NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

VOLUME 57 ★★★ December 2015

Implications of Tam v. The Eighth Circuit Regarding Noneconomic Damages

By: Mistee Arias, JD and Rachel V. Rose, JD, MBA

Introduction

The tort system is designed to hold wrongdoers responsible for injuries to others caused by the wrongdoer's negligent or intentional acts. This system of accountability generally requires the wrongdoer to compensate the injured party by a payment of a monetary award. The scope of such an award can include compensation for loss of income; medical expenses; payment for pain, suffering, and/or disfigurement; and loss of future income.

Tort reform, which encompasses limiting the amount of non-economic damages that can be awarded, has been a topic of discussion for several years.[1] "For example, California insurance regulators can mandate a public hearing when insurers request a rate hike greater than 15%. Illinois, which passed a $500,000 noneconomic damage cap in 2005, requires medical liability insurers to publicly disclose their rates."[2] A recent Nevada Supreme Court Opinion, *Tam v. The Eighth Circuit*, No. 66346 (Nev., Oct. 1, 2015), underscores that this issue remains on the forefront and, in Nevada, the noneconomic damages cap in medical malpractice cases is constitutional. Hence, this article focuses on Nevada's medical malpractice statutes and the implications of *Tam v. The Eighth Circuit*.

FEATURED IN THIS ISSUE:

ALSO IN THIS ISSUE:

Analysis

Tort reform in the area of medical malpractice claims impacts a wide range of stakeholders, including physicians, insurance companies, consumers of medical care and injured patients. In Nevada, both statutes and case law impact medical and professional malpractice, as well as the damages stemming from both. The relevant Nevada Statutes[3] and recent case law[4] will be addressed below.

Nevada Statutes

In order to appreciate the nuances in the law related to malpractice, it is important to discern between the different terms and types of damages as they appear in the Nevada Revised Statutes (NRS). Chapter 41A sets forth the following critical definitions:

- **NRS 41A.007 "Economic damages" defined.** "Economic damages" includes damages for medical treatment, care or custody, loss of earnings and loss of earning capacity. *Article continued on page 3*

MISSION STATEMENT

The Nevada State Board of Medical Examiners serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants, respiratory therapists and perfusionists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board will place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

BOARD NEWS

Victor M. Muro, M.D., Joins Board of Medical Examiners

Dr. Victor M. Muro was appointed by Governor Sandoval to a position on the Board of Medical Examiners effective September 28, 2015.

Dr. Muro is the Medical Director of Optum Medical Partners, Henderson, Nevada, and was previously with Jacobs & Mobader/Caremore Medical Group, Las Vegas, Nevada. He was initially certified by the American Board of Internal Medicine in 1997 and re-certified with the American Board of Internal Medicine in 2007, and is a graduate of UCLA School of Medicine. Dr. Muro is currently an appointee by the State Board of Health as a physician member of the Medical Laboratory Advisory Committee.

The Board welcomes Dr. Muro as a physician member.

Interstate Medical Compact Representatives Gather for Inaugural Meeting

Group begins shaping new streamlined multi-state licensure process for physicians

The Interstate Medical Licensure Compact Commission met on Oct. 27-28 in Chicago to establish an administrative framework for the Interstate Medical Licensure Compact, which offers a streamlined licensing process for physicians interested in practicing medicine in multiple states.

The Compact establishes a voluntary licensing pathway for physicians that eliminates the need to apply separately for a license in more than one state. By significantly streamlining the licensure process, the Compact is expected to expand access to health care – especially to patients in underserved areas of the country – and facilitate new modes of health care delivery, such as telemedicine.

The Interstate Medical Licensure Compact Commission consists of two voting representatives from each state that has enacted the Compact. In its first year of legislative consideration, 12 states have enacted the Compact. As additional states enact the Compact, new representatives will be added to the Commission. The Compact has been endorsed by a broad coalition of health care stakeholders, including the American Medical Association (AMA) and the American Osteopathic Association (AOA).

During its inaugural meeting in Chicago, Commission members adopted temporary bylaws, appointed committees and elected the following officers:

- Chair: Ian Marquand (Montana)
- Vice Chair: Jon Thomas, MD (Minnesota)
- Secretary: Diana Shepard, CMBE (West Virginia)
- Treasurer: Brian Zachariah, MD (Illinois)

The second meeting of the Interstate Medical Licensure Compact Commission was held in Salt Lake City, Utah on December 18, 2015. The next meeting will take place in Minneapolis, Minnesota, March 31 and April 1, 2016.

For more information about the Interstate Medical Licensure Compact, visit: http://licenseportability.org/. To read the Interstate Medical Licensure Compact legislation, click here.

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Public Member - *vacant*

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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.

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- **NRS 41A.009 "Medical malpractice" defined.** "Medical malpractice" means the failure of a physician, hospital or employee of a hospital, in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances.

- **NRS 41A.011 "Noneconomic damages" defined.** "Noneconomic damages" includes damages to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damages.

- **NRS 41A.015 "Professional negligence" defined.** "Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.

