News & Views

Citizen Advocacy Center

Third Quarter, 2009 A Health Care Public Policy Forum Volume 21 Number 3

Announcements

Our 2010 Annual Meeting will be held on Thursday and Friday, November 11 – 12, 2010, in Washington, D.C. Please mark your calendars.

Digital recordings *of our recent* ***Annual Meeting*** *in Orlando are now available for sale. Please see page 33 of this newsletter.*

CAC is now a membership organization *and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see pages 34 – 35 of this issue.*

Although we encourage you to receive our newsletter by becoming a ***CAC member****, you may still subscribe to our newsletter without becoming a member. Please see page 36 of this issue.*

Editorial Note: This issue of CAC News & Views begins with a guest article by Peter Lee, Executive Director of National Policy for the Pacific Business Group on Health (http://www.pbgh.org/). CAC News & Views encourages others to submit guest articles to our editorial board.

THE VALUE OF KNOWING:

The Case for Performance Measurement in Health Care

Without measurement we cannot improve – and the need to improve the quality and affordability of health care is all too clear. Yet, far too often we don't know much about who is or isn't delivering the right care at the right time. Measuring how well health care professionals provide care is vital to filling these information gaps and improving care. This is now more critical

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than ever because of the serious quality deficits and waste that exist in the health care system. Consider these facts:

- Every year, nearly 80,000 Americans die unnecessarily from high blood pressure, diabetes and heart disease because they do not receive care based on proven medical research.
- Over 180,000 Americans are dying each year from avoidable medical errors and preventable infections during a hospital stay.
- Roughly 30 cents of every health care dollar is spent on poor quality care or waste.

Knowing how well health care professionals deliver patient care is a necessary first step to addressing these and other issues. Health care professionals in every community in America want to provide the best care and to improve their performance – but they can't get far if they don't know how they're doing. And, consumers and purchasers of care cannot identify and reward high quality efficient care without data on who is providing the right care.

Getting and using performance measurement in health care is one of the foundations that can enable licensing boards to fulfill their promise of assuring that all Americans get quality health care. And in licensing boards, public members have an important role to play advocating for the incorporation of measurement into medical licensure and certification, and helping to ensure that the measures used to gauge performance represent the public good.

How Measurement Can Contribute to Medical Licensure and Certification

There is growing interest in incorporating performance measurement into medical licensure and certification to better ensure

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competency of health care professionals throughout their careers. Measurement is a tool that medical licensure boards can use to determine whether a health care professional:

- Uses current best practices
- Demonstrates improvement in patient care over time
- Is responsive to patients' experience of care and engages patients and families in the decision-making process

Expanding the use of performance measurement in medical licensure can also help health care professionals in a variety of ways. It can assist them in: determining what their medical educational needs are; developing a culture of accountability and quality improvement; targeting their quality improvement efforts; understanding how to best interact with their patients to improve patients' experiences; and preparing for national performance measurement initiatives that will likely be a central feature of major health care reform.

Some specialty boards have begun leading the way. For example, the American Board of Medical Specialties (ABMS) recently integrated measures of patient experience into its Maintenance of Certification (MOC) program. Measures of patient experience are important indicators of quality of care, and can lead to patients playing a more active role in their care, which has been shown to result in improved health outcomes.

Public members of health professional licensing boards can take the lead in encouraging their boards to address quality measurement. For example, boards that require continuing education (CE) for license renewal might encourage CE providers to offer courses in the subject. Boards can even mandate that licensees take at least one course in quality measurement during the renewal cycle. (Some boards may have to seek legislative authority to enact such a mandate.) Public members of voluntary certification bodies could take similar initiatives, especially given that legislative authority is not a consideration.

With quality measurement results in hand, public members of licensing boards can also encourage their boards to routinely consider whether or not licensees charged with quality of care violations followed evidence-based practice guidelines for patient care. And, public members of both licensing

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boards and certifying bodies could urge their institutions to incorporate information about quality measurement in their education and outreach programs and on their Websites.

Measures that Reflect the Public Good

Robust measures of performance are essential to improving care. However, while there are many measures out there, not all of them will lead to tangible improvements in patient care. For example, some measures may only reflect basic competencies of care, which may meet minimum requirements for licensure but are unlikely to spur the improvements needed in quality and affordability.

Looking beyond the measures that may meet the needs of defining minimum competence, consumers and purchasers are increasingly seeking public reporting of measures (e.g., outcomes and composite measures) that provide a full picture of the care provided. Currently, there are too few measures that resonate with those who receive and pay for care. As patients are increasingly seeking (or in some cases, being called upon) to take a more active role in their care, they need measures that they can use to help them make better decisions about their providers and the care they receive. In particular, patients need measures that will tell them whether care: will result in better health outcomes; is based on evidence; and is respectful of their preferences. Additionally, we need measures that let us know if our health care dollars are being used wisely.

Getting Involved

All too often during the process of developing and endorsing measures, those whose work is being measured are well represented, but those who receive or pay for care are not. The participation of public members is critical to addressing these disparities. There are multiple opportunities for representatives of the public to help shape the development of health care performance measures. Public members of licensing boards can bring a unique and important perspective by participating in:

- Workgroups where measures are developed
- Committees involved in approving measures for national use
- Opportunities for public comment on measures

By being involved in these processes, individuals who come with a public perspective can help to ensure that measures are robust and meaningful to those who receive and pay for care.

There are a number of ways public members can get involved in advancing measurement. Helping consumers and purchasers actively participate in the development and use of performance measures is one of the missions of the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information.

If you're interested in becoming part of the effort to help shape the future of health care performance measurement or learning more, please contact Christine Chen at cchen@pbgh.org or visit our website at www.healthcaredisclosure.org.

Peter V. Lee
Co-Chair
Consumer-Purchaser Disclosure Project
Executive Director of National Policy
Pacific Business Group on Health

IN DEPTH: SHOCK WAVES HIT CALIFORNIA REGULATORY BOARDS

Editorial Note: At press time, the California Department of Consumer Affairs announced that a legislature-mandated committee has produced standards which must be followed by all of California's health professional boards, whether or not they presently operate a formal program for chemically dependent practitioners. Among the new standards are these:

> ***Health care professionals suspected of substance abuse must undergo a clinical evaluation at their own expense. Their licenses will become inactive; they will be subject to twice-weekly random drug tests and must be "clean" for at least a month in order to regain their licenses. Significantly, boards will make public the fact that a license has been restricted, although details about involvement in substance abuse treatment will not be revealed.***

In early July 2009, the Los Angeles Times (www.latimes.com) and independent investigative journal ProPublica (www.propublica.org) published a harshly negative investigation of the California Board of Nursing. The report documented the failure of the board to discipline nurses in a timely manner, permitting nurses accused of wrongdoing and/or substance abuse or diversion to continue to practice for an average of two-three years without restriction. Governor Schwarzenegger reacted swiftly and replaced most of the members of the board. Shortly thereafter, the long-time executive director of the board resigned under a cloud.

A flurry of editorial comments followed, some pointing the finger at other California regulatory boards which also experience discipline lapses and backlogs, others blaming some of the enforcement delays on 3-day a month work furloughs imposed by the Governor in an attempt to mitigate the state's serious budget difficulties.

On August 11, 2009, the Governor announced the appointment of Brian Stiger as the director of the Department of Consumer Affairs (DCA) which oversees the state's regulatory boards. Stiger was "tasked with leading the state's efforts to review all consumer protection practices at the department and enact any needed reforms to ensure the people of this state are protected against bad actors." An internal DCA review confirmed backlogs at nineteen health professional licensing boards.

On August 17, 2009, the Senate Committee on Business, Professions and Economic Development held an informational hearing entitled "Creating a Seamless Enforcement Program for Consumer Boards". The Committee heard from the nursing board president, interim executive officer, and the enforcement program and diversion program managers. Responders to this testimony included the leaders of the State Consumer Services Agency and DCA, the head of the AG's enforcement office, and the Director of Administrative Hearings. Also testifying were CAC Board Member Julianne D'Angelo Fellmeth and George Papageorge who prepared the Enforcement Monitor Report for the state medical board. (See http://www.cpil.org/MBC_Final_Report.htm). The Committee also heard from representatives of the boards of medicine, behavioral sciences, vocational nursing and psychiatric technicians, dentistry, pharmacy, podiatric medicine, chiropractic examiners and respiratory care.

This "In Depth" feature consists of excerpts from the background paper

circulated in advance of the hearing. Although the information in the background paper applies to California's licensing boards, other states and boards that experience backlogs and weaknesses in their enforcement systems and procedures may find useful guidance in the paper:

INFORMATIONAL HEARING

CREATING A SEAMLESS ENFORCEMENT PROGRAM FOR CONSUMER BOARDS

Monday, August 17, 2009
9:00 A.M. – 12:00 P.M.
Room 3191, State Capitol

BACKGROUND PAPER

Problems with the Board of Registered Nursing (BRNO) Enforcement and Diversion Programs

…On July 11, 2009, the *Los Angeles Times*, in conjunction with *Pro-Publica*, a non-profit investigative news agency, published an article entitled "*When Caregivers Harm: Problem Nurses Stay on the Job as Patients Suffer*"[1] charging that the BRN, which oversees California's more than 350,000 nurses, often takes years to act on complaints of egregious misconduct. Nurses with histories of drug abuse, negligence, violence, and incompetence continue to provide care, and the BRN often took more than three years, on average, to investigate and discipline errant nurses. The other findings and issues raised by the article include the following:

1) Delays. Complaints often take a circuitous route through several clogged bureaucracies: from the nursing board for initial assessment to the Department of Consumer Affairs (DCA) for investigation, to the California Attorney General's Office (AG's Office) for case filing and the state Office of Administrative Hearings (OAH) for trial. Lastly, the case goes back to the BRN for a final decision. The biggest bottleneck occurs at the investigation stage, as DCA staffers struggle to handle complaints against nurses as well as those against cosmetologists, acupuncturists and others. Another reason given for the delay is that the nursing board must share a pool of fewer than 40 field investigators with up to 25 other licensing boards and bureaus, and some investigators handle up to 100 cases at a time.
2) Sanctions by Other Agencies or Boards. The BRN failed to act against nurses whose misconduct already had been thoroughly documented and sanctioned by others. There were 120 nurses that were identified by the reporters who were suspended or fired by employers, disciplined by another California licensing board or restricted from practice by other states, yet have blemish-free records with the BRN.
3) Probation and Grounds for Revocation. The BRN gave probation to hundreds of nurses, ordering monitoring and work restrictions, then failed to crack down as many landed in trouble again and again. One nurse given probation in 2005 missed 38 drug screens, tested positive for alcohol five times and was fired from a job

[1] See Charles Ornstein, Tracy Weber & Maloy Moore, When Caregivers Harm: Problem Nurses Stay on the Job as Patients Suffer, L.A. Times, July 11, 2009, available at http://www.latimes.com/news/local/la-me-nurse12-2009jul12,0,2185588.story.

before the BRN revoked his probation three years later. More than half the nurses who respond to allegations from the BRN are handed a second chance. Each year, California places at least 110 nurses on probation, warning that if they get in trouble again, their licensees may be yanked. In reality, such action seldom happens quickly, if at all, according to a review of hundreds of nurse disciplinary records. Just five board staff monitors 470 nurses on probation. Often nurses must undergo physical and mental exams, take drug tests, submit to workplace monitoring and attend rehabilitation or support groups. But when they don't meet some or any of those requirements, years often pass before the BRN tries to revoke their probation. At times, the punishment for violating probation is more probation.

4) Emergency Suspensions. The BRN failed to use its authority to immediately stop potentially dangerous nurses from practicing. It obtained emergency suspensions of nursing licenses just 29 times from 2002-2007. In contrast, Florida's nursing regulators, who oversee 40% fewer nurses, take such action more than 70 times each year.

5) Funding. Current and former state attorneys indicate that at times they have been asked to suspend work on nursing board cases to save money. The BRN has not raised its fees in 18 years.

6) Statute of Limitations. There is no legal pressure for the BRN to act faster. Unlike with disciplinary cases against doctors, there is no statute of limitations on nurses. The delays make the pursuit of cases more difficult: witnesses die, records are purged and former co-workers cannot be found.

7) Hospital Reporting. Most states require hospitals to report nurses who have been fired or suspended for harming a patient or other serious misconduct. The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) also has this requirement[2]. However, the BRN does not have a similar requirement for nurses.

8) Disclosure and Tracking of Cases. The BRN also largely shuts itself off from information about nurses licensed in California who get in trouble. It is not part of a national compact of 23 state nursing boards that share information about nurses who are under investigation or have been disciplined. And unlike 35 states, California does not put the names of all its registered nurses into an industry database. So if a California-licensed nurse gets in trouble in another state, the state may not know to notify California. Perhaps the most telling instances of dysfunction is when other states act against nurses for crimes and misdeeds committed in California before California's own board does.

9) Fingerprinting and Criminal or Disciplinary Disclosure Requirements. In a separate article published by the LA Times, and in collaboration with ProPublica on October 4, 2008[3], it was revealed

[2] See Business and Professions Code § 2878.1. Any employer of a licensed vocational nurse is required to report to the BVNPT the suspension or termination for cause of any licensed vocational nurse in its employ. This Section also defines suspension or termination for cause for purposes of reporting.

[3] See Charles Ornstein & Tracy Weber, Criminal Past Is No Bar to Nursing in California, L.A. Times, October 4, 2008, available at

that nurses convicted of crimes, including sex offenses and attempted murder continue to be licensed by the BRN. As a result of these findings, emergency measures were adopted to require all nurses licensed by the BRN to be fingerprinted and to disclose in their license renewal forms criminal convictions or any discipline imposed by another jurisdiction. The fingerprinting and criminal or disciplinary disclosure requirements were later implemented for other consumer health-boards…

Recommended Changes

Auditing of Enforcement and Diversion Programs

Staff Recommends: Legislation should be immediately pursued which would require the appointment of an "Enforcement Monitor" to thoroughly audit the BRN's enforcement and diversion programs.

Increased Resources for Enforcement Programs

Staff Recommends: Increasing the annual licensing fee for nurses to cover increased costs for the BRN's enforcement program and to also provide for the increase in staffing levels necessary for BRN's enforcement program.

The DCA should immediately move forward with providing an information/ computer system that would allow for the BRN and other boards, DOI, DCA and DOJ to be more integrated in handling all aspects of licensing and enforcement; especially allowing for the tracking of complaints and disciplinary cases. This system should be fully integrated with DOI's Case Assignment Tracking System (CATS).

Authorization to Spend Licensing Fees on Enforcement

Staff Recommends: Exempt from the furloughs enforcement officers of the DCA and various special-fund healthcare licensing boards who are directly involved in pursuing consumer complaints. (The Chair of this Committee has introduced SR 25 urging the Governor to implement this recommendation.)

Rather than reserve funds being loaned to the general fund, all reserve funds should be placed in an "emergency reserve enforcement fund" to be used only for purposes related to the board's enforcement programs. These funds should be immediately available, without the need to receive spending authority, if for some reason enforcement costs exceed budgetary allocations. This will ensure that boards are not placed in the position of having to either "slow down" their cases or ask either DOI or the AG to stop work on their cases and that boards are sufficiently funded for other purposes related to enforcement.

Enhanced Detection and Reporting of Problem Licensees

Staff Recommends: This Committee should conduct a hearing during the interim recess to determine which of the mandatory reporting requirements and notice provisions for physicians and surgeons should be applicable to nurses and other healthcare professionals. The prohibition on a "regulatory gag clause" in a civil malpractice lawsuit settlement involving other

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http://www.latimes.com/news/local/la-na-nursing5-2008oct05,0,3509040.story.

healthcare practitioners should be immediately implemented.

Faster Screening of Complaints and Prioritization of Cases

Staff Recommends: This Committee should work with the BRN to establish priorities for the handling of complaints and those which should be immediately sent for investigation and these priorities should be immediately implemented. The BRN should also utilize, similar to the MBC, nurse consultants to assist in the screening and prioritization of complaints for investigation or possible referral to the District Attorney's Office for criminal violations.

Faster and More Efficient Investigations by DOI and Boards

Staff Recommends: The BRN and the DCA should consider either consolidating all sworn investigators under DOI and creating two sections similar to the AG's office, one which deals with health quality cases from the various healthcare boards and the other section which would deal with general licensing board cases, or as recommended by CPIL, allow the BRN to both seek and have its own investigators or use investigators of the MBC. (Another alternative is indicated below under discussion of the AG's Office and would either eliminate DOI and move all sworn investigators to the AG's Office or at least allow investigators who specialize in health related cases to be under the AG's Office.)

Other recommendations include:

1) DOI should immediately prioritize existing cases and work with boards to assist them in prioritizing cases which could be handled by the individual boards or referred immediately to DOI.
2) Allow boards to hire non-sworn investigators to investigate cases which may or may not be referred to DOI and allow boards to continue with their own specialized investigators, but working more in conjunction with the AG's Office when necessary.
3) Assure that all sworn and non-sworn investigators receive appropriate training.
4) Create within DCA a position of Deputy Director of Enforcement with major oversight responsibility for DCA's enforcement programs and act as liaison with the boards, the DOI, the AG, the OAH and local law enforcement agencies to ensure timely filing of disciplinary actions and prosecution and hearing of cases. However, the day to day responsibilities of the DOI should continue to be the responsibility of the Chief of DOI.
5) Change the process of payment for DOI services to that more closely aligned with the AG's office.

Faster and More Efficient Prosecution of Cases by the AG's Office

Staff Recommends: If maintaining and reforming DOI is not considered as a viable option, or if it is decided that DOI should only be responsible for investigating non-health related cases, then the DCA, MBC and the

AG should consider moving all of the MBC and DOI investigators involved with health-related cases to the AG's Office so they can work in teams with HQE prosecutors in a VE format, as recommended by the CPIL.

The AG's Office attorneys should also be realigned into two units:

- the HQE which would do all healthcare cases (MBC, BRN, Pharmacy, Dentists, etc.), and
- the Licensing Section which would handle disciplinary matters for all other non-health DCA boards (e.g., Architects, Engineers, Accountants, etc.).

More evidence of the success of the DIDO program as a proven effective model of investigative/prosecutorial services would need to be provided before consideration should be given to rejecting the implementation of the VE format for investigations and prosecution of cases. Initial reports seem to indicate some success of the VE format in both the investigation and prosecution of health-related disciplinary cases.

Except for the reinstatement of the DIDO program, all recommendations of the AG's Licensing Section should be given strong consideration, some of which could be implemented immediately.

Consideration should also be given to setting certain timeframes for the AG in the filing of accusations, proposed default decisions, the setting of a hearing date once a notice of defense is received, etc.

Use of Specialist Administrative Law Judges

Staff Recommends: The OAH should consider whether the BRN and other major healthcare boards could utilize the Medical Quality Hearing Panel so as to have more specialize ALJ's dealing with the more complicated healthcare quality cases.

More Effective Probation Monitoring

Staff Recommends: There should be created within the revamped DOI or HQE a special "strike force" to handle cases involving failed diversion, criminal convictions, violations of probation, and other cases needing immediate attention such as an interim suspension order (ISO) or temporary restraining order (TRO). The BRN staff and other boards which lack sufficient staff should have staffing levels immediately increased to deal with probation monitoring of cases.

Enhanced Disclosure of Information about Licensees

Staff Recommends: This Committee should include as part of its hearing during the interim recess what public disclosure requirements for physicians and surgeons should be applicable to nurses and other healthcare professionals.

Diversion Programs should be Substantially Improved or be Abolished

Staff Recommends: As recommended earlier, the Enforcement Monitor appointed to the BRN should audit the diversion program and recommend either

substantial changes to the program to assure that substance-abusing nurses are properly monitored or the elimination of the program operated by the BRN. In the meantime, a sunset date of January 1, 2011, should be placed immediately on this program and other diversion programs provided by the boards. The DCA shall also immediately proceed with the audit on the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of healthcare licensing boards. Based on this audit, the DCA shall immediately make recommendations to the Legislature regarding the continuation of these programs by the boards, and if continued, any changes or reforms necessary to ensure that individuals participating in these programs are properly monitored, and that the public is protected from healthcare practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

The DCA shall also immediately provide to the Legislature an update on the work of the Substance Abuse Coordination Committee and at what time the Committee will have completed its work and provide uniform standards that will be used by all health licensing boards which provide diversion programs.

As recommended by CPIL and the BRN, provide for the automatic suspension of a nurse's license similar to that in Penal Code Section 1000, to ensure that those who do not and cannot comply with the terms and conditions of a diversion program are promptly removed from practice.

Other Changes and Recommendations for the BRN and Other Health Related Boards

Staff Recommendations: The following are other changes and recommendations which should be made to the BRN and possibly other health related boards under the DCA:

1) Immediately provide for the BRN a medical records request statute (similar to Business and Professions Code Section 2225 which applies to the MBC and its investigators) and a penalty on doctors/hospitals/facilities for failure to comply with a lawful request for medical records (similar to Business and Professions Code Section 2225.5).

2) Immediately require the BRN as well as other health related boards to provide an annual report (similar to the MBC under Business and Professions Code Section 2313) on its enforcement program statistics, including the timeframes for every step in the enforcement process.

Editorial Note: In her testimony at the August 17 hearing, Julianne D'Angelo Fellmeth urged the committee to enact legislation instructing other health professional boards to adopt reforms enacted by the state medical board over the years, including mandatory reporting requirements and public disclosure statutes. She also advocated for restoration of sunset review for regulatory boards and a refashioning of all board

diversion programs into zero-tolerance programs.

She stressed the need for more resources for enforcement: more complaint intake personnel, more investigators, more prosecutors in the Attorney General's office, more probation staff, and more diversion program staff. More importantly, she expressed the view that the heart of the enforcement problem is the inefficient "hand-off" approach to investigations and prosecutions in which complaints are screened, handed off to an investigator, then handed off to an analyst, then handed off to a prosecutor, then handed off to an Administrative Law Judge. Fellmeth and other witnesses recommend instead the "vertical enforcement" model in which investigators and prosecutors work together in teams from start to finish.

On September 4, legislation was introduced (SB 294) calling for several reforms, including authority for the Board of Nursing to hire its own investigators, a requirement that diversion program vendors immediately report "substantial noncompliance" to the affected regulatory board, and automatic suspension of the licenses of individuals terminated from a diversion program. The legislation would also have created an enforcement program monitor at the Board of Nursing to evaluate the board's enforcement and diversion programs and report to the legislature in December 2010 and again in December 2011.

Succumbing to arguments by the regulatory boards and professional associations that there wasn't time during the current legislative session to meaningfully consider such major changes, the legislature shelved the legislation. It can be re-considered again in January, the second year of a two-year legislative session.

PATIENT SAFETY AND MEDICAL ERRORS

State Bans Mandatory Overtime for Nurses

As of July, 2009, Pennsylvania's hospitals and other health care institutions may no longer require nurses and other caregivers to work overtime. Known as Act 102, the law outlaws discipline or discrimination against a caregiver for refusing to work longer hours than an agreed-to work shift. The only exceptions to this rule is a "last resort" situation in which the employer has exhausted all reasonable alternatives or in cases of natural disaster, terrorism attack or an epidemic.

The law applies to direct patient caregivers, including nurses, technicians and technologists, certified nursing assistants and phlebotomists. It applies in all health care settings, including acute care and psychiatric hospitals, rehabilitation facilities, nursing homes, ambulatory surgical facilities and state health facilities.

Caregivers are permitted to work overtime hours voluntarily. However, a caregiver who works more than 12 consecutive hours in a day is entitled to a minimum of 10 hours off-duty time immediately after the overtime hours.

Pharmacy Errors Under-Reported

On September 20, 2009, Alison Young reported in The Atlanta Journal-Constitution that most errors in filling prescriptions are handled internally by Georgia's pharmacies rather than reported to the state pharmacy

board. Studies indicate that as many as 3% of prescriptions dispensed by pharmacies have potentially harmful errors.

Young criticizes the secrecy of the complaint process – complaints are confidential; letters of reprimand are confidential; final orders may not be made public for as long as two years. Further, the typical penalty for a dispensing error is a fine and an order to attend a medication safety course.

Of the final orders that are made public, Young included the following in her article:

> A 27-year-old woman who was prescribed an anti-anxiety medication for an allergic condition instead received a powerful heart drug from a Kmart pharmacy in Cartersville. The woman was hospitalized for three days after suffering a reaction to the drug. The board order was issued in September 2008; the prescription was misfilled in February 2007.
>
> Pharmacists at a Wal-Mart in Newnan misfilled a patient's prescription for Quinamm, to treat malaria, with Quinapril, a blood pressure medication. And they did it three times. A board order was issued in January 2008; the incidents occurred in November 2005 and in June and July 2006.
>
> A CVS pharmacy on Jones Bridge Road in Alpharetta improperly refilled a 10-month-old child's prescription for Zantac – needed to control stomach acid — with liquid Zyrtec, an allergy medication. Even though the child's mother called the pharmacy to ask why the liquid smelled different, she "was assured by the pharmacist on duty that the correct drug had been given." The child took the drug for a week before the mother noticed the pharmacy label was covering another showing the drug was actually Zyrtec. The board issued its order in July 2007; the incident occurred in May 2005.
>
> A Kmart pharmacy in Canton sent a patient home with a bottle of the antibiotic Levaquin that said to take the pills four times a day — instead of just once a day as the doctor prescribed. The patient followed the wrong instructions on the bottle and in August 2007 Kmart settled a claim over the misfill and notified the board. The board issued its order in December 2008; the incident occurred in 2005.
>
> The article can be found online at: http://www.ajc.com/news/the-harm-in-pharmacy-141985.html?printArticle=y

Long Hours, Lack of Sleep Dangerous for Attending Physicians

Much has been written about the dangers to patients posed by residents who work long hours with insufficient sleep. A study published October 14 in ***The Journal of the American Medical Association (JAMA)*** concludes that attending physicians are susceptible to the same problems.

The research team, led by Jeffrey M. Rothschild, MD, of Boston's Brigham and Women's Hospital, found a nearly 3% increase in complications in early morning surgical procedures performed by attending physicians who had less than six hours of sleep compared to physicians who had more sleep the night before.

Complications occurred in 6.2% of procedures performed by sleep-deprived physicians compared with 3.4% complications in the control group. Complications included surgical site infections, bleeding, organ injury, wound failure, neural damage, and fracture or dislocation.

The authors suggest that hospitals and physicians consider adopting strategies to reduce the opportunities for surgeons to enter the operating room with insufficient sleep. The recommended strategies are:

- Avoid scheduling elective procedures following being on-call the night before;
- Use hospital-based physicians to handle overnight emergencies;
- Consider re-scheduling elective procedures when risks are high or when colleagues feel risks are high;
- Rely on teams, including backups, to assist or relieve overtired physicians;
- Consider using caffeine if the surgeon must perform lifesaving procedures.

Most Physicians Depend on Pharmacists for Drug Interaction Information

Researchers at the University of Arizona and the Arizona Center for Education and Research on Therapeutics found that the physicians surveyed correctly identified fewer than half of drug pairs with potentially dangerous drug-drug interactions (DDIs). (*Drug Safety*, 31(6), pp. 525-536, 2008) The research team, led by Yu Ko, Ph.D., mailed questionnaires to 12,500 prescribers with a history of prescribing drugs known to have a potential for DDI.

The prescribers were asked to classify 14 drug pairs as "contraindicated," "may be used together but with monitoring," or "no interaction." The 950 respondents classified 42.7 percent of the drug combinations correctly. More than one-third of respondents answered that they were "not sure" about half of the drug pairs.

Asked what sources of information they relied on the identify DDIs, one-fourth of the respondents said they consulted personal digital assistants (PDAs) for information about potential drug interactions. About two-thirds of respondents said they rely on pharmacists to identify potential DDIs.

Nurse Laid Off During Surgery

To cope with the unfavorable economy, for-profit Dean Health System in Madison, WI decided to lay off 90 employees. One such employee, a nurse, was laid off in April 2009 while he or she was part of the team doing a surgical procedure. The nurse manager who dismissed the employee during surgery had thirty years of nursing experience, the director of corporate communications informed the *Wisconsin State Journal*. The identities of the dismissed nurse and the nurse manager were not made public.

The Wisconsin Department of Regulation and Licensing decided in July, 2009 not to formally investigate the incident because there were an adequate number of other care givers present at the time.

Process, Not Outcome, is Key to Error Investigations

Research conducted by the Rand Corporation, funded by the Agency for Healthcare Research and Quality and published in the *Joint Commission Journal on Quality and Patient Safety* (35[3], pp. 139-145) examined how two Southern California hospitals conducted reviews of adverse events. One approach focuses on patient outcomes, the other focuses on process-- that is, the chain of events leading up to the adverse events. The researchers found that reviewing processes offers more useful information for identifying why the event occurred and how to avoid a similar event in the future.

According to the AHRQ *Research Activities* (347, July 2009, p. 23):

> The authors suggest that neither process- nor outcome-oriented

reports are perfect instruments. Process-oriented reports need more particulars to be useful. One way to gather richer details is by using an electronic reporting system that offers a classification system for patient events and encourages providers to provide in-depth descriptions that may reveal factors that contributed to the incident. Although outcome-oriented reports do not specify if an adverse event occurred and don't offer information n preventing them, hospitals can still use the information to conduct thorough investigations when necessary.

Editorial Note: It is not surprising that reviews of processes reveal more about the causes of an error than do reviews of outcomes. Now that this has been confirmed by research, are there implications for complaint investigations conducted by licensing boards? It is hard to imagine that a board would not treat cases involving adverse patient outcomes as a top priority. But, investigators look beyond the outcome to see if there was practitioner error in the chain of events leading to the outcome.

Seattle Hospital Admits Fatal Mistake

A fifteen-year-old boy died in Seattle Children's Hospital in March, 2009 from an opiate overdose after dental surgery. The family has since sued the hospital whose spokespersons admit that their "processes failed at multiple points."

The patient, an autistic boy with difficulty swallowing medication, was prescribed a fentanyl patch for pain after oral surgery. The patient's mother checked with several hospital caregivers because the child had never had a patch before. They all assured her the patch was appropriate. In fact, it delivered a fatal dose of medication.

The hospital chose not to discipline the dentist, but has made changes to its procedures. They modified their process for prescribing and administering fentanyl patches and added information about the patch to their medication database. They reported the incident to the Washington State Department of Health.

Patient Safety Neglected in Federal Health Reform Bills

In an online article for Hearst Newspapers, reporters Eric Nalder and Cathleen F. Crowley analyze the health reform bills under consideration in the U.S. Congress and observe that none of the bills adequately addresses the avoidance medical errors, which would advance patient safety and reduce health care costs. "Studies show," they write, "that preventable medical errors — ranging from poor sanitation to mistakes during surgery — kill four times as many people as the lack of medical insurance:"

In August, a national Hearst investigation, "Dead by Mistake," concluded that up to 200,000 people per year die from medical errors and infections in the United States. It also pointed out that 10 years after a landmark federal study, "To Err Is Human," first highlighted the problem, many of the solutions the study proposed haven't been adopted. The entire Hearst report can be found at www.DeadbyMistake.com. …

In contrast to the annual toll of up to 200,000 deaths from hospital-acquired infections and medical errors, a Harvard Medical School study this year estimated 45,000 people died in 2005 due to lack of health insurance.

Two major recommendations of "To Err Is Human" are mandatory reporting of medical errors and, based on those reports, systemic changes to prevent future mistakes.

None of the bills include mandatory reporting and, without that, the steps towards systemic change are vague…

Patient safety experts say mandatory reporting is too important to be left out of the current health care reform legislation.

Dr. Peter Pronovost, an anesthesiologist at Johns Hopkins University School of Medicine and a national leader in patient safety, wants a national oversight board for medicine, much like the Securities and Exchange Commission that collects corporate financial data and makes it available to the public. He said he'd like to see national reporting of both medical errors and infections.

"If every hospital had to post their rates of infection, and it was accurate data, you would be rest assured that this problem would be solved," he said.

Instead, infections affect an estimated 1.7 million people and kill 99,000 annually, according to the Centers for Disease Control and Prevention.

The entire article can be found at: http://www.mysanantonio.com/health/64471062.html.

QUALITY OF CARE

Nurse-Led Disease Management Cost-Effective

Research published in the *Annals of Internal Medicine* (149, pp. 540-548, October, 2008) found that nurse-led disease management of heart failure in ethnically diverse communities improved the quality of life for patients and was cost-effective. The researchers assigned 406 ethnically diverse cardiac patients in Harlem, NY to either a nurse manager or to more traditional forms of care for a 12-month period. The nurse managers met with their patients and followed up with regular phone calls.

The patients assigned to nurse managers had better physical functioning and better quality of life than the control group. The cost for each nurse manager patient was $2,177. In addition, there was a $2,378 per-patient savings resulting from lower rates of hospitalization among the nurse manager group of patients.

SCOPE OF PRACTICE

Minnesota Licenses Mid-Level Oral Health Providers

A law granting licensure to Dental Therapists and Advanced Dental Therapists in Minnesota became effective in May 2009. Under the law, practitioners trained under the Advanced Dental Hygiene Practitioner (ADHA) model will provide oral health services to underserved populations in the state. Their practice will include educational, preventive, palliative, therapeutic, and restorative services. Supporters of the legislation include the Minnesota Dental Hygienists' Association and the Minnesota Safety Net Coalition. The Minnesota Dental Association did not oppose the legislation.

The ADHA educational model teaches dental hygienists additional clinical skills. They also learn how to manage a clinic or practice and to advocate for patients. (For more information, visit http://www.adha.org/media/backgrounders/adhp.htm.)

The American Dental Hygienists' Association offers answers to frequently asked questions about the new specialty, including the following questions about state practice acts:

> Q: What does this mean in relation to the practice acts within each state? How will this affect the legislative efforts in each state to increase practice areas for the registered dental hygienist?
>
> A: ADHA recognizes that much of the restorative aspect of the ADHP will require some widespread changes with regard to scope of

practice enhancements. That said, many states, including Minnesota and Washington, have some degree of restorative duties in current law. We envision that once this position is established, state lawmakers and regulators will look to the ADHP as one of the solutions to the access to oral health care dilemma and make scope enhancements. Practice acts are, in most cases, permissive laws and there will not be any mandate for all dental hygienists to practice as an ADHP.

Q: What is the difference between a registered dental hygienist, an advanced dental hygiene practitioner, a dentist and a dental assistant?

A: The professional roles of a dentist, a dental hygienist and a dental assistant are fairly well defined in their respective scopes of practice. The ADHP would be a new professional entity with its own prescribed scope of practice, which can be further delineated as the curriculum and educational programming is determined.

Q: How will the ADHP differ from the dental therapist or dental aide positions available elsewhere?

A: ADHA will examine all related models of oral health providers such as the dental therapist, dental nurse or dental health aide as background information and research for the advanced dental hygiene practitioner. However, the ADHP will be developed in a unique way that considers the oral health needs and the health care delivery system in the U.S.

Q: How does this new position impact access to oral health care?

A: The dental hygiene profession is already on the frontline of defense against disease. However, due to current state practice acts, there are barriers imposed that do not allow the public direct access to preventive care and education from dental hygienists.

Additionally, the U.S. is experiencing a crisis shortage of dentists available to treat the populations who need oral care the most. Millions of Americans in both rural and urban areas are unable to obtain care because there are not enough dentists practicing in those areas.

Further, with government statistics revealing a projected decline in the number of dentists while there is a projected growth in the dental hygiene profession, it is clear that dental hygienists will be able to make a huge impact through this expanded role. The ADHP will expand the practice areas and offer this person the ability to serve the public in un-served areas by providing both preventive and restorative care.

Kaiser Call Centers Cleared – For Now

In August, 2008, a nurse employed by Kaiser Permanente filed a whistleblower complaint with the California Department of Managed Health Care alleging that unlicensed teleservice representatives (TSRs) were evaluating medical information and giving medical advice over the phone to Kaiser enrollees. Specifically, she said TSRs were deciding whether to schedule an appointment, leave a message for the physician, transfer the caller to an advice nurse, or direct the caller to an emergency room.

After an investigation the Department of Managed Health Care determined that the TSRs were not engaging in the practice of medicine:

> The DMHC concluded that review of (selected) documents and evaluation of TSR performance during the site visit yielded insufficient substantiation of the allegations to warrant a broader audit at this time. Had this examination raised any red flags on the operation, a broader, more formalized investigation would have been initiated. Nevertheless, the (DMHC) will continue to monitor the situation through audits of TSR calls for the next six months to ensure that unlicensed health plan call center agents are not improperly providing medical advice in violation of state law.
>
> It is important to note that all health plans use some form of telephone triage service to route callers to the level of care appropriate to their need. Properly executed, this type of customer service is crucial to ensuring access to health care for millions of Californians. Nothing uncovered in the examination of this complaint calls for current change to Kaiser's operations.
>
> It is important to also acknowledge that the DMHC does have some level of concern that TSRs have limited discretion to choose between alternative scripts. However, it may not be possible to completely eliminate all exercise of judgment or common sense in this or any process, even if an automated and interactive voice messaging system were used.

American Medical News Boasts of Scope of Practice "Victories"

In the *Professional Issues* column in the May 11, 2009 online edition of ***American Medical News (Amednews.com)***, Amy Lynn Sorrel wrote that two State Supreme Court cases "send a strong message about the importance of safeguarding patient safety and the practice of medicine." She was referring to a case decided by the Louisiana Supreme Court prohibiting nurse anesthetists in the state from engaging in chronic pain management and a Kentucky Supreme Court decision allowing physicians to perform and bill for physical therapy services.

In the Louisiana case, the Board of Nursing asked the Louisiana Supreme Court to overturn an appeals court decision that a nursing board rule permitting nurse anesthetists to perform chronic pain management violated the state laws related to the practice of medicine. One factor in the higher court's April 13, 2009 decision not to overrule the lower court was an opinion issued by the state medical board asserting that interventional pain management is the practice of medicine.

Commenting on the impact of the medical board opinion, Sorrel wrote:

> Physician leaders say that as non-physician boards get more aggressive, medical boards are beginning to take more of an active role in such regulatory disputes by weighing in with position statements.
>
> Such moves are likely to carry weight in the courts and the Legislature because "the medical board is there to protect the public and to decide what constitutes the practice of medicine," said Amy Phillips, general counsