News & Views

Citizen Advocacy Center

First Quarter, 2008 A Health Care Public Policy Forum Volume 20 Number 1

Announcements

SAVE THE DATES:
We will convene a multi-disciplinary Continuing Competence Workshop May 12 and 13, 2008, in Washington, DC. Please visit our website at www.cacenter.org for more information and for registration forms.

Our 2008 annual meeting will be held on Monday, Tuesday, and Wednesday, October 27, 28, and 29, 2008, at the Renaissance Hotel in Asheville, North Carolina. It will be co-sponsored by The Health Licensing Boards of North Carolina.

IN-DEPTH

FOURTH ANNUAL BEN SHIMBERG MEMORIAL LECTURE - October, 2007, Seattle, Washington

Editorial Note: The Ben Shimberg Public Service Award is named after CAC's first Chairman of the Board, Ben Shimberg, who was among the first to draw attention to the impact of licensure on safety and quality as well as on the cost and availability of professional services. He also wrote about the mischief that professional regulation can do. As a consequence, he was a great advocate of accountability – which he thought would come primarily from the appointment and nourishment of public members. The 2007 Shimberg award winner, Barbara Safriet, has influenced professional regulation in her teachings, her writings and her advocacy. She is currently the public member of the Federation of State Boards of Physical Therapy.

~ TABLE OF CONTENTS ~

Continued on page 2…

Barbara Safriet:

I am truly honored to be here and to be associated with just about anything that memorializes Ben Shimberg. Over the years, I have used his articles, books, and speeches about the regulation of health care providers. The lessons and truths he identified are just as relevant today as they were when he first published them.

I also thank the CAC and its Board of Directors for their continued efforts to promote and protect the public interest in the health care arena. They do this first by insisting that if the public is to be served, the public ought to participate in the process of drawing up the regulatory framework for the provision of care. Secondly, CAC has continually had as one of its principal goals education of the public about the most important issues and about some of the best practices we can draw on in improving our regulatory framework. They not only have done this consistently, but they have done it in a consistently excellent fashion. For that I am eternally thankful.

I consider this to be the hardest talk I've ever been asked to give – expect perhaps for the call I made to my parents after my first term in college to tell them that I had received two Cs and one D minus, and the D minus was really a gift. They were surprised by this news, but nevertheless supportive. My Dad's comment during that conversation has been a guiding light for me over the years. He said, "Well, you're still in the game. And, think of it this way: there's lots of room for improvement."

Why, then, is this the second hardest talk I have ever had to give? When Becky pulled me aside at the Federation of State Medical Boards meeting earlier this spring to tell me that the CAC Board of Directors had voted to honor me with the Shimberg Award, I said, "You really can't be serious! If the award were for orneriness and persistence, okay. Ben Shimberg did really important work. You must

…continued from page 1

NOTICE

Citizen Advocacy Center derives a significant portion of its operating funds from the sale of the **CAC *News & Views*** newsletter. By purchasing a subscription to **CAC *News & Views***, you are entitled to download one copy of each newsletter. Unauthorized reproduction of newsletters, whether through multiple downloads or through the use of a copy machine, undermines our ability to fulfill our mission.

Once a representative of an organization has subscribed to **CAC *News & Views*** online for $195.00 for one year or $330.00 for two years, additional members of that same organization may subscribe for $50.00 each.

A subscription form is at the end of this newsletter.

Thank you!

have made a mistake." From that moment until now, I think there must have been a major typo that is responsible for me having received this award.

The second reason why this is difficult is that David told me I have only thirty minutes. He has told me this every time we talked. He told me in letters. He told me in notes. "You only have thirty minutes, Barbara." I think he really means it.

People who have heard me speak before, or who know me even slightly, know that it takes me thirty minutes to get warmed up! That's because I care about what I do and there is so much to talk about in this area. So, if I don't get to the really important part of the message, blame David. Don't blame me.

The third reason this is quite difficult for me is that I wasn't given any guidance on what I am supposed to talk about. David said, "You can talk about whatever you want – just so long as it is only thirty minutes."

He said he'd help me by sending me transcripts of the previous Shimberg recipients' remarks. But this wasn't helpful at all because their remarks were frighteningly well organized. They were extraordinarily cogent and compelling. *And,* they were all done in thirty minutes.

So, now you know why this is the second hardest talk I've ever had to give. I don't have ways to express to you how much I feel like and imposter, and I don't have enough time to offer remarks worthy of my predecessors, so maybe you'll be a little forgiving. And, do remember, on behalf of the CAC Board, that if I was really the intended recipient of this award, their decision was based on previous acts of mine and was made before they heard these remarks. So, don't hold these remarks against them.

CAC *News & Views* is published quarterly by the

Citizen Advocacy Center
1400 Sixteenth Street NW, Suite #101, Washington, DC 20036
Phone: (202) 462-1174   Fax: (202) 354-5372
Email: cac@cacenter.org
Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Subscription Manager: Steven Papier

Since I learned about this honor in May, I have imagined about fourteen or fifteen different speeches I might deliver. All are still competing with each other in my mind. Let me try to focus on two. The first is about *you* as regulators in the health care arena – board members, board executives, members of other governmental agencies, or national organizations dealing with health policy. The second topic is about *me* as a public member who is interested in health care.

First, there is you. You have unique challenges as licensing board members and other regulators. The good news is that what you do is important. I can't think of a more central aspect of all our lives than health. What you do should have as its goal promoting comfortable, competent, appropriate care that people can afford for themselves and their loved ones. I can't think of a more important public goal, and you are centrally involved.

The bad news is that the cards you have been dealt to utilize in your regulation are a mixed deck. Some cards are missing. Others are marked.

What are some of the things you face in your regulatory efforts? First, the licensees you work with are the product of an uncoordinated educational system. There is too little interdisciplinary education – almost none.

I was heartened to hear yesterday that in some places, physicians and pharmacists will be trained together in some of the basic science courses. How novel! Anatomy is anatomy. I don't care if you are a student nurse, student physician, or student whatever. Anatomy and biology don't change depending on your profession. Yet, we don't educate people together. I think a lot of the inter-discipline fighting and fussing starts right there, because we don't have a coordinated, sensible educational system.

Also, our educational system typically addresses care in the most acute settings, not community settings, not across large populations. We focus on teaching very sophisticated technology, which is great, but most people don't need CAT scanners, or nuclear medicine infusers, or whatever. These things are helpful for some, but when the focus of health care practitioner training is high-tech, high-intervention, acute, episodic care, it is no wonder that we have problems.

Your licensees practice in settings with other types of health care providers who they may be meeting for the first time. They are totally dependent upon working with others, but we don't educate people from the get-go to work with other professions, licensed or unlicensed. We train them up in educational silos and spit them out to situations where they have to be able to practice in teams and recognize, respect, and draw on the skills and learning of others. We just throw them out there and let them flounder.

Secondly, the licensees you work with practice in what we call a "health care delivery system." But, it is not focused on health; it is focused on illness. It is not focused on care; it is focused on cure. And, there is no *system* to it.

If we talk about "the system" for shorthand's sake, it is fragmented; its dynamic contours reflect an ever-evolving payment structure rather than good, rational organizational principles. If it were anything other than this, we wouldn't have employment-based health coverage, which is really a silly notion. When is the time you might need health coverage the most? It is when you are not employed. Employment-based health coverage for the majority masks the true cost of health because no one knows exactly how much their health care costs.

Also, your licensees face conflicting expectations and missions. They want to provide the *best* care. Their license says they should be able to provide *good* care. The payers often don't pay for good care; they may pay for *just barely adequate* care. This ongoing tension between the best and the good, combined with the focus on the individual vs. the larger population, is a factor in the lived experiences of health care providers.

Also, your licensees, across the spectrum of health care providers, suffer from a statutory and regulatory framework that is preordained to maximize conflict through scope of practice battles. It is all preordained. This is not to say that health care providers were born with genetic defects making nurse practitioner fight with internists, or certified registered nurse anesthetists fight with the physician anesthetists. (That's what I call them. They call themselves anesthesiologists.)

It is not genetic predisposition. It is the legal system because medical practice acts were enacted first in every state and they took up the entire turf. A physician's scope of practice deals with treating by any means – real or imaginary – any disease, defect, deformity, or illness. Never *health*, which is intriguing because one could argue that any physician who practices health promotion or prevention is practicing nursing, not medicine, because the medical practice acts talk only about disease, defect, deformity, illness – real or imagined, physical or mental – and treating it by any means possible, including magnetism. The definition of medicine also includes prescribing any drug or treatment modality, and piercing the tissue of any human.

Well, what's left after all that? When other health care providers came later seeking legal authority for what they do – pharmacists, optometrists, nurses, clinical therapists, physical therapists audiologists, and others – they were perceived by medicine and many other policy makers to be taking away from medicine that which was medicine's. That legal regime persists today as a powerful and historical artifact that you and your licensees have to grapple with every day.

Keep in mind, it is neither necessary nor right to perpetuate this approach of "We got there first, we took it all, and now that you want something, even though you are capable of doing it, it's ours. You can't have it." That is the wrong mind set.

There is a little brochure on your table which represents a progressive effort by six national organizations representing different providers and regulatory groups to come up with guidelines from a public protection perspective for how to go about addressing scope of practice issues. It is called ***Changes in Healthcare Professions' Scope of Practice: Legislative Considerations.*** (Copies are available at: www.ncsbn.org/ScopeofPractice.pdf.)

Finally, you have huge challenges in that boards and board members are asked to do more and more each day – investigate more things, verify more things, gather more data, interpret more data, inspect and investigate more people and places, respond to responsible and irresponsible articles in the paper. You are asked to do these things with little staff, less and less money, more and more tasks, and you have to also be mindful of political winds that affect what you do.

When you get frustrated, you need to keep in mind that what you do *matters*. As you face unique structural, political, cultural challenges, don't forget it is a privilege for you to be in a position to try to improve the health of the people in this country.

Turning to me, what is it about me that might be instructive – other than confirming in your mind that it really was a mistake about who should get this award? What have I learned or experienced that might be helpful in framing some of the issues you have to deal with? All public members, including me, bring with them experiences and perspectives that reflect what really matters from their life on the ground.

I'd like to offer you some snapshots of health care as experienced by me and people close to me over the years. I'm not complaining because, in fact, I and those close to me are among the lucky ones.

First issue: No matter how much regulation you have, it is likely to fail in weeding out providers who have the social skills of a spit bug. Our regulatory scheme is based upon the notion that we are measuring competence. We know we really can't do this, so we require two expensive and arduous hurdles which are proxies for competence – expensive education and passage of a licensure exam. I'm not saying this is bad. But, remember, if we had full faith in either one of these, we would require only one of them. We require both because we don't trust either one. So, at best, we have two extensive and expensive filters for those we license to be health professionals. But there is no educational system or exam I know that deals with the spit bug problem.

Let me give you two examples of what I mean by a practitioner with the social skills of a spit bug. When my mother was in the hospital twenty years ago, her room mate, Gladys, was recovering all by herself from the amputation of a leg as a result of diabetes. I, along with my mother, father, sister, and family friends tried to pay special attention to Gladys because she had no support system and she had just lost her leg. One afternoon, a young woman physician entered the room, drew back the incredibly ineffective privacy curtain around Gladys' bed and said, "Well, Gladys, I have bad news. We have to take off the other one." And she left. This surgeon may have been fabulously skilled, but to say to a woman who has just lost one leg and whose prognosis is not ducky, "Well, we have to take off the other one" is a spit bug problem that somewhere along the way should impact that person's ability to continue practicing medicine.

A more recent example of the spit bug problem is right here in town. A dear and close friend of mine, after many months of visiting health care providers and sophisticated testing, ended up in a neurologist's office. The neurologist said "Well, you have ALS, or Lou Gehrig's Disease. As you know, that is a death sentence. Here are some pamphlets on ALS. When you have read them, call me if you have any questions." This neurologist is, by all accounts, one of the best diagnosticians and treating clinicians. But, I can assure you that saying what he said is not the best practice of medicine. I don't consider it even *good* practice of medicine. But it is the sort of thing people encounter every day from some who are licensed to practice. Unfortunately, there is very little one can do to squash spit bugs.

A second issue is clinical skills. Let's return to my mother, aged 89. Some time ago, she went to her cardiologist with both legs very red, very hot to the touch and so swollen that fluid was oozing out of her skin. You don't have to be a rocket scientist to know that something is wrong. Her cardiologist told her to go home and prop up her legs, review her medications and call next week. Two days later, Mother was in the midst of raging cellulitis and septic shock and ended up in the ER with "do not resuscitate" orders because everyone thought her case was hopeless. She spent three weeks in intensive care and three more weeks in the hospital as a result of other misadventures like being dropped and having the skin of both legs stripped to the ankle when they picked her up off the floor. But she lived and she laughs about it now.

What kind of diagnostician or health care provider of any sort would say "go home and put your feet up and call me if it doesn't get better"? Fortunately, through the steadfast good judgment, clinical skills and intervention of her internist, nurses, and physical therapist, Mother got better and is doing quite well, although the experience was so traumatic that she has almost no memory of it.

Let's talk also about my Mother's experience when she was diagnosed with breast cancer. I'm talking about competence, not spit bug problems. When her surgeon stood on the operating table and put his knee on her sternum in order to do the needle biopsy, this should have been a sign that subtle interventions were not his strength. He went ahead and did the mastectomy and, in the process, he placed two clamps which cut off the major artery and major vein going to and from Mother's arm. This caused ongoing problems with what I call "elephant arm" and several bouts of blood poisoning or infection because, not only are the lymph nodes gone, but the circulation is impaired. What I remember the most about this experience is what my Mother said after she returned from one of her follow-up visits. She said, "Barbara, I am so blessed and lucky. Yes, I had to have a breast removed, but I don't have the huge arms I saw on all the other women sitting in the waiting room." *All* the other women in the waiting room… This is a snapshot of why competence and ability matter.

So, we have looked at one thing regulations can't deal with – spit bugs – and one they can do something about – ongoing clinical competence in diagnosis and treatment. Let's look quickly at two or three snapshots from my experience dealing with the other issues that licensing boards spend their time on: problems with sex, drugs and lies.

I don't have a lot of patience for this. How much education does it take to know that if you are in a position of trust, you don't have sex with your patients? How much education does it take to know that you should not appropriate drugs and use them for yourself or others in inappropriate ways? How much education does it take to know it is not a good or appropriate thing to lie on reimbursement forms?

I'd like you to focus on competence and quality and clinical skills, but if you poll licensing boards across the country, you will find they spend most of their time on sex, drugs, and lies. Here are just one or two snap shots of my experience with sex, drugs and lies.

My first job out of college was with a local city agency. As a precondition of being formally appointed to the job, I had to have a physical examination by a city physician. It was a 45-minute examination, about 40 minutes of which was spent thoroughly examining and massaging my breasts. I was twenty-one. I had never had a breast exam before. I didn't say anything.

Once I got home, I thought "there is something weird about this and maybe I should tell someone. But if I do," I thought, "maybe it will rock the boat and I won't get the job." I've kicked myself ever since for not saying something. I especially kicked myself when, in the early 1990s, a young male student came to me to talk about a problem his wife was having in the same city. Twenty-five years after my experience, his wife had been offered a job in city government and was required to take a mandatory physical examination. Guess what? Most of the examination was spent massaging her breasts. She was traumatized. He was thinking about quitting school to go join her. He came to ask me what to do.

This time we did something. We got her into counseling and I called the City Attorney, the Director of Human Services, and the Board of Medicine to say "twenty-five years of this is enough!" I wonder how many others have been subjected to this kind of "care" and didn't know to whom to report, that they should report, or even that they could report. Sex, drugs, and lies are a much more common problem than even the disciplinary matrix would indicate.

Let me give you two more snapshots of my lived experience in health care and health law. Forty-five years ago, working as a candy-striper in a hospital in Paintsville, Kentucky, I was told to help bathe and feed a patient named Mr. Turner. I walked up to his bed and said, "Mr. Turner, I am Barbara

Safriet and I am here to help you in any way I can." Mr. Turner didn't respond. I repeated myself. I prodded Mr. Turner.

Mr. Turner was dead.

I went to the nurses' station and said, "Mr. Turner is dead." The nurse said, "You can't say that." I said, "Well, why in the world not?" She said, "Doctor has not examined Mr. Turner and only Doctor can determine if he is dead." I said, "Doctor can examine Mr. Turner all he wants, and he can say whatever he wants about Mr. Turner, but I'm here to tell you, he's dead!"

What I know now that I didn't know then is that I had waded into the very messy area of scope of practice. If I had said, "I *think* Mr. Turner is dead," or, "Mr. Turner *appears* to be dead," that would be a nursing diagnosis and I would have been okay. But I was being introduced to the monopoly on interpreting reality that is called scope of practice. It was a preview of what I have spent about thirty years of my life doing, which is to try to improve and modify and rationalize the legally imposed turf-protection scheme we call scope of practice.

I'll leave you with one more snapshot – a positive one. It is the collaborative ***Legislative Considerations*** document I referred to earlier, prepared by representatives of six different regulatory organizations who sat down and asked how, from a public protection and promotion perspective, the regulatory system can identify the things that really should matter in deciding who may determine whether Mr. Turner is dead, appears dead, or might be dead. I didn't think I'd live long enough to see a document like this one produced through a collaborative effort on the part of six different licensed professions.

The nub of it for me is in this excerpt:

> This paper rests on the premise that the only factors relevant to scope of practice decision-making are those designed to ensure that all licensed practitioners are capable of providing competent care.

What a novel notion! It is not about turf or money or professional prestige. It is about ability and competence to do what the law says you can do.

What do any of these snapshots matter? Well, as a public member of a regulatory board and a person interested in health care regulation, they seem to me to contain the following lessons:

- Regulation is a balancing act. We talk in health care about balancing access, quality and cost. Every decision strikes such a balance.
- Boards and other health regulators need to do the least restrictive thing possible with their regulations, consistent with achieving the goals that have been identified. Sometimes we over-regulate based on inaccurate or incomplete information, poorly formulated goals, or ignorance of the ramifications of our actions on other aspects of health care.
- Things stay in perspective if we remember that it is all about people and their desire to have good health care for themselves and their loved ones at a cost that they and society can afford.

You and other regulators can't do everything to address all the issues. But keep asking "Why?", as we talked about yesterday in the session on root cause analysis. Then, ask "Why not?" We don't need to keep doing everything the same old way. Finally, ask "Who is going to benefit from this action?"

If you ask these three questions, I think you will find, as my father said to me many years ago, "You are still in the game, and there is plenty of room for improvement."

SCOPE OF PRACTICE

New Research on Nurse Practitioners

The Center for the Health Professions (CHP) at the University of California, San Francisco (UCSF) recently published two research documents on nurse practitioner practice funded by the California Healthcare Foundation (CHCF). One is a 24-page ***Overview of Nurse Practitioner Scopes of Practice in the United States – Discussion*** and the second is an eight-page ***Chart Overview*** that provides summary information regarding legal scopes of practice for nurse practitioners in the U.S. Both documents may be downloaded from www.futurehealth.ucsf.edu.

Both documents confirm the wide variation in nurse practitioner (NP) scopes of practice and educational requirements around the country. The longer document includes analysis and recommendations. The conclusion states, in part:

> To summarize, 11 states currently allow NPs to practice independently. Ten states require practicing NPs to be supervised by physicians, while 27 states require varying degrees of collaboration between NPs and physicians. Moreover, NPs in 21 states must first secure a written practice protocol with a physician. With regard to practice authorities, 44 states explicitly permit NPs to diagnose patients, 20 states explicitly permit NPs to order tests and 33 states explicitly permit NPs to refer patients to other providers. With regard to prescriptive privileges, 11 states allow NPs to prescribe drugs independently, 40 states allow NPs to prescribe in collaboration with a physician and 48 states allow NPs to prescribe controlled substances. NP candidates in 42 states must be nationally certified. In 17 states, the Board of Nursing and the Board of Medicine share joint rule-making authority over NP practice.
>
> Although NP scopes of practice have steadily broadened over the past four decades, the actual practice has experienced some contractions. Despite an overall expansive trend, NP scopes of practice still vary widely among the states. The consequent inconsistencies among actual NP practices constrain the uniform expansion of NP services. The profession and the public are ill-served where practice authorities can be dramatically different between bordering states. For example, an NP in Iowa may practice with complete independence, while an NP a few miles away in Missouri may not prescribe controlled substances under any circumstance. Moreover, the laws of certain states internally conflict. Such inconsistencies point to the inescapable realization that NPs are needlessly restricted by divergent practice laws for reasons that have nothing to do with their competencies…

> Other negative influences include financing and reimbursement mechanisms, malpractice insurance policies and outdated practice models… Further despite the predominance of laws that require NPs to practice collaboratively with physicians, the increased exposure to malpractice liability, and consequent increased physicians' insurance rates, are often strong disincentives for physicians to engage in practice with NPs…
>
> To conclude, the evolution of the NP profession is restrained due to current delivery models. First, physician preferences and NP practices are inextricably intertwined. Remarkably, a 2003 study of rural and urban physicians' perceptions of NPs found that physicians in both settings perceived that non-physician providers: 1) possess the necessary skills and knowledge to provide primary care to patients; 2) are an asset to a physician's practice; 3) free the physician's time to handle more critically ill patients; and 4) increase revenue for the practice. Secondly, health maintenance organizations may shift the number of NPs they employ, depending on presumed public opinion of NPs ability to provide adequate care. Finally, efficient use of the NP workforce may be hindered by traditional views of physician-run practices as the only mechanism for quality delivery.
>
> Currently, there is considerable discussion about a looming physician shortage in primary and specialty medicine. These shortages, real or speculative, are drive in part by existing rigid practice models that focus on physicians as sole providers… The clustering of NPs in progressive states will not alleviate, and may exacerbate, the existing maldistribution of primary care providers. This trend suggests that efficiency, access, and quality would be significantly improved by more interprofessional collaboration and revised delivery models with uniform, shared scopes of practice.

The CHCF published a research brief entitled, ***Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners*** based on the research it funded and focusing on the situation in California. This 10-page document may be found at www.chcf.org.

Scope of Practice Models Analyzed

Another new brief prepared by the Center for the Health Professions (CHP) (www.futurehealth.ucsf.edu) with funding from the California Healthcare Foundation (CHCF) (www.chcf.org) is entitled ***Promising Scopes of Practice Models for the Health Professions.*** Written by Catherine Dower, Sharon Christian, and Edward O'Neill, the purpose of this extremely useful document is:

> to examine scope of practice issues within the context of improving access to care in California. First, out of hundreds of differences in scopes of practice between California and other states, (the document highlights) a small sampling and compares the California scopes of practice of four

> occupations (nurse practitioners, physical therapists, physician assistants, and paramedics and the administration of intravenous infusions) to more expansive scopes of practice in other states or institutions. Secondly, the brief (discusses) efforts to improve scope of practice decision-making.

The brief evaluates and compares how scopes of practice are determined in New Mexico, Iowa, Texas, Virginia, Ontario and the U.S. Military. This section of the document "elucidates the importance of implementing a single impartial mechanism to review all scope of practice expansion proposals in a state or institution," shows "the inherent conflict of allowing one professional board to govern members of a different profession," and "discusses efforts to address the lack of interstate scope of practice uniformity."

Another section of the brief examines the rulemaking authority of dental and dental hygiene boards in several states to illustrate why "health board X, with professional and financial interests that inherently conflict with those of health board Y, should not be involved in shaping scope of practice laws governing practitioners Y." The authors make the point that independent rulemaking authority is a step in the right direction.

The brief concludes with a section that discusses attempts to establish national uniformity in scopes of practice. The premise is that widely varying scopes of practice in different jurisdictions and restrictions such as requiring a practitioner to be re-examined in order to set up practice in a new state interfere with practitioners practicing up to their full capability and negatively affect consumer access to care.

This 21-page document may be downloaded from www.futurehealth.ucsf.edu.

Pharmacists Taking On Patient Care

Two federal programs are paving the way for pharmacists to become more involved in direct patient care. The Medicare Modernization Act that created a prescription drug benefit also opened the door for pharmacists to be reimbursed for patient care. The Act permits pharmacists to be reimbursed for counseling Medicare beneficiaries with chronic illnesses who spend at least $4,000 per year on medications. Major health insurers, such as Humana, are signing on retail pharmacies to conduct disease management.

A second federal program at a small number of federally-funded health centers around the country is testing the hypothesis that involving pharmacists more directly with patients can improve care and cut the cost of treating chronic conditions such as diabetes, heart disease, and asthma.

Optometrists Revise Prescriptive Authority Requirement

The Association of Regulatory Boards of Optometry (ARBO) (www.arbo.org) reports in its December, 2007 ***Green Sheet*** that the Council on Endorsed Licensure Mobility for Optometrists (CELMO) voted to recommend that ARBO change the wording on the prescriptive authority to: "The optometrist must hold the highest level of prescriptive authority in the state in which they currently practice." The ARBO board adopted this change at this October, 2007 meeting.

CONTINUING COMPETENCE

Optometry Organization to Implement New Standards for Continuing Education

The Council on Optometric Practitioners Education (COPE) is developing new Standards for Commercial Support of optometry continuing education courses. COPE chose to be proactive in light of recent federal scrutiny of the Accreditation for Continuing Medical Education (ACCME), according to an article in the December 2007 ***Green Sheet***, the newsletter of the Association of Regulatory Boards of Optometry (ARBO) (www.arbo.org). The article explains that:

> COPE plans to identify areas of inherent conflict of interest for both administrators and instructors that exist when there is commercial support of their programs. These conflicts will be required to be resolved in a transparent manner. One manner in which this will be accomplished will be by requiring standardized contractual agreements between the administrators and supporting companies. In addition, instructors will be required to agree to ethical standards and to reveal all potential conflicts of interest through mandatory full disclosure to the audience prior to the presentation. Finally, a system for monitoring compliance with these standards is being developed. COPE is confident that this will provide assurance to our member boards that continuing education events are of the highest educational integrity and free of commercial influence.
>
> The onsite Reviews (OSR) system for COPE-approved continuing education has been initiated. A password-protected area of the ARBO Web site has been created that will allow certified COPE reviewers to obtain copies of all application materials submitted by instructors so they may be compared to the actual presentation. This standardized review system will also document whether the required conflict of interest disclosure statement is given, the presentation is free of commercial bias, and the actual length of the presentation is in compliance with the hours of credit awarded the course…

Are Patient Ratings a Good Measure of Current Competence?

Two studies funded by the Agency for Healthcare Research and Quality (www.ahrq.gov) look at the utility of patient ratings as measures of physician competence and performance. Writing about these studies in the November 2007 issue of ***Research Activities***, AHRQ points out that, "In the future, patient ratings of physicians may be used for recredentialing by physician specialty boards and determining physician bonus payments."

The first study, by P. Duberstein, et al., identified factors that influence patient ratings of physicians. Patients treated for only a year by a doctor rated male physicians higher than female. For patients treated longer periods of time, openness first and then conscientiousness mattered more than gender. Older patients tended to rate their physicians higher than younger patients. ("Influences on patients' ratings of physicians: Physician demographics and personality," ***Patient Education and Counseling*** 65, pp. 270-274.)

A second study led by K. Fiscella questions the use of subjective patient ratings to evaluate physician performance. The researchers compared the ratings of 96 physicians by 49 real patients and two standardized patients who portrayed the symptoms of gastroesophageal disorder reflux and poorly characterized chest pain with multiple unexplained symptoms. The researchers concluded that standardized patients are likely to supply more objective ratings because they are less likely to be influenced by the longevity of the relationship and personality characteristics. ("Ratings of physician communication by real and standardized patients," ***Annals of Family Medicine***, 5(2), pp. 151-158.)

CONSUMER INFORMATION

On October 3, 2007, the Robert Wood Johnson Foundation announced grants of $16 million to help a broadly-based group of health care organizations and health experts to bring consistency to efforts to measure and report information on the quality and cost of patient care. The information will be used to help providers improve care, consumers make decisions, and policymakers to develop effective policies regarding payment that rewards or fosters better provider performance.

Specific elements of the RWJF-funded work include:

- Aggregating patient data nationally,
- Identifying cost measures,
- Sharing information in communities, and,
- Using information to address health disparities.

The foundation's announcement can be found at www.rwjf.org/newsroom.

Tennessee Blue Cross to Share Doctor Ratings

Beginning in April, 2008 Blue Cross Blue Shield of Tennessee will give members with private insurance online access to data showing doctors' charges for various procedures and doctors' ratings according to whether they give patients the right treatments or recommended tests for certain conditions.

Critics of the plan warn that the ratings could be used to steer patients to the least expensive doctors, regardless of their clinical skill. They are also concerned that publishing physician-specific data could discourage doctors from taking sicker patients for fear that this would affect their rating.

New York Health Coalition to Grade Doctors

The Niagara Health Quality Coalition has been designated by the Department of Health and Human Services (HHS) to expand its hospital report card program to include care provided by groups. The Coalition is a nonprofit, independent organization whose members represent hospitals, health plans and business leaders working toward transparency in the quality of Western New York healthcare services. Reports can be found at www.myhealthfinder.com.

HHS has awarded the same designation to the New York Quality Alliance in Albany, N.Y. Other designated organizations are in the states of Louisiana, Maine, Massachusetts, Michigan, Minnesota, Oregon, Pennsylvania, Utah, Tennessee, Washington, and Wisconsin.

ACCOUNTABILITY

Funeral Boards Criticized for Secrecy, Lack of Accountability

The Summer-Fall 2007 newsletter of the Vermont-based Funeral Ethics Organization contains harsh critiques of the funeral boards in Massachusetts and Alabama. The Funeral Ethics Organization's (www.funeralethics.org.) mission is to promote ethical dealings in all death-related transactions by working for better understanding of ethical issues among funeral, cemetery, memorial industry practitioners, law enforcement, organ procurement organizations, and state agencies, as well as better understanding between these and the general public.

The Massachusetts Board of Registration in Embalming and Funeral Directing is accused in a front-page article by Funeral Consumers Alliance of Eastern Mass (www.fcaemass.org) activist Byron Blanchard of operating almost entirely in secret. Blanchard recommends the board be abolished. He writes, in part:

> The Board of Registration in Embalming and Funeral Directing will not provide access to any of the following public records:
>
> - Meeting Agendas
> - Meeting Minutes
> - Establishment Inspection Blank Forms
> - Establishment Inspection Reports
> - List of Disciplinary Cases Referred for Prosecution
> - Disciplinary Case Final Decisions
> - Disciplinary Case Charges (Orders to Show Cause)
> - Disciplinary Case Consent Agreements
> - Disciplinary Case Negotiated Settlements
>
> Annual Reports from funeral homes about their pre-need funeral contracts are available, but at an unaffordable price…. The Board does issue brief press releases on final decisions in some cases. Public records requests to the Board are not acknowledged or denied, just ignored….The Board's non-response strategy started about two years ago when their long-time counsel retired and was replaced with a new more aggressive attorney. Under their former counsel, most public records were available. The few cases of denials were almost all settled in favor of the requestor…
>
> Large portions of each of the Board's meetings are closed as executive sessions under the litigation strategy exemption. A few of these executive sessions are legal and proper when they

concern lawsuits in which the board is the defendant. But the Board also uses the litigation strategy exemption for their discussions of how to handle complaints against licensees… It is like having the preliminary hearing in a criminal case with no notice to the accused.

There are some complaints that should not be discussed in open meeting because of their sensitive nature. The open meeting law has an exemption for such cases. It differs from the litigation strategy exemption in that it requires notice to the accused and opportunity to attend the meeting. That would be due process. The Board doesn't ever use that exemption!

Massachusetts should abolish the Board. Its secrecy, failure to enforce consumer protections in its regulations, and blocking of innovation in funeral service are ample reasons for abolition. The Board's thinking remains where it started, a century ago, that embalming is the key element of funeral service and that funerals should be held only in funeral homes. Funeral homes must have elaborate embalming rooms of specific dimensions, and chapels of so many square feet. But, they don't have to have refrigeration.

Colorado abolished its Funeral Board a decade ago, but business goes on with no more abuses than before. Full-service funeral homes continue to co-exist with others offering minimal facilities and service at a lower cost because of lesser overhead. Massachusetts should follow Colorado's lead.

The Alabama Board of Funeral Service recently underwent an audit prepared by the state legislature's Sunset Committee. The audit found several significant deficiencies, including the following:

- The board does not maintain an internet Website.
- The board pays for email addresses for the staff, but the auditor was unable to utilize email to communicate with the board's office.
- The board's staff does not have internet access.
- A large majority of the board's records are paper-based and written in longhand.
- The board's staff was unable to provide a listing of its licensees and accompanying information without retrieving and compiling it by hand.
- Licensees surveyed by the auditor indicated that they are not kept adequately informed of laws, rules, and policies of the board and that at least some establishments have been asked for money (beyond normal fees) for performing a board service.
- The board is not actively monitoring unlicensed funeral homes.
- The board did not obtain adequate examining facilities for its January 2007 examination.
- The board's enabling statutes concerning the examination of candidates for licensure are not consistent with the procedures now

being used by the board and do not allow the use of modern testing methods.

- Inspection logs do not support the board's compliance with annual inspection requirements.
- A survey by the Funeral Consumers Alliance found violations of federal funeral regulations in nearly all Montgomery area funeral establishments surveyed.
- Economic conflict of interest statements for board members were not available.
- Board member information is not posted to the Secretary of State's Website.
- The board does not post public notice of its meetings.

The entire audit is available at www.examiners.state.al.us/PDFs/Audit28S-0013.pdf.

PAIN MANAGEMENT AND END OF LIFE CARE

Racial Disparity Found in Pain Care

A study published in the January 2, 2008 issue of the ***Journal of the American Medical Association (JAMA)*** found that minority patients are less likely to be prescribed strong narcotics in hospital emergency rooms. Researchers reviewed more than 150,000 emergency room visits over 13 years and found differences in prescribing in urban and rural hospitals in all areas of the country and for all types of pain. Overall prescribing of narcotics rose during the study period from 23% of patients with pain in 1993 to 37% in 2005. The racial gap persisted. Some speculate that emergency room doctors are more inclined to suspect minority patients of fabricating pain to obtain narcotics. Another theory is that minority patients may not expect adequate pain care.

Dr. David Esses of the associate director of the ED at Montefiore Medical Center in New York told the Associated Press that his hospital has eliminated racial disparities in pain care for broken bones. Montefiore is developing strict protocols for pain management, which he believes may eliminate racial disparities.

Pain Care Experts Review DEA Amendment

Pain care experts Aaron Gilson and David Joranson at the Pain & Policy Studies Group at the University of Wisconsin published an evaluation of the latest Drug Enforcement Agency (DEA) amendment to the Code of Federal Regulations which became effective in December, 2007. The amendment addresses the issuance of a "prescription series" for Schedule II controlled substances. The author's evaluation was to determine whether the DEA had developed a balanced policy. The concluded that:

> It is clear that the DEA's Final Rule aims to affirm a practitioner's legal authority to issue a prescription for a Schedule II controlled substance, with the intention to allow (and even enhance) continued patient access to medications to treat chronic pain while decreasing the potential for abuse and diversion.

Federal regulations continue to prohibit refills of Schedule II controlled substances, and establish no new standards relating to the quantity or duration of a Schedule II prescription or for controlling medication abuse or diversion. The PPSG considers the Final Rule to be balanced, and an important step to improve the regulatory environment for both diversion control and pain management and palliative care. The DEA also recognizes the need for balance:

> …DEA, through its enforcement of the CSA and its implementing regulations, must prevent the diversion and abuse of controlled substances while ensuring that there is an adequate supply for legitimate medical purposes. DEA supports the intent of this Final Rule to address patients' needs for schedule II controlled substances while preventing the diversion of those substances.

This new rule should mark the beginning of a re-dedication to education for law enforcement, healthcare regulators, and practitioners. It is important for the DEA to renew its commitment to disseminate information about federal controlled substances regulations, along with examples of practical application, to field agents state and local law enforcement, and medical and pharmacy practitioners throughout the U.S. It is equally important for such information to be addressed in professional and continuing education for health care practitioners.

The full analysis is at:

> www.painpolicy.wisc.edu/DEA/Rx_Series_Adoption.pdf.

Alliance of State Pain Initiatives Recommends Guidelines for State Prescription Monitoring Programs

The Alliance of Pain Initiatives (ASPI), a national network of interdisciplinary, state-based organizations dedicated to improving pain management, issued a statement in January 2008 on state prescription monitoring programs (PMPs). More than half the states have established a monitoring program as a means of preventing and detecting diversion and abuse of controlled substances. Some clinicians worry that such programs have a chilling effect that interferes with appropriate opioid use and optimal pain control.

In 2005, the U.S. Congress passed the National All Schedules Prescription Electronic Reporting Act which authorized federally-funded state-based prescription drug monitoring programs, but no funding has been appropriated for the program. Instead, Congress has been funding a Justice Department program that takes a law-enforcement rather than a public health approach to prescription monitoring. "The ASPI believes," according to the January 2008 statement, "that PMPs should not be administered by law enforcement agencies, but rather should be seen as public health intervention tools." The statement continues:

> The ASPI does not oppose PMP program *per se*. It believes that states should only adopt

programs that are balanced and address all sources of diversion while not interfering with the use of controlled substances for legitimate medical purposes. Based on this belief, and absent clear scientific evidence for guidance, the ASPI recommends that PMPs:

- Avoid the use of government-issued multiple-copy or single-copy serialized prescription forms;
- Include all controlled substances in Schedules II, III and IV under both federal and state law, and allow states the flexibility to include other drugs of concern;
- Assure that programs are administered by a state agency responsible for regulating health care rather than the agency responsible for enforcing the laws of the state;
- Use a multidisciplinary medical review group to assure that legitimate prescribing and dispensing are protected…;
- Protect patient confidentiality to the greatest extent possible;
- Assure individual health care professionals access to PMP data about their individual patients to they can evaluate those patients' use of controlled substances;
- Allow law enforcement agencies access to the data, but only when probably cause justifies such access…;
- Develop educational programs to address healthcare professionals' perceptions about PMPs…;
- Encourage healthcare professionals to communicate with their state PMP administrators if they have questions or concerns…

The entire statement can be found at: http://aspi.wisc.edu/position.htm.

Pain Care Group Seeks Injunction to Stop Board Action

The New Mexico-based Pain Relief Network and patients of Dr. Schneider filed suit in Kansas to stop the Board of Health Arts from issuing an emergency suspension of Schneider's license until he can appear personally to contest the action. The state hearing officer agreed to postpone a decision on the board's request for a month.

A grand jury has indicted Schneider for overprescribing dangerous medications and being complicit in the overdose deaths of at least 56 patients. He is also charged with fraud and money laundering. He is in custody pending resolution of the federal charges.

The board's postponed Motion for Emergency Order Temporarily Suspending Respondent's License says that disciplinary action was first initiated in May, 2006 for "inappropriately prescribing medications, practicing below applicable standards of care, and failing to adequately keep patient records." There are 12 pending counts of alleged violations of the practice act, including allegations that five patients died from drug overdoses. More information about the case can be found at: www.ksbha.org/boardactions.html.

Editorial Note: See the article in this quarter's QUALITY OF CARE section on variables in patient-centered care.

ACCESS TO CARE

Health Literacy Encompasses Language and Cultural Barriers

Scholars recommend that efforts to communicate health information to individuals with limited health literacy must take into account cultural factors as well as language abilities. Drs. Dennis Andrulis, PhD., M.P.H, of Drexel University and Cindy Brach, M.P.P., of the Agency for Healthcare Research and Quality (AHRQ) wrote in the ***American Journal of Health Behavior*** (31, pp. S122-S133) that low health literacy scores could result from low literacy or from lack of familiarity with Western health terms and concepts.

Therefore, Andrulis and Brach recommend that clinicians need to "integrate health literacy techniques, such as having patients explain back to the clinician what they have been told, with culturally competent communication practices, such as asking a patient what she thinks caused the illness and what type of treatment she thinks she should receive to reveal cultural barriers, use of folk medicine, or culturally dictated family involvement in medical decisions." The leadership of health care organizations, they point out, also needs to commit to invest in training, staffing and physical plants to improve care for patients from diverse cultural backgrounds and with limited health literacy.

Literacy Tool Available for Pharmacies

The Robert Wood Johnson Foundation and the Agency for Healthcare Research and Quality jointly funded a project conducted by Emory University to develop tools for pharmacies to improve the quality of their services for people with limited health literacy.

Research has shown that people with limited health literacy – estimated at more than one-third of Americans -- are twelve to eighteen percent more likely to be unable to identify their own medications and distinguish them from one another. They also have difficulty understanding instructions for how and when to take their medications and are more prone to misunderstand warning labels.

One of the tools developed for pharmacy use are an assessment tool to raise pharmacy staff awareness of literacy issues and provide guidance for identifying and responding to literacy problems. The second tool is a training program for pharmacy staff which includes a slide show, material for small group discussions, handouts for role play and a concluding question and answer session.

Is our Pharmacy Meeting Patients' Needs? A Pharmacy Health Literacy Assessment Tool User's Guide can be found at: www.ahrq.gov/qual/pharmlit/. ***Strategies to Improve Communication between Pharmacy Staff and Patients: A Training Program for Pharmacy Staff*** is at www.ahrq.gov/qual/pharmlit/pharmtrain.htm.

UC Riverside Plans Medical School Focused on Diverse Local Healthcare Needs

The University of California Riverside is considering a proposal to establish a research-based medical school utilizing an innovative clinical education model. The draft plan, based on the recommendations of approximately 80 campus and community representatives, provides the framework for establishing a University of California medical school with research, teaching and service programs to improve the health of Californians, with special attention to the needs of the diverse and growing Inland Southern California region.

"We have the opportunity to build a nationally distinctive school of medicine tailored especially for the needs of our region, which is already medically underserved and facing a physician shortage of crisis proportions in just a few years time," said Acting Chancellor Robert D. Grey. "It is vitally important that the operational and financial model for achieving the mission of the medical school is viable."

As envisioned, medical students and residents will have clinical education experiences in a variety of healthcare settings thus exposing them to a broad range of patients in hospitals, clinics and medical practice groups. Inland Southern California – the counties of Riverside, San Bernardino and Imperial – faces a growing shortfall of physicians. As of 2002, the diverse and rapidly growing region had one of the lowest ratios of generalist physicians per 100,000 people in the state, at less than 60. As outlined in the draft proposal, the medical school will also:

- Focus research efforts on the medical and health needs of residents in the Inland Southern California region, such as cardiovascular diseases, insulin-resistant diabetes and metabolic syndrome, neurodegenerative diseases, emerging infectious diseases, and health services, public health and health care access.

- Allocate significant resources and effort to ensure the school achieves its goals to enroll a diverse student body and attract faculty from underrepresented minority groups.

- Launch as early as summer 2012 a residency program which, in the near term, will provide additional access to healthcare and which will offer the required training for post-graduate medical students to achieve board certification and medical licensure.

QUALITY OF CARE

Study Examines Variables in Patient-Centered Care

Researcher Michael J. Yedidia of Rutgers University recommends personal awareness training for physicians as a means to get closer to patient-centered care. Funded by the Agency for Healthcare Research and Quality (www.ahrg.gov) and published in the ***Journal of Pain and Symptom Management*** 33(1), pp. 40-57, the study, "Transforming doctor-patient relationships to promote patient-centered care: Lessons from palliative care," is based on a review of hospice-based and in-home palliative care of 40 patients.

Yedidia examined five dimensions of doctor-patient relationships: range of needs addressed, source of authority (e.g., for tests or treatments), maintenance of trust, emotional involvement, and expressions of authenticity. He found, according to a report in AHRQ's November 2007 newsletter:

> that addressing patients' need to maintain their identities as their illnesses progress is central to the delivery of effective hospice care, and requires sensitivity to patients' belief systems and models of health and illness. This may entail modifying established procedures to harmonize with particular patient and family expectations. In making clinical decisions, providers rarely relied strictly on their status as experts in asserting authority. Both physicians and patients agreed that belief in the provider's technical competence was essential to establish trust, but not sufficient to maintain it, particularly as care shifted from curative to palliative goals. Patients had to feel they would not be abandoned, regardless of the unpleasantness of the illness or the uncertainties of the therapy. Often, the physician's emotional involvement served as a mechanism for entering the patient's world. Finally, patients' needs are often entangled with complex social problems, are too numerous to address in the course of a normal workday, and require a team approach.

Commonwealth Fund Defines Patient-Centered Care

On October 24, 2007, the Commonwealth Fund (www.commonwealthfund.org) issued a report by Dale Shaller entitled, "Patient-Centered Care: What Does it Take?"   Key attributes of patient-centered care, according to the report are:

- Education and shared knowledge;
- Involvement of family and friends;
- Collaboration and team management;
- Sensitivity to the nonmedical and spiritual dimensions of care;
- Respect for patient needs and preferences; and
- Free flow and accessibility of information.

Briefly, factors contributing to patient-centered care are:

- Leadership;
- A strategic vision clearly and constantly communicated;
- Involvement of patients and families;
- Care for the caregivers though a supportive work environment;
- Systematic measurement and feedback;
- Quality of the build environment; and
- Supportive technology.

The complete report is available at the Commonwealth Fund Web site.

Pennsylvania Announces Introduction of Chronic Care Management Plan

The following press release was issued by the Governor's Office of Healthcare Reform in Pittsburgh, Pennsylvania on February 13, 2008:

> Governor Edward G. Rendell today received a blueprint that will save the health care system in Pennsylvania billions of dollars as the commonwealth becomes the national leader in the way it delivers and pays for treatment of chronic diseases while significantly improving care.
>
> The Chronic Care Management, Reimbursement and Cost Reduction Commission delivered its first report to the Governor today as part of the Governor's Prescription for Pennsylvania health care reform plan.
>
> "Chronic diseases are the leading cause of death and disability in Pennsylvania and account for 80 percent of our health care costs," Governor Rendell said. "Our present system treats acute illness; it doesn't control chronic disease. And, faced with the increasing cost of health care, governments, businesses, insurers and Pennsylvania families have -- out of necessity -- chosen to limit health care services.
>
> "In Pennsylvania, only 56 percent of people with a chronic condition receive the recommended care to manage their disease. Unfortunately, evidence is mounting that exactly the opposite approach is more successful.
>
> "The good news is that we know that if health care providers adopt evidence-based protocols proven to help manage chronic disease, it will have long-term health benefits for people. It will also have economic benefits as healthier employees mean improved productivity for our businesses and taking appropriate preventative measures can reduce the need for many expensive emergency room visits and translates to lower insurance premiums overall. That's why this report – this blueprint – is critical for improving quality of life and to save money."
>
> The 44 members of the Chronic Care Management, Reimbursement and Cost Reduction Commission have worked since last September to develop a plan that proposes a pilot program enrolling 30-60 primary care practices in the southeastern region in learning collaboratives that will help to improve how they monitor, deliver and are reimbursed for chronic care management. The first collaborative will start in May and, by the fall, additional collaboratives will begin in other regions of the state.
>
> While a few other states, such as Vermont, Washington, Colorado and North Carolina, have begun chronic care initiatives, Pennsylvania's is the first that also takes into consideration the way health care practitioners are paid for delivering care. The

commission members agree that it pays dividends to work to pay a little more to improve the time that is spent with patients before problems are exacerbated and become difficult for the patient to handle and more costly to the system.

"What is significant about this report is that it comes from a 'who's who' of Pennsylvania health care providers – from health insurance providers and hospital executives, to physicians and nurses, and labor and consumer representatives," Governor Rendell said. "They all agree that we must adopt a stronger, proactive approach to address chronic conditions while also addressing how we pay for chronic care services. We must work together to update information systems and improve the attention we give to self management.

"Rarely, when it comes to health policy, do you get every group involved to agree on the changes that are required, but that's what has happened in Pennsylvania with this new initiative to tackle chronic care."

The 44 commission members represent a broad cross section of health care related fields and come from all geographic areas of the state. In addition, the secretaries of Health, Public Welfare and Insurance and the Director of the Governor's Office of Health Care Reform serve as members of the commission.

"This strategic plan represents hundreds of hours of research, discussion and careful consideration of the core principles and necessary actions required to fundamentally change the way health care is delivered in Pennsylvania," Governor Rendell said. "It is a visionary plan that puts Pennsylvania on an innovative path to significantly improved health outcomes and real cost savings.

"I thank the commission members for their contribution of time, energy and expertise on a plan that will improve the health of Pennsylvanians with chronic disease and reduce the costs for all Pennsylvanians."

The completion of the plan is only the beginning of the commission's work. The Governor's Office of Health Care Reform has already begun implementing the strategies outlined in the plan.

To illustrate some of the evidence-based, patient oriented strategies that will be implemented as part of Pennsylvania's new chronic care model, the commission's report included a comparative scenario focused on a hypothetical patient named "May."

May is a 52-year-old woman with diabetes who, under the current system, is having trouble dealing with her disease. While she knows she needs to take care of herself because she saw first-hand how her mother's diabetes led to severe disabilities that could have been avoided, she has a limited idea of how to best take care of her health. Under the current system, May does not have the time with her doctor that she needs to be able to be proactive in her own care, and is likely to end up using the hospital and emergency room as her disease progresses. The cost of this care and the diminished capacity she would experience would seriously affect the quality of life for her and her children.

Under the new chronic care model, May would have a care management team including her doctor, nutritionists and registered nurses who work together to provide a comprehensive and simple support network to help May manage her condition. The cost of these programs is far less than the cost of avoidable hospitalizations and May will live a longer, healthier life. The chronic care plan, as well as more information on Governor Rendell's Prescription for Pennsylvania, can be found at www.rxforpa.com.

QIOs to Adopt More Narrow Focus

According to an article by John Reichard in the ***Congressional Quarterly***, the Centers for Medicare and Medicaid Services (CMS) have responded to criticism of Quality Improvement Organizations (QIOs) by narrowing their focus to nursing homes and hospitals that offer the best opportunity for quality improvement. The facilities thought to be most susceptible to improvement are not necessarily the "worst" facilities. Their identities (4,000 nursing homes and 900 hospitals) are posted on the CMS Web site (www.cms.gov).

The revised assignment is contained in the new contract with QIOs, called the Ninth Scope of Work. For nursing homes, QIOs will focus on reducing the incidence of bed sores and the use of physician restraints. For hospitals, QIOs will work on preventing post-operative complications, such as infections. Under this scope of work, CMS rather than the QIOs will select most of the providers that will receive assistance. QIOs were suspected of choosing providers that were easy to work with rather than providers needing the most improvement.

The Ninth Scope of Work has QIOs working in four areas. "Beneficiary protection" involves reviewing appeals by patients of their doctors' care decisions. "Patient safety" includes reducing medication errors and staph infections. "Prevention" includes increasing the use of mammography, colorectal cancer screening, vaccination and other preventive measures. "Care transitions" includes improving plans of care for patients who move from one health care setting to another.

PATIENT SAFETY AND MEDICAL ERRORS

Study Links Pharmacy Workload to Errors

A study entitled "Pharmacist Workload and Pharmacy Characteristics Associated with the Dispensing of Potentially Clinically Important Drug-Drug Interactions (DDIs)" published in ***Medical Care***, 45(5), pp.456-462 analyzed the association between pharmacist workload and pharmacy characteristics in 672 community pharmacies with dispensing of medications with potential DDIs over a three-month period. The findings of the study, which was supported by the Agency for Healthcare

Research and Quality (AHRQ) were explained in the AHRQ's January newsletter:

> Pharmacies were typically fairly busy. They filled an average of 1,375 prescriptions per week and submitted 17,948 pharmacy claims to participating pharmacy benefit managers. They had 1.2 full-time-equivalent pharmacists per hour the pharmacy was open, and pharmacists processed a mean of 14 prescriptions per hour. The relative risk for dispensing a potential DDI increased by just over 3 percent for each additional prescription processed per pharmacist hour and by 10 percent for each additional prescription per pharmacy staff hour.
>
> These results suggest that as pharmacists become busier, they have less time to evaluate DDI warnings or to act on those warnings. Pharmacies with automated telephone systems for prescription orders were also significantly more likely to dispense medications with potential DDIs. Pharmacies with higher rates of dispensed potential DDIs were also more likely to have computer systems that provided DDI alerts and clinical information.

Some Hospitals Won't Charge for Preventable Errors

Hospitals in at least three states (Washington, Massachusetts, and Maine) have voluntarily agreed not to charge patients or insurers for hospital care involving a preventable medical error. In Washington State, the medical association, hospital association and ambulatory surgery center association have agreed not to bill for serious medical errors called "never events." These include 28 situations that should never happen, such as wrong site surgery, death or disability resulting from contaminated drugs or devices burns, foreign objects left behind after surgery, and so on.

In Massachusetts, the state hospital association announced in November, 2007 that all state hospitals adopted a policy not to charge for nine rare but serious events, including wrong site, wrong patient, or wrong procedure surgery; retention of a foreign object; air embolism-associated injury; medication error injury; artificial insemination from the wrong donor; and infant discharged to the wrong family. The goal of this policy, according to the hospital association, is to eliminate such errors.

In Maine, the hospital association announced a similar voluntary initiative in February, 2008. However, state Representative Patsy Crockett has introduced legislation that would make it illegal to charge patients or insurers for the 28 "never events" on the National Quality Forum's list. (www.qualityforum.org) Maine's mandatory reporting law applies to only seven broad categories of events, such as "unanticipated death." Neither the legislation, nor the hospital association's voluntary policy covers infections because, according to the Bangor Daily News (February 5, 2008), it is too difficult to determine whether a patient acquired the infection before or after being hospitalized.

Hospital Improves Team Practice to Avoid Errors

Rhode Island Hospital, the largest in the state and the teaching hospital for Brown University was reprimanded in November 2007 after three incidents of surgery on the wrong side of the brain. The chief of the neurosurgery department stepped down while the cases are being investigated by the health department, which fined the hospital $50,000.

The hospital issued a statement saying it would review its training and policies. Specific measures include improvements in team practice, such as permitting nurses to see that procedures are being followed, improving the transmission of patient information between departments and the availability of patient records during surgery. A second physician will now review all surgical cases before surgery to be sure of the correct site and side, and monitors will be present to eliminate potential sources of medical error.

DISCIPLINE

Medical Board Imposes Fines for Errors

The ***Orlando Sentinel*** reported October 9, 2007 on sanctions issued by the Florida Board of Medicine. One surgeon was fined $5,000 for placing a chest tube in the wrong side of a patient. He told medical writer Robyn Shelton that the error occurred because a nurse had mistakenly prepared the wrong side.

An anesthesiologist was fined $5,000 and ordered to perform 50 hours of community service for giving a patient a nerve block on the wrong side of the neck. Another doctor was fined $5,000 and ordered to perform 25 hours of community service for treating an ER patient with medications that interacted badly with other medications the patient was taking. Another doctor was fined and ordered to perform community service for two instances of improper prescribing. A psychiatrist was fined for inappropriately prescribing pain medication to a patient who subsequently died from a drug overdose. The board also accepted the voluntary surrender of a physician's license, but declined to reveal details about the case.

Editorial Note: Without knowing details about these reported cases, CAC News & Views finds the board's reliance on fines and community service in instances of medical errors a little disturbing. We would have expected to see the board craft penalties more directly related to the infractions – such as remedial education, or something stronger. We also note that the board appears to have lost the opportunity to explore any system safety problems that could have contributed to the errors and that should be brought to the attention of the involved health care facilities.

IN THE COURTS

Maryland Ruling on Patient Records Raises Alarms

In its December 2007 ***Newsline*** the Federation of State Medical Boards (FSMB) comments on a Maryland appellate court ruling which denies the state's medical board access to patient medical records. (Maryland State Board of Physicians v. Eist, 2007 WL 2683024 [Md.App.]) In an article entitled, "Maryland Patient Records Ruling Raises Concerns for Medical Boards," the FSMB writes that the decision could have implications for other medical boards. The appeals court affirmed a lower court ruling in a case involving a medical board disciplinary action against psychiatrist, Harold Eist, who had been accused of overmedicating three patients -- the estranged wife and two children of the accuser. The allegation was made in the midst of a divorce and custody battle in which Dr. Eist had filed an affidavit supporting the mother in the custody dispute.

As a routine part of investigating the complaint, the medical board subpoenaed the three patients' medical records. Dr. Eist replied that he believed the medical records to be protected by the patients' privacy rights. Eleven months later, Eist produced the documents. The board found no evidence of inappropriate treatment and the complaint was dropped.

Nevertheless, the board decided to sanction Dr. Eist with a reprimand and $5,000 fine for the delay in responding to the board's subpoena. The Circuit Court of Montgomery County Maryland ruled that the board's sanction was unlawful. The Court of Special Appeals agreed, finding that the U.S. Constitution protects the privacy of patient records and that to obtain them, the medical board needs to meet a certain standard. That standard, according to the court's ruling requires the board to balance seven factors:

1) the type of record requested for release,

2) the information it contains,

3) the potential for harm that exists if the information is re-released,

4) the injury from disclosure that would be incurred by the relationship that generated the record,

5) the adequacy of safeguards that exist to prevent re-release,

6) the degree to which the government needs access to the records, and

7) any express statutory mandate or articulated public policy favoring access.

Tom Keech, counsel to the Maryland Board of Physicians told ***Newsline*** that "The Maryland ruling raises significant issues for all state medical boards because it was decided on constitutional grounds. According to the ruling, if a physician or patient objects to the release of records to the state medical board, then the state statute requiring release may be unenforceable."

The Federation feels there are significant implications for other state medical boards that would hamper a board's ability to efficiently investigate cases. For example, the decision seems to require a board to overcome a physician's refusal to turn over patient's records every time a physician objected. Boards may be forced to go to court to enforce subpoenas if a patient or physician raises privacy rights. Boards may be held to the standard specified in the Maryland court decision, even though information needed to meet some of the factors would be contained in the undisclosed medical records.

The Maryland board is appealing the ruling to the state's highest court, in cooperation with the Federation. Tim Miller, J.D., senior director of Government Affairs and Public Policy at the Federation, believes that if the Maryland Court of Appeals does not overturn the lower court decisions, an appeal is possible in federal court because the ruling was based on privacy rights in the U.S. Constitution.

Writing about the same case in ***Association News***, Association of Social Work Boards counsel, Dale Atkinson puts it into the context of "the potential for conflict between requests to produce records in response to an administrative investigation and the licensees' obligations to maintain confidences." He points out that twice during the medical board's pursuit of the sanction against Eist, an Administrative Law Judge (ALJ) recommended finding in favor of the licensee.

Atkinson summarizes the court's ruling as follows:

In framing the issues, the court first addressed the board argument that the licensee, under the practice act and Confidentiality of Medical Records Act, had an obligation to produce the records under the subpoena. While relevant, the court noted that such a determination was not central to the core issue on appeal. The court held that the rights of the board to demand production of records are not absolute. When the governmental interest does not outweigh the patient's privacy interest, the records do not need to be produced. The fact that the constitutional privacy interests of the patients were invoked and the board was informed that they had exercised their rights does not give rise to an allegation of non-cooperativeness. Non-production took place in the face of a challenge to the subpoena.

The court also rejected arguments of the board that the licensee had to overcome every presumption that the statute under which the subpoena was issued was valid. The court held that the facial constitutionality was not in question and that the matter must be assessed under the particular facts. Again the court held in favor of the licensee that the patients asserted privacy rights and that there was not a compelling governmental interest that trumped such patient rights.

The court also addressed the remaining elements of an analysis which weighs the rights of government against the rights of patients and held that the board was not justified in its findings that the licensee failed to cooperate with its investigation. The assessment covered points including the likelihood of harm in disclosing, the statutory mandates, public policy considerations, and the government's need for the documents. Accordingly, as a matter of law, the court held that the licensee did not fail to cooperate with a lawful investigation and should not be subjected to sanctions.

Court Rules Doctors are Liable for Second-Hand Drug Effects

The Massachusetts Supreme Court ruled on December 10, 2007 that doctors who fail to warn patients about potential side effects of medications they prescribe are liable to the patient and also to others who are foreseeably put at risk should unwanted side effects occur. This decision opens the way for a lower court suit against a doctor whose patient, to whom the doctor had prescribed numerous medications, was involved in a fatal automobile crash. The mother of the accident victim is planning to sue Dr. Roland Florio, alleging that he knew his 75-year old patient, David Sacca, suffered from numerous conditions that made it unsafe for him to drive.

Sacca was taking painkillers, anti-depressants, blood pressure medication and steroids when he lost consciousness behind the wheel and ran into 10-year old Kevin Coombes on the sidewalk. The court found that Dr. Florio's act of prescribing the medication caused the foreseeable risk of an accident and thereby created a duty to warn that extends to others foreseeably put at risk.

The medical community argued in court that this interpretation goes beyond what other jurisdictions have determined in similar cases. They are concerned that such sweeping liability would expose them to suits not covered by their liability insurance. The Massachusetts Medical Society recommends that, pending the outcome of the trial, doctors document their conversations with patients.

Medical Board Sued by Physician Organization

Texas State Representative Fred Brown (R-Bryan) called a special investigative hearing on October 23, 2007 to question whether the Texas Medical Board (TMB) is too aggressive in its disciplinary oversight. According to articles by ***Dallas Morning News*** reporter Doug Swanson and ***Capitol Annex*** reporter Vince Leibowitz Brown was chided by medical board members for convening the hearing to help his business partner and campaign contributor, Dr. Royal H. Benson, III, who had a case pending before the medical board for three alleged instances of sub-standard care.

According to the articles, Brown was encouraged to convene the hearing by physician and radio talk-show host, Steven Hotze, MD, who has likened the medical board to a "Communist regime holding secret trials." Hotze was upset that the board had brought charges against a Dr. William Rea for practicing "pseudoscience" by injecting jet fuel and natural gas as treatments for chemical sensitivity. Some medical board members, who believe Brown's actions constitute a conflict of interest, confided that they believe Hotze had hired a private detective to check into their backgrounds.

The hearing produced eleven hours of testimony and was attended by numerous members of the Association of American Physicians & Surgeons, Inc. (AAPS), which considers the Texas Medical Board to be "the worst in the nation in inflicting unjust, arbitrary punishments, often against free-marketor conservative-appearing physicians." A transcript and video of the hearing can be found at www.aapsonline.org/tmb.php.

Subsequent to the hearing, the AAPS sued the medical board (The Association of American Physicians & Surgeons, Inc, v, The Texas Medical Board, et, al.) "to end the pervasive and continuing violations of constitutional rights of its members by Defendants…" The medical board and its members are accused in the suit of:

1) manipulation of anonymous complaints,
2) conflicts of interest,
3) violation of due process,
4) breach of privacy, and
5) retaliation against those who speak out.

Among the relief sought in the lawsuit are declaratory judgments re-opening cases handled by Dr. Keith Miller, who resigned from the board prior to the October 23 hearing and finding that alleged conflicts of interest and arbitrary procedures violated the Due Process Clause of the U. S. Constitution. The suit also seeks an injunction preventing the board from retaliating against physicians for exercising their rights of free speech. A copy of the suit can be found at www.aapsonline.org/tmb.php.

SPOTLIGHT

Kansas Board Requires License Notice in Practitioners' Offices

CAC *News & Views* shines a spotlight on the Kansas Board of Healing Arts for enacting a "notice to the public of licensure" rule which went into effect November 2007. All licensees must post the following notice "in a conspicuous location where the notice is reasonably likely to be seen by persons who receive direct patient care in the office:"

NOTICE TO PATIENTS

It is unlawful for any person who is not licensed under the Kansas health arts act to open or maintain an office for the practice of the healing arts in this state. This office is maintained under the authority of a person who is licensed to practice the healing arts in Kansas. Questions and concerns regarding this professional practice may be directed to:

KANSAS STATE BOARD OF
HEALING ARTS
235 S. Topeka Blvd.
Topeka, KS 66603

PHONE: 785-296-7413
TOLL FREE: 888-886-7205
FAX: 785-296-0852
WEBSITE: www.ksbha.org

LETTERS

Dear **CAC *News & Views***:

My term as Public Member of the Missouri Dental Board ended on 1 November 2007. After nine incredibly rewarding years, it is time to pass the torch.

At my first CAC meeting in Orlando, Florida, the book ***Blind Eye*** was recommended. En route home in the airport book store, I found a copy, read it on the plane and have sine purchased a copy for every member of the MO Dental Board. One is in the staff office and is considered required reading! That book has been instrumental in numerous discussions and decisions over the years. Thank you for a superb organization.

Sincerely,
E. Maxine Thompson
Dear **CAC *News & Views***:

In August, 2007, the National Council of State Boards of Nursing (NCSBN) Delegate Assembly adopted a ***Statement on the Regulatory Implications of Pain Management*** at the NCSBN Annual Meeting in Chicago. The Statement identifies four unique situations when Boards of Nursing may address aspects of pain management:

1) when a nurse fails to meet expected standards of nursing pain management;
2) when an advanced practice registered nurse (APRN) fails to appropriately prescribe medications for pain management;
3) when a nurse's personal pain or treatment for pain affects his/her ability to practice safely; and
4) when a chemically dependent nurse requires pharmacologic pain management.

The statement also discusses ways that boards may be proactive in meeting their charge to protect the public. NCSBN fully supports the nursing role in the assessment and effective management of pain.

Sincerely,

Vickie Sheets
Director, Practice and Regulation
NCSBN

Editorial Note: The full statement reads as follows:

National Council of State Boards of Nursing
Statement on the Regulatory Implications of Pain Management

Pain management raises important regulatory issues to be addressed by boards of nursing. The treatment of pain is a complex issue, requiring increased awareness and specialized education by nurses. In recent years there have been pharmacological and technical advances that provide new approaches to pain management. Nurses may be concerned about possible side effects of analgesics or fear patients becoming tolerant to analgesics or addicted to the medications. Nurses may fear the scrutiny of regulation, especially related to controlled substances. In addition, when a nurse experiences pain, that nurse's ability to practice safely may be questioned due to the nurse's condition and/or pain treatment. For these reasons there is a need for a statement identifying the regulatory implications for nursing.

Role of the Board of Nursing

Boards of nursing deal with four unique pain management situations:

1) A nurse fails to meet the expected standards of nursing pain management, resulting in the risk of harm or suffering for patients.

2) An advanced practice registered nurse (APRN) fails to appropriately prescribe medications for pain management.

3) A nurse's personal pain or treatment for pain affects his/her ability to practice safely.

4) A chemically dependent nurse requires pharmacologic pain management.

Boards of nursing can be proactive in their charge to protect the public by:

- Acknowledging the unique regulatory challenges presented by pain management

- Holding nurses accountable for…

    - acquiring the education necessary to effectively manage patients experiencing pain,

    - adhering to accepted nursing pain management standards,

    - practicing within the appropriate role of the level of licensure, and

    - evaluating one's own ability to safely and competently practice.

- Imposing appropriate action when a nurse fails to comply with the statutory and regulatory requirements and places patients at risk.

- Collaborating with stakeholders (e.g., regulatory entities, educators, professional organizations, employers, and consumers) in implementing regulatory processes that support effective pain management.

Future Steps

Additional resources are planned to provide model policies and guidelines for each of the regulatory issues addressed above. This work will support boards of nursing in meeting the regulatory challenges presented by pain management.

Announcements

SAVE THE DATES:

We will convene a multi-disciplinary Continuing Competence Workshop May 12 and 13, 2008, in Washington, DC. Please visit our website at www.cacenter.org for more information and for registration forms.

Our 2008 annual meeting will be held on Monday, Tuesday, and Wednesday, October 27, 28, and 29, 2008, at the Renaissance Hotel in Asheville, North Carolina. It will be co-sponsored by The Health Licensing Boards of North Carolina.

☞ WE WANT YOU!

SUBSCRIPTION FORM

Subscribe to **CAC *News & Views*** and stay in touch with health care regulatory issues.

Please select how you want to receive your copies:

Downloaded from our website: _____ **One year (four issues) for $195.00.**

_____ **Two years (eight issues) for $330.00.**

OR

Delivered by mail: _____ **One year (four issues) for $220.00.**

_____ **Two years (eight issues) for $355.00.**

Name:	
Title:	
Agency:	
Mailing Address:	
City, State, Zip:	
Telephone numbers (work, home, cell):	
Email Address:	

PAYMENT OPTIONS:

1) Go to www.cacenter.org and subscribe online using PayPal or any major credit card;
2) Send us a check made payable to CAC for the appropriate amount;
3) Provide us with a purchase order number so that we can bill you. Our Federal Identification Number is 52-1856543;

Purchase order number:	

4) or complete the following form if paying with Visa or MasterCard:

Please enter your name and address exactly as they appear on your credit card bill:

Name:	
Company name (if company card):	
Credit card number:	
Expiration date:	
Billing Address:	
City, State, Zip:	