In general, economic damages can be ascertained as a sum certain; they are supported by "hard" evidence such as receipts, medical bills, pay stubs and other documentation demonstrating out-of-pocket losses. Speculative economic damages are generally disallowed. Noneconomic damages are less susceptible objective quantification.

Noneconomic damages in medical malpractice actions are subject to a $350,000 statutory cap.[5] The viability of the statutory cap was recently affirmed by the Nevada Supreme Court in the *Tam* case.

Tam v. The Eighth Circuit

The *Tam* case involved a patient who allegedly died as a result of being discharged from care without medications or prescriptions for various medications needed to treat his medical condition, including insulin.

After dismissing various claims, the district court determined that the remaining claims involved medical malpractice, as defined in NRS 41A.009, and therefore was not covered by the statutory cap. The ruling of the lower court was significant because the statutory cap on damages did not contain language specifically extending the cap to medical malpractice. It referenced only "professional negligence."

> [I]n an action for injury or death against a provider of health care based upon professional negligence, the injured plaintiff may recover noneconomic damages, but the amount of noneconomic damages awarded in such an action must not exceed $350,000.[6]

Dr. Tam appealed the case to the Nevada Supreme Court. The Supreme Court considered three issues: Whether the statute violates a plaintiff's constitutional rights; whether the cap applies separately to each cause of action; and whether the statute applies to medical malpractice actions. The court's finding on each of these issues is positive news for medical practitioners.

Constitutionality: The Court determined that the statute passed constitutional muster. The cap did not deprive plaintiffs of the right to a trial by jury, because the cap is applied after the jury has already made a determination that damages should be awarded. Further, the Court determined that the cap did not violate equal protection rights guaranteed by the constitution because "NRS 41A.035's aggregate cap on noneconomic damages is rationally related to the legitimate governmental interest of ensuring that adequate and affordable health care is available to Nevada's citizens."[7]

Number of Caps: The Supreme Court was not persuaded by the argument that the cap should apply separately to each plaintiff for each defendant, thereby, permitting multiple caps in a single case. The Court evaluated the legislative history to determine the intent of the statute and concluded that the cap "applies per incident, regardless of how many plaintiffs, defendants, or claims are involved."[8]

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Cap in medical malpractice claims: Because the statute's language indicated that the cap applies to actions against "…a provider of healthcare based on professional negligence,"[9] the court evaluated the relationship between professional negligence and medical malpractice and concluded that medical malpractice is incorporated into professional negligence. Therefore, the cap would apply equally to medical malpractice cases and professional negligence cases.

Conclusion

The ruling in the *Tam* case provides a measure of protection against irrational and excessive damages awards in medical malpractice cases. With the affirmation of the constitutionality of the cap, the limitation to a single cap, and the assurance that the $350,000 cap applies in medical malpractice cases, practitioners and their insurers have a more predictable measurement of exposure in medical malpractice cases involving noneconomic damages.

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[1] Amy Lynn Sorrel, *AMA analysis reaffirms: Tort reforms work* (Mar. 3, 2008), *available at* http://www.amednews.com/article/20080303/profession/303039964/4/.
[2] *Ibid*.
[3] NRS, CHAPTER 41A - ACTIONS FOR MEDICAL OR DENTAL MALPRACTICE, *available at* http://www.leg.state.nv.us/nrs/nrs-041a.html.
[4] *Tam v. The Eighth Circuit*, No. 66346 (Nev., Oct. 1, 2015).
[5] NRS 41A.035
[6] *Id*. The statute has since been amended to include language consistent with the ruling in the *Tam* case.
[7] *Tam* at 9.
[8] *Tam* at 12.
[9] *Tam* at 13.

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

HHS Releases Security Risk Assessment Tool to Help Providers with HIPAA Compliance

A new security risk assessment (SRA) tool to help guide health care providers in small to medium sized offices conduct risk assessments of their organizations is now available from HHS.

The SRA tool is the result of a collaborative effort by the HHS Office of the National Coordinator for Health Information Technology (ONC) and Office for Civil Rights (OCR). The tool is designed to help practices conduct and document a risk assessment in a thorough, organized fashion at their own pace by allowing them to assess the information security risks in their organizations under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The application, available for downloading at www.HealthIT.gov/security-risk-assessment, also produces a report that can be provided to auditors.

HIPAA requires organizations that handle protected health information to regularly review the administrative, physical and technical safeguards they have in place to protect the security of the information. By conducting these risk assessments, health care providers can uncover potential weaknesses in their security policies, processes and systems. Risk assessments also help providers address vulnerabilities, potentially preventing health data breaches or other adverse security events. A vigorous risk assessment process supports improved security of patient health data.

Conducting a security risk assessment is a key requirement of the HIPAA Security Rule and a core requirement for providers seeking payment through the Medicare and Medicaid EHR Incentive Program, commonly known as the Meaningful Use Program.

"Protecting patients' protected health information is important to all health care providers and the new tool we are releasing today will help them assess the security of their organizations," said Karen DeSalvo, MD, National Coordinator for Health Information Technology. "The SRA tool and its additional resources have been designed to help health care providers conduct a risk assessment to support better security for patient health data."

"We are pleased to have collaborated with the ONC on this project," said Susan McAndrew, Deputy Director of OCR's Division of Health Information Privacy. "We believe this tool will greatly assist providers in performing a risk assessment to meet their obligations under the HIPAA Security Rule."

The SRA tool's website contains a User Guide and Tutorial video to help providers begin using the tool. Videos on risk analysis and contingency planning are available at the website to provide further context.

Available for both Windows operating systems and iOS iPads: Download the Windows version at http://www.HealthIT.gov/security-risk-assessment. Download the iOS iPad version at the Apple App Store (search under "HHS SRA tool").

Note: All HHS press releases, fact sheets and other news materials are available at http://www.hhs.gov/news . Sign up for HHS Email Updates.

VA Makes Changes to Veterans Choice Program

Changes Remove Barriers and Expand Access to Care

WASHINGTON – The Department of Veterans Affairs (VA) announced a number of changes to make participation in the Veterans Choice Program easier and more convenient for Veterans who need to use it. The move, which streamlines eligibility requirements, follows feedback from Veterans along with organizations working on their behalf.

"As we implement the Veterans Choice Program, we are learning from our stakeholders what works and what needs to be refined," said VA Secretary Robert A. McDonald. "It is our goal to do all that we can to remove barriers that separate Veterans from the care they deserve." To date, more than 400,000 medical appointments have been scheduled since the Veterans Choice Program went into effect on November 5, 2014.

Under the old policy, a Veteran was eligible for the Veterans Choice Program if he or she met the following criteria:

- Enrolled in VA health care by 8/1/14 or able to enroll as a combat Veteran to be eligible for the Veterans Choice Program;
- Experienced unusual or excessive burden eligibility determined by geographical challenges, environmental factors or a medical condition impacting the Veteran's ability to travel;
- Determined eligible based on the Veteran's current residence being more than 40 miles driving distance from the closest VA medical facility.

Under the updated eligibility requirements, a Veteran is eligible for the Veterans Choice Program if he or she is enrolled in the VA health care system and meets at least one of the following criteria:

- Told by his or her local VA medical facility that they will not be able to schedule an appointment for care within 30 days of the date the Veteran's physician determines he/she needs to be seen or within 30 days of the date the Veteran wishes to be seen if there is no specific date from his or her physician;
- Lives more than 40 miles driving distance from the closest VA medical facility with a full-time primary care physician;
- Needs to travel by air, boat or ferry to the VA medical facility closest to his/her home;
- Faces an unusual or excessive burden in traveling to the closest VA medical facility based on geographic challenges, environmental factors, a medical condition, the nature or simplicity or frequency of the care needed and whether an attendant is needed. Staff at the Veteran's local VA medical facility will work with him or her to determine if the Veteran is eligible for any of these reasons; or
- Lives in a state or territory without a full-service VA medical facility which includes: Alaska, Hawaii, New Hampshire (Note: this excludes New Hampshire Veterans who live within 20 miles of the White River Junction VAMC) and the United States Territories (excluding Puerto Rico, which has a full-service VA medical facility).

Veterans seeking to use the Veterans Choice Program or wanting to know more about it, can call 1-866-606-8198 to confirm their eligibility and to schedule an appointment. For more details about the Veterans Choice Program and VA's progress, visit: www.va.gov/opa/choiceact.

Clinical Care: Team Innovations in Diabetes Prevention and Control

By: *Marjorie Franzen-Weiss, MPH, CHES*
Diabetes Prevention and Control Program Coordinator, NV Division of Public and Behavioral Health

The number of patients with diabetes, or prediabetes, is escalating to unprecedented rates. Approximately 9.6 percent of Nevadans were diagnosed with diabetes in 2013, as reported by the Centers for Disease Control and Prevention (CDC).[1] Nationally, it is estimated that 27.8 percent of people with diabetes are undiagnosed.[2] In the average primary care practice, up to one-third of patients age 18 and older – and up to half age 65 and older –are at risk for prediabetes.[3] Up to 30 percent of people with prediabetes will develop diabetes within five years.[4-5] People with prediabetes also have an increased risk of heart disease and stroke.[3] Physicians and their care teams can play an important role in helping patients find ways of preventing and controlling type 2 diabetes through education, screening and local referral programs.

Several significant practice innovations were introduced in 2015 relating to diabetes diagnostic codes (ICD-10), screening guidelines and referral protocols to address the diabetes epidemic in the U.S. and Nevada.

In October 2015, the U.S. Preventive Service Task Force (USPSTF) issued the Final Recommendations Statement on *Screening for Abnormal Blood Glucose and Type 2 Diabetes Mellitus.*[6] The USPSTF recommendation statement summarizes the potential benefits, as well as the harmful risks, associated with screening for abnormal blood glucose and type 2 diabetes. This recommendation applies to adults aged 40 to 70 years who are seen in primary care settings and do not have symptoms of diabetes but are overweight or obese. The target population includes persons who are most likely to have glucose abnormalities that are associated with increased cardiovascular disease (CVD) risk and can be expected to benefit from primary prevention of CVD through risk factor modification.

Clinicians should consider earlier screening for persons with one or more of the following characteristics:

- A family history of diabetes;
- A history of gestational diabetes or polycystic ovarian syndrome;
- Or are members of certain racial/ethnic groups (*i.e.*, African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, and Native Hawaiians or Pacific Islanders), who may be at increased risk for diabetes at a younger age or at a lower body mass index.

Glucose abnormalities can be detected by measuring glycated hemoglobin (HbA1c), fasting plasma glucose (FPG), or by administering an oral glucose tolerance test (OGTT). Because HbA1c measurements do not require fasting, they are more convenient than using an FPG or OGTT. The OGTT is done in the morning in a fasting state; blood glucose concentration is measured 2 hours after ingestion of a 75-g oral glucose load. The diagnosis of IFG, IGT or type 2 diabetes should be confirmed; repeated testing with the same test on a different day is the preferred method of confirmation.

The Task Force recommends that clinicians refer patients with abnormal blood glucose levels to intensive programs that can help them lose weight, eat a healthy diet and be physically active. This recommendation is based on a systematic review of studies focusing on the potential benefits and detriments of screening adults at increased risk of high blood sugar and diabetes. They found that by measuring blood sugar levels and treating those who have high levels with intensive lifestyle change programs, their chances of developing diabetes may be reduced. The Task Force also found that intensive lifestyle changes can lead to fewer cases of diabetes and its related complications. The Clinical Guidelines document can be accessed under the "Healthcare Provider Team" tab at: www.NVDiabetesEd.org.

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In line with the USPSTF guidelines and recognizing prediabetes as a critical and serious medical condition, the American Medical Association (AMA) and CDC jointly announced in March 2015 that they have combined forces to take urgent action to **Prevent Diabetes *STAT*. Prevent Diabetes *STAT: S*creen, *T*est, *A*ct - *T*oday**™ is a multi-year initiative that expands on the work each organization has begun to reach more Americans with prediabetes and stop the progression to type 2 diabetes. As an immediate result of this partnership, the AMA and CDC have co-developed the **Prevent Diabetes *STAT*** toolkit to serve as a guide for physicians and other health care providers on the best methods to screen and refer high-risk patients to diabetes prevention programs in their communities. Physicians and their care teams play an important role in diabetes prevention by educating patients about their risk for developing diabetes and referring at-risk patients to an evidence-based diabetes prevention program. The toolkit assists physicians in determining care team roles and responsibilities, as well as practice flow for diabetes prevention in their clinical setting. The Nevada-specific toolkit, along with information on how physicians and other key stakeholders can **Prevent Diabetes STAT,** is available under the "Healthcare Provider Team/Tools for Better Patient Outcomes" tab at: www.NVDiabetesEd.org.

The AMA and CDC recommend five steps for clinicians to follow in helping patients prevent diabetes:

1. **Create awareness** by using toolkit handouts and educational materials to raise awareness among patients, colleagues and clinicians about the evidence-based diabetes prevention program and why it makes sense to screen and refer;
2. **Identify patients with prediabetes** by using the toolkit screening guidelines or retrospectively identifying patients by setting up a query in the electronic health record for patients with a BMI≥ 24 kg/m2 (≥ 22 for Asians) and blood glucose or HbA1C levels in the prediabetes range;
3. **Educate at-risk patients by focusing on four key messages:**
    a. *Prediabetes is a serious condition:* It raises your risk of heart attack and stroke and poses a very high risk of eventually progressing to diabetes;
    b. *Prediabetes is treatable:* The good news is that most patients with prediabetes can avoid or delay developing diabetes by losing weight, becoming more active, and eating a more healthful diet;
    c. *Losing 5-7% of body weight is the goal for prevention; and*
    d. *Evidence-based diabetes prevention programs are available: These programs help people* with prediabetes accomplish these healthy changes, lose weight and avoid developing diabetes.
4. **Refer patients to an evidence-based diabetes prevention program:** See: the "Healthcare Provider Team/ Diabetes Education Providers/Programs" tab at: www.NVDiabetesEd.org for National DPP offerings in Nevada; and
5. **Follow up on weight loss progress** by scheduling three- or six-month follow-up visits with patients to assess their progress toward their weight loss goals, and to address barriers to weight loss and a healthy lifestyle.

The National DPP is a lifestyle intervention program based on research funded by the National Institutes of Health. This program showed, among those with prediabetes, a 58 percent reduction in the number of new cases of diabetes overall and a 71 percent reduction in new cases for those over age 60.[7] Researchers published the findings of the DPP study in the February 7, 2002, issue of the *New England Journal of Medicine*. Additional studies [7, 8] have since been published showing the efficacy of the DPP. Although pharmacological agents, such as metformin, are less effective than lifestyle modification for diabetes prevention, the DPP study[7, 9] found that metformin can reduce the risk of developing diabetes by 31 percent over three years. Lifestyle modification with diet and exercise is approximately twice as effective as metformin for preventing diabetes, especially in older patients.

On June 5, 2015, the American Diabetes Association (ADA), the American Association of Diabetes Educators (AADE), and the Academy of Nutrition and Dietetics released a *Joint Position Statement on Diabetes Self-Management Education and Support in Type 2 Diabetes*[10]. Diabetes self-management education and support (DSME/S) provides the foundation to help people with diabetes to navigate these decisions and activities and has been shown to improve health outcomes. Diabetes self-management education (DSME) is the process of facilitating the knowledge, skill,

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and ability necessary for diabetes self-care. Reimbursement for DSME/S is available from NV Medicare and Medicaid Services and many private payers. However, in order to be eligible for DSME/S reimbursement, DSME/S programs must be either ADA-recognized or AADE–accredited. Referrals for DSME/S must be made by a health care provider and include specified indicators, such as diabetes type, treatment plan, and reason for referral.

The Joint Position Statement provides a diabetes education algorithm of when to identify and refer individuals to DSME/S. The algorithm defines four critical time points for delivery and key information on the necessary self-management skills. The diabetes education algorithm can be used by health care systems, staff or teams, as well as individuals with diabetes, to guide when and how to refer to and deliver/receive diabetes education. The Algorithm of Care relies on five guiding principles and represents how DSME/S should be provided through patient engagement, information sharing, psychosocial and behavioral support, integration with other therapies, and coordinated care.

Also, in June 2015, a companion toolkit to *Prevent Diabetes STAT,* entitled: *Diabetes Self-Management Education: A guide to better outcomes through referral of your patients with diabetes to an Evidence-Based DSME* was introduced in Nevada. The Nevada DSME Toolkit was prepared by an interdisciplinary team of volunteer Certified Diabetes Educators (CDEs) and professional staff at the Nevada Division of Public and Behavioral Health, Diabetes Prevention and Control Program. The DSME Toolkit is designed to assist primary care providers in implementing quality improvement efforts. The toolkit is in line with the Minimum Standards of Care and evidence-based treatment algorithms for detection of diabetes among undiagnosed/asymptomatic individuals. The toolkit also provides the diabetes education algorithms identifying when and how patients should be referred to Diabetes Education Team members, who provide approved DSME Programs that are based on the National Standards for Diabetes Education. The DSME Toolkit and Joint Position Statement can be downloaded under the "Healthcare Provider Team/Tools for Better Patient Outcomes" tab at: www.NVDiabetesEd.org.

Physician involvement is encouraged with the *Nevada Improving Diabetes and Obesity Outcomes Committee* and the *Diabetes Education Stakeholders Workgroup.* For more information contact Marjorie Franzen-Weiss, MPH, CHES.

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U.S. Preventative Task Force Recommends Screening Adults at Increased Risk for Diabetes

Task Force recommends screening as part of a cardiovascular risk assessment in overweight or obese adults ages 40 to 70 years

WASHINGTON, D.C. – The U.S. Preventive Services Task Force (Task Force) published a final recommendation statement on screening to prevent type 2 diabetes, a potentially debilitating illness that has risen in prevalence over the past 15 years. The Task Force recommends screening for abnormal blood glucose in adults ages 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose, also known as abnormal blood sugar, to intensive behavioral counseling interventions to promote healthful diet and physical activity. This is a grade B recommendation. Learn more here.

In 2012, 12 percent of American adults had diabetes and 37 percent had abnormal blood sugar levels that put them at increased risk for developing diabetes and cardiovascular disease. Type 2 diabetes, which occurs when the body cannot maintain a normal blood sugar level, is the most common type of diabetes in the United States. Abnormal blood sugar levels occur when the body does not consistently break down and use sugar adequately.

"Diabetes is a leading cause of heart attacks and strokes" said Task Force member Michael Pignone, MD, MPH. "The good news is, we can identify people at risk and help them make lifestyle changes that may ultimately prevent or delay complications associated with this serious illness."

"Losing weight reduces the chances of developing diabetes, which is why our recommendation focuses on diet and exercise," said Task Force member William Phillips, MD, MPH. "Patients who have abnormal blood sugar levels can be referred to programs that help them eat a more healthful diet and exercise more often."

The Task Force's final recommendation statement has been published online in *Annals of Internal Medicine*, as well as on the Task Force website at www.uspreventiveservicestaskforce.org. A fact sheet that explains the recommendation statement in plain language is also available. A draft recommendation was available for public comment from October 7 to November 3, 2014.

About the USPSTF:

The Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine that works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.

Dr. Pignone is a professor of medicine at the University of North Carolina Department of Medicine and chief of the Division of General Internal Medicine. He also serves as director of the university's Institute for Healthcare Quality Improvement. www.uspreventiveservicestaskforces.org

Dr. Phillips is the Theodore J. Phillips Endowed Professor in Family Medicine and Clinical Professor of health services and epidemiology at the University of Washington, Seattle. Dr. Phillips is also senior associate editor of the *Annals of Family Medicine*.

