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NEWSLETTER

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Lessons from the Battlefield: Effective Implementation of Mass Casualty Response

By: Rachel V. Rose, JD, MBA

Overview

The first week in October proved to be one of shock, resilience and caring, as medical professionals and ordinary citizens did extraordinary things in the wake of the Las Vegas shooting from the Mandalay Bay Hotel into a crowd of nearby concert goers. Thankfully, military medical personnel like Maj. Charles Chesnut, III and Lt. Col. Jason Compton, who had "practiced assembling mobile medical operations within 10 minutes of landing in a war zone to treat wounds from high-caliber bullets, shrapnel and explosions", were available to treat the victims on the Las Vegas Strip.[1] Fifty-eight people were killed and 500 were wounded. Of those nearly 558 patients, the University Medical Center treated nearly 20%. Gunshot wounds from high-caliber ammunition were suffered by nearly 80% of those wounded or killed.[2]

Once reserved for the battlefields of war, unfortunately, these types of mass casualties have become a reality for civilian medical providers. When we consider the Boston Marathon Bombing in Boston, Massachusetts (2013), the Orlando, Florida nightclub shooting (2016) and the pedestrian car attack in New York, New York (2017), a key question emerges – are civilian hospitals and physicians equipped to transition to an effective mass casualty response?

"Effective mass casualty response is founded on the principle of ***triage***, the system of sorting and prioritizing casualties based on the tactical situation, mission, and available resources."[3] Triage is the first step in taking control of an otherwise chaotic situation. While triage is used daily in emergency rooms across the country to prioritize a patient who is having a myocardial infarction over a patient with a sore throat, the importance of prudently using resources to benefit the greatest number of people becomes paramount. Hence, the dynamic movement of casualties through the system of care from the time of injury until discharge from the medical facility becomes paramount.

The purpose of this article is to provide an overview of the military's perspective on mass casualties, as well as triage techniques. The late Red Duke, MD, one of the pioneers of transferring battlefield medicine to civilian medical treatment, collaborated with Memorial Hermann Health System (Houston, Texas) to bring a Life Flight helicopter to the Houston community. Prior to Life Flight, automobile accident victims had to rely on ambulances and pray that there was no traffic between the site of the accident and the hospital. This is just one example of military medicine that was adopted by civilian medicine. Just as important as the military's perspective and techniques is making sure physicians

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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

FSMB Calls for Improved Information Sharing Between VA and State Medical Boards

GAO report: 90% of potentially dangerous VA physicians not reported to National Practitioner Data Bank (NPDB) or state medical boards

The Federation of State Medical Boards (FSMB) testified before the House Committee on Veterans Affairs (VA) Subcommittee on Oversight and Investigations, December 1, 2017, on the issue of "Examining VA's Failure to Address Provider Quality and Safety Concerns." Members of the committee called for the hearing after a new Government Accountability Office (GAO) report found that in an audit of five VA medical facilities, eight of nine providers who had adverse privileging actions were never reported to the NPDB or state medical boards.

"Providers who are unqualified or unsafe to practice medicine in the VA should not be allowed to practice outside of, or elsewhere in, the VA, nor should such providers be able to conceal their disciplinary actions with secret settlement arrangements," said Humayun Chaudhry, DO, MACP, President and CEO of the FSMB. "Proper notification of provider disciplinary proceedings within the VA to the appropriate state medical board and the NPDB will help ensure that unsafe and dangerous physicians are identified and prevented from also treating patients outside the VA."

In his testimony, Dr. Chaudhry shared that through consultation with several state medical boards, FSMB confirmed that the VA does not always alert state boards in a timely fashion about violations, disciplinary actions, or suspected violations of a state's Medical Practice Act. He stressed that the primary mission of every state medical board is public protection, and it is imperative that boards are provided with disciplinary information so that they can carry out their critically important work.

Dr. Phil Roe (R-TN), Chairman of the House Committee on Veterans Affairs, echoed Dr. Chaudhry's concern: "One of the reasons we have such confidence in our medical system is because of our board system that allows us to make sure that patients understand when they come in that they are going to get the highest quality of care. And with no information, you're absolutely right you [state medical boards] can't do your job."

In response to the GAO report and testifying before the committee, the VA states it is currently rewriting and updating its policies and taking three major steps to improve clinical competency and reporting:

1. Reporting more clinical occupations to the NPDB
2. Improving the timeliness of reporting
3 Enhancing oversight to ensure that no settlement agreement waive VA's ability to report to NPDB and state licensing boards

To watch Dr. Chaudhry's opening statements to the committee: https://www.youtube.com/watch?v=MbrfXk14GF0&feature=youtu.be
The FSMB's full written testimony and other hearing documents can be viewed here:
http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=106654

Learn more about FSMB, visit www.fsmb.org. Follow FSMB on Twitter (@theFSMB).
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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

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

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

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

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and other healthcare professionals are taking care of their own emotional and psychological health. Overall, the aftermath of mass casualties affects victims and healthcare providers alike, and everyone involved must take an ongoing pulse of their physical, mental and emotional health.[4]

Triage

A mass casualty scenario is a place where entropy could reign supreme; however, triage provides stability and order. During a mass casualty, the allocation of resources, as well as the assessment time of the injuries, is vital to mitigating loss of life. Not everyone needs to be resuscitated. Those victims should be diverted into the appropriate medical treatment or surgical area.

There are four general categories of triage: immediate, delayed, minimal and expectant. These categories are based on the severity of injury and the timeframe for significant treatment in order to avoid death or major disability.

- **Immediate (threatened loss of limb; multiple extremity amputations; uncontrolled hemorrhage; etc.)**: these individuals are the most critical, with the greatest chance of survival, unlike those who are expectant.
- **Delayed (blunt or penetrating torso injuries without signs of shock; fracture; survivable burns; etc.)**: this group needs surgery but they can wait to undergo the treatment without a significant threat to loss of life or limb. Typically, sustaining treatment in the form of antibiotics, fracture stabilization, pain relief and gastric decompression is required.
- **Minimal (abrasions; low degree burns; small bone fractures; etc.)**: nursing staff can handle these individuals and they should be detoured away from the main medical treatment facility.
- **Expectant (no vital signs; transcranial gunshot wounds; etc.)**: although these types of casualties should not be abandoned, there should be a separate area where they can be monitored and assessed, while the greater resource allocation should go to those whose injuries have a greater chance of recovery.

Triage can form the basis for what we have learned from military medicine. And, the subsequent sections provide the history and the utilization of that knowledge into the civilian world.

The Military Perspective & Transferring Knowledge Gained From War to Civilian Mass Casualties

The American Academy of Orthopaedic Surgeons (AAOS) published a story - *Cyclical Nature of the Treatment of War Wounds*.[5] It begins, "[t]he most ancient archeological sites from around the world offer proof that from before recorded history we set bones, broken by accident and violent force, with reed, bark, wood and bamboo splints, padding them with cotton and linen."[6] From there, the historical path of treatment and triage in military medicine moves to Hippocrates and onto Galen, who is regarded as "the father of sports medicine for his treatment of Roman gladiators [and Roman Legionnairs]."[7] Now, fast forward to World War I (WW I) and, subsequently, to World War II (WW II), wherein the increasingly sophisticated artillery, chemicals and aerial-delivered bombs increased death tolls of both servicemen and women, as well as noncombatants.

Interestingly, the benefits of wound debridement and open wound techniques were forgotten until WW I. "At the start of the First World War, a gunshot femur wound resulted in 80% morbidity. By 1917, using better debridement and open wound techniques, it was down to 15%."[8] It was not until the Vietnam War that a more formal system was in place for combat surgeons and military personnel.

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> ***"Combat surgeons fall roughly into two categories: the experienced surgeon and the inexperienced. The experienced were usually part of a university-sponsored hospital team assigned to evacuation, field or general hospitals. The inexperienced were sent to battalion aid stations and collecting and clearing companies in combat zones, or to sea on combat ships. In medicine, as in all things, the military had regulations and procedures that were to be followed without questioning. Although the more experienced surgeons sometimes chafed under the restrictions, the strict parameters and the sheer numbers of the wounded helped the younger doctors quickly grow in the craft of treating and healing the wounded. They learned the lessons of wartime medicine swiftly and well. (Emphasis added.)"***[9]

The standardization of training and protocols in the context of warfare led to more efficient triage, utilization of resources and reduced death tolls. Fast forward to today, and we see that over the past forty years, these items have been refined and, in turn, adopted by civilian medical professionals. The one advantage that military surgeons have is that mass casualties are more common than not. For civilians, the one-to-four victims scenario is more common. Therefore, because civilian doctors are not dealing with the number of atrocities on a daily basis, their response time and the psychological impact on the provider is different.

As Johnathan Woodson, MD, Assistant Secretary of Defense for Health Affairs indicated, "[t]hroughout every war, the Military Health System (www.health.mil) has made significant medical advancements to help protect our troops. Our innovations not only save the lives of our service members but also impact the lives of civilians back home." Some basic attributes of military medical personnel that are readily apparent include: providing care under extreme conditions; quickly identifying and treating critical injuries on the battlefield; and using resources in a prudent manner, which often means the difference between life and death.[10]

For example, during the Boston Marathon bombing, active military and veterans who were participating in the marathon responded immediately and assisted the injured. Surveying the damage and then triaging the injuries to make sure that those most severely injured "made it to hospitals within the 'golden hour' – the window of time in which doctors have the greatest chance of preventing death."[11] The thirteen-year period from 2001 to 2014 proved to be pivotal in reducing the transport time to under an hour. This has led to the historic all-time highest rate of survival from warfare wounds.[12]

Physician Decompression After Treating Victims

"Terrorism is psychological warfare, often utilizing tactics designed to create mass casualties with maximum psychological impact."[13] Physicians and other health care providers are not immune from the side effects of treating mass casualties. Just like the patients and their families and friends, early psychiatric intervention and stress reduction techniques (e.g., yoga, exercise, hiking) are equally as important for physicians. Various medical journals have discerned two goals:[14]

> ***"Two psychiatric goals in a disaster situation are to mitigate the effect of the incident on the mental health of patients in the acute period and to prevent long-term sequelae of the incident, such as post traumatic stress disorder (PTSD). The first priority in dealing with the psychological consequences of a biological or chemical attack is addressing normal mass anxiety through "psychological first aid" and psychoeducation through the media or institutions such as schools and churches. It should be emphasized that it would be difficult to distinguish between a normal stress reaction and acute stress disorder (with the increased risk of developing PTSD) until 10 to 14 days after the incident."***[15]

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Nevada offers a cornucopia of options for physicians. Some of these are as follows:

- TRY – Trauma Recovery Yoga (http://www.traumarecoveryyoga.org/about/);
- Mental Health Specialists (702-485-2100); and
- UNLV School of Medicine Department of Psychiatry (702-253-0818).

The residual trauma that victims and providers experience during and after mass casualties provides another area where the military and civilian medicine can collaborate.

Conclusion

So, are civilian hospitals and physicians equipped to transition to an effective mass casualty response? Some hospitals are better equipped than others. Just like a disaster and recovery plan is required under the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic Act and the Clinical Health Act, hospitals, especially Level 1 Trauma Centers, should have drills, as well as ascertain what medical staff and hospital personnel are former servicemen and women. It is prudent to send physicians for training and value placed on those physicians that continue to volunteer in war zones through organizations such as Doctors Without Borders and serve our country in the Reserves or the National Guard. Their experiences could provide indispensable assistance refining hospital triage policies and procedures as well as planning preparedness drills. Psychologists and mental health professionals specializing in PTSD should also be available for post-casualty response. As Maj. Charles Chesnut, III recalled after having to tell a man who was huddled in the University Medical Center that his wife did not survive a gunshot wound to the head,"Every surgeon has a graveyard in their mind of the patients that we have lost, and we use what we learned from the patients that we lost to better care for patients in the future."[16]

[1] Tim Craig, *'Something we would see in a war zone': Military surgeons on the wounds they treated in Las Vegas*, *The Washington Post* (Oct. 5, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/10/05/something-we-would-see-in-a-war-zone-military-surgeons-on-the-wounds-they-treated-in-las-vegas/?utm_term=.9fa52afe757d.
[2] *Id*.
[3] Cubano, Miguel L, Lenhart, Martha K., *Emergency War Surgery*, Mass Casualty and Triage, Chap. 3, p.29, http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=68aca9a0-9cd7-4d8f-a17f-a4c01264daef.
[4] Johnathan Woodson, MD, *Military Medicine Benefits Civilians* (Apr. 2014), http://www.usmedicine.com/agencies/department-of-defense-dod/military-medicine-also-benefits-civilians/ (last visited Dec. 10, 2017).
[5] American Academy of Orthopaedic Surgeons, *Cyclical Nature of the Treatment of War Wounds*, http://legacyofheroes.aaos.org/About/Heroes/Essays/essay_warwounds.cfm (last visited Dec. 10, 2017).
[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] Everly, GS Jr, Mitchell JT... *America under attack: the "10 commandments" of responding to mass terrorist attacks*. *Int J Emerg Ment Health*, 2001; 3:133–135.
[14] Fetter, JC, *Psychosocial Response to Mass Casualty Terrorism: Guidelines for Physicians, Prim Care Companion J Clin Psychiatry*, 2005; 7(2): 49-52.
[15] *Id*.
[16] Tim Craig, *'Something we would see in a war zone': Military surgeons on the wounds they treated in Las Vegas*, *The Washington Post* (Oct. 5, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/10/05/something-we-would-see-in-a-war-zone-military-surgeons-on-the-wounds-they-treated-in-las-vegas/?utm_term=.9fa52afe757d.

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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.

AB474: Is Your Practice Ready?
New Controlled Substance Prescriber Law Effective January 1, 2018

By Guest Author: Catherine M. O'Mara, JD, Executive Director, Nevada State Medical Association

Every Nevadan, whether physician, patient, or citizen, has been impacted by the prevalence of opioids in our community. In response to the nationwide opioid epidemic[1] and the effects felt in Nevada, Governor Sandoval brought forth legislation known as the Prescription Drug Abuse Prevention Act (AB474).[2] Passed unanimously by the legislature, AB474 goes into effect on January 1, 2018 and will impact all prescriptions for controlled substances, although most provisions of the law uniquely apply to controlled substances prescribed to treat pain.

As an advocate for physicians, the Nevada State Medical Association (NSMA) understands that there is much angst about how to comply with the new law. It is critical that physicians (including residents) and physician assistants take the time to understand these requirements so that you can best treat your patients within the confines of the law. The key to successfully complying with AB474 is to clearly understand what is required, focus on what you can do now to prepare, and to consider some best practices to assist your workflow.

Requirements of AB474

The law's requirements are best understood broken down into five categories, with the most significant changes being the new provider guidelines found in sections 52-58 of AB474. The five categories are: (1) required reports of overdoses, (2) continuing medical education (CME) requirements; (3) mandated registry and use of the prescription monitoring program (PMP); (4) required prescription components; and (5) prescriber guidelines.

I. Providers Will Be Required to Report Cases of Overdose.

Under AB474, a physician, physician assistant, nurse or veterinarian licensed in accordance with Nevada state law will be required to report **actual or suspected** cases of drug overdoses to the State's Chief Medical Officer (State of Nevada Division of Public and Behavioral Health - DPBH). DPBH is currently working on draft regulations, and the promulgation process on these regulations will begin in early 2018. While the law is effective on January 1, 2018, the overdose reporting requirement will not kick in until after the regulatory process is concluded.

What should you do now? Look for future updates on this requirement in 2018.

II. Providers Are Required to Obtain Two Units of Continuing Medical Education on the Topic of Misuse and Abuse of Controlled Substances, the Prescribing of Opioids or Addiction.

Under the new law, all licensed providers registered to dispense controlled substances will be required to complete two (2) units of CME each licensing cycle specifically to the misuse and abuse of controlled substances, the prescribing of opioids or addiction.[3] The units may be substituted for ethics or any other general requirement. Entities like NSMA and our county medical societies, Project ECHO and others frequently offer these CME opportunities, and many exist online.

What should you do now? Look for opportunities to fulfill these two units of CME. The first two units must be completed by the 2019 Nevada State Board of Medical Examiners licensing cycle.

III. Providers with Licenses to Prescribe Must Register for and Query the PMP.

The Prescription Drug Monitoring Program (PMP)[4] is a computerized program that tracks prescriptions for controlled substances. It is housed by the Nevada State Board of Pharmacy (BOP) and is accessible at all hours through a secure website. According to data provided by the BOP, 83.5% of MD and 87.8% of DO prescribers are registered with the PMP, but only 10.7% of DOs and 15% of MDs queried the system in 2016. While we expect those numbers to be higher in 2017, the law now requires both registry and use.

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All prescribers of any controlled substance must check the patient's utilization report in the PMP before issuing an initial prescription[5] and at least once every 90 days for the duration of that course of treatment. The PMP is a tool to help the provider assess the medical necessity of prescribing the controlled substance for that patient. Providers may use extenders or agents to access the PMP but must review the information themselves. If the provider determines that the PMP does not support medical necessity or if the patient has already been issued a prescription for the same controlled substance to treat the same diagnosis for the same period of time, the provider must not issue an additional prescription.[6]

What should you do now? Register for the PMP at: https://nevada.pmpaware.net or call the Nevada Prescription Monitoring Program at 1-855-5NV-4PMP and begin checking the PMP before issuing an initial prescription and every 90 days for all controlled substances, including opioids for pain.

IV. To Be Valid, Prescriptions Must Contain the Patient's Date of Birth, ICD-10 Code, the Fewest Number of Days Necessary to Consume the Medication, and the Prescriber's Name and DEA License Number.

In addition to current requirements, all prescriptions must now contain four elements along with the medication being prescribed: (1) patient's date of birth; (2) patient's diagnosis through the ICD-10 code, (3) the lowest number of days the medication is intended for; and (4) the prescriber's name and DEA number.[7] Through regulations promulgated by the BOP, pharmacists working with prescriber offices can work to correct a lack of an ICD-10 code or a number of days dosage but cannot assign a DEA number to a prescription, even if the pharmacist personally knows the prescriber.[8] If multiple practitioners' names and DEA numbers are printed on the prescription form, the prescription cannot be filled unless the prescribing practitioner and DEA number are clearly indicated.

It is important to note that for electronic prescriptions, electronic medical record/electronic health record (EMR/EHR) systems doing business in Nevada must offer the ability to transmit a legal prescription.[9] If your practice is having any issues getting your EHR/EMR systems in place, the BOP or the NSMA can help intervene.

What should you do now? Ensure preprinted prescriptions and EMR/EHR system contain new requirement for legal prescriptions, including the ability to clearly delineate the DEA number of the prescriber.

V. All Prescribers of Controlled Substances Must Follow New Prescribing Guidelines.

The most substantive provisions of AB474 are the provider guidelines.[10] Nevada policy-makers approached this legislation with the stated objective to prioritize patient safety and responsibility and to preserve clinical judgment in the face of addressing a public health crisis. There are some requirements that apply to all prescriptions for controlled substances; however, most provisions apply only to those controlled substances prescribed to treat pain.

a. Prescriptions for All Controlled Substances Require the Prescriber to Query the PMP, Consider Important Factors Prior To Prescribing and Write the Prescription in Accordance with the New Law.

For all prescriptions of controlled substances, the prescriber must query the PMP upon initial prescription and at least once every 90 days during the course of treatment. Here, the provider is using the PMP as a tool to consider medical necessity and must refrain from prescribing if the prescription is not medically necessary or if another prescription exists to cover that diagnosis and time.

Providers must also consider certain factors, if applicable, prior to prescribing. These factors are itemized in the law, and include considerations such as any history of aberrant behavior or public intoxication, unauthorized increase in dosage of controlled substance, or substance abuse, any evidence that the patient has been addicted to, misused, abused or diverted a controlled substance, reluctance to discontinue usage despite improvement, lack of cooperation, or discharge from other provider clinics, any changes in the patient's health (such as pregnancy), or any other factors that may that may influence or affect the decision to prescribe.[11]

In addition, the prescription for any controlled substance must contain the statutory requirements as explained above: current requirements plus patient's date of birth, ICD-10 diagnosis, minimum number of days for the prescription and the prescriber's name and DEA license number.

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b. Prescriptions for Controlled Substances to Treat Pain Have Additional Requirements.

Prescriptions for controlled substances issued to treat pain include the above requirements and more. Although the hard caps prevalent in other states are not found in the new Nevada law, the general guidelines on prescribing controlled substances for pain include three specific "restrictions" to achieve policy objectives.

First, a patient may not receive more than 365-days' worth of controlled substances to treat pain during a 365-day period, or 90-days' worth of medication in a 90-day period.[12] This is intended to reduce overprescribing and duplicative prescribing.

Second, initial prescriptions for a controlled substance to treat acute pain may be no more than 14 days – and allow for one refill.[13] This was a negotiated provision, intended to strike a balance between reducing the amount of prescribed controlled substances initially issued for an acute injury without requiring the patient to seek a refill or be required to follow up after only 7 days. It may be appropriate to prescribe less than 14 days for an acute injury. Emergency departments routinely prescribe less than 7 days and national pharmacy chains such as CVS have implemented a 7-day maximum on prescriptions for acute pain.[14] The Nevada law, however, allows you to prescribe an initial prescription of 14 days if your clinical judgment determines this is appropriate.

Third, prescriptions for opiates written to an opioid naïve patient (a patient who has not had an opiate for 19 days) may not be more than 90 morphine milligram equivalents (MME).[15] This is intended to encourage prescribing of the lowest effective dosage and tracks guidance by the CDC guidelines that encourages "go low and go slow."[16] Note that if you inherit a patient that has been issued an opiate, you are not subject to this restriction; however, you should use your clinical judgment to prescribe within the standard of care.

c. Requirements for Prescriptions for Controlled Substances to Treat Pain Increase as You Prescribe for Under 30 Days, 30 Days, and 90 Days.

Before issuing an initial prescription, a practitioner must have a bona fide relationship with the patient. The practitioner must perform an evaluation and risk assessment of the patient that includes obtaining and reviewing the medical history, checking the PMP, conducting a physical examination, making a good faith effort to obtain medical records and documenting this effort and any conclusions, assessing the patient's mental health and risk of abuse, dependency and addiction of the patient using a method supported by peer-reviewed scientific research and validated by a nationally recognized organization. Lastly, the practitioner must obtain an informed consent in writing from the patient prior to prescribing. The statute requires certain components be included in the written **informed consent**.[17]

If the course of treatment goes beyond 30 days, you must complete a **prescription medication agreement** with the patient.[18] The agreement needs to be updated once per year. Like the informed consent, the statute mandates that this agreement contain certain provisions.[19] For example, it must include, among many other requirements, the treatment goals, the requirement to take the controlled substance as prescribed, and it must include consent to drug testing as deemed necessary by the provider.[20] Notably, while the patient must consent to undergo drug testing if required by the clinician, these drug tests themselves are not mandated. Instead it is left up to the provider, in his or her clinical judgment, to require drug testing as deemed medically necessary.

If the course of treatment goes beyond 90 days, the provider must obtain an evidence-based diagnostic work-up. For example, any previous diagnosis of "chronic pain" or "lower back pain" should be replaced by a diagnosis of the cause of the pain. The Provider must discuss the treatment plan with patient and assess the patient for risk of adverse effects from long-term use of controlled substances. The Provider must check the PMP (once every 90 days for the course of the treatment) and review a patient's completed **Risk of Abuse Assessment**. For example, a provider can utilize "Screener and Opioid Assessment for Patients with Pain" known as (SOAPP-R) or the Opioid Risk Tool (ORT). These tools are brief self-report screening tools that will assist the provider in determining the medical necessity and risks associated with continued prescribing of controlled substances. If the patient is receiving a prescription in an amount great than 90 MME, the provider should consider referral to a pain management specialist.

If treatment lasts beyond 90 days, remember that the law requires that you provide no more than 365-days' worth of controlled substance medication for pain during a 365-day period. Providers should continue to treat patients in accordance with their clinical judgment and the standard of care. If, in the interests of patient care, the provider must deviate from the 365-day requirement, the reasoning must be clearly documented in the patient's medical record.[21]

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What should you do now? Consider Some Best Practices for Successful Compliance with AB474:

- Contact your patients and let them know that there has been a change in the law that will affect the way you prescribe controlled substances for pain.
- Work with your office managers and other colleagues to plan out your workflow.
- Consider making templates for your EMR/EHR to check off required elements, particularly those that need to be documented:
    - At initial prescription: risk factors considered prior to prescribing, PMP check, attempts to obtain prior medical records and conclusions, consideration of alternatives to opioid therapy and reasons why not selected, obtained informed consent
    - At 30 days: create prescription medication agreement
    - At 90 days: Risk of Abuse Assessment, Evidence-Based Diagnosis and Revised Treatment Plan, PMP check, and consider referral
    - At 365 days: update prescription medication agreement
- Obtain important sample forms and risk assessment tools. NSMA, the Department of Public and Behavioral Health and Safety and the state licensing boards will have many resources available and accessible online. Links to these websites and other resources can be found online at www.nvdoctors.org.
- State issued prescriber and patient resources can be accessed at Prescribe365.nv.gov.
- Ask for help! NSMA advocates for Nevada's physicians. NSMA is sponsoring many educational forums on AB474 around the state and is actively working with practice groups and practice group managers to assist in implementation. NSMA members are welcome to contact us at (775) 825-6788 to review workflow issues or set up a CME.

[1] The United States is 5% of the world's population and consumes 80% of the world's supply of opioids, 75% of the worlds supply of oxycodone, and 99% of the world's supply of hydrocodone. Manchikanti L, et al. Pain Physician. 2008 Mar;11(2 Suppl):S63-88; Kenan K, et al. Open Med. 2012 Apr 10;6(2):e41-7

[2] AB474 text can be accessed at https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB474_EN.pdf

[3] CME requirement found in AB474 Section 16; *See also* Nevada State Board of Medical Examiners LCB File No. R163-16

[4] Register for the PMP at https://nevada.pmpaware.net or call.

[5] The "Initial prescription" means a prescription originated for a new patient of a practitioner, other than a veterinarian, or a new prescription to begin a new course of treatment for an existing patient of a practitioner, other than a veterinarian. The term does not include any act concerning an ongoing prescription that is issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner.

[6] AB474, Section 60

[7] AB474, Section 61

[8] The Nevada State Board of Pharmacy has adopted new regulations amending NAC 453.440 to reflect these changes in the law. *See* LCB File No. R046-17.

[9] NAC 639.7102(1)(a) permits a practitioner to issue a prescription using a computer system approved by the Board. After January 1, 2018, any such system will need to comply with the new requirements to be approved.

[10] AB474 Sections 52-58. These provisions do not apply to veterinarians.

[11] An exhaustive list of factors is found in AB474 Section 57: Whether there is reason to believe that the patient is not using the controlled substance (CS) as prescribed, or is diverting the CS for use by another person; where the patient was previously prescribed the CS, whether it had the expected effect on the patient's symptoms for which it was prescribed; whether there is reason to believe that the patient is using other drugs, including, without limitation, alcohol or another CS that: may interact negatively with the CS prescribed by the practitioner; or was not prescribed by a practitioner who is treating the patient; the number of attempts by the patient to obtain an early refill of the prescription; the number of times the patient has claimed that the CS has been lost or stolen; irregular or inconsistent information in the patient's PMP Report that may indicate the patient is using the CS inappropriately; whether previous blood or urine tests indicate inappropriate use of the CS; the need to verify that unauthorized CS are not present in the patient's body; whether the patient has demonstrated aberrant behavior or intoxication; whether the patient has increased his or her dose of the CS without the practitioner's authorization; whether the patient has been reluctant to stop using the CS or has requested or demanded a CS that is likely to be abused or cause dependency or addiction; whether the patient has been reluctant to cooperate with any examination, analysis or test recommended by the practitioner; whether the patient has a history of substance abuse; any major change in the patient's health that would affect the medical appropriateness of the CS; other evidence that the patient is misusing or is addicted to any drug, or is failing to comply with the practitioner's instructions; any other factor that will help the practitioner make an informed decision as to the medical necessity and appropriateness of the CS.

[12] AB474, Section 52(1)

[13] AB474, Section 52(2)(a) and 53(2)

[14] https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

[15] AB474, Section 52(2)(b)

[16] https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

[17] AB474, Section 54(2): The informed written consent must include information concerning: (a) The potential risks and benefits of treatment using the controlled substance, including if a form of the controlled substance that is designed to deter abuse is available, the risks and benefits of using that form; (b) Proper use of the controlled substance; (c) Any alternative means of treating the symptoms of the patient and the cause of such symptoms; (d) The important provisions of the treatment plan established for the patient in a clear and simple manner; (e) The risks of dependency, addiction and overdose during treatment using the controlled substance; (f) Methods to safely store and legally dispose of the controlled substance; (g) The manner in which the practitioner will address requests for refills of the prescription, including, without limitation, an explanation of the provisions of section 55 of this act, if applicable; (h) If the patient is a woman between 15 and 45 years of age, the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome; (i) If the controlled substance is an opioid, the availability of an opioid antagonist without a prescription; and (j) If the patient is an unemancipated minor, the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

[18] AB474, Section 56

[19] AB474, Section 56(2): A prescription medication agreement entered into pursuant to subsection 1 must include, without limitation: (a) The goals of the treatment of the patient; (b) Consent of the patient to testing to monitor drug use when deemed medically necessary by the practitioner; (c) A requirement that the patient take the controlled substance only as prescribed; (d) A prohibition on sharing medication with any other person; (e) A requirement that the patient inform the practitioner: (1) Of any other controlled substances prescribed to or taken by the patient; (2) Whether the patient drinks alcohol or uses marijuana or any other cannabinoid compound while using the controlled substance; (3) Whether the patient has been treated for side effects or complications relating to the use of the controlled substance, including, without limitation, whether the patient has experienced an overdose; and (4) Each state in which the patient has previously resided or had a prescription for a controlled substance filled; (f) Authorization for the practitioner to conduct random counts of the amount of the controlled substance in the possession of the patient; (g) The reasons the practitioner may change or discontinue treatment of the patient using the controlled substance; and (h) Any other requirements that the practitioner may impose.

[20] AB474, Section 56 The Treatment agreement must contain without limitation: (a) The goals of the treatment of the patient; (b) Consent of the patient to testing to monitor drug use when deemed medically necessary by the practitioner; (c) A requirement that the patient take the controlled substance only as prescribed; (d) A prohibition on sharing medication with any other person; (e) A requirement that the patient inform the practitioner: (1) Of any other controlled substances prescribed to or taken by the patient; (2) Whether the patient drinks alcohol or uses marijuana or any other cannabinoid compound while using the controlled substance; (3) Whether the patient has been treated for side effects or complications relating to the use of the controlled substance, including, without limitation, whether the patient has experienced an overdose; and (4) Each state in which the patient has previously resided or had a prescription for a controlled substance filled; (f) Authorization for the practitioner to conduct random counts of the amount of the controlled substance in the possession of the patient; (g) The reasons the practitioner may change or discontinue treatment of the patient using the controlled substance; and (h) Any other requirements that the practitioner may impose.

[21] AB474, Section 52(1)

Disclosure: The information contained in this article does not constitute legal advice. The author is not acting as your attorney and makes no claims, promises or guarantees about the accuracy, completeness, or adequacy of the information contained herein. Any opinions expressed are the sole opinions of the author and do not represent the Nevada State Medical Association or the Nevada State Board of Medical Examiners members or staff. Nothing that you read should be used as a substitute for the advice of competent legal counsel.

Antimicrobial Resistance – An Emergency in Nevada

By Guest Author: James M. Wilson V, MD, FAAP, Director, Nevada Medical Intelligence Center, School of Community Health Sciences, University of Nevada, Reno

Antimicrobial (antibiotic) resistance is a serious problem here in the state of Nevada. The World Health Organization (WHO) has indicated the spread of antimicrobial resistance has accelerated and is the direct result of inappropriate use. While the agricultural and food industry plays a role in this, the medical community is a major contributor to resistance through overprescribing and inappropriate antibiotic selection.

In the state of Nevada, the University of Nevada, Reno deployed the Antimicrobial Resistance Intelligence System (ARIS) in partnership with our healthcare and public health institutions and laboratory providers to analyze resistance data across all care settings and patient age groups. As shown in Table 1, we are seeing dangerous indicators of antimicrobial resistance.

Typically, maximal antimicrobial resistance is seen in Long Term Acute Care (LTAC) among our older, sicker patients. But after mixing these patients with other care settings such as the intensive care unit or outpatient clinic, we see "echoes" of similar resistance patterns there as well. We see resistance spread from the sicker patients to the healthy and from the old to the young.

	Bacteria			
Nevada Care Setting	***Staph aureus***	***E. coli***	***Pseudomonas***	***Acinetobacter***
Long Term Acute Care (LTAC)	MDR/MRSA	MDR	XDR (PDR?)	XDR (PDR?)
Acute Care (ED, inpatient, ICU)	MDR/MRSA	MDR	XDR	XDR (PDR?)
Outpatient	MDR/MRSA	MDR	susceptible	XDR (PDR?)

MDR= Multi-Drug Resistant bacteria non-susceptible to 1 or more agent in 3 or more antimicrobial categories
XDR= eXtremely Drug Resistant bacteria non-susceptible to 1 or more agent in all but 2 or less antimicrobial categories
PDR= Pan Drug Resistant bacteria non-susceptible to all antimicrobials

E. coli is the most common bacteria isolated in clinical medicine. It has been Multi-Drug Resistant (MDR) status for at least a decade in Nevada, and we expect to lose three more antimicrobial categories within the next ten years and progress to eXtremely Drug Resistant (XDR) status. We are concerned that *Pseudomonas* and *Acinetobacter* will approach Pan Drug Resistant (PDR) status (if we are not already there). We are seeing *Acinetobacter* resistance reported annually for our last line of antimicrobials, colistin. So, our antimicrobial resistance trends are not reassuring - there is ongoing progression of resistance.

The answer to uncontrolled antimicrobial resistance is stewardship. The Infectious Diseases Society of America (IDSA) (2017)[1] defines antimicrobial stewardship as:

"… coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration. Antimicrobial stewards seek to achieve optimal clinical outcomes related to antimicrobial use, minimize toxicity and other adverse events, reduce the costs of health care for infections, and limit the selection for antimicrobial resistant strains. Currently, there are no national or coordinated legislative or regulatory mandates designed to optimize use of antimicrobial therapy through antimicrobial stewardship. ***Given the societal value of antimicrobials and their diminishing effectiveness due to antimicrobial resistance, IDSA supports broad implementation of antimicrobial stewardship programs across all health care settings (e.g., hospitals, long-term care facilities, long-term acute care facilities, ambulatory surgical centers, dialysis centers, and private practices.")***

Here in the state of Nevada, the situation represents an emergency. The good news is there are now many peer-reviewed studies showing that effective stewardship will not only halt the progression of resistance but even return susceptibility. We have seen gentamicin and tetracycline resistance patterns for some care settings revert to susceptibility status in Nevada. This is due to low usage among healthcare providers.

The first step is recognition we have a serious problem in Nevada, and are most certainly in the same boat as the rest of the country on this issue. It is "all hands on deck", and requires all of us to row together to succeed. At the University of Nevada, Reno, we host a series of operationally-focused Antimicrobial Stewardship Summits every six months. There we review the latest antimicrobial resistance intelligence for Nevada and discuss best practices in stewardship. We heartily encourage you to attend these important meetings. In the meantime, we have released adult outpatient empiric prescribing guidelines based on our review of the antimicrobial resistance intelligence. We strongly recommend your consideration of these guidelines.

[1] http://www.idsociety.org/Stewardship_Policy/

James Miller Wilson V, MD FAAP is Director of the Nevada Medical Intelligence Center at the University of Nevada, Reno. Dr. Wilson provided warning of the 2009 H1N1 influenza pandemic and recognition of the United Nations as the source of the 2010 cholera disaster in Haiti. He is an international expert in health security intelligence.

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.

HealthInsight Encourages Antibiotic Stewardship

By Guest Author: Vicky Kolar, EMT-P, Project Manager, HealthInsight Nevada

The time for Antibiotic Stewardship is now. Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) are driving the initiative with calls for action. In November 2016, CDC released the core elements for outpatient antibiotic stewardship. Outpatient antibiotic stewardship consists of four core measures:

1. Commitment
2. Action for policies and practices
3. Tracking and reporting
4. Education and expertise

CDC previously released hospital core measures and skilled nursing/long term acute care core measures, followed by guidance directing skilled nursing and long-term acute centers to implement stewardship by November 2017.

Antibiotic overprescribing is not a new issue faced by the United States, however as it continues, the threat to existing antibiotics effectiveness lingers and increases. Primary care physicians account for 110.8 million of the 269 million antibiotic prescriptions in 2015[1], demonstrating that outpatient providers lead in antibiotic prescribing. Approximately 750 out of 1000 Nevadans received antibiotic prescriptions in 2011[2]. Appropriately prescribed antibiotics are a necessary and needed intervention in caring for patients. However, at least 30 percent of all antibiotics prescribed in primary care, emergency departments and hospital clinics are unnecessary.[3]

HealthInsight has partnered with the Nevada State Medical Association Antibiotic Task Force to assist practices within Nevada establishing antibiotic stewardship programs. Currently, 183 outpatient clinics, emergency departments and federally qualified health centers have joined the initiative and committed to antibiotic stewardship.

Reoccurring concerns among the participants and within the outpatient provider community are patient demands for antibiotic prescriptions, coupled with a willingness to engage and change providers until they receive prescriptions they are seeking. To this end, patients' willingness to supply poor reviews and negative comments on surveys expressing their dissatisfaction with providers further complicates overprescribing and lack of stewardship. Providers acknowledge the weight placed in their treatment decisions and implementation of stewardship programs. CDC suggests the total inappropriate antibiotic use, unnecessary use and inappropriate selection, dosing and duration of prescribing may account for 50 percent of all outpatient antibiotic use[4].

HealthInsight works to help Nevada participants and outpatient providers find positive solutions and interventions to care for patients, while offering tools to mitigate patient demands and clarify misunderstandings regarding antibiotics. HealthInsight can assist with the implementation of watchful waiting, delayed prescribing and viral prescription initiatives in clinics.

Viral prescriptions offer providers the opportunity to write detailed instructions for a patient's viral illness in a prescription format. This helps create an understanding for viral versus bacterial prescribing and can assist with reducing antibiotic demand.

An antibiotic stewardship tool kit is available at https://healthinsight.org/tool-kit. The tool kit offers materials for watchful waiting, delayed prescribing, viral prescriptions and patient education. Additional educational materials for the patient, provider and clinician are available at CDC Antibiotic Awareness at https://www.cdc.gov/antibiotic-use/week/index.html. CDC offers provider education modules at https://www.cdc.gov/antibiotic-use/community/for-hcp/continuing-education.html.

HealthInsight is currently working with the University of Nevada, Reno (UNR) Antimicrobial Summit and Project ECHO to promote and improve outpatient setting stewardship. The Antimicrobial Summit is conducted by the Medical Intelligence Center to update CDC Outpatient Prescriber Guidance. The Medical Intelligence Center utilizes culture and sensitivity data from patients within Nevada and local antibiograms to update the prescriber guidance scaled to Nevada-specific detail based on exhibited resistance patterns. Project ECHO offers Antibiotic Stewardship ECHO clinics the third Thursday of each month from 12:15 pm to 1 pm. Providers that would like to have a case review can submit an Antibiotic Stewardship Case Presentation request to discuss at the next clinic. For more information, to register for the monthly clinic, or submit a case, please visit the UNR School of Medicine Antibiotic Stewardship ECHO Clinic website at https://med.unr.edu/echo/clinics/antibiotic-stewardship.

The most effective way to preserve the power of antibiotics for the future is by implementing stewardship programs that include watchful waiting, delayed prescribing, and incorporating antibiograms in prescribing decisions including length and dosing. Quality staff and patient education regarding virus versus bacterial when antibiotics are indicated, and completing antibiotic prescriptions as directed, will further support stewardship and preserve antibiotics for future use in medicine.

[1] Centers for Disease Control and Prevention. Outpatient antibiotic prescriptions the United States, 2015. Available via the internet: https://www.cdc.gov/antibiotic-use/community/pdfs/Annual-Report-2015.pdf.
[2] https://www.cdc.gov/antibiotic-use/community/images/programs-measurement/usmap-2011.jpg.
[3] Fleming-Dutra, K., et al. (2017). "Prevalence of Inappropriate Antibiotic Prescriptions Among US Ambulatory Care Visits, 2010-2011. "Jama: the Journal of the American Medical Association 315(17): 1864-1873.
[4] https://www.cdc.gov/antibiotic-use/community/programs-measurement/measuring-antibiotic-prescribing.html.

For a copy of the Nevada Empiric Outpatient Prescriber Guidance, assistance with implementing a stewardship program within your clinic, or additional materials, please contact Vicky Kolar at vkolar@healthinsight.org.

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.

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NEVADA PSYCHIATRIC ASSOCIATION
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Lesley Dickson, MD, FAPM, LFAPA, attended the University of Kentucky College of Medicine where she also completed a residency in psychiatry. She is ABPN board certified in general psychiatry and addiction psychiatry. She has been on the faculties of the University of Kentucky, New York University, UNSOM and Touro. She worked as an inpatient psychiatrist for VA Hospitals in New York City and Las Vegas.

She is now the Las Vegas Medical Director for the Center for Behavioral Health which operates opiate substitution programs. Dr. Dickson is a Past President of the Nevada Psychiatric Association and is now the Executive Director. She has served as a Trustee of the Clark County Medical Society and was a member of the Nevada State Medical Association Council.

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INVESTIGATIVE COMMITTEE STATS 2016

Investigative Committee A

Total Cases Considered	553
Total Cases Authorized for Filing of Formal Complaint (to be Published)	37
Total Cases Authorized for Peer Review	56
Total Cases Requiring an Appearance	55
Total Cases Authorized for a Letter of Concern	101
Total Cases Authorized for Further Follow-up or Investigation	24
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	280

Investigative Committee B

Total Cases Considered	350
Total Cases Authorized for Filing of Formal Complaint (to be Published)	11
Total Cases Authorized for Peer Review	34
Total Cases Requiring an Appearance	19
Total Cases Authorized for a Letter of Concern	82
Total Cases Authorized for Further Follow-up or Investigation	8
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	196

INVESTIGATIVE COMMITTEE STATS 2017

Investigative Committee A, Year to Date

Total Cases Considered	440
Total Cases Authorized for Filing of Formal Complaint (to be Published)	25
Total Cases Authorized for Peer Review	66
Total Cases Requiring an Appearance	42
Total Cases Authorized for a Letter of Concern	92
Total Cases Authorized for Further Follow-up or Investigation	13
Total Cases Reviewed for Compliance	2
Total Cases Authorized for Closure	202

Investigative Committee B, Year to Date

Total Cases Considered	420
Total Cases Authorized for Filing of Formal Complaint (to be Published)	4
Total Cases Authorized for Peer Review	42
Total Cases Requiring an Appearance	30
Total Cases Authorized for a Letter of Concern	76
Total Cases Authorized for Further Follow-up or Investigation	7
Total Cases Reviewed for Compliance	2
Total Cases Authorized for Closure	259

LICENSING STATS 2016

In 2016, the Board issued the following total licenses:

- 665 physician licenses
- 178 limited licenses for residency training
- 112 physician assistant licenses
- 148 practitioner of respiratory care licenses
- 15 perfusionist licenses

LICENSING STATS 2017 – *YEAR TO DATE (12/19/2017)*

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

- 805 physician licenses
- 171 limited licenses for residency training
- 110 physician assistant licenses
- 148 practitioner of respiratory care licenses
- 21 perfusionist licenses

WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Edward O. Cousineau, JD Executive Director
	Jasmine K. Mehta, JD 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

2018 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day (observed)
January 15 – Martin Luther King, Jr. Day
February 19 – Presidents' Day
March 2-3 – Board meeting
May 28 – Memorial Day
June 1-2 – Board meeting
July 4 – Independence Day
September 3 – Labor Day
September 7-8 – Board meeting
October 26 – Nevada Day
November 12 – Veterans' Day (observed)
November 22 & 23 – Thanksgiving Day & Family Day
November 30 and December 1 – Board meeting (Las Vegas)
December 25 – Christmas

Nevada State Medical Association
5355 Kietzke Lane
Suite 100
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
5355 Kietzke Lane
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Reno, NV 89511
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775-825-0785 fax
http://www.wcmsnv.org

Nevada State Board of Pharmacy
431 W. Plumb Lane
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775-850-1444 fax
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pharmacy@pharmacy.nv.gov

Nevada State Board of Osteopathic Medicine
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Henderson, NV 89074
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www.bom.nv.gov

Nevada State Board of Nursing
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702-486-5800 phone
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Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
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775-687-7707 fax
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

BOSS, Donald J., M.D. (11086)
Rancho Palos Verdes, California

Summary: Disciplinary action taken against Dr. Boss' medical licenses in California and Illinois, alleged failure to report disciplinary action taken against his medical licenses in California, Kentucky and Illinois to the Nevada State Board of Medical Examiners, and alleged failure to disclose a criminal conviction on his license renewal application.

Charges: Two violations of NRS 630.301(3) [disciplinary action taken against his medical license in another state]; three violations of NRS 630.306(1)(k) [failure to report in writing, within 30 days, disciplinary action taken against him by another state]; one violation of NRS 630.304(1) [obtaining, maintaining or renewing a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Boss violated NRS 630.306(1)(k), as set forth in Count III of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $500.00 fine; (3) one hour of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts I, II, IV, V and VI of the Complaint were dismissed with prejudice.

BRAUNSTEIN, Michael C., M.D. (3143)
Las Vegas, Nevada

Summary: Alleged failure to adequately supervise a medical assistant, aiding an unlicensed person to engage in the practice of medicine, failure to maintain appropriate medical records related to treatment of patients, engaging in conduct which was in violation of a regulation adopted by the State Board of Pharmacy, and malpractice.

Charges: One violation of NRS 630.306(1)(r) [failure to adequately supervise a medical assistant]; one violation of NRS 630.305(1)(e) [aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine]; 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 630.306(1)(b)(3) [engaging in conduct which is in violation of a regulation adopted by the State Board of Pharmacy]; one violation of NRS 630.301(4) [malpractice].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Braunstein violated NRS 630.306(1)(r), NRS 630.3062(1) and NRS 630.306(1)(b)(3), as set forth in Counts I, III and IV of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $500.00 fine; (3) three hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts II and V of the Complaint were dismissed with prejudice.

BURGOS, Jorge Y., M.D. (10622)
Las Vegas, Nevada

Summary: Engaging in conduct that brings the medical profession into disrepute and conviction of criminal offenses.

Charges: One violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute]; one violation of NRS 630.301(11)(d) [conviction of sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime]; one violation of NRS 630.301(11)(g) [conviction of an offense involving moral turpitude].

Disposition: On December 1 2017, the Board accepted a Settlement Agreement by which it found Dr. Burgos violated NRS 630.301(9), NRS 630.301(11)(d) and NRS 630.301(11)(g), as set forth in the First Amended Complaint, and imposed the following discipline against him: (1) Dr. Burgos' license to practice medicine in the state of Nevada shall be suspended for four months, with the suspension to be lifted on 4/2/18; (2) His license to practice medicine in the state of Nevada shall be placed on probation for an indeterminate period of time, subject to various terms and conditions; (3) public reprimand; (4) six hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (5) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

KIA, Ali, M.D. (11940)
Las Vegas, Nevada

Summary: Disciplinary action taken against Dr. Kia's medical license in California.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Kia violated NRS 630.301(3), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) one hour 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.

KRUGER, Chad G., RRT (RC214)
Henderson, Nevada

Summary: Alleged participation in criminal conspiracy to commit insurance fraud and conviction for such.

Charges: One violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Mr. Kruger violated NRS 630.301(9), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) three 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.

LORENZO, Angela L., PA (PA816)
Las Vegas, Nevada

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

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

Action Taken: On September 28, 2017, the Investigative Committee summarily suspended Ms. Lorenzo's license until

Continued from page 15

further order of the Investigative Committee or the Board of Medical Examiners.

