



## Human Trafficking: What Every Healthcare Provider Needs to Know

By: Rachel V. Rose, JD, MBA

### Overview

Human trafficking, sex trafficking, as well as the campaigns to thwart these heinous acts, are terms that are becoming more prevalent. From airports, to international not-for-profit humanitarian organizations, to local governments, many entities are joining forces to combat these unpalatable activities. In order to begin addressing the issue, it is helpful to understand the differences and similarities between human trafficking and sex trafficking. According to the U.S. Department of Immigration and Customs Enforcement, *Trafficking in Persons*<sup>1</sup> is defined as:

- Sex trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery.

Overall, human trafficking can be thought of in a broader sense – meaning that the purpose behind enslaving an individual is not solely limited to sexual purposes. In turn, sex trafficking has a more narrow purpose – to enslave an adult or a child solely for the purpose of commercial sexual acts. Victims of both types of trafficking may show physical, mental and emotional signs of abuse. The American Medical Association’s (AMA) policy, H-65.966, [Physicians Response to Victims of Human Trafficking](#), clearly encourages raising awareness about human trafficking. The policy specifically states that “physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.”<sup>2</sup> Notably, the AMA’s policy has been cited by governments throughout the world.

Therefore, the purpose of this article is to raise awareness in the medical community, just as United Nations International Children’s Emergency Foundation (UNICEF) is doing on a broader scale through their [End Trafficking Campaign](#), as well as to give physicians different avenues to embark on if a victim presents as a patient in an office, hospital, clinic or other medical treatment facility.

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### 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

## BEFORE YOU RENEW!

**MEDICAL DOCTORS:** Pursuant to Nevada Revised Statute 630.30665, you are required to submit to the Nevada State Board of Medical Examiners the requisite in-office surgery reporting form for the period of January 1, 2015 through December 31, 2016, **prior** to renewing your license in 2017, and you will be required to attest on your renewal application that you have submitted the form. Forms are available on the Board's website. Further information can be found on pages 12 and 13 of this Newsletter.

## HOW TO RENEW!

You must renew your license before 5:00 PDT, June 30, 2017. Please ensure the Board has your current mailing address! Licensees will receive a renewal notification which includes **individual** renewal information. Please retain your notification for renewal purposes, as you will need the information contained thereon (such as your Renewal I.D.) in order to renew your license online. There is a \$10 administrative processing fee included for online renewals and a \$30 administrative processing fee for renewals by paper application. The administrative processing fee will be waived for those licensees who are not eligible to renew online in 2017. Once renewed, licenses are valid from July 1, 2017 – June 30, 2019\*.

### Fees are as follows:

	Online Renewal Fee	Paper Renewal Fee
Active Medical Doctors	\$760	\$780
Inactive Medical Doctors	\$385	\$405
Physician Assistants	\$385	\$405
Perfusionists	N/A	\$375
Practitioners of Respiratory Care	\$195	\$215

Online, you can pay with American Express, Discover, MasterCard or Visa. By paper, you can pay with personal check, money order, cashier's check or the above-listed credit cards (no cash please).

Perfusionists are not eligible for online renewal in 2017 and will receive their renewal applications in the mail. The administrative processing fee will be waived for these licensees in 2017.

All licensees are subject to a random audit of their CME/CE, which includes licensees who are renewing by paper application. If you are selected to provide proof of completion of your continuing medical education (CME)/continuing education (CE) at the time you renew online, and cannot satisfy the CME/CE requirement, your license **will not** be renewed, and you will be mandatorily audited the next renewal period. Word to the wise: please have your CME/CE up to date. Further information regarding CME/CE requirements can be found on the [Board's website](#).

*\*Renewing licensees who currently hold a Visa, Employment Authorization or Conditional Resident Alien Card are required to fax proof of extension of their immigration status to licensing staff at (775) 688-2551, prior to renewal of their licenses. Licenses are only valid for the duration of the existing immigration status, which is verified through USCIS, and if extended by USCIS may be valid until June 30, 2019.*

## BOARD MEMBERS

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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.

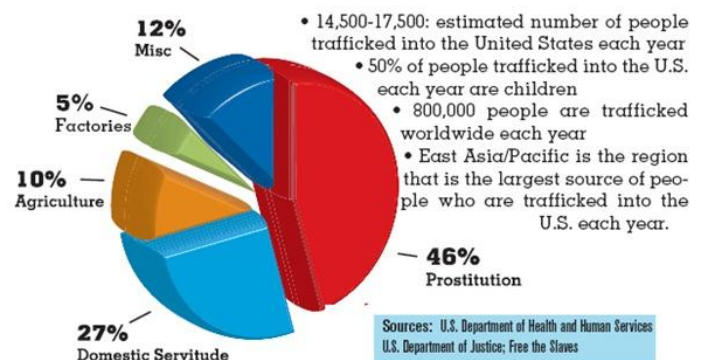
## Analysis

As UNICEF explains, trafficking is not a phenomenon that is limited to people living outside of the United States. To the contrary, not only is the United States a source of trafficking, it ranks among the top destinations for victims. To this end, trafficking has been reported in all 50 states. “[A]nyone can be trafficked regardless of race, class, education, gender, age, or citizenship when forcefully coerced or enticed by false promises.”<sup>3</sup> In a concerted effort to raise awareness, UNICEF, in conjunction with the International Labour Office, published the [Training Manual to Fight Trafficking In Children for Labour, Sexual and Other Forms of Exploitation](#) (*Training Manual*). This is an excellent resource for understanding the global nature of the issue, various conventions, as well as risk factors and vulnerabilities. Given that any patient could potentially be a trafficking victim, the *Training Manual* serves as an extensive and broad resource.

In January 2017, the AMA published a series of ethics cases penned by various authors in its [Journal of Ethics](#).<sup>4</sup> Below is a synopsis of four significant ethics cases pulled from those articles, which appeared in that edition of the AMA’s *Journal of Ethics*. These cases create a pathway for the practitioner to walk beginning with considering who is in the waiting room, continuing on to caring for the trafficked patient, then, moving forward to addressing insights and avoiding “diagnostic overshadowing”, and ending with legal and ethical considerations for physicians.

### Case A. Who Is in Your Waiting Room? Healthcare Professionals as Culturally Responsive and Trauma-Informed First Responders to Human Trafficking.<sup>5</sup>

This article’s focus is on the notion of a lack of evidence-based practices for potential victims of human trafficking and the heightened role of bioethics in filling the gap. By combining ethics with the law, physicians and patients can protect themselves, while impacting the larger problem. “According to Beauchamp and Childress, the fundamental principles governing physician-patient relationships are beneficence (the obligation to prevent harm and promote good), nonmaleficence (the obligation to do no harm), justice (the obligation to provide others with whatever they are owed or deserve), and autonomy (the obligation to respect the self-determination of other persons).<sup>6</sup> These principles are important directives for healthcare professionals faced with a potential victim of human trafficking in a healthcare setting, and they guide and form the foundation for any effective response.” These fundamentals of bioethics should be utilized by physicians as part of their algorithm for treating patients who may be potential human trafficking victims.



One step towards a more evidence-based approach was taken by the U.S. Department of Health and Human Services (HHS) in 2008. “[Stop. Observe. Ask. Respond to Human Trafficking \(SOAR\) to Health and Wellness Training](#) was created to educate healthcare professionals and other community leaders about human trafficking and victim identification.” The article identifies gaps on the provider side (e.g., not having adequate trauma training or knowing what questions to ask and who to report to) and on the patient side (e.g., fear and lying).<sup>7</sup> In sum, there are still areas that should be addressed from an evidenced-based standpoint in relation to patients who may be victims of human trafficking; however, there is more awareness now than ever before and that is positive for both the physician and the patient.

### Case B. Caring for the Trafficked Patient: Ethical Challenges and Recommendations for Healthcare Professionals.<sup>8</sup>

To say that human trafficking is morally repulsive and an egregious human rights violation is an understatement. Words cannot express the heinous nature of sex trafficking in particular, especially of children. Yet, the number of victims that access the healthcare system is staggering. “Research suggests that up to 87.8 percent of trafficked persons access healthcare. Healthcare visits represent unique opportunities for healthcare professionals to provide clinical care and offer assistance to victims and survivors of trafficking.”<sup>9</sup>

One theme that resonates throughout this article is that the injuries and illnesses stem beyond physical and the patient’s treatment plan is complex. A solution-based approach will need to intertwine and, in many instances, parallel the concepts of ethics of care and a trauma-informed approach. This is a prudent path for physicians to consider. In doing so, physicians are acting in the best interest of the patients, uncovering items that may need to be disclosed to the authorities and taking one more victim out of the vicious cycle of human trafficking.

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**Case C. Human Trafficking, Mental Illness, and Addiction: Avoiding Diagnostic Overshadowing.**<sup>10</sup>

In this case study, Dr. Shah, an emergency department resident in New York City was confronted with a situation similar to one that she had previously read about. “Dr. Shah had recently read about a case in which a 14-year-old girl had been to the emergency department for treatment and had told the staff she was being sex trafficked. The man accompanying the girl had also claimed she had schizophrenia. The clinicians believed the man and discharged the girl to his care; he was later found to be trafficking girls into commercial sex. The girl was not rescued until police found her bound in a closet during a drug raid weeks later.” Sadly, this scenario is not an unusual occurrence. Dr. Shah wondered what to do.

Knowledge of a trauma-informed approach to care is critical. The authors ultimately conclude: “[t]rauma-informed approach to care [is] [a]ny patient encounter involves obtaining and analyzing subjective and objective data with varying degrees of uncertainty and using this information to formulate a care plan. However, in cases of potential human trafficking, like this one, the stakes are particularly high, underlining the need for a protocol, and a multidisciplinary approach that is survivor-centered, culturally relevant, evidence-based, gender-sensitive and trauma-informed.” This article establishes that treating a person who is a human trafficking victim is complex and trauma and interpersonal violence protocols should be in place. For physicians looking for examples of protocols and steps to approach the physical, mental and emotional well-being of the patient within the legal requirements, this article is an excellent starting point.

**Case D. Physician Encounters with Human Trafficking: Legal Consequences and Ethical Considerations.**<sup>11</sup>

In this case study, the physician is faced with treating a woman for a sexually transmitted infection (STI), with the caveat that she treats other employees of the couple, whose job is to “employ and manage several young women as sex workers.” The couple asks that no medical records be kept and that compensation should be provided. “Dr. W. feels torn: she wants to give the women the best care possible while also protecting the community from the possible spread of STIs. But she also worries that, by agreeing to terms set by the couple who employs and manages these women (who might be trafficked and some of whom might be minors), she might be complicit in their exploitation.”

This vignette poses a multitude of legal issues; however, the author narrowed the scope to the following areas: “criminal law, with a focus on conspiracy; service provider regulations, with a focus on mandatory reporting laws; and human rights law.” In order to prove criminal conspiracy, four elements must be met:

1. An objective;
2. A plan showing the means to accomplish that objective;
3. An agreement between two or more people to cooperate to achieve that objective; and
4. An overt act in furtherance of the crime.<sup>12</sup>

According to a referenced law review article, in order to determine whether the four elements of conspiracy are met, the following clarifying items need to be established: (1) the physician knows of the crime and (2) either (a) he/she intends to participate, (b) the crime is very harmful, and/or (c) he/she has a “stake” in the crime.<sup>13</sup> Ultimately, although well intentioned, Dr. W. decided to treat the individual and did not report. In doing so the four elements of criminal conspiracy were met, as well as the additional knowledge elements. This would have resulted in both criminal penalties and human rights violations by the physician.

**Reporting In Nevada**

Nevada and the United States have a multitude of laws addressing both human trafficking and sex trafficking.<sup>14</sup> For example, the initial federal law, the Trafficking Victims Protection Act (TVPA) of 2000, has been through three reauthorizations. In turn, this law increases society’s power both to address needs of victims and open a path to justice. [The Nevada Attorney General’s website](#) provides contact information for physicians, as well as the community at large.<sup>15</sup>



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Here are a few helpful entities provided on the Nevada Attorney General's website:

### Report Instances of Human Trafficking -

- The National Human Trafficking Resource Center Hotline - 888-373-7888 - The National Human Trafficking Resource Center (NHTRC) is a national, toll-free hotline, available to answer calls from anywhere in the country, 24 hours a day, 7 days a week, every day of the year. They are not a government entity, law enforcement or an immigration authority.
- The U.S. Department of Justice Hotline - 888-428-7581.
- U.S. Immigration and Customs Enforcement Victim Assistance Program - 866-872-4973.
- Local authorities.
- Polaris Project, [www.polarisproject.org](http://www.polarisproject.org)

### Victim Service Providers -

- AwakenReno, Reno, NV - 775-393-9183.
- Facts NV - Family and Child Treatment of Southern Nevada, Las Vegas, NV - 702-258-5855.
- The Embracing Project, Las Vegas, NV – 702-463-6929.
- Hopelink, Henderson, NV – 702-466-0576.

This issue is uncomfortable to both discuss and to address. Physicians, as well as other providers, can and do play a crucial role in helping victims directly. Because human trafficking carries criminal penalties, it is incumbent upon medical professionals to report.

### Conclusion

In sum, trafficking is a complex issue with no borders. As an initial step, physicians should educate themselves on the basics of trafficking. From there, the clinical aspects of care and reporting should be considered. Finally, legal and ethical considerations dictate certain courses of action. Hopefully, this article raises awareness within the medical community so that patients will not only receive thoughtful care, but also by reporting to legal authorities, a bigger impact may be made in combating these forms of modern-day abuse and slavery.