Contact: *Nicole Raisch at Newsroom@USPSTF.net (202) 572 -2044*

U.S. Preventive Services TASK FORCE

Screening for Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Clinical Summary

Population	**Adults aged 40 to 70 y who are overweight or obese**
Recommendation	**Screen for abnormal blood glucose. Offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.** **Grade: B**

Risk Assessment	Risk factors for abnormal glucose metabolism include overweight and obesity or a high percentage of abdominal fat, physical inactivity, and smoking. Abnormal glucose metabolism is also frequently associated with other cardiovascular risk factors, such as hyperlipidemia and hypertension.
Screening Tests	Glucose abnormalities can be detected by measuring hemoglobin A_{1c} or fasting plasma glucose or with an oral glucose tolerance test. Diagnosis of IFG, IGT, or type 2 diabetes should be confirmed with repeated testing (the same test on a different day is the preferred method of confirmation).
Screening Interval	Evidence on the optimal rescreening interval for adults with an initial normal glucose test is limited. Studies suggest that rescreening every 3 y may be a reasonable approach.
Treatment and Interventions	Effective behavioral interventions combine counseling on a healthful diet and physical activity and involve multiple contacts over extended periods. There is insufficient evidence that medications have the same benefits as behavioral interventions.
Balance of Benefits and Harms	The overall benefit of screening for IFG, IGT, and diabetes and implementing intensive lifestyle interventions is moderate.
Other Relevant USPSTF Recommendations	The USPSTF recommends screening and appropriate interventions for modifiable risk factors for cardiovascular events (overweight and obesity, physical inactivity, abnormal lipid levels, high blood pressure, and smoking). These recommendations are available on the USPSTF Web site (www.uspreventiveservicestaskforce.org).

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.

Abbreviations: IFG = impaired fasting glucose; IGT = impaired glucose tolerance.

Industry-Financed Clinical Trials on the Rise, As Number of NIH-Funded Trials Falls

RESEARCHERS CONCERNED ABOUT TRENDS IN RESEARCH FUNDING AS COMMERCIAL VENTURES RUN SIX TIMES MORE TRIALS THAN ACADEMIC INVESTIGATORS

Since 2006, the number of industry-sponsored clinical trials studying the benefits and harms of medical treatments has risen dramatically, while the number of clinical trials funded by the National Institutes of Health (NIH) has fallen substantially, according to new Johns Hopkins Bloomberg School of Public Health research.

The researchers say that the findings, published in the December 15, 2015 *Journal of the American Medical Association (JAMA)*, suggest a growing influence of clinical trials being conducted by companies with a vested interest in the outcome and a dilution of the impact of government-funded trials. Results from NIH-funded clinical trials often provide the basis for prevention and treatment recommendations.

"My concern is that independent trials are on the decline and *that* means we have less high-quality data to inform public health that are not influenced by commercial interests," says study leader Stephan Ehrhardt, MD, MPH, an associate professor in the Bloomberg School's Department of Epidemiology. "When I am doing a government-funded trial comparing two treatments, I start with the assumption that both treatments are equal. I don't have a vested financial interest in the outcome.

"But when I am a drug company testing my new product, my objectivity can be compromised by the company's bottom line since it costs me millions of dollars to develop and test my product to get it on the market. It might be difficult for me to be completely objective. The stakes are very high."

For the study, Ehrhardt and his colleagues searched ClinicalTrials.gov for "interventional study" and then searched by funder type for trials registered between 2006 and 2014. The number of newly registered industry-sponsored trials increased 43 percent over the time period from 4,585 in 2006 to 6,550 in 2014. The number of newly registered NIH-funded trials decreased 24 percent over the same period from 1,376 in 2006 to 1,048 in 2014. Both NIH and industry trials are required to be registered if researchers intend to publish the results. ClinicalTrials.gov is the world's largest online registry.

Clinical trials are research studies conducted in human subjects. Trials take many forms. In general, trial participants agree to be randomized to receive either a new therapy or a conventional therapy (or placebo). Some trials test three or more interventions. While many trials test new drugs, trials can also test treatment approaches (medical therapy versus surgical therapy) or lifestyle modifications (one diet versus another). Pharmaceutical companies generally test their own products.

Ehrhardt says he believes that the decline in NIH-funded studies can be traced to two things: Flat NIH funding (the 2014 budget was 14 percent less than in 2006, after adjusting for inflation) and greater competition for these limited dollars from other, relatively new research areas such as genomic research or personalized medicine studies.

"We need a discussion on how to best allocate our health-related research budgets," Ehrhardt says. "What best informs public health? It's probably clinical trials in large populations, such as testing to see if a reduced-salt diet reduces blood pressure. That study changed the way people eat and helped to reduce hypertension in many people. Industry would never do that. They'd have no interest in a reduced-salt diet. There's no money in that."

"Trends in National Institutes of Health Funding for Clinical Trials Registered in ClinicalTrials.gov" was written by Stephan Ehrhardt, MD, MPH, Lawrence J. Appel, MD, MPH, and Curtis L. Meinert, PhD. The researchers have received NIH and/or industry funding to conduct clinical trials.

Media contacts for the Johns Hopkins Bloomberg School of Public Health:
Stephanie Desmon at 410-955-7619 or sdesmon1@jhu.edu and Barbara Benham at 410-614-6029 or bbenham1@jhu.edu

INVESTIGATIVE COMMITTEE STATS 2014

Investigative Committee A

Total Cases Considered	475
Total Cases Authorized for Filing of Formal Complaint (to be Published)	23
Total Cases Authorized for Peer Review	27
Total Cases Requiring an Appearance	39
Total Cases Authorized for a Letter of Concern	116
Total Cases Authorized for Further Follow-up or Investigation	22
Total Cases Reviewed for Compliance	2
Total Cases Authorized for Closure	246

Investigative Committee B

Total Cases Considered	271
Total Cases Authorized for Filing of Formal Complaint (to be Published)	11
Total Cases Authorized for Peer Review	24
Total Cases Requiring an Appearance	6
Total Cases Authorized for a Letter of Concern	60
Total Cases Authorized for Further Follow-up or Investigation	5
Total Cases Reviewed for Compliance	1
Total Cases Authorized for Closure	164

INVESTIGATIVE COMMITTEE STATS 2015

Investigative Committee A, Year to Date

Total Cases Considered	387
Total Cases Authorized for Filing of Formal Complaint (to be Published)	17
Total Cases Authorized for Peer Review	27
Total Cases Requiring an Appearance	28
Total Cases Authorized for a Letter of Concern	117
Total Cases Authorized for Further Follow-up or Investigation	13
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	185

Investigative Committee B, Year to Date

Total Cases Considered	331
Total Cases Authorized for Filing of Formal Complaint (to be Published)	5
Total Cases Authorized for Peer Review	20
Total Cases Requiring an Appearance	8
Total Cases Authorized for a Letter of Concern	85
Total Cases Authorized for Further Follow-up or Investigation	7
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	206

LICENSING STATS 2014

In 2014, the Board issued the following total licenses:

- 576 physician licenses
- 121 limited licenses for residency training
- 97 physician assistant licenses
- 160 practitioner of respiratory care licenses
- 11 perfusionist licenses

LICENSING STATS 2015 – *YEAR TO DATE (12/16/2015)*

For the year to date, the Board has issued the following licenses:

- 587 physician licenses
- 130 limited licenses for residency training
- 100 physician assistant licenses
- 146 practitioner of respiratory care licenses
- 11 perfusionist licenses

Touro University Nevada

College of Osteopathic Medicine

is pleased to present a FREE live CME Activity on:

Saturday, January 9, 2016
9 am to 11:15 am
Registration will begin at 8:30 am

Clark County Medical Society Building
2590 E. Russell Road
Las Vegas, Nevada 89120

2015 Legislative Update, Pain Medication Misuse/Abuse, and Related Ethical Issues

Welcome and Introduction by Loretta Moses,
Executive Director of the Clark County Medical Society

Presenters:

Mitchell Forman, DO, FACR, FACOI, MACP
Dean, College of Osteopathic Medicine
Touro University Nevada

Weldon (Don) Havins, MD, JD, FACS
Assoc. Dean & Professor, Medical Jurisprudence, COM
Touro University Nevada

This live CME activity is designed for physicians and other interested healthcare practitioners, to increase knowledge, enhance clinical competence and ultimately improve patient care by examining the new 2015 legislative mandates related to the practice of medicine and medical ethics.

Following the activity, participants should be able to:

- Describe new mandates in controlled substance prescribing
- Name two changes to Nevada's medical tort reform laws
- Differentiate between telemedicine and telehealth
- Describe new licensing advantages for veterans
- Identify and discuss medical ethical issues related to the 2015 legislative updates

Register online by Monday, January 4, 2016 at:

http://clarkcountymedical.org/rsvp3.php

or by phone to 702-739-9989

Special thanks to our friends at CCMS for hosting the event at their facility!

CME Accreditation and Designation Touro University Nevada College of Osteopathic Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Touro University Nevada College of Osteopathic Medicine designates this live educational activity for a maximum of **2.25** *AMA PRA Category 1 Credit(s)™.* Physicians should only claim credit commensurate with the extent of their participation in the activity.

Osteopathic Continuing Education Credit Touro University Nevada College of Osteopathic Medicine is accredited by the American Osteopathic Association. This course is approved for **2.25** Category 1-A credits.

Ethics Credit: This activity maybe use toward fulfilling the Nevada State Board of Medical Examiners requirement for medical ethics and pain management.

In Collaboration
Nevada Psychiatric Association & Clark County Medical Society

Earn 2 CME

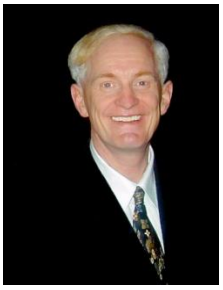
INCLUDES DINNER

S U I C I D E

Prevention & Ethics of Assisted Suicide

Laura B. Dunn, M.D.
Professor of Psychiatry
Dept. of Psychiatry & Behavioral Sciences
Stanford University

Laura B. Dunn, M.D. is Professor of Psychiatry in the Department of Psychiatry and Behavioral Sciences at Stanford University. Prior to moving to Stanford, she was Professor of Psychiatry, Director of Psycho-Oncology, and the Gloria Hubner Endowed Chair in Psycho-Oncology in the Department of Psychiatry at UCSF. She is a Board Certified Geriatric Psychiatrist with extensive research and clinical experience in the evaluation and management of older adults with neuropsychiatric disorders. She has expertise in clinical care and research in psycho-oncology and palliative care, and is an internationally-recognized expert on ethical issues in the conduct of clinical research.



David V. Sheehan, M.D., MBA
Distinguished University Health
Professor Emeritus
University of South Florida

David V. Sheehan, M.D., M.B.A. is Distinguished University Health Professor Emeritus at the University of South Florida College of Medicine. He was Professor of Psychiatry, Director of Psychiatric Research and Director of the Depression and Anxiety Disorders Research Institute at the University of South Florida College of Medicine and Professor of Psychology at the University of South Florida College of Arts and Sciences.

Earn 2 CME

Meets requirement for
Ethics & Suicide Prevention

University of Nevada School of Medicine

CME Accreditation and Designation

The University of Nevada School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The University of Nevada School of Medicine designates this live activity for a maximum of 2.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nursing
The University of Nevada School of Medicine approves this program for 2.00 hours of nursing continuing education credit.

Disclosure: It is the policy of NPA and UNSOM to comply with the ACCME standards for commercial support of CME. Planning Committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in jointly sponsored programs by UNSOM are required to disclose to the program audience any real or apparent conflict of interest related to the content of their presentation. Faculty also are responsible for disclosing any discussion of off-label or investigational use of a product. In accordance with the ACCME requirements on disclosure, information and relationships of presenters with commercial interests, if any, will be included in materials distributed at the time of the conference.

Wednesday, February 10, 2016
Bally's Las Vegas

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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:	Robert Kilroy, JD General Counsel
Licensing:	Lynnette L. Daniels, Chief
Investigations:	Pamela J. Castagnola, CMBI, Chief

2016 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day holiday
January 18 – Martin Luther King, Jr. Day holiday
February 15 – Presidents' Day holiday
March 4-5 – Board meeting
May 30 – Memorial Day holiday
June 3-4 – Board meeting
July 4 – Independence Day holiday
September 5 – Labor Day holiday
September 9-10 – Board meeting
October 28 – Nevada Day holiday
November 11 – Veterans' Day holiday
November 24 & 25 – Thanksgiving/Family Day holiday
December 2-3 – Board meeting (Las Vegas)
December 26 – Christmas holiday (observed)

Nevada State Medical Association
3700 Barron Way
Reno, NV 89511
775-825-6788
http://www.nvdoctors.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
3700 Barron Way
Reno, NV 89511
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

ROHRER, Heather L., PA-C (PA789)
Las Vegas, Nevada

Summary: Alleged unlawful prescribing of a controlled substance and failure to maintain appropriate medical records related to her treatment of a patient.

Charges: One violation of NRS 630.306(3) [administering, dispensing or prescribing a controlled substance to or for herself or to others except as authorized by law]; one violation 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 December 4, 2015, the Board accepted a Settlement Agreement by which it found Ms. Rohrer violated NRS 630.306(3), as set forth in Count I of the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) 10 hours of continuing medical education (CME) in both of the following categories: prescribing controlled substances and medical record keeping; the aforementioned hours of CME shall be in addition to any CME requirements as a condition of licensure in the state of Nevada; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter; (4) reimbursement for reasonable costs and expenses incurred by the Board in monitoring her compliance with the Settlement Agreement. Count II of the Complaint was dismissed with prejudice.

EGTEDAR, Ascar, M.D. (3055)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On November 19, 2015, the Investigative Committee summarily suspended Dr. Egtedar's license until further order of the Investigative Committee or the Board of Medical Examiners.

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Public Reprimands Ordered by the Board

Heather L. Roherer, PA-C

December 10, 2015

Heather L. Rohrer, PA-C.
c/o Matthew W. Hoffmann, Esq.
Atkinson, Watkins & Hoffmann
10789 W. Twain Avenue, Suite 100
Las Vegas, NV 89135

Dear Ms. Rohrer:

On December 4, 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 15-28202-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(3) when you prescribed a controlled substance to others except as authorized by law.

For this violation, you shall be publicly reprimanded; you shall take 10 hours of continuing medical education (CME) in both of the following categories: prescribing controlled substances and medical record keeping as the aforementioned hours of CME shall be in addition to any CME requirements as a condition of licensure in the state of Nevada. In addition, you shall pay the fees and costs related to the investigation and prosecution of this matter, as well as reimburse the Board for any further costs incurred in monitoring your compliance with 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

★ ★ ★

NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144