MIRKIA, Kiarash L., M.D. (12548)
Las Vegas, Nevada

Summary: Alleged failure to disclose suspension of his medical staff member and clinical privileges at a hospital on his license renewal application, engaging in conduct which was in violation of regulations adopted by the State Board of Pharmacy, and failure to maintain appropriate medical records related to treatment of a patient.

Charges: One violation of NRS 630.304(1) [obtaining, maintaining or renewing a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement]; three violations of NRS 630.306(1)(b)(3) [engaging in conduct which is in violation of a regulation adopted by the State Board of Pharmacy]; one violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Mirkia violated NRS 630.304(1) and NRS 630.306(1)(b)(3), as set forth in Counts I and II of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $500.00 fine; (3) three hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts III, IV and V of the Complaint were dismissed with prejudice.

VIRDEN, Charles P., M.D. (7420)
Reno, Nevada

Summary: Alleged failure to maintain appropriate medical records related to his treatment of 10 patients, altering medical records of 1 patient, and aiding an unlicensed person to engage in the practice of medicine.

Charges: Ten violations of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; 1 violation of NRS 630.3062(2) [altering medical records of a patient]; 11 violations of NRS 630.305(1)(e) [aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Virden 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. All other allegations contained in the Complaint were dismissed with prejudice.

ZIAEI, Poupak P., M.D. (12525)
Las Vegas, Nevada

Summary: Alleged failure to disclose criminal action against her on her license renewal application, failure to report criminal action taken against her to the Nevada State Board of Medical Examiners, engaging in conduct intended to deceive, engaging in conduct that brings the medical profession into disrepute, engaging in conduct which was in violation of a regulation adopted by the State Board of Pharmacy, failure to maintain appropriate medical records related to treatment of a patient, inability to practice medicine with reasonable skill and safety because of the use of drugs, narcotics or other substances, and failure to be found competent to practice medicine as a result of an examination to determine medical competency.

Charges: One violation of NRS 630.304(1) [obtaining, maintaining or renewing a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement]; three violations of NRS 630.306(1)(l) [failure to report in writing, within 30 days, any criminal action taken or conviction obtained against her in this state or any other state]; two violations of NRS 630.306(1)(b)(1) [engaging in conduct which is intended to deceive]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute]; three violations of NRS 630.306(1)(b)(3) [engaging in conduct which is in violation of a regulation adopted by the State Board of Pharmacy]; 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 630.306(1)(a) [inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance]; one violation of NRS 630.306(1)(m) [failure to be found competent to practice medicine as a result of an examination to determine medical competency].

Disposition: On December 1, 2017, the Board accepted a Settlement Agreement by which it found Dr. Ziaei violated NRS 630.306(1)(b)(3), as set forth in Counts VIII and IX of the Complaint, NRS 630.3062(1), as set forth in Count XI of the Complaint, NRS 630.306(1)(a), as set forth in Count XII of the Complaint, and NRS 630.306(1)(m), as set forth in Count XIII of the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter; (3) if Dr. Ziaei chooses to apply for reinstatement of her license to practice medicine in Nevada, or if she applies for licensure anew after expiration of the reinstatement period, and if she satisfies all other applicable licensing requirements, she will be required to undergo an evaluation to determine her fitness to practice medicine, at her own expense. She will be required to appear at a regularly scheduled meeting of the Board subsequent to submittal of an application for reinstatement of license, or licensure anew after expiration of the reinstatement period. Counts I, II, IV, V, VI, VII and X of the Complaint shall be dismissed with prejudice and Count III shall be dismissed without prejudice.

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Public Reprimands Ordered by the Board

December 12, 2017

Donald Jeffrey Boss, M.D.
30057 Avenida Tranquila
Rancho Palos Verdes, CA 90275

Dr. Boss:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-29055-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1)(k), failure to report disciplinary action taken by the Medical Board of California. For the same, you shall receive a public reprimand; take one (1) hour 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Michael C. Braunstein, M.D.
939 S. Decatur Blvd.
Las Vegas, NV 89107

Dr. Braunstein:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-4698-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1)(r), failing to adequately supervise a medical assistant; Nevada Revised Statute 630.3062(1), failing to maintain proper medical records; and Nevada Revised Statute 630.306(1)(b)(3), engaging in conduct that violated regulations of the Nevada State Board of Pharmacy. 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Jorge Ysacc Burgos, M.D.
c/o Crane Pomerantz, Esq.
SklarWilliams, PLLC
410 S. Rampart Blvd., Suite 350
Las Vegas, NV 89145

Dr. Burgos:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-26547-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(9), engaging in conduct that brings the medical profession into disrepute; Nevada Revised Statute 630.301(11)(d), conviction of a sexually related crime; and Nevada Revised Statute 630.301(11)(g), conviction of an offense involving moral turpitude. For the same, you shall receive a public reprimand; suspension of your license to practice medicine in the State of Nevada for four (4) months (suspended license status to be lifted on Monday, April 2, 2018); term of probation at forty-eight (48) months; take six (6) 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Ali Kia, M.D.
3022 S. Durango Drive, #100
Las Vegas, NV 89117

Dr. Kia:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-27978-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3), disciplinary action by another licensing authority, to wit: the Medical Board of California. For the same, you shall receive a public reprimand; take one (1) hour 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

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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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Chad Kruger, RRT.
3025 Cooper Creek Drive
Henderson, NV 89074

Mr. Kruger:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-23950-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(9), disreputable conduct. 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Kiarash L. Mirkia, M.D.
9050 West Warm Springs Road, Suite 2179
Las Vegas, NV 89148

Dr. Mirkia:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-32904-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.304(1), renewing a license by misrepresentation; and Nevada Revised Statute NRS 630.306(1)(b)(3), engaging in conduct that violates regulations adopted by the state board of pharmacy for prescribing in 2014 only. 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Charles P. Virden, M.D.
c/o Ed Lemons, Esq.
6005 Plumas Street, Third Floor
Reno, NV 89519

Dr. Virden:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 16-10736-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), failure to maintain proper medical records for ten (10) patient 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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

December 12, 2017

Poupak P. Ziaei, M.D.
c/o Monte Neil Stewart, Esq.
Wright, Stanish & Winckler
300 South Fourth Street, Suite 701
Las Vegas, NV 89101

Dr. Ziaei:

On December 1, 2017, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee (IC) in relation to the formal Complaint filed against you in Case Number 17-32905-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1)(b)(3) (Counts VIII and IX as set forth in the Complaint), engaging in conduct which is in violation of a regulation adopted by the State Board of Pharmacy; Nevada Revised Statute 630.3062(1), failure to maintain timely,

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legible, accurate and complete medical records; Nevada Revised Statute 630.306(1)(a), inability to practice medicine with reasonable skill and safety; and Nevada Revised Statute 630.306(1)(m), failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318. For the same, you shall receive a public reprimand; and pay the fees and costs related to the investigation and prosecution of this matter.

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

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144