NEVADA STATE BOARD OF MEDICAL EXAMINERS
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Executive Director

* * * MINUTES * * *

OPEN SESSION R100-17 SUBCOMMITTEE MEETING

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

and videoconferenced to

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

WEDNESDAY, MARCH 14, 2018 – 2:00 P.M.

Subcommittee Members Present at Board Office in Las Vegas
Victor M. Muro, M.D., Chair
Daniel Burkhead, M.D.
Michael C. Edwards, M.D., FACS (via telephone and then in person)
Senator Joseph P. Hardy, M.D.
Rudy Manthei, D.O.
Ms. April Mastroluca
Rupesh Parikh, M.D.
Crane Pomerantz, J.D.
Robert Pretzlaff, M.D.
Faisal Suba, M.D.
Ms. Karen Rubel
Erin Russell, Ph.D.

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

Subcommittee Members Absent
Wayne Hardwick, M.D.

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

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

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

The meeting was called to order by Dr. Muro at 2:04 p.m.

Ms. Mehta took roll call of the Subcommittee members. Subcommittee members not present were Wayne Hardwick, M.D., Crane Pomerantz, J.D. and Erin Russell, Ph.D. Ms. Mehta announced there was a quorum. Mr. Pomerantz and Dr. Russell arrived shortly thereafter.

Agenda Item 2
PUBLIC COMMENT

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

Aline Rosenberg addressed the Subcommittee regarding her perspective about how stressful and unfair it is to be a patient with chronic, acute pain under the new opioid laws that have been put into effect. Ms. Rosenberg's husband had been recently diagnosed with a rare advanced cancer of the appendix and pseudomyxoma peritonei (PMP). Due to previous medical conditions, her husband has a high tolerance for pain, as he has been living with chronic nerve pain and weakness from nerve damage for the last five years. He thought his pain was a side effect from switching to new diabetic medicine. It progressed almost overnight to a very acute, unbearable abdominal pain, which led to the hospital visit where the terminal cancer was diagnosed.

Ms. Rosenberg's husband has been on pain medication from time to time due to a lumbar fusion and subsequent surgeries. He uses pain medication sparingly, as he does not like the effects of this type of medication. He is very aware of living life with pain and working through it to maximize quality of life.

While in the hospital, they tried to greatly reduce his pain medication for his release. They went so far as to say his pain was psychological and he should only expect 80% relief from pain. On average, he has experienced 50% relief of his pain over the last month.

When released from the hospital, his prescription was for a week (Thursday to Thursday), until he met with his PCP for managing his pain medication. After his release, they had to go to three different pharmacies, they were out of the morphine he was being prescribed, and they advised it would take a week to fill the prescription. Once the morphine was found in stock, it

took quite some time and effort to get the prescription filled. They had to pay for the prescription out of pocket because the insurance company would not approve it. Mr. Rosenberg was trying to be frugal with the medication because the doctors had said to try and stretch the medication out. By Friday evening, they counted the pills and realized if taken as prescribed, he would be out of pain medication in three days (Saturday). They had to ration out the rest of the medication until Thursday. It was difficult and stressful to imagine he might be living in excruciating pain, without pain medication, for days.

Ms. Rosenberg's husband saw the PCP on Monday, who wrote a new prescription. Again, the insurance company would not approve it. Everyone had different protocols for the pain medication. The pharmacy, the insurance company and the doctors took three days to finally approve the medication. Mr. Rosenberg was passed between the PCP doctor, a physiatrist, his spine care physician and oncologist, all at a cost of $50.00 per visit. Each one did not seem to have a clear protocol in place. Mr. Rosenberg requires high dosages of pain medication, and no one wants to take responsibility for his care. She said it seems medical professionals, pharmacists and insurance companies are scrambling to find a protocol that bridges the law, which has created confusion and inhumane treatment of patients, who are the real victims.

Ms. Rosenberg asked the Subcommittee to be diligent in fighting to protect the rights of those patients who are in need of special circumstances. Many cannot advocate for themselves and are being unjustly and inhumanely treated.

Dr. Muro thanked Ms. Rosenberg for sharing her story, which points out some of the complexities the Subcommittee is currently facing and is trying to address. He said unfortunately, there are a lot of issues creating impediments to effective and quality care at the end of life.

Agenda Item 3
APPROVAL OF MINUTES
- February 28, 2018 Subcommittee Meeting – Open Session

Senator Hardy moved that the Board approve the Minutes of the February 28, 2018 Subcommittee Meeting – Open Session. Ms. Mastroluca seconded the motion, and it passed unanimously.

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

Dr. Muro explained that since the last meeting of the Subcommittee, the Pharmacy Board held a public workshop on a proposed regulation, and asked Mr. Edwards and Mr. Wuest to share the proposed draft.

Ms. Mehta directed the Subcommittee to the handout entitled "Proposed Regulation of the Nevada State Board of Pharmacy," and asked Mr. Wuest if he would provide the Subcommittee with an overview of the workshop and the proposed language that came out of it.

Mr. Edwards said he would provide the overview for Mr. Wuest. He said they tried very carefully to listen to the feedback from this Subcommittee and they think the proposed language captured the essence of what had been discussed by the Subcommittee. They received public comment from Mary Ann Allison, M.D. and others, which was supportive and useful. It was very

clear from the Pharmacy Board members that their concerns were patient safety and patient care, and the language was drafted with those primary concerns in mind.

Mr. Edwards read Section 2(1) of the proposed regulation, defining course of treatment. He asked if there were any questions or comments with regard to that section, and there were none.

Mr. Edwards read Section 2(2), defining acute pain. He stated this definition mirrors the proposed definition that has been put before Congress. Congress hasn't approved it yet, but the thinking was if we can be consistent with that definition if it goes through, that will avoid some confusion for practitioners.

Mr. Edwards read Section 2(3), regarding an informed written consent, Section 2(4), regarding a medical history review and physical examination, Section 2(5), defining good-faith effort to obtain medical records, and Section 2(6), defining on-going treatment. He stated these were the definitions approved by the Board of Pharmacy, and they have been submitted to the Legislative Counsel Bureau (LCB). Once the proposed regulation comes back from the LCB, it will be set for public hearing and move forward from that point.

Ms. Russell asked when the Pharmacy Board anticipated the proposed regulation would be set for public hearing, and Mr. Edwards stated it is dependent upon the LCB and how quickly the proposed regulation gets turned around and back to the Pharmacy Board. The Pharmacy Board meets every six weeks, and as soon as it receives the proposed regulation back from the LCB, it will be noticed for public hearing as soon as possible, which will most likely be held at the Pharmacy Board's June meeting.

Mr. Wuest said Mr. Edwards was correct. The posting deadline for the April meeting was yesterday, and the Pharmacy Board won't have the language back in time for the April meeting, so the soonest the public hearing will be held is at the June meeting.

Ms. O'Mara said she wanted to be sure they also included the pain medication agreement, as the Pharmacy Board voted to add in the pain medication agreement in a similar vein as in subsection number 3 for informed written consent.

Mr. Wuest stated the Pharmacy Board's intent was to mirror the informed consent language for the medication agreement, and he could provide that language for the Subcommittee's next meeting.

Dr. Salas asked if the Pharmacy Board had a definition for palliative care. Mr. Edwards stated they had not included that in the proposed regulation, as they hadn't looked at that specifically.

Dr. Salas explained this is something he grapples with regularly as a pain medicine physician. He has patients, as probably many other physicians do, that appear to be palliative care patients with no other reasonable option available for their care. The question is whether those patients can be included under the palliative care provisions, and it would be helpful to define that because otherwise we might end up having to overwhelm our palliative care doctors.

Mr. Wuest said there is clearly a definition of palliative care, which he thinks means treating pain without treating the condition, but if referring to one in statute or regulation, he would have to look that up. He said not everyone that is at end of life goes to hospice, not everyone

that is on palliative care has hospice, and certainly everyone that is on hospice has a component of palliative care.

Dr. Pretzlaff said there is a State Palliative Care Committee, and suggested the Pharmacy Board reach out to it for a definition.

Ms. O'Mara said if those who practice palliative care are treating chronic pain, and not acute pain, it may not be necessary to clarify it for the purposes of this law.

