her license and lifestyle is a major aspect of their high recovery rate. This may be a factor, but published data indicates that other independent variables may account for the high recovery rate, monitoring being the most obvious.

Monitoring for drugs and alcohol in the urine has been shown to increase the recovery rate of physicians compared to control groups of unmonitored physicians (Shore, 1987) and compared to unmonitored middle-class patients (Morse et al., 1984). The program run by the FAA discussed above is conducted for pilots with substance use diagnoses. It also utilizes monitoring and the ability to return to active professional activities (analogous to PHPs). It reported a recovery rate of over 90% (Pakull, 2002).

In a like manner, confidential treatment and the ability to continue or resume practice encourages physicians to accept the support of PHPs. These factors motivate physicians to seek treatment earlier and promote colleagues to refer to the PHP with assurance that they are not destroying, but preserving a fellow physician's career. The Nevada Professionals Assistance Program (NPAP), like other PHPs, monitors behavior, the work place, attendance at mutual help groups, and treatment, along with urine and hair toxicology testing. With close monitoring, PHPs are able to identify a relapse in the early stages and before patient harm.

Advocacy

Advocacy is an important part of recovery for physicians and includes relating to medical boards, other regulatory agencies, managed care companies, malpractice insurance carriers, credentialing entities, hospitals, and employers. Sometimes the advocacy includes civil and criminal court proceedings. Most PHP staff relate to multiple entities gaining the trust of those entities to accept the opinions of the PHP. Additionally, PHP staff works with the physician's attorneys.

Mutual Support Groups

Many PHPs require attendance at mutual help groups of fellow recovering addicts or alcoholics seeking to learn a new way of life conducive to recovery and sober living. There are many such groups listed by federal agencies concerned with SUDs, especially the Substance Abuse and Mental Health Services Administration (SAMHSA). Almost all of the PHP participants have chosen 12-step programs. In addition to mutual support through traditional 12-step programs, physicians are encouraged to attend Caduceus groups. Caduceus groups are for health care professionals and many include only physicians. Nevada has a group in Reno and one in Las Vegas.

There is also a group which meets annually called *International Doctors in Alcoholics Anonymous* (IDAA). Caduceus groups and IDAA allow for confidential mutual support, especially for discussion of professional, career and recovery factors (Angres et al., 1998). IDAA meetings and membership include all doctoral-level recovering health care professionals (IDAA, 2002). Pilots have also developed special groups similar to Caduceus called, "Birds of a Feather."

Outcome

Physicians participating in PHPs tend to respond well to SUD treatment. The recovery rate for physicians participating in PHPs has been reported to be over 90%, if allowance is made for a slip or a single brief relapse, usually at a time when the physician is off call or on vacation. The recovery rate reported from a number of PHPs has been shown to be in the 70s percentage range or higher with lack of even a brief relapse as criteria. However, over 90% of physicians in PHPs maintain the strength of recovery and a return to premorbid functioning and often better (Mansky, 1993; Reading, 1992; Shore, 1987). Often, physicians report that their experience in a PHP and their treatment has led them to have a fuller and more satisfying personal and professional life. Many know the PHP not only saved their careers, but also their lives.

The Future

As the FSPHP continues to grow and the PHPs develop further, they will also promulgate recommendations for psychiatric illnesses other than SUDs, behavioral issues, stress, aging in physicians and other health issues. PHPs and others in the field of physician health will continue to gather data and examine the processes in the service of improvement in the structure and function of PHPs.

Conclusions

State PHPs exist in all but a few states. They provide many functions which help to preserve a physician's career while at the same time protecting patients. Because of the many functions, PHPs are able to address alcoholism and addiction early in the disease progression and recommend flexibility in treatment which takes into consideration the physician's personal and professional needs balanced with the best treatment based on sound evaluation, evidence-based procedure,

and input from multiple sources, including referral sources and families. The prognosis of a physician treated for an SUD with the support of a state PHP is excellent. It is important for physicians in a state with a PHP to realize the PHP exists and can assist in their return to practice safely and effectively on the basis of their recovery from illness. The PHP must be aware of factors in the physician's SUD recovery in relation to the interaction of the illness within the workplace, organizations and institutions. Confidential referral and treatment is an important factor as well as the flexibility and responsiveness of the state PHP within the limits of effective clinical treatment and patient safety.

It is a privilege to serve as the Executive Medical Director of the Nevada PHP, the Nevada Professionals Assistance Program (NPAP). It presents an opportunity to promote healthy physicians in recovery from illnesses which can lead to impairment at the work site and patient harm. By helping one physician in his or her pathway to recovery the NPAP helps many patients.

Please address questions and comments regarding this article to Peter A. Mansky, MD: peterama@post.harvard.edu

For more information about NPAP please contact Shauna Eger, MHA, Senior Associate Director: npap2shauna@gmail.com or 702-257-6727.

About the Author

Dr. Peter Mansky is a psychiatrist, specializing in addiction medicine and psychopharmacology. He has a B.A. from Cornell University, a medical degree from SUNY Buffalo Medical School, and has trained in both Internal Medicine and Psychiatry. He has two postgraduate fellowships in pharmacology, one at the NIMH Addiction Research Center and the other at the University of Illinois. Dr. Mansky completed his residency in Psychiatry at Massachusetts General Hospital and was a Fellow at Harvard Medical School. Dr. Mansky is widely published in Psychiatry, Psychopharmacology, and Addiction Psychiatry. He is credited with over 41 formal publications and has given over 130 national and international formal presentations.

Dr. Mansky is currently the Executive Medical Director of the Nevada Professionals Assistance Program which provides guidance, monitoring, and advocacy services to professionals including physicians and attorneys. Dr. Mansky has a small private practice, Clinical Services of Nevada, and is presently an Adjunct Professor in Psychiatry, Addiction Medicine, and Physician Impairment at Touro University – Nevada. He is also Past President of the Federation of State Physician Health Programs and presently serves on the Board of Trustees at the Clark County Medical Society. Dr. Mansky is a Distinguished Life Fellow of the American Psychiatric Association (APA).

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The Ponemon Report: Reaffirming the Importance of HIPAA Compliance

By: Rachel V. Rose, JD, MBA

Overview

On May 1, 2015, two significant items were released. First, Partners HealthCare notified approximately 3,300 people that a major data breach occurred and that their patient data was compromised.¹ Second, a new study by the Ponemon Institute was released indicating that the leading cause of health care data breaches is criminal cyber attacks.² The irony is striking and the implications are alarming.

Partners' data breach stemmed "from a group of employees who had received 'phishing' emails, and had provided information in response to the emails believing they were legitimate. The information allowed for unauthorized access to these employees' email accounts within the Partners HealthCare network."³ This is considered a criminal cyber attack. Likewise, Anthem Inc.,⁴ the second largest insurer in the United States, and Community Health Systems (CHS),⁵ a large for-profit hospital corporation, also experienced criminal cyber attacks within the past nine months and reported data breaches.

The potential cost to Partners has not been estimated publically; however, the CHS breach was estimated to cost \$150 million dollars.⁶ The total cost was estimated utilizing the following factors:

1. Remediation (technical, legal and administrative);
2. OCR fines associated with HIPAA violations;
3. Identity theft protection or credit monitoring for patients;
4. Defending against both patient and shareholder lawsuits and settlements;
5. The incalculable cost of potential insurance fraud stemming from 4.5 million exposed Social Security numbers.⁷



Physicians, other covered entities and business associates should take note. Personally identifiable information (PII),⁸ which is found within protected health information (PHI), is within the purview of the Health Insurance Accountability and Affordability Act (HIPAA)⁹ and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act").¹⁰ The fundamental concepts of confidentiality, integrity and availability of the protected health information (PHI) are integrated into every facet of the subsequent rules, which culminated in the Final Omnibus Rules.¹¹ Hence, the purpose of this article is to highlight some of the key areas of the study in relation to the recent criminal attacks and provide physicians and other entities covered by HIPAA with some privacy and security measures to implement.

Analysis

According to the Ponemon Institute, 91% of health care organizations and 59% of business associates experienced data breaches.¹² This year was the first year that criminal data breaches topped the charts. Moreover, the estimated cost of data breaches for the health care industry was estimated at \$6 billion.¹³

Regardless of whether or not an entity was considered a covered entity or a business associate, only 50% of the study participants indicated that they performed a four-factor risk assessment. Moreover, only 10% engaged a thirdparty to do the assessment.¹⁴ The CFR requires risk assessments and risk analyses annually so the outcome was very disconcerting.

To identify and combat potential threats leading to a breach, the following list provides possible sources of the breach:

- Lost or stolen devices;
- Phishing;
- Web-borne malware attacks;
- Exploit existing software vulnerability;
- SQL injection;
- Advance persistent threats (APT)/targeted attacks; and
- DDoS attacks.¹⁵

These items are problematic because they could be avoided with adequate security measures, policies and procedures, and training. Humans pose the biggest threat to data security: whether an internal employee, external subcontractor or criminal attacker. Hence, internally, policies and procedures, coupled with training and monitoring, provide the best defense. Externally, doing adequate due diligence is the first step in obtaining reasonable assurances that the person is compliant. Finally, investing in the requisite technology controls can mitigate the risk of a criminal attack, which results in a breach.

Conclusion/Action Steps

Data breaches are costly. Whenever I am asked questions during presentations, receive inquiries from clients or provide guidance at what needs to be done, I am often amazed at the responses that I get. First, a breach is costly regardless of the size of the organization. Financial, reputational and legal damages all result. Second, everyone needs to comply with the law. The excuses of “we’re a small company” or “look what we have already done” will not fly. In fact, the U.S. Department of Health and Human Services (HHS) already addressed this in the Omnibus Rule when commentators indicated they needed more time to become compliant. HHS has basically responded that HIPAA has been around since 1996 and the subsequent regulations and related laws have been implemented on an ongoing basis since that time. Aside from a couple of fine tunings, major adjustments should not be necessary. Hence, everyone should be in almost pristine shape: unfortunately this is not the case.

HHS’ language in the Omnibus Rule was echoed in the Ponemon Study, “[n]o healthcare organization, regardless of size, is immune from data breach.”¹⁶ A couple of action steps that can help avert breaches and reduce the risk of fines include:

- Substantive policies and procedures;
- Encrypting data at rest and in transit, including USB drives;
- Send out a due diligence sheet when engaging business associates;
- Adopt a no-violation policy for HIPAA and have physicians adhere to it; and
- Make sure annual third-party risk assessments are done to ensure that the privacy and security measures in relation to the technical, administrative and physical areas are met.

In sum, treating your patient’s data as you would your own bank account can lead to a more compliant environment with greater patient trust. Common sense tells us that dealing with PII or PHI being stolen is going to be time consuming in terms of rectifying all the accounts that a person’s Social Security number is tied to. By “doing unto others” in relation to data security, physicians can come out ahead from a financial, reputational and legal perspective.

About the Author

Rachel V. Rose, JD, MBA is a Principal with Rachel V. Rose – Attorney at Law, PLLC located in Houston, TX. Ms. Rose holds an MBA with minors in healthcare and entrepreneurship from Vanderbilt University, and a law degree from Stetson University College of Law, where she graduated with various honors, including the *National Scribes Award* and *The William F. Blews Pro Bono Service Award*. Ms. Rose is licensed in Texas. Currently, she is Vice Chair of Publications for the Federal Bar Association’s Corporations and Associations Counsel Division, the Co-editor of the American Health Lawyers Association’s *Enterprise Risk Management Handbook for Healthcare Entities* (2nd Edition) and Vice Chair of the Book Publication Committee for the Health Law Section of the American Bar Association and Co-author of the ABA’s publication, *The ABCs of ACOs*. Ms. Rose is an Affiliated Member with the Baylor College of Medicine’s Center for Medical Ethics and Health Policy. She can be reached at: rvrose@rvrose.com.