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Ms. Rose has a unique background, having worked in many different facets of healthcare, securities and international law and business throughout her career. She is published and presents on a variety of topics including: Dodd-Frank, the False Claims Act, the Foreign Corrupt Practices Act, physician reimbursement, women's health, ICD-10, access to care, anti-kickback and Stark laws, international comparative laws, cyber security and the HIPAA/the HITECH Act. Her practice focuses on a variety of cyber security, healthcare and securities law issues related to industry compliance, transactional work and Dodd-Frank/False Claims Act whistleblower claims, which remain under seal.

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. She is licensed to practice in Texas. She has co-authored various books and book chapters, including the American Bar Association's *What Are International HIPAA Considerations?* Currently, she is on the Executive Committee of the Federal Bar Association's *Qui Tam* Section and a member of the Government Relations Committee. Ms. Rose is an Affiliated Member with the Baylor College of Medicine's Center for Medical Ethics and Health Policy, where she teaches bioethics. She also serves on the Southwest Regional Board for UNICEF. She can be reached at [rvrose@rvrose.com](mailto:rvrose@rvrose.com).

<sup>1</sup> <https://www.ice.gov/human-trafficking> (last visited March 11, 2017).

<sup>2</sup> Commission on Security and Cooperation in Europe, *Best Practices for Rescuing Trafficking Victims* (Dec. 2, 2015), citing the AMA's Policy H-65.966 [https://www.csce.gov/sites/helsinkicommission.house.gov/files/Best%20Practices%20for%20Rescuing%20Trafficking%20Victims\\_0.PDF](https://www.csce.gov/sites/helsinkicommission.house.gov/files/Best%20Practices%20for%20Rescuing%20Trafficking%20Victims_0.PDF) (last visited Feb. 9, 2017).

<sup>3</sup> <https://www.unicefusa.org/mission/protect/trafficking> (last visited Feb. 8, 2017).

<sup>4</sup> American Medical Association, *AMA Journal of Ethics*, Vol. 19, No. 1 (Jan. 2017), available at <http://journalofethics.ama-assn.org/2017/01/toc-1701.html>.

<sup>5</sup> <http://journalofethics.ama-assn.org/2017/01/pfor2-1701.html> (last visited Feb. 9, 2017).

<sup>6</sup> Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 2nd ed. New York, NY: Oxford University Press; 1983.

<sup>7</sup> <http://www.acf.hhs.gov/endtrafficking/initiatives/soar> (last visited Feb. 9, 2017).

<sup>8</sup> <http://journalofethics.ama-assn.org/2017/01/pfor2-1701.html> (last visited Feb. 9, 2017).

<sup>9</sup> Lederer LJ, Wetzel CA. *The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities*, *Ann Health Law*. 2014;23(1):61-87; *Turning pain into power: trafficking survivors' perspectives on early intervention strategies*. *Family Violence Prevention Fund*, <https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Turning%20Pain%20intoPower.pdf> (last visited Feb. 9, 2017); Chisolm-Straker M, Baldwin S, Gaïgbé-Togbé B, Ndukwe N, Johnson PN, Richardson LD. *Health care and human trafficking: we are seeing the unseen*, *J Health Care Poor Underserved*. 2016;27(3):1220-1233; and Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. *Identification of human trafficking victims in health care settings*, *Health Hum Rights*, 2011.

<sup>10</sup> <http://journalofethics.ama-assn.org/2017/01/ecas3-1701.html> (last visited Feb. 9, 2017).

<sup>11</sup> <http://journalofethics.ama-assn.org/2017/01/ecas2-1701.html> (last visited Feb. 9, 2017).

<sup>12</sup> 15A CJS *Conspiracy* sec 116 (2016).

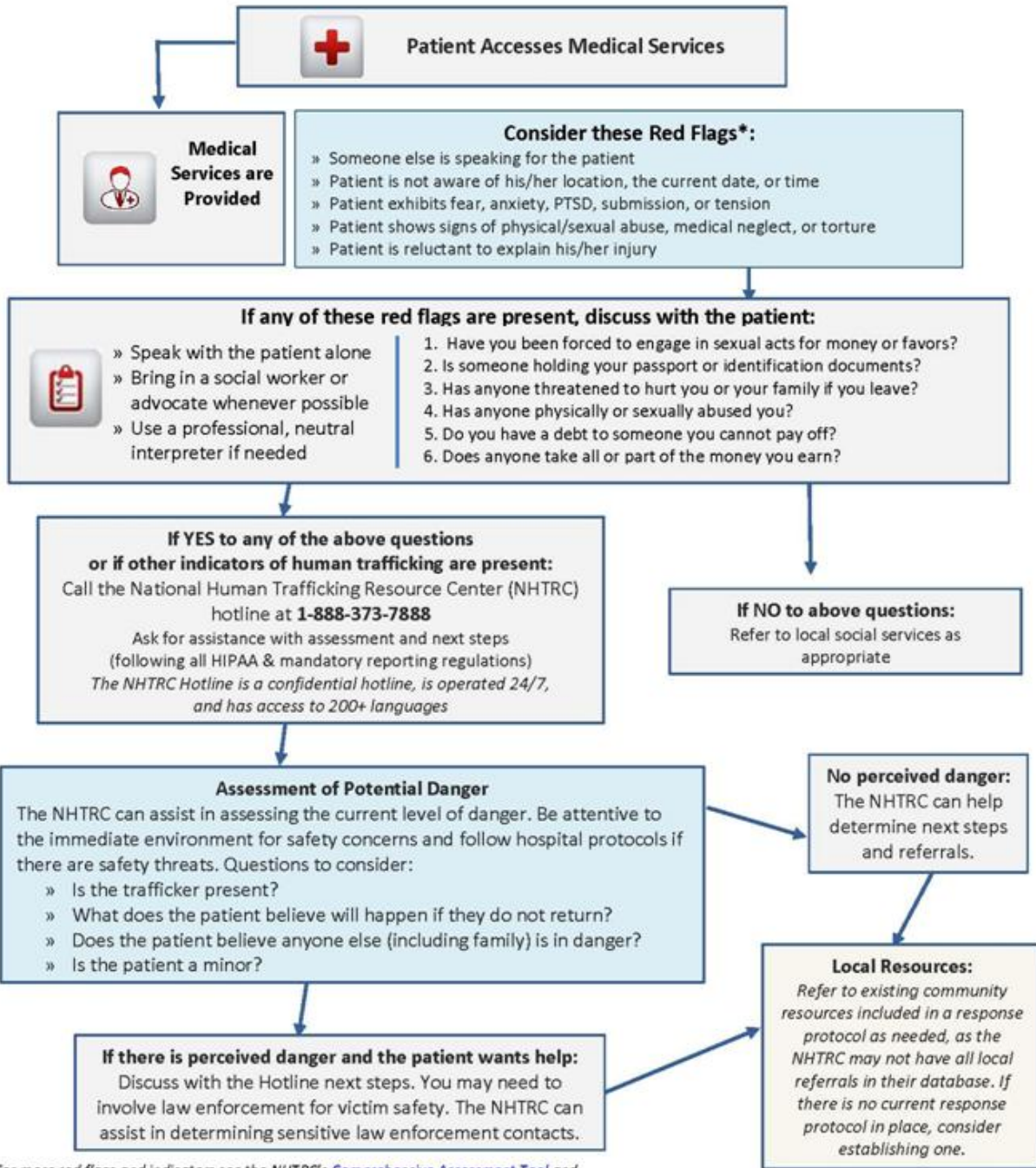
<sup>13</sup> Weisberg R. Reappraising complicity. *Buffalo Crim Law Rev*. 2000;4(1):217-281.