Discussion ensued regarding how to define palliative care. Dr. Muro suggested this be discussed at a future meeting, as it would be helpful to provide some direction for the physicians who practice it, because it is a very important part of treatment.

Mr. Wuest said that cancer wouldn't need to be included in a definition for palliative care because it is already included in the exceptions.

Mr. Edwards stated that anything that is not acute pain is excluded, and the provisions of AB 474 do not apply.

Dr. Muro suggested that by keeping it broad, it will also allay some of the fears practitioners have in trying to care for patients.

Dr. Burkhead stated Dr. (Weldon) Havins had just provided the Subcommittee with a statutory definition of palliative care, and read that definition, contained in NRS 449.0156: "'Palliative services' defined. 'Palliative services' means services and treatments directed toward the control of pain and symptoms which provide the greatest degree of relief for the longest period while minimizing any adverse effects of the services and treatments, including, without limitation, any side effects of any medications given or administered."

Dr. Burkhead said he wanted to address subsection 3 of the Pharmacy Board's proposed regulation regarding the prescription medication agreement. That section currently only directs our attention to Sections 53 and 54 of AB 474, and the prescription medication agreement is addressed in Section 56, so he asked if Mr. Edwards and Mr. Wuest would include Section 56 when addressing that with the Board of Pharmacy.

Mr. Wuest said it is a separate item and he would get the language to the Subcommittee, but it basically says for the purposes of Section 56, a prescription medication agreement may be shared as a common database allows.

Ms. Mehta stated at the last meeting, the Subcommittee had left off at Section 54(1), but she thought it would be worthwhile to go back to the discussion on a bona fide relationship and telehealth, which is in Section 53(1)(a), because there was some concern that the definition of telehealth would circumscribe the ability of hospice practitioners to prescribe. She had conferred with Mr. Edwards to make sure that when reading the Pharmacy Board statute, NRS 639.235(4), she understood it. She said it defines a bona fide relationship as: "a bona fide relationship between the patient and the person prescribing the controlled substance shall be deemed to exist if the patient was examined in person, electronically, telephonically or by fiber optics, including, without limitation through telehealth." Telehealth is a subset of all those other means of examining a patient, so she thinks that will address the concern that was raised by hospice practitioners. At the last meeting, the Subcommittee focused on the definition of telehealth, which says it can't be done

telephonically, and this definition is much broader than that, and is what controls pursuant to Section 53(1)(a).

Dr. Muro said he thinks this is a critical part of what the Subcommittee was trying to accomplish at the last meeting, as it provides some direction and perhaps eliminates some of the counterpoints at which the Subcommittee found itself.

Dr. Salas asked if there was a plan or intention to provide additional education regarding the bona fide relationship section.

Dr. Muro said he thought it was part of the goals of the Subcommittee to provide information up the ladder, which can then be disseminated, because one of the things the Subcommittee is finding is there is a lot of confusion as to what the bill says, how it will be applied and what the intent was. So the biggest task is to come up with recommendations that are keeping with the bill, point out areas of concern and how the Subcommittee sees it actually being applied, without hindering patient care.

Ms. O'Mara thanked Dr. Muro and Ms. Mehta for putting this on the record. She said she had a call with Hospice just before the meeting and it is something they are still concerned about, so she will take this record and try to make sure they are educated.

Mr. Wuest said the Board of Pharmacy would put this out, but it may be appropriate for the Subcommittee to make a motion that they want the Medical Board to get out the same thing in whatever manner they educate its practitioners.

Ms. O'Mara moved that the Subcommittee make a recommendation to the Board of Medical Examiners to issue a statement clarifying for Hospice how they may establish a bona fide relationship in accordance with Ms. Mehta's comments.

Mr. Wuest suggested the motion be amended to include all practitioners because the bona fide relationship is the same for a family doctor as it is for a hospice doctor.

Ms. O'Mara amended her motion to include all practitioners, and not just hospice physicians. Senator Hardy seconded the amended motion, and it passed unanimously.

Senator Hardy moved that the Subcommittee recommend to the Board of Medical Examiners that it recommend the definitions as proposed by the Board of Pharmacy. Dr. Manthei seconded the motion, and it passed unanimously.

Ms. Mehta said she believed the Subcommittee left off at Section 54(1) at the last meeting, the evaluation and risk assessment and a good-faith effort to obtain and review medical records. She stated a proposed definition of good-faith effort had been put together by the Pharmacy Board, and asked if the Subcommittee wanted to entertain further discussion regarding that. Senator Hardy stated it was included in the last motion.

Ms. Mehta explained that Section 54(1)(d) outlines what must be included in the evaluation and risk assessment and (d) is assessing the mental health and risk of abuse, dependency and addiction of the patient using methods supported by peer-reviewed, scientific research and validated by a nationally recognized organization. She looked at the Division of Public Health's website, Prescribe 365, and there is a risk assessment section there. She didn't have a chance to

print it out and disseminate to everyone before the meeting, but there appear to be publications from peer-reviewed, nationally recognized organizations.

Dr. Muro said the key thing is there are a variety of tools available and it is a matter of selecting one that meets the criteria and implementing it within the workflow of the organization. But it is clear that the evaluation does have to occur and there are tools to accomplish it.

Senator Hardy stated that this requirement doesn't take away the autonomy of the physician to treat the patient for pain.

Discussion ensued regarding the fact that this is another matter that requires education be advanced to practitioners as well as patients.

Ms. Massey said that one of the complexities to this section is not just doing it, but how it is documented, and she reads it to say that the physician should be making that assessment, but not necessarily that a full-blown, piece-of-paper assessment should be in the chart, and she asked for clarification regarding this.

Discussion ensued regarding the necessary requirements for and logistics of documentation of the assessment, and the possibility of providing a list of acceptable tools for providers to use in performing the assessment.

Dr. Muro stated there is obviously going to be a different workflow and process in different practice settings.

Mr. Wuest said going back to the intent of the law, as he understands it, the thing that needs to be written is the informed consent, and it is clear that the risk assessment doesn't have to be written. He thinks Senator Hardy is correct; you have to document that you did it, but it may be as simple as documenting that you performed it. He thinks this is how care is being delivered now. He said this Subcommittee has the unique ability to advise the Board of Medical Examiners and if it wants to recommend the risk assessment has to be documented and it has to be a hard copy, it should make that recommendation, or it can recommend this is something that can be documented in any manner.

Further discussion ensued regarding the requirements for and logistics of documentation of the assessment.

Dr. Salas asked for clarification regarding who can perform the risk assessment and how often it needs to be accomplished.

Mr. Wuest said only the practitioner can make the clinical decision as to whether to prescribe; however, extenders may be used to collect the information.

Ms. Mastroluca said that Section 54 references Section 53, which references "initial prescription," so it should be done for each initial prescription, and also at 90 days.

Discussion ensued regarding how frequently a risk assessment must be done.

Dr. Burkhead stated that Section 55(1)(a) requires that an assessment be completed at 90 days, so it is apparent from his reading of the law that this is required at the time of the initial

prescription and at least at the 90-day mark, but he doesn't know that it is cited anywhere in the law that it has to be done on a repetitive basis.

Further discussion ensued regarding how often the risk assessment must be performed.

Dr. Manthei suggested this section is something that should be brought up at the next legislative session for clarification.

Dr. Muro said he thought the consensus of the Subcommittee was that it needs to occur initially, and it can be carried forward as you move through the continuation of care, and it could be as simple as documenting that you reviewed the initial assessment and it is still valid, that nothing has changed dramatically, unless you have someone who keeps losing their medication or keeps asking for more, you may obviously want to rethink that, but that could be an individual thing based on the discretion of the provider.

Further discussion ensued regarding how often the risk assessment must be done.

Mr. Pomerantz stated that Section 55 says, "[r]equire the patient to complete an assessment"; it does not say, "perform an assessment." If a patient is required to complete something, then documenting in the EMR or elsewhere that the provider performed an assessment isn't enough or appropriate.

Mr. Wuest said it could be interpreted both ways. Nowhere does it say that it has to be a written assessment, so it could be a verbal assessment between the patient and the physician. This Subcommittee can make whatever recommendation it wants, but he would avoid trying to apply "written" when it doesn't say "written" because it could come with unintended consequences.

Discussion ensued regarding how this could be clarified for practitioners.

Further discussion ensued regarding the requirements for documentation of the assessment.

Senator Hardy said there is pool of people who are in pain who are on medicine, and the intent of Section 55 is not an assessment with respect to the initial prescription, but is probably to capture all those people who are already on pain medicine and have been getting their prescription every month for years, and the need to find out why they are still in pain after they have been on pain medicine for 90 days.

Discussion ensued regarding the requirements for documentation of the assessment, and specifically with respect to the emergency room environment.

Mr. Wuest said he wanted to point out to be clear that Section 53 requires the risk assessment at the initial prescription, so it is at the initial prescription and at 90 days.

Further discussion ensued regarding the requirements for documentation of the assessment and specifically with respect to the emergency room environment.

Dr. Muro said he thought what the Subcommittee was left with was that this is something that needs to occur when applicable, regardless of the environment, when a prescription is being initiated or continued, and how individual entities decide to incorporate it into their workflow is up to them.

Dr. Burkhead asked Mr. Edwards and Mr. Wuest to discuss clarification of Section 54(1)(d), where physicians are expected to assess the mental health and risk of abuse, dependency and addiction. He asked if this implies they are to provide a separate assessment of the mental health of the patient as well as an assessment of the risk of abuse, dependency and addiction, and if not, could that be put into the next discussion of regulations at the Board of Pharmacy level, or whether that was the appropriate place for that.

Mr. Wuest said when he looks at it, it is clear that you have to do a mental health assessment and you have to do a risk assessment, but there is nothing that prohibits combining them.

Mr. Edwards said he recalled as the law was going through the process, there was a recognition that every practice is different and every type of medicine is different, and there was an intent to not over-dictate exactly how you have to do it so the practitioners can practice in a manner that fits how they practice. So the Subcommittee needs to be cautious about trying to over-apply rules or add things into it.

Discussion ensued regarding whether, under the law, the two assessments must be independent or whether they can be combined.

Mr. Wuest said he thinks the Board of Pharmacy has the opportunity to clarify that section as it is clearly in its chapter. He said it goes back to the standard of care, and you would have to look at it on a case-by-case basis, and he thinks it is up to the practitioners to decide whether they have met the criteria of the law. This is an opportunity to direct the Medical Board that when they go to do things, this is what the Subcommittee says is the standard of care.

Dr. Pretzlaff said the thing the providers in his group fear most is ambiguity, so the Subcommittee needs to be very clear that providers need to do X, Y and Z, even if it's painful.

Dr. Muro said this is an opportunity for the Subcommittee to provide clarity in these areas that are somewhat vague. First, going back to the mental health assessment and the risk assessment, he thinks these are two separate assessments.

Dr. Pretzlaff said he would argue that, as it stands now, it is not the standard of care for an emergency room physician to, prior to providing five days of pain medication, obtain a mental health assessment.

Ms. Mastroluca said ambiguity will come if the Subcommittee keeps trying to break out for different practices what is and isn't acceptable. The regulations can't be written that way, the law isn't written that way, and the Board of Medical Examiners can't make determinations that way.

Discussion ensued regarding the requirements for the mental health assessment.

Mr. Pomerantz moved that as a group, the Subcommittee attempt to define Section 54(d) and Section 55(a); that it attempt to come up with regulations for those two provisions because there seems to be uncertainty surrounding them. Dr. Burkhead seconded the motion.

Senator Hardy asked what needed to be defined in those sections.

Mr. Pomerantz said in Section 54(d), the issue is whether you need to perform separate mental health and risk of abuse assessments, and the primary question in Section 55(a) is whether

it needs to be written or oral. If the answer is it can be written or oral, and physician extenders can administer the tool and the physician can make the assessment, so be it.

Mr. Pomerantz clarified that his motion was that the Subcommittee agree to come up with regulations defining Section 54(d) and Section 55(a). Dr. Burkhead seconded the motion.

Ms. O'Mara asked for clarification that the motion was to make a recommendation to the Board of Medical Examiners to make a recommendation to the Board of Pharmacy to come up with regulations, and Mr. Pomerantz stated it was.

Ms. O'Mara said she would prefer that the Subcommittee agree what it wants the regulations to say, and forward that recommendation to the Board. Mr. Pomerantz said he agreed.

Ms. Mastroluca said she felt that Mr. Pomerantz was just trying to ask that the Subcommittee move this along and have the conversation, and her recommendation was that he withdraw the motion and the Subcommittee have that discussion and make a decision on this.

Mr. Pomerantz withdrew his motion.

Dr. Burkhead said he would argue the intent of the law was to determine the risk of abuse and diversion, more so than the risk of intentional overdose, so the opioid risk tools and any other tools that would identify the risk of abuse and addiction should suffice to cover what was intended by including the verbiage of mental health in this section of the law.

Discussion ensued regarding the requirements for the mental health assessment.

Mr. Wuest said he was going to make an attempt at some language to address Section 54(d). Something to the effect that to meet that requirement, you have to do the peer-reviewed risk assessment and you must include at least one question regarding depression.

Further discussion ensued regarding the requirements for the mental health assessment and documentation of the risk assessment.

Senator Hardy stated the law requires that physicians use a nationally-recognized tool.

Mr. Wuest said then, at a minimum, it has to have that and two questions. And for the second question, he would say what the Subcommittee has been saying all along, which is that you have document it, but it can either be something completed by the patient or the doctor can document it in the chart that he or she performed it.

Dr. Muro suggested there could be a menu of the acceptable tools that may be used, saying he thought it would be a welcome source of guidance to the providers on the community, and providers could pick the ones that work best for them in the environment in which they are practicing.

Mr. Wuest said this would also give the practitioner the ability to blend the two things together if they choose to and just use one questionnaire if they want to.

Senator Hardy moved that the Subcommittee clarify Section 54(d) to allow for a practitioner to use a nationally recognized, scientific researched and validated form that uses at least two questions from the suggested ones the Subcommittee is going to come up with, such as

the PHQ-2, the PHQ-9, the DEX depression scale and/or any other scientific research from a nationally recognized organization assessing mental health. Dr. Suba seconded the motion.

Dr. Parikh asked if Dr. Hardy would be willing to amend his motion to say that if you blend those two questions with your assessment tool on the same form that would be allowed as well, in order to try to reduce paperwork.

Dr. Hardy accepted the amendment.

Discussion ensued regarding blending of the two assessments into one document.

Dr. Muro stated they would be two separate things, scored separately and independently, but would be accessible within the same document.

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

Ms. Mehta said as a matter of clarification, the Prescribe 365 website references four opioid risk assessment tools – the ORT, the DIER, the SOAPP-R and the SISAP, which appear to be acceptable tools. There is also a 306-page document, and she printed out Section 2 of it, which addresses opioid use disorder and general medical signs. At the end of that section, there is an appendix that has a TAPS tool for conducting a risk assessment. She said she had not had enough time to determine whether it is a peer reviewed, scientifically accepted tool; however it does include 103 citations.

Dr. Burkhead asked if it was within the scope of the Subcommittee to make recommendations to the Department of Health and Human Services (DHHS) to list specific tools on the Prescribe 365 website that are acceptable to the Medical Board and the Board of Pharmacy. Ms. Mehta said it was beyond the scope that the Board of Medical Examiners assigned to the Subcommittee, but the Subcommittee could make the recommendation that the Board ask DHHS to put it on the website, if that was the desire of the Subcommittee.

Mr. Wuest said the list of tools on the Prescribe 365 website was never meant to be all-inclusive, it was meant to provide examples of available tools.

Ms. O'Mara said she would like to work with the Nevada Psychiatric Association and ask them if they have some suggestions for the Subcommittee, which she will bring back to the Subcommittee at the next meeting.

Agenda Item 5
PUBLIC COMMENT

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

Agenda Item 6
ADJOURNMENT

Dr. Burkhead moved to adjourn the meeting. Ms. Mastroluca seconded the motion, and it passed unanimously. Dr. Muro adjourned the meeting at 4:30 p.m.

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