¹ *Partners HealthCare Reports Data Breach*, <http://www.healthleadersmedia.com/content/TEC-315915/Partners-HealthCare-reports-data-breach> (last accessed, May 10, 2015).

² Ponemon Institute, *Fifth Annual Benchmark Study on Privacy & Security of Healthcare Data* (May 2015) http://ipa.idexperts.com/acton/attachment/6200/f-037a/1/-/-/-/Fifth%20Annual%20Privacy%20and%20Security%20of%20Healthcare%20Data%20Report.pdf?cm_mmc=Act-On%20Software-_-email-_-Thank%20you%20for%20downloading%20the%20Fifth%20Annual%20Benchmark%20Study%20on%20Privacy%20and%20Security%20of%20Healthcare%20Data-_-Click%20here%20to%20download%20the%20report.&sid=ZTAWmB8E.

³ *Supra* at n. 1.

⁴ Anthem Facts, <https://www.anthemfacts.com> (last accessed, May 10, 2015).

⁵ Community Health Systems, <http://www.chs.net/media-notice/> (last accessed, May 10, 2015).

⁶ *Community Health Systems Breach Could Cost Up to \$150 Million*, <http://venturebeat.com/2014/08/25/community-health-systems-breach-could-cost-up-to-150-million/> (last accessed, May 10, 2015).

⁷ *Ibid*.

⁸ 45 CFR 155.260 - Privacy and security of personally identifiable information.

⁹ Pub. L. 104-191 (Aug. 21, 1996).

¹⁰ Pub. L. 111-5 (Feb. 17, 2009).

¹¹ 78 Fed. Reg. 5565 (Jan. 25, 2013).

¹² *Supra* n. 2 at p. 1.

¹³ *Ibid* at p. 2.

¹⁴ *Ibid* at p. 6.

¹⁵ *Supra*, n. 2 at p 11.

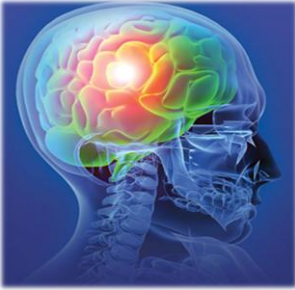
¹⁶ *Supra* n. 2 at p. 2.

Disclaimer: The opinions expressed in the Guest Contributor’s article are those of the author, and do not necessarily reflect the opinions of the Board members or staff of the Nevada State Board of Medical Examiners.

A Common Sense Approach to the Patient With Headaches

Guest Author: J. Ivan Lopez, MD, FAAN, FAHS

Director, Stroke Center, Renown Regional Medical Center, and Professor of Medicine and Pediatrics, University of Nevada, Reno



Patients present with headaches in the outpatient clinics as well as in the Emergency Department (ED). This complaint is very common, making a large percentage of outpatient visits in both settings. Headaches affect both the adult and the pediatric population.

It is useful to divide headaches into two categories: primary and secondary. Examples of primary headaches include migraines, cluster, or tension-type headaches. Examples of secondary headaches include headaches due to a brain tumor, stroke or an aneurysm.

Primary headaches are, by far, more common than secondary headaches in the clinic and in the ED. Although the most common type of primary headache is tension-type headache, one rarely sees these patients in a clinical setting. The reason for this is, by definition, tension-type headaches are brief in duration, mild to moderate in nature (not disabling), and not associated with autonomic symptoms such as nausea or vomiting. On the other hand, the most common type of headache one is likely to see in clinic or the ED is migraine. By definition, migraines last four or more hours, if untreated or if treatment fails, the pain is moderate to severe, forcing the patient to seek bed rest and medical help, and is associated with light and noise sensitivity, and nausea or vomiting. Cluster headaches and other types of primary headaches are rare in a general medical practice. The origin of primary headaches is genetic, and not due to anything ominous. Certainly poor sleeping habits, dietary habits, poor stress coping skills, and other variables can serve as triggers.

How does one know that one is dealing with a primary headache and not with a life-threatening, secondary headache? We must rely on the history and physical exam. For the most part, there is no need to obtain neuro-imaging studies such as CT or MRI of the brain. Often, the sentiment, "If you want to know what's wrong with your patient, ask him" can aid in treatment. If the patient has been experiencing pain for years and the examination is normal, it would be extremely unlikely the patient is dealing with a ruptured aneurysm.

The treatment of migraines, the most common type of headache to show in our practices, depends on the frequency of these headaches. As an example, if the individual has three headache days per month, then, an acute symptomatic approach should suffice. In this particular case, one can use an NSAID, acetaminophen or a triptan (there are seven of these on the market, and all of them are safe and effective). Avoid the use of narcotics (habit-forming medications) because of the risk associated with their use and also because the use is not based in the scientific evidence narcotics have not been shown to be more effective than other, less risky, options to treat the acute pain associated with migraines.

On the other hand, if the headache frequency exceeds six days per month, more likely than not, that individual will need to take an oral preventive agent, such as an anti-epileptic, anti-depressant, or a medication used to treat high blood pressure (beta-blockers are the best studied medication in this category). Usually, it takes six to eight weeks of consistent usage with any of these preventive agents to experience possible benefits. Trying these medications for a short period of time, say, for only a couple of weeks, and then discontinuing use is a common mistake. If oral agents fail to improve the patient's quality of life by decreasing the frequency and/or severity of these headaches, a patient can use occipital nerve blocks or botulinum injections.

How about red flags? When should one get concerned that one is not dealing with a primary headache, but rather with a life-threatening condition? If the pain does not seem to be a migraine, based on the history, one must conclude that a further inquiry must be done. As an example, a man in his 50s with new-onset headaches and an abnormal neurologic exam is less likely to have migraines and more likely to have something more serious. In this particular case, neuro-imaging studies and an MRI of the brain, preferably, are mandatory.

The approach to the patient with headaches is more complex than this, but I have tried to summarize in a few paragraphs a sensible approach to this common condition in our clinics and EDs. I cannot emphasize enough the importance of obtaining an accurate description of the features of the headache. This, associated with a normal neurological examination, should reassure the clinician that he/she is dealing with a primary headache disorder, and not with a life-threatening condition.

One should also remember to use an evidence-based pharmacological approach when needed, and minimize or even eliminate the use of habit-forming substances. One should also obtain neuro-imaging studies if the diagnosis is not clear after obtaining a history and performing a neurologic exam.

Finally, if in doubt, any neurologist in Nevada would be happy to provide assistance helping these patients and the primary care physician should have a low threshold to refer a patient if the diagnosis or the response to treatment proves to be challenging.

Disclaimer: *The opinions expressed in the Guest Contributor's article are those of the author, and do not necessarily reflect the opinions of the Board members or staff of the Nevada State Board of Medical Examiners.*

Study May Help Department of Veterans Affairs Find Patients With High Risk of Suicide

Clinicians are challenged every day to make difficult decisions regarding patients' suicide risk. Using Veterans Health Administration (VHA) health system electronic medical record data, Veterans Affairs (VA) and National Institute of Mental Health (NIMH) scientists were able to identify very small groups of individuals within the VHA's patient population with very high, predicted suicide risk - most of whom had not been identified for suicide risk by clinicians. Such methods can help the VHA to target suicide prevention efforts for patients at high risk, and may have more wide-ranging benefits.

John McCarthy, PhD., MPH, director of the Serious Mental Illness Treatment Resource and Evaluation Center in the VA Office of Mental Health Operations, Robert Bossarte, PhD., Director of Epidemiology in the VA Office of Public Health, Ira Katz, MD, Senior Consultant for Mental Health Program Analysis in the VA Office of Mental Health Operations, and colleagues report their findings today in the online issue of *American Journal of Public Health*. This paper is the result of a collaboration between the VA and NIMH, which is part of the National Institutes of Health.

Dr. McCarthy and colleagues developed their suicide-risk algorithm by studying the VHA patient population from fiscal years 2009-2011. Data on manner of death came from the National Death Index, and predictors of suicide and other types of death came from VHA clinical records. Dividing randomly the patient population in half, the team used data from one half to develop the predictive model, and then tested the model using data from the other half. Each of the two study samples included 3,180 suicide cases and 1,056,004 control patients. Researchers compared predicted suicide risk to actual mortality to assess the performance of the predictive model.



"As the largest health care provider in the U.S., VA has the responsibility to continuously examine how our extensive suicide prevention efforts are working, and to identify critical opportunities for improvement in service to our nation's Veterans," said Dr. Caitlin Thompson, Deputy Director for Suicide Prevention for VA. "This collaborative effort with NIMH provides us with unprecedented information that will allow us to design and implement innovative strategies on how to assess and care for those Veterans who may be at high risk for suicide. This model will advance the care provided to Veterans through VA's suicide prevention programs to allow us to better tailor our suicide prevention efforts so that we can ensure that ALL Veterans remain safe."

The VHA care system identifies patients as being at high risk of suicide based on information assessed during clinical encounters. Researchers found that their predictive model was more sensitive than this clinical flagging, in the sense that, even in groups with the highest predicted suicide risk based on the model, less than one-third of patients had been identified clinically.

"This is valuable, because it gives the VA more extensive information about suicide risk," said Michael Schoenbaum, PhD, Senior Advisor for Mental Health Service, Epidemiology and Economics at NIMH and one of the co-authors of the report. "If the VA can identify small groups of people with a particularly high risk of suicide, then they can target enhanced prevention and treatment services to these highest-risk individuals,"

"It's particularly encouraging that these analyses use the types of data available to any large health care system," said NIMH Director Thomas Insel, MD. "These methods could help us prevent civilian as well as veteran suicides."

In addition to identifying suicide risk, the team looked at deaths among people identified as highest risk for suicide in 2010. The team found that this group had both very high suicide and non-suicide death rates over the next 12 months.

"This finding reinforces the idea that using this process to target suicide-risk interventions may have wide benefits across an extended span of time," concluded Dr. Schoenbaum.

Reference:

McCarthy J.F., et al., Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. *American Journal of Public Health* (in press)

About the National Institute of Mental Health (NIMH): The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. For more information, visit: <http://www.nimh.nih.gov>.

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 institutes and centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit: <http://www.nih.gov>

About the Department of Veterans Affairs: The VA is the second largest Federal department with close to 300,000 employees. The Department's mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support and recognition earned in service to this Nation.

Links: <http://www.annarbor.hsrdr.research.va.gov/ANNARBORHSRDRESEARCH/investigators2014.asp>
<https://www.urmc.rochester.edu/people/27210512-robert-m-bossarte>

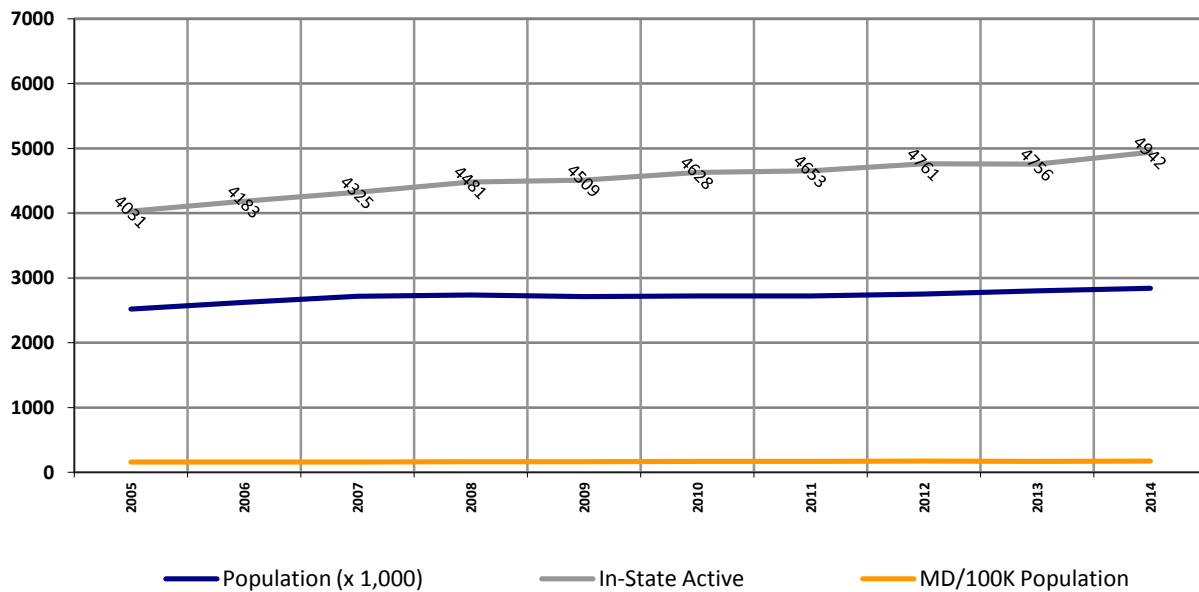
2014 ANNUAL REPORT HIGHLIGHTS

The Board licenses physicians, physician assistants, respiratory therapists and perfusionists. In 2014, the Board issued the following new licenses:

Practice	
Physicians	572
Physician Assistants	97
Respiratory Therapists	160
Perfusionists	11

In 2014, the ratio of physicians to 100,000 population* increased slightly over the previous year. The following graph shows the growth of the state's population (measured in thousands so that the trend line will fit on the graph, and last reported at 2,843,301), the state's active, in-state physician population (in absolute numbers), and the ratio of physicians to population (measured as physician per 100,000 population). From 2005 through 2007, the ratio averaged between 159 and 161 physicians per 100,000. From 2008 through 2012, the ratio increased, averaging between 164 and 173. In 2013, the ratio was 170, and in 2014, the ratio increased to 174.

Comparison of Population With In-State Active Physicians



*Population statistics provided by the Nevada State Demographer, University of Nevada.

The physician licensure for active, in-state physicians increased by 3.9% in 2014. The following table is a county-by-county breakdown of physician licenses for the last ten years. In 2014, Carson City, Churchill, Clark, Douglas, Lyon, Nye and Washoe Counties showed growth in their physician populations, Humboldt County showed a decrease, and the remaining nine counties remained static in their physician populations.

Physician Licensure Counts (2005-2014)

County	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Carson City	143	144	140	142	143	151	158	152	164	168
Churchill	24	22	21	23	22	20	22	23	27	29
Clark	2729	2850	2949	3060	3086	3186	3207	3305	3277	3403
Douglas	79	82	93	97	85	84	87	89	80	86
Elko	42	41	41	46	45	46	48	41	40	40
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	0	1	1	1	1	0	0	1	0	0
Humboldt	6	7	9	9	10	9	10	11	12	11
Lander	3	2	2	2	3	3	2	2	2	2
Lincoln	1	1	1	2	2	2	2	2	2	2
Lyon	11	13	13	11	14	13	15	16	15	16
Mineral	6	5	6	5	6	6	5	6	5	5
Nye	20	18	19	17	16	15	16	14	13	16
Pershing	2	3	2	2	2	3	2	1	0	0
Storey	1	1	0	0	0	0	0	0	0	0
Washoe	952	981	1017	1056	1064	1081	1069	1088	1110	1155
White Pine	12	12	11	8	10	9	10	10	9	9
In-State Active Status	4031	4183	4325	4481	4509	4628	4653	4761	4756	4942
Out-of-State Active Status	1076	1388	1309	1655	1577	1888	1757	2084	1868	2251
TOTAL ACTIVE STATUS	5107	5571	5634	6136	6086	6516	6410	6845	6624	7193
Inactive & Retired Statuses	833	834	776	760	781	770	758	748	818	801
TOTAL LICENSED (Active, Inactive & Retired Statuses)	5940	6405	6410	6896	6867	7286	7168	7593	7442	7994

The number of physician assistants increased by a sizeable 12.4% in 2014. The locale of physician assistants trends similarly to the locale of physicians statewide, as is shown on the following table. In 2014, there was growth in Carson City, Clark, Douglas, Elko, Lyon and Washoe Counties, with Churchill and Eureka Counties showing decreases and the remaining nine counties remaining static.

Physician Assistant Licensure Counts (2005-2014)

County	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Carson City	12	14	15	15	14	13	16	17	14	18
Churchill	5	3	6	7	6	4	6	9	10	9
Clark	230	262	271	307	310	332	342	386	398	452
Douglas	8	10	15	15	10	11	9	12	16	17
Elko	3	7	7	6	5	5	5	7	9	10
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	0	1	1	1	1	1	1	1	1	0
Humboldt	1	1	1	1	0	0	0	0	0	0
Lander	1	1	1	1	1	0	1	2	1	1
Lincoln	1	2	3	2	3	3	3	3	3	3
Lyon	4	4	2	4	5	6	6	4	5	6
Mineral	1	1	1	1	1	1	2	2	3	3
Nye	10	10	6	10	6	7	4	4	2	2
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	1	1	1	1	1	1	1	1	2	2
Washoe	61	71	76	83	82	91	91	104	109	121
White Pine	1	1	1	1	1	1	1	1	1	1
TOTAL ACTIVE STATUS	339	389	407	455	446	476	488	553	574	645

The number of respiratory therapists increased by 8.7% in 2014. The largest increases were in Clark and Washoe Counties, with four other counties showing slight increases and the remaining eleven counties remaining static.

Respiratory Therapist Licensure Counts (2005-2014)

County	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Carson City	9	10	9	10	12	12	12	13	12	13
Churchill	8	9	8	8	5	5	4	5	4	4
Clark	557	640	655	743	798	880	920	1006	982	1069
Douglas	12	14	16	18	20	20	18	15	16	16
Elko	7	10	7	7	5	6	8	9	7	8
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	0	0	0	0	0	0	0	0	0	0
Humboldt	3	3	5	5	4	4	5	5	4	4
Lander	2	2	2	3	1	1	1	1	2	2
Lincoln	2	2	2	2	0	0	0	0	0	0
Lyon	19	19	19	20	16	18	15	16	15	16
Mineral	2	2	2	3	3	3	2	2	2	2
Nye	11	10	11	8	10	11	13	12	13	15
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	1	1	0	1	0	0	0	0	0	0
Washoe	151	153	154	163	160	176	192	197	186	202
White Pine	3	3	2	2	3	4	3	3	3	3
TOTAL ACTIVE STATUS	787	878	892	993	1037	1140	1193	1284	1246	1354

The number of perfusionists increased significantly by 16% in 2014, with growth in Clark and Washoe Counties and all other counties remaining static.

Perfusionist Licensure Counts (2010-2014)*

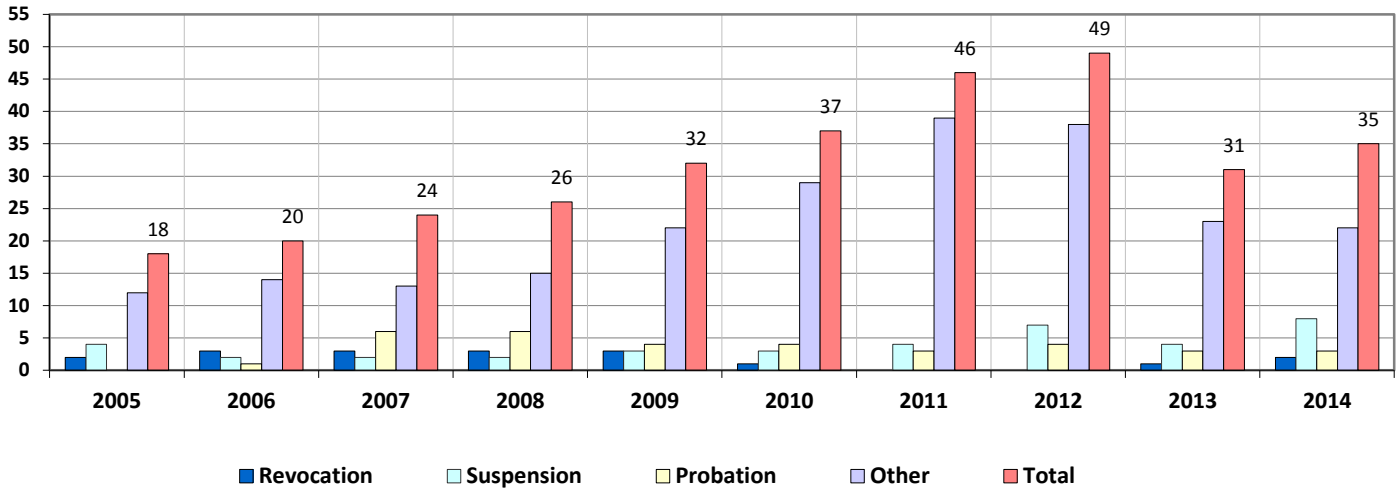
County	2010	2011	2012	2013	2014
Carson City	1	1	1	1	1
Churchill	0	0	0	0	0
Clark	20	19	25	20	23
Douglas	0	0	0	0	0
Elko	0	0	0	0	0
Esmeralda	0	0	0	0	0
Eureka	0	0	0	0	0
Humboldt	0	0	0	0	0
Lander	0	0	0	0	0
Lincoln	0	0	0	0	0
Lyon	0	0	0	0	0
Mineral	0	0	0	0	0
Nye	0	0	0	0	0
Pershing	0	0	0	0	0
Storey	0	0	0	0	0
Washoe	5	5	5	4	5
White Pine	0	0	0	0	0
TOTAL ACTIVE STATUS	26	25	31	25	29

*In 2009, the Nevada State Legislature passed legislation requiring that all perfusionists must be licensed. No perfusionists were licensed by the Board prior to 2010.

COMPLAINTS, INVESTIGATIONS AND DISCIPLINE

In 2014, the Board opened 651 investigations, closed 410 investigations (many of which, of course, originated in preceding years) and imposed 35 disciplinary actions against physicians. The graph below shows the number and types of discipline imposed by the Board regarding physicians for the last ten years.

Disciplinary Actions Taken Against Medical Doctors*

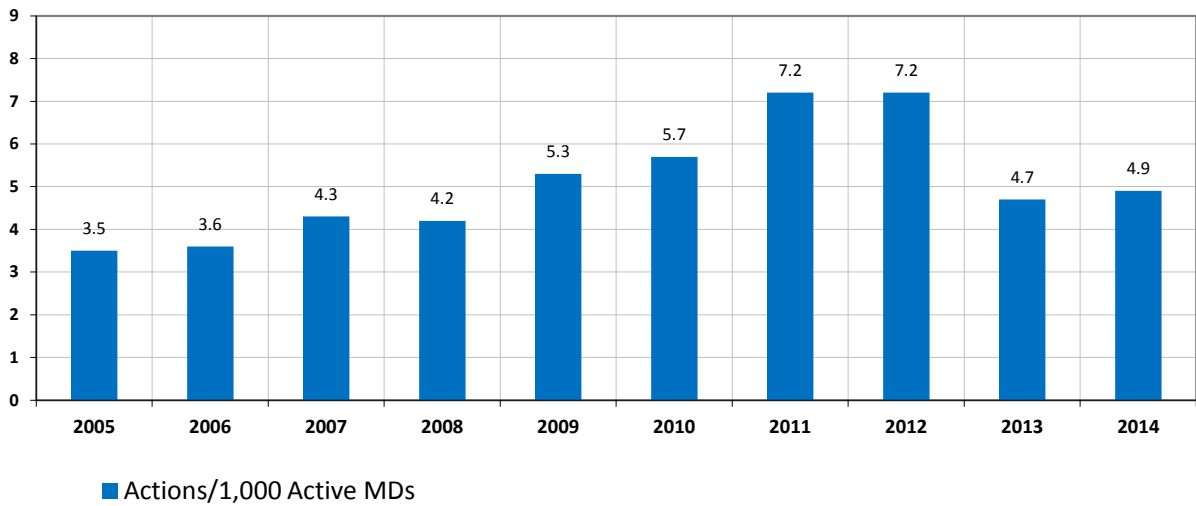


Note: "Other" actions include: Voluntary Surrender of License While Under Investigation, License Restriction, Public Reprimand, License Denial, CME Ordered, Fine, Drug or Alcohol Treatment Program Ordered, and Competency Exam Ordered.

*Any discrepancy in these numbers from a report published by any other source is due to: (1) differences in verbiage or categorization; or (2) differences in the number of actions taken per practitioner.

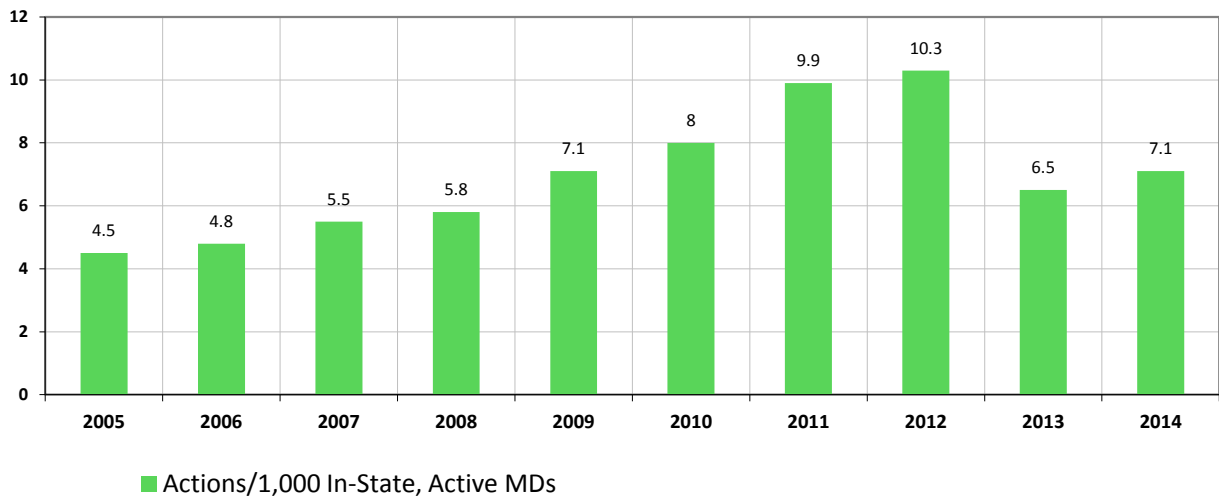
The graph below shows the rate of disciplinary actions taken by the Board per 1,000 active-status licensed physicians for the last ten years.

Rate of Disciplinary Actions Per All Licensed Active-Status Medical Doctors



The graph below shows the rate of disciplinary actions taken by the Board per 1,000 in-state, active-status, licensed physicians for the last ten years.

Rate of Disciplinary Actions Per In-State, Active-Status Medical Doctors



**WHOM TO CALL IF YOU
HAVE QUESTIONS**

Management: Edward O. Cousineau, JD
Executive Director
Todd C. Rich
Deputy Executive Director
Donya Jenkins
Finance Manager

Administration: Laurie L. Munson, Chief

Legal: Erin L. Albright, JD
General Counsel
Alexia M. Emmermann, JD
General Counsel

Licensing: Lynnette L. Daniels, Chief

Investigations: Pamela J. Castagnola, CMBI, Chief

**2015 BME MEETING &
HOLIDAY SCHEDULE**

January 1 – New Year’s Day holiday
January 19 – Martin Luther King, Jr. Day holiday
February 16 – Presidents’ Day holiday
March 6-7 – Board meeting
May 25 – Memorial Day holiday
June 5-7 – Board meeting
July 3 – Independence Day holiday (observed)
September 7 – Labor Day holiday
September 11-12 – Board meeting
October 30 – Nevada Day holiday
November 11 – Veterans’ Day holiday
November 26 & 27 – Thanksgiving/family day holiday
December 4-5 – Board meeting
December 25 – Christmas holiday

Nevada State Medical Association

3660 Baker Lane #101
Reno, NV 89509
775-825-6788
<http://www.nsmadocs.org> website

Clark County Medical Society

2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
<http://www.clarkcountymedical.org> website

Washoe County Medical Society

3660 Baker Lane #202
Reno, NV 89509
775-825-0278 phone
775-825-0785 fax
<http://www.wcmsnv.org> website

Nevada State Board of Pharmacy

431 W. Plumb Lane
Reno, NV 89509
775-850-1440 phone
775-850-1444 fax
<http://bop.nv.gov/> website
pharmacy@pharmacy.nv.gov email

Nevada State Board of Osteopathic Medicine

2275 Corporate Circle, Ste. 210
Henderson, NV 89074
702-732-2147 phone
702-732-2079 fax
www.bom.nv.gov website

Nevada State Board of Nursing

Las Vegas Office
4220 S. Maryland Pkwy, Bldg. B, Suite 300
Las Vegas, NV 89119
702-486-5800 phone
702-486-5803 fax

Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
775-687-7700 phone
775-687-7707 fax
www.nevadanursingboard.org website

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners 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 Blvd., Building A, Suite 1, in Las Vegas.

Hours of operation of the Board are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays.

DISCIPLINARY ACTION REPORT

ACOSTA, Emmanuel, M.D. (10462) **Las Vegas, Nevada**

Summary: Dr. Acosta voluntarily surrendered his license to practice medicine in Nevada.

Statutory Authority: NRS 630.240 [voluntary surrender of license].

Disposition: On June 5, 2015, the Board accepted Dr. Acosta's voluntary surrender of his license to practice medicine in Nevada while under investigation.

HOLPER, Steven A., M.D. (6061) **Las Vegas, Nevada**

Summary: Alleged malpractice and failure to maintain appropriate medical records related to his treatment of a patient.

Charges: One violation of NRS 630.301(4) [malpractice]; five violations of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On June 5, 2015, the Board accepted a Settlement Agreement by which it found Dr. Holper violated NRS 630.3062(1) (2 counts), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count I and the three remaining counts of Count II of the Complaint were dismissed.

KLEIN, Arnold W., M.D. (11881) **Beverly Hills, California**

Summary: Failure to disclose an Accusation filed against him by the Medical Board of California on license reinstatement form.

Charges: One violation of NRS 630.304(1) [obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement].

Disposition: On June 5, 2015, the Board accepted a Settlement Agreement by which it found Dr. Klein violated NRS 630.304(1), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) \$1,000 fine; (3) reimburse-

ment of the Board's fees and costs of investigation and prosecution of the matter.

STACEY, Michelle L., M.D. (11436) **Las Vegas, Nevada**

Summary: Alleged failure to provide adequate supervision of a physician assistant.

Charges: One violation of NAC 630.370(1)(b) [failure to ensure that a physician assistant performed only those medical services that had been approved by her as his supervising physician]; one violation of NAC 630.370(2) [failure to review and initial selected charts of patients of a physician assistant for whom she was the supervising physician]; one violation of NAC 630.370(5) [failure to develop and carry out a program to ensure the quality of care provided by a physician assistant for whom she was the supervising physician]; one violation of NAC 630.230(1)(i) [failure to provide adequate supervision of a physician assistant].

Disposition: On June 5, 2015, the Board accepted a Settlement Agreement by which it found Dr. Stacey violated NAC 630.370(1)(b), NAC 630.370(2), NAC 630.370(5) and NAC 630.230(1)(i), as set forth in the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) \$5,000 fine; (3) 12 hours of CME regarding the topics of supervising physician assistants (6 hours), prescription abuse and overdose (4 hours) and practicing outside one's scope of practice (2 hours); (4) that she agree never to supervise a physician assistant while licensed in Nevada; (5) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter.

VOLKOVA, Irina V., M.D. (14228) **Schenectady, New York**

Summary: Disciplinary action taken against Dr. Volkova's medical license in California, and alleged failure to report said disciplinary action to the Nevada State Board of Medical Examiners.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against her medical license in another state]; one violation of NRS 630.306(11) [failure to report in writing, within 30 days, disci-

plinary action taken against her by another state].

Disposition: On June 5, 2015, the Board accepted a Settlement Agreement by which it found Dr. Volkova violated NRS 630.306(11), as set forth in Count II of the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) \$1,000 fine; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter.

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Public Reprimands Ordered by the Board

Stephen A. Holper, M.D.

June 16, 2015

Steven A. Holper, M.D.
c/o L. Kristopher Rath, Esq.
10080 West Alta Drive, Ste 200
Las Vegas, NV 89145

Dr. Holper:

On June 5, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 14-8552-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), failure to maintain timely, legible, accurate and complete medical records related to your care and treatment of the patient at issue, on two separate occasions. For these violations, you shall receive a public reprimand and pay the fees and costs related to the investigation and prosecution of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Arnold W. Klein, M.D.

June 16, 2015

Arnold W. Klein, M.D.
9615 Brighton Way, Ste M-110
Beverly Hills, CA 90210

Dr. Klein:

On June 5, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 15-31252-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.304(1), obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement. For this violation, you shall receive a public reprimand, pay a \$1,000 fine and pay the fees and costs related to the investigation and prosecution of this Agreement.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Michelle L. Stacey, M.D.

June 16, 2015

Michelle L. Stacey, M.D.
c/o Maria Nutile, Esq.
1070 W. Horizon Ridge Pkwy., Ste. 210
Henderson, NV 89012

Dr. Stacey:

On June 5, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 14-29866-1.

In accordance with the Agreement, the Board entered an Order finding you violated Nevada Administrative Code (NAC) 630.370(1)(b),(2),(5), and NAC 630.230(1)(i), for failing to adequately supervise a physician assistant. For these violations, you shall receive a public reprimand, pay a \$5,000 fine, you shall complete 12 additional hours of CME, you agree that you shall never supervise a physician assistant while licensed in Nevada, and you shall pay the fees and costs related to the investigation, prosecution, and compliance of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Irina V. Volkova, M.D.

June 16, 2015

Irina V. Volkova, M.D.
2150 Rosa Rd. #C4A
Schenectady, NY 12309

Dr. Volkova:

On June 5, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 14-38887-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(11), failure by a licensee to report in writing, within 30 days, any disciplinary action taken against the licensee by another state. For this violation, you shall receive a public reprimand, pay a \$1,000 fine and pay the fees and costs related to the investigation and prosecution of this agreement.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144