<sup>14</sup> 22 USC § 7102; NRS 200.467; NRS 200.468; NRS 432.153; NRS 201.300; and NRS 201.300. There are also other statutes.

<sup>15</sup> [http://ag.nv.gov/Human\\_Trafficking/HT\\_Help/](http://ag.nv.gov/Human_Trafficking/HT_Help/).

**Disclaimer:** The opinions expressed in the 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.

**Framework for a Human Trafficking Protocol in Healthcare Settings**



*\*For more red flags and indicators see the NHTRC's [Comprehensive Assessment Tool](#) and [Identifying Victims of Human Trafficking](#) document for healthcare providers.*

Report Online or Access Resources & Referrals: [www.traffickingresourcecenter.org](http://www.traffickingresourcecenter.org)

Call: 1-888-373-7888 (24/7)

Email: [nhtrc@polarisproject.org](mailto:nhtrc@polarisproject.org)

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## Stop. Observe. Ask. Respond (SOAR) Human Trafficking Training

Many victims of human trafficking come into contact with healthcare and social service professionals and remain unidentified. Potential victims can present with a wide-range of physical and psychological health issues and social service needs. The SOAR training aims to educate healthcare and social service professionals how to identify, treat, and respond appropriately to potential victims of human trafficking.

### 1. What is the history of the SOAR training?

The SOAR training was originally designed in 2014 by the HHS Administration for Children & Families (ACF) and the Office on Women's Health (OWH) as a pilot training for healthcare providers. It was tested by partnering with hospitals and community clinics in Atlanta, Boston, Houston, Oakland, and Williston and New Town, North Dakota with the goal of increasing provider awareness and identification of potential victims of human trafficking. Two SOAR Technical Working Groups and several regional work groups comprised of human trafficking survivors and other experts helped develop the SOAR content.

### 2. Who should take the SOAR training?

Anyone interested in learning more about how to recognize and respond to human trafficking in a healthcare or social services setting is encouraged to enroll in SOAR. In particular, training content will be available for the following specific audiences:

- Healthcare providers (e.g., physicians, dentists, nurses)
- Social workers (e.g., school-based social workers)
- Public health professionals (e.g., health department staff)
- Behavioral health professionals (e.g., mental health/substance use counselors)

### 3. What will I learn in the SOAR training?

You will learn how to:

- **Stop** - Become aware of the scope of human trafficking
- **Observe** - Recognize the verbal and non-verbal indicators of human trafficking
- **Ask** - Identify and interact with a potential human trafficking victim using a victim-centered approach
- **Respond** - Respond effectively to a potential human trafficking victim

### 4. Will the SOAR training be available online?

Yes, you have the option to take the SOAR training through an online virtual classroom. These training sessions use the same content as the in-person SOAR training, and will be conducted in real-time by a SOAR trainer.

### 5. When will the SOAR training be available and how do I enroll?

In-person and virtual training has been available since August 2016. Watch for specific instructions once the course is open for enrollment. <https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training>

### 6. Will the SOAR training be available in a self-paced format?

No, you must attend a scheduled training session. However, the course materials will be available for you to download and reference any time after you have completed the training.

### 7. How long does the training take?

The SOAR training is a three-hour course.

### 8. Can I receive continuing education (CE) or continuing medical education(CME) credit for completing the SOAR training?

CE and CME credit information available at:

<https://www.acf.hhs.gov/otip/training/soar/continuing-education-credit>

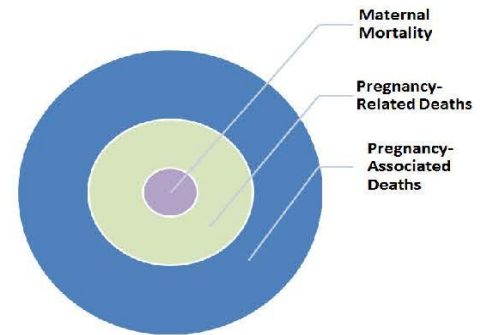


# Nevada Division of Public and Behavioral Health Releases Report: *Deaths During and After Pregnancy in Nevada, 2003-2014*

Deaths during and after pregnancy can be categorized into pregnancy-associated deaths, pregnancy-related deaths, or maternal mortality<sup>1-3</sup>.

- Pregnancy-associated deaths include the death of a woman while pregnant or within one year of the termination of pregnancy, from any cause.
- Pregnancy-related deaths include the death of a woman while pregnant or within one year of the end of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes.
- Maternal mortality (also known as maternal death) includes the death of a woman while pregnant or within 42 days of the end of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes.

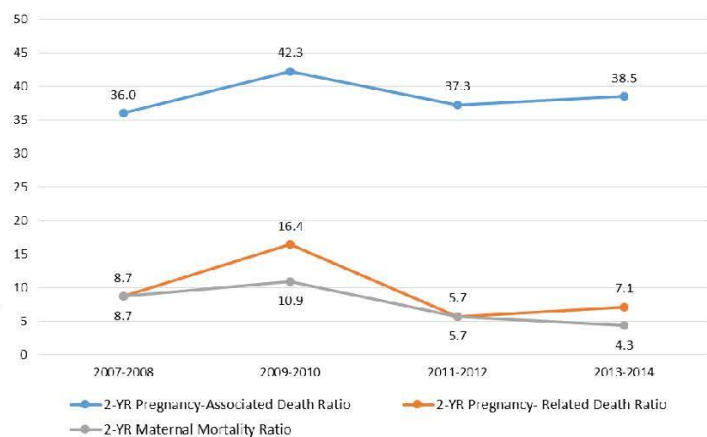
Figure 1. Pregnancy Death Classification



Healthy People 2020 has an objective for maternal deaths to be reduced to a rate of 11.4 maternal deaths per 100,000 live births.

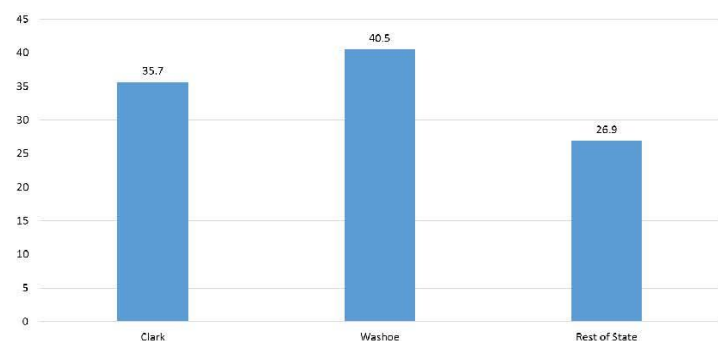
From 2003 to 2014, Nevada experienced 156 pregnancy-associated deaths. In 2013-2014, there were 27 pregnancy-associated deaths, a ratio of 38.5 per 100,000 live births (Figure 2). Nevada's pregnancy-associated deaths has increased but with trends similar to national data. It is unclear if the increase is due to changes in reporting after the implementation of the revised 2003 vital records certificate. The revised death certificate captures additional information related to pregnancy status, not previously captured, likely helping further identify pregnancy-associated deaths, pregnancy-related deaths, and maternal mortality.

Figure 2. Trends in Pregnancy Deaths, Ratio per 100,000 Live Births, Nevada 2007-2014<sup>4</sup>



National trends in pregnancy-related mortality show an increase from 7.2 per 100,000 live births in 1987 to 15.9 per 100,000 live births in 2012<sup>1</sup>. Nevada's pregnancy-related mortality rate was below the national trend at 5.7 per 100,000 for 2011-2012.

Figure 3. Pregnancy-Associated Deaths Ratio per 100,00 Live Births by County of Residence, Nevada 2003-2014<sup>4</sup>



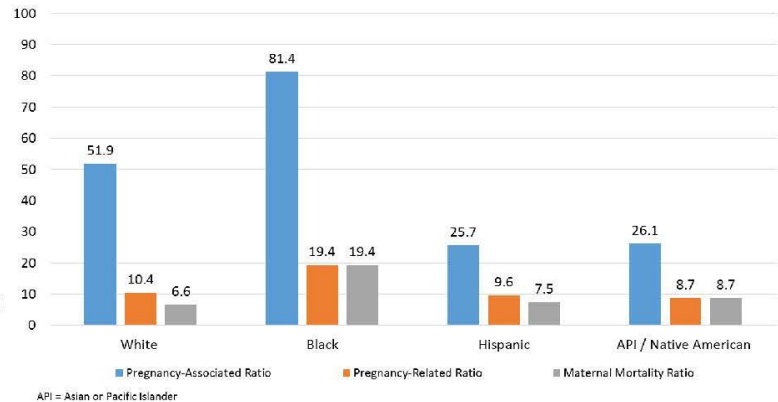
Although Clark County accounted for 75% of the pregnancy-associated deaths, Washoe County had a higher pregnancy-associated ratio per 100,000 live births than Clark and the rest of the state (Figure 3). Washoe County's pregnancy-associated death ratio was 40.5 per 100,000 live births compared to Clark County's ratio of 35.7 per 100,000 live births and 26.6 for the rest of the state.

Continued on page 9



From 2008 to 2014, Black women had the highest ratio of pregnancy deaths by race/ethnicity, followed by White women (Figure 4). The ratios show a potential indication of racial disparities. The ratio of Black women’s pregnancy-associated deaths was more than 3 times the ratio of Hispanic women’s pregnancy-associated deaths. All of the race/ethnic groups in Nevada except for Black women met the Healthy People 2020 target of less than 11.4 maternal deaths per 100,000 live births.

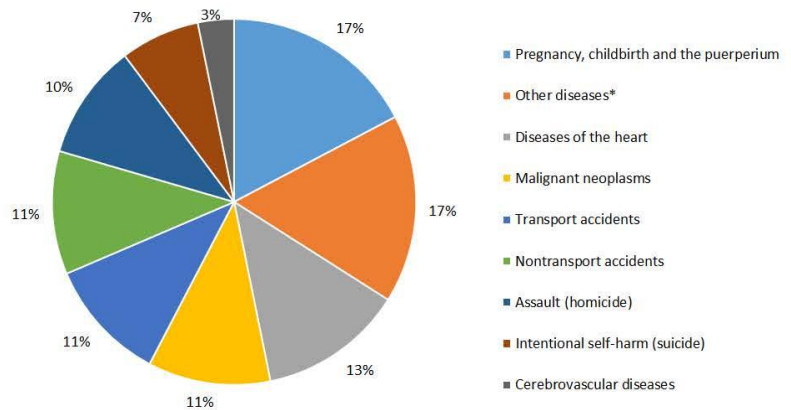
Figure 4. Death Ratio per 100,000 Live Births by Race/Ethnicity, Nevada 2008-2014<sup>4</sup>



Nationally, from 2011-2012 Black women had the highest pregnancy-related mortality ratio at 41.1 per 100,000 live births, more than twice the ratio of White women of 11.8 per 100,000 live births and almost four times the ratio of women of other races of 15.7 per 100,000 live births<sup>1</sup>.

Top causes of pregnancy-associated deaths in Nevada were related to pregnancy, childbirth, and the puerperium time period (Figure 5). Other diseases category including an aggregate total of cases such as septicemia, complications during surgery, meningitis, or chronic liver disease and cirrhosis, accounted for 17% of the pregnancy-associated deaths. Diseases of the heart accounted for 13% of the pregnancy-associated deaths; cancer, transport accident, and non-transport accidents accounted for 11% each; assaults 10%; and 7% from intentional self-harm.

Figure 5. Percent of Pregnancy-Associated Deaths Grouped by Top Causes of Deaths, Nevada 2003-2014<sup>4</sup>



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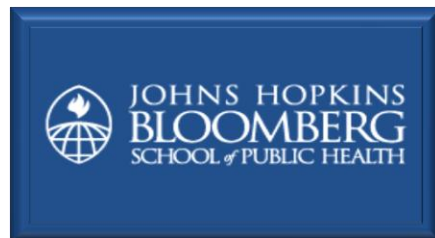
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- Office of Public Health Informatics and Epidemiology. Office of Vital Records- Nevada Electronic Birth and Death Certificates. Accessed August 2016.

# Many Patients Receive Prescription Opioids During Medication-Assisted Treatment for Opioid Addiction

## THE MAJORITY CONTINUE TO RECEIVE OPIOID PRESCRIPTIONS AFTER BUPRENORPHINE TREATMENT

More than two in five people receiving buprenorphine, a drug commonly used to treat opioid addiction, are also given prescriptions for other opioid painkillers – and two-thirds are prescribed opioids after their treatment is complete, a new Johns Hopkins Bloomberg School of Public Health study suggests.



The findings, published February 23 in the journal *Addiction*, demonstrate the need for greater resources devoted to medication-assisted treatment, a common clinical tool to address the epidemic.

The idea behind medication-assisted treatment is that patients are given low-dose opioids that produce some of the effects of opioids while staving off physical withdrawal symptoms. The low-dose opioids produce weaker effects than drugs such as oxycodone or heroin, which come with the risk of addiction and overdose. With medication-assisted treatment, rigorous studies have shown that patients are more able to remain healthy and productive members of society.

Historically, the most common drug to treat opioid use disorders has been methadone, though over the past 15 years, buprenorphine, a shorter-acting opioid similar to methadone, has been increasingly used instead. For this study, the researchers looked at prescriptions for buprenorphine and Suboxone, a combination of buprenorphine and naloxone, an anti-overdose medication. Rather than requiring a special clinic like methadone does, buprenorphine can be prescribed in a doctor's office, making it accessible to more patients.

"Policymakers may believe that people treated for opioid addiction are cured, but people with substance use disorders have a lifelong vulnerability, even if they are not actively using," says study leader G. Caleb Alexander, MD, MS, an associate professor of epidemiology at the Johns Hopkins Bloomberg School of Public Health and the co-director of the school's Center for Drug Safety and Effectiveness. "Our findings highlight the importance of stable, ongoing care for these patients."

Increases in prescription opioid use over the past two decades have led to an epidemic of addiction, injuries and deaths in the United States. In 2013, providers wrote nearly 250 million opioid prescriptions, enough to supply every adult in the United States with a bottle of pills. While it is sometimes appropriate for a patient to receive a prescription opioid during medication-assisted treatment – patients who are in acute pain from a major trauma or surgery may require short-term prescription opioids in addition to their medication-assisted treatment – the researchers say they are concerned to see such high rates of combined use of these products. This pattern suggests that many patients do not have well-coordinated treatment for opioid use disorders and chronic pain, which could lead to higher rates of relapse or overdose, Alexander says.

For their study, Alexander and his colleagues examined pharmacy claims for more than 38,000 new buprenorphine users who filled prescriptions between 2006 and 2013 in 11 states. They looked at non-buprenorphine opioid prescriptions before, during, and after each patient's first course of buprenorphine treatment, which typically lasted between one to six months. Even though there are no universally agreed-upon guidelines regarding the optimal length of treatment, most people discontinued buprenorphine within three months.

They found that 43 percent of patients who received buprenorphine filled an opioid prescription during treatment and 67 percent filled an opioid prescription during the 12 months following buprenorphine treatment. Most patients continued to receive similar amounts of opioids before and after buprenorphine treatment.

*Continued on page 11*

Because the study data lacked information on patients' use of illegal opioids like heroin, the results likely underestimate the proportion of patients using opioids during and after buprenorphine treatment. "The statistics are startling," says Alexander, "but are consistent with studies of patients treated with methadone showing that many patients resume opioid use after treatment."

Recent federal efforts have tried to improve the availability of medication-assisted treatment, so providing ongoing professional education and support to these providers will be important.

"Unlike methadone, buprenorphine can be prescribed for opioid use disorders in primary care, so it is an important treatment option for clinicians and patients to have," says study co-author Matthew Daubresse, a doctoral student in the Department of Epidemiology at the Bloomberg School. "But many patients, especially those with shorter lengths of treatment, appear to be continuing to use prescription opioids during and after buprenorphine treatment. We need to find better ways to keep patients engaged in long-term treatment, and these efforts couldn't be more urgent given how many Americans continue to die or get injured from opioids."

*"Non-Buprenorphine Opioid Utilizations among Patients Using Buprenorphine" was written by Matthew Daubresse, Brendan Saloner, Harold A. Pollack and G. Caleb Alexander.*

*The work was funded by the Centers for Disease Control and Prevention under Cooperative Agreement U01CE002499.*

*Alexander is chair of the FDA's Peripheral and Central Nervous System Advisory Committee, serves as a paid consultant to a mobile start-up, PainNavigator, serves as a consultant to QuintileIMS and serves on its advisory board. This arrangement has been reviewed and approved by the Johns Hopkins University in accordance with its conflict of interest policies.*

**Media contacts for the Johns Hopkins Bloomberg School of Public Health:**

Stephanie Desmon at 410-955-7619 or [sdesmon1@jhu.edu](mailto:sdesmon1@jhu.edu) and Barbara Benham at 410-614-6029 or [bbenham1@jhu.edu](mailto:bbenham1@jhu.edu)

## CDC Offers Opioid Guideline Mobile App



CDC's new [Opioid Guideline App](#) is designed to help providers apply the recommendations of CDC's Guideline for Prescribing Opioids for Chronic Pain into clinical practice by putting the entire guideline, tools, and resources in the palm of their hand. Managing chronic pain is complex, but accessing prescribing guidance has never been easier.

The application includes a **Morphine Milligram Equivalent (MME) calculator\***, summaries of key recommendations, a link to the full Guideline, and an interactive motivational interviewing feature to help providers practice effective communications skills and prescribe with confidence.

### Free Download

The new CDC Opioid Guideline App is now available for free download on [Google Play](#) (Android devices) and in the [Apple Store](#) (iOS devices).

### Infographic: [Opioid Prescribing Guideline Mobile App](#)

**\*MME Calculator Disclaimer:** This calculator is not intended to replace clinical judgement or to guide opioid dosing for patients receiving active cancer treatment, palliative care, end-of-life care, or for patients younger than 18. The application is not intended to provide guidance on dosing of opioids as part of medication-assisted treatment for opioid use disorder. The calculator does not account for incomplete cross-tolerance between opioids and should not be used to guide opioid rotation or conversion between different opioids. This is especially important for fentanyl and methadone conversions. Equianalgesic dose ratios are approximations and do not account for interactions between opioids and other drugs, patient weight, hepatic or renal insufficiency, genetic factors, and other factors affecting pharmacokinetics.

# Mandatory In-Office Surgery Reporting 2015-2016

## INSTRUCTIONS FOR REPORTING IN-OFFICE SURGERIES OR PROCEDURES INVOLVING CONSCIOUS SEDATION, DEEP SEDATION OR GENERAL ANESTHESIA, AND ANY ASSOCIATED SENTINEL EVENTS, FOR 2015-2016

**Instructions and forms are available on the [Board's website](#) by clicking the red "[In-Office Surgery Reporting](#)" link on the home page.**

All allopathic physicians licensed in the state of Nevada are required by Nevada Revised Statute 630.30665 to report to the Nevada State Board of Medical Examiners, **prior** to licensure renewal, all in-office surgeries or procedures that involved the use of conscious sedation, deep sedation or general anesthesia, and the occurrence of any sentinel event arising from any such surgeries or procedures, between January 1, 2015 and December 31, 2016.

This reporting requirement, to include negative reporting, is mandatory. Your failure to submit a report or knowingly filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act. You will be required to attest on your 2017 license renewal application that you have completed the applicable reporting form, either:

**Form A:** Which is to be completed and signed by you if you DID perform surgeries or procedures which involved the use of conscious sedation, deep sedation or general anesthesia, and any associated sentinel events, in your office or other location within the state of Nevada, other than those excepted facilities which are listed on page two of these instructions.

**Form B:** Which is to be completed and signed by you if you DID NOT perform any surgeries or procedures which involved the use of conscious sedation, deep sedation or general anesthesia, in your office or other location within the state of Nevada, other than those excepted facilities which are listed on page two of these instructions. Again, negative reporting is required by law.

### **Definitions:**

#### **Conscious Sedation**

"Conscious sedation" means a minimally-depressed level of consciousness, produced by a pharmacologic or non-pharmacologic method, or a combination thereof, in which the patient retains the ability independently and continuously to maintain an airway and to respond appropriately to physical stimulation and verbal commands.

*You must report the number (how many) and type (name of the surgery or procedure) of surgeries/procedures in which you used **conscious sedation** on a patient on Form A.*

*You must also report any sentinel event associated with any surgery or procedure, while a patient was under **conscious sedation**, on Form A.*

#### **Deep Sedation**

"Deep sedation" means a controlled state of depressed consciousness, produced by a pharmacologic or non-pharmacologic method, or a combination thereof, and accompanied by a partial loss of protective reflexes and the inability to respond purposefully to verbal commands.

*You must report the number (how many) and type (name of the surgery or procedure) of surgeries/procedures in which you used **deep sedation** on a patient on Form A.*

*You must also report any sentinel event associated with any surgery or procedure, while a patient was under **deep sedation**, on Form A.*

#### **General Anesthesia**

"General anesthesia" means a controlled state of unconsciousness, produced by a pharmacologic or non-pharmacologic method, or a combination thereof, and accompanied by partial or complete loss of protective reflexes and the inability independently to maintain an airway and respond purposefully to physical stimulation or verbal commands.

*Continued on page 13*

You must **report the number (how many)** and **type (name of the surgery or procedure)** of surgeries/procedures in which you used **general anesthesia** on a patient on Form A.

You must also report any sentinel event associated with any surgery or procedure, while a patient was under **general anesthesia**, on Form A.

### Sentinel Event

“Sentinel event” means an event included in Appendix A of “Serious Reportable Events in Healthcare--2011 Update: A Consensus Report,” published by the National Quality Forum. If this publication is revised, the term “sentinel events” means the most current version of the list of serious reportable events published by the National Quality Forum as it exists on the effective date of the revision. If the National Quality Forum ceases to exist, the most current version of the list shall be deemed to be the last version of the publication in existence before the National Quality Forum ceased to exist.

#### Examples of reportable sentinel events:

- surgery performed on the wrong body part
- surgery performed on a wrong patient
- wrong surgical procedure performed on a patient
- unintentional retention of a foreign object in a patient after surgery or other procedure
- serious injury or death associated with a medication error
- serious injury or death associated with a burn incurred from any source
- serious injury or death associated with equipment malfunction

### Reminders:

The physician's signature is required, whether you submit Form A or Form B. Do not provide a report for a group practice as a whole - a report is required from each and every physician within a group practice. Report only those surgeries/procedures performed within the state of Nevada, **as you do not have to report any surgeries or procedures performed at one of the following facilities, or outside the state of Nevada:**

1. A surgical center for ambulatory patients;
2. An obstetric center;
3. An independent center for emergency medical care;
4. An agency to provide nursing in the home;
5. A facility for intermediate care;
6. A facility for skilled nursing;
7. A facility for hospice care;
8. A hospital;
9. A psychiatric hospital;
10. A facility for the treatment of irreversible renal disease;
11. A rural clinic;
12. A nursing pool;
13. A facility for modified medical detoxification;
14. A facility for refractive surgery;
15. A mobile unit; and
16. A community triage center.

### Submission of Forms:

Please submit all completed applicable forms to the Nevada State Board of Medical Examiners:

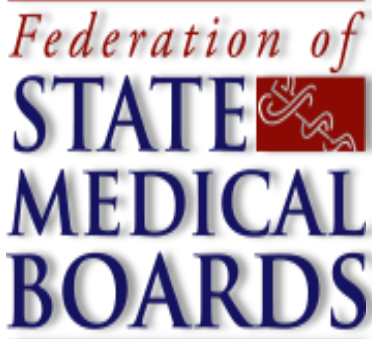
By mail or hand delivery to: 1105 Terminal Way, Suite 301, Reno, NV 89502

By fax to: (775) 688-2553

By email to: [surgeryreport@medboard.nv.gov](mailto:surgeryreport@medboard.nv.gov)

# FSMB Offers Series of Free Online Education Modules for Medical Students and Residents

*Designed to inform physicians about various aspects of medical regulation*



Washington, D.C. – The Federation of State Medical Boards (FSMB) announced a new initiative designed to inform future physicians about medical licensing and regulation. The series of online education modules, developed by the FSMB Workgroup on Education for Medical Regulation, will address a variety of issue areas such as navigating the licensing process and dealing with physician health and impairment.

“Becoming a new physician remains an exciting and challenging time,” said FSMB President and CEO Humayun Chaudhry, DO, MACP. “The FSMB and our member boards are dedicated to making this transition easier for medical students and residents by providing them with free online modules that will help them navigate this process and ultimately become better physicians.”

The first module of the series has been released and is currently live on the FSMB website. [“The Role of State Medical Boards”](#) is focused on providing graduates with sufficient information about the functions of medical regulation so they will be prepared to interact effectively and professionally with state medical boards, fellow physicians and patients. Upon completion of the module, graduates will be able to:

- Describe the legal foundations of state-based medical regulation
- Explain the three functions of state medical boards
- State the mission of state medical boards
- Discuss the concept of physicians’ social contract with the public

Upcoming modules will address the following topics:

- Understanding and navigating the medical licensing process
- Reasons why physicians get in trouble
- What is the medical disciplinary process?
- Physician health and impairment

To access [“The Role of State Medical Boards”](#) module and future offerings, please visit the FSMB’s Educational Modules on Medical Regulation website at: <https://www.fsmb.org/policy/education-meetings/educational-modules>.

*About the Federation of State Medical Boards - The Federation of State Medical Boards (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other healthcare professionals. The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality healthcare and regulatory best practices. To learn more about FSMB, visit [www.fsmb.org](http://www.fsmb.org). You can also follow FSMB on Twitter (@theFSMB).*

Contact: Joe Knickrehm  
(202) 601-7803  
[jknickrehm@fsmb.org](mailto:jknickrehm@fsmb.org)  
[www.fsmb.org](http://www.fsmb.org)

# THE PRACTICAL APPLICATION OF REDUCING DEPENDENCE ON OPIOID PRESCRIBING

HOW CDC GUIDELINES, ALTERNATIVE THERAPIES  
& COMMUNITY PARTNERSHIPS CAN HELP YOUR PRACTICE

APPROVED FOR 5 CME CREDITS  
(Includes Ethics Credits)

Wednesday, May 17, 2017

Harras, Reno, Nevada

8:00 am - 2:00 pm

## Overview

Attendees will learn about current state legislation that relates to prescribing controlled substances and review details of SB459 that passed in 2015. Presenters will discuss alternative methods for pain treatment, the value of the CDC guidelines for prescribing narcotic medications, how to screen patients for substance use disorders, and how to partner with substance abuse treatment professionals. Additionally, attendees will learn the cost to employers and society when a patient is kept on narcotic medications for more than a few weeks.

The per-participant registration fee is \$25  
The conference registration deadline is May 10, 2017.

**FOR MORE INFORMATION OR TO REGISTER:**

<http://med.unr.edu/cme/opioidprescribing2017>





# Payment Reform CME Conference

The MACRA, MIPS & You CME is to prepare Nevada Physicians & Clinicians for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Merit Based Incentive (MIPS) Payment System- Quality Payment Program that goes in to effect January 1, 2017. The program will highlight current Medicare payments for volume of services that are being replaced by payments for outcomes of care achieved through delivering higher quality, efficiency, and effectiveness of clinical practice, clinicians delivering higher value care- higher quality of care at lower cost- will receive higher reimbursements than those delivering lower value services, and current systems that do not adequately pay for coordination of care, clinical improvement activities, clinical information sharing, early preventive services and rapid access to care for those with higher needs but rather provides more incentives to deliver higher volume of discretionary procedures that marginally improve health and wellbeing. Attendees will include: Physicians, Residents, Physician Assistants, Don't miss this opportunity to showcase your organization!

## May 11th, 2017

8:00 AM - 12:00 PM

Location(s) Statewide CME held simultaneously at three (3) campus locations:

LAS VEGAS, NEVADA | Vegas PBS Technology Campus  
3050 E. Flamingo Rd. | Las Vegas, NV 89121

RENO, NEVADA | University of Nevada, Reno

ELKO, NEVADA | University of Nevada, Reno

CCMS/NSMA/WCMS Members: \$45

Non-Member and/or Guest: \$75

## Guest Speakers

Jean Moody-Williams  
Deputy Director of the Center for  
Clinical Standards and Quality |  
Centers for Medicare  
& Medicaid Services



Shannon Sprout  
Chief III, Policy Development  
and Program Management |  
Nevada Department of Health  
and Human Services

Lawrence M. Preston  
CEO and ACO  
Operations Executive |  
Silver State Accountable  
Care Organization

Laurine Tibaldi, MD  
Chief Medical Officer |  
United Health Care

**Reserve Your Seat Today | 702.739.9989 | [clarkcountymedical.org](http://clarkcountymedical.org)**



**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

**2017 BME MEETING &  
HOLIDAY SCHEDULE**

**January 2** – New Year’s Day (observed)  
**January 16** – Martin Luther King, Jr. Day  
**February 20** – Presidents’ Day  
**March 3-4** – Board meeting  
**May 29** – Memorial Day  
**June 2-3** – Board meeting  
**July 4** – Independence Day  
**September 4** – Labor Day  
**September 8-9** – Board meeting  
**October 27** – Nevada Day  
**November 10** – Veterans’ Day (observed)  
**November 23 & 24** – Thanksgiving Day & Family Day  
**December 1-2** – Board meeting (Las Vegas)  
**December 25** – Christmas

**Nevada State Medical Association**

3700 Barron Way  
Reno, NV 89511  
775-825-6788  
<http://www.nvdoctors.org>

**Clark County Medical Society**

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

**Washoe County Medical Society**

3700 Barron Way  
Reno, NV 89511  
775-825-0278 phone  
775-825-0785 fax  
<http://www.wcmsnv.org>

**Nevada State Board of Pharmacy**

431 W. Plumb Lane  
Reno, NV 89509  
775-850-1440 phone  
775-850-1444 fax  
[http://bop.nv.gov/  
pharmacy@pharmacy.nv.gov](http://bop.nv.gov/pharmacy@pharmacy.nv.gov)

**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](http://www.bom.nv.gov)

**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](http://www.nevadanursingboard.org)

*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

## **DANA, Ali P., M.D. (13550)**

### **Oxnard, California**

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

Charges: 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]; one violation of NRS 630.301(4) [malpractice].

Disposition: On March 3, 2017, the Board accepted a Settlement Agreement by which it found Dr. Dana violated NRS 630.3062(1), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed with prejudice.

which it found Mr. Schmidt violated NRS 630.3062(1), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

★ ★ ★

## **MACHUCA, Rogelio, M.D. (13983)**

### **Las Vegas, Nevada**

Summary: Alleged signing of nine blank prescription forms.

Charges: One violation of NRS 630.304(4) [signing a blank prescription form].

Disposition: On March 3, 2017, the Board accepted a Settlement Agreement by which it found Dr. Machuca violated NRS 630.304(4), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (3) \$1,000.00 fine; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

## **SCHMIDT, Trevor A., PA-C (PA1219)**

### **Henderson, Nevada**

Summary: Alleged failure to maintain appropriate medical records related to his treatment of eight patients.

Charges: 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 March 3, 2017, the Board accepted a Settlement Agreement by

# Public Reprimands Ordered by the Board

March 6, 2017

Ali Dana, M.D.  
c/o S. Brent Vogel, Esq.  
Lewis, Brisbois, Bisgaard & Smith, LLP  
6385 S. Rainbow Blvd., Ste. 600  
Las Vegas, NV 89118

Dr. Dana:

On March 3, 2017, 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 16-37541-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), medical records. For the same, you shall receive a public reprimand; take three (3) hours of continuing medical education, the aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada; 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

March 6, 2017

Rogelio Machuca, M.D.  
c/o Todd M. Leventhal, Esq.  
626 South Third St.  
Las Vegas, NV 89101

Dr. Machuca:

On March 3, 2017, 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 15-33896-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.304(4), signing blank prescription forms. For the same, you shall receive a public reprimand; take three (3) hours of continuing medical education, the aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada; pay the fees and costs related to the investigation and prosecution of this matter; and pay a fine.

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

March 6, 2017

Trevor Schmidt, PA-C  
2610 Horizon Ridge Pkwy., #203  
Henderson, NV 89052

Mr. Schmidt:

On March 3, 2017, 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 17-36566-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), medical records. For the same, you shall receive a public reprimand; take three (3) hours of continuing medical education, the aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed upon you as a condition of licensure

in the State of Nevada; 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

★ ★ ★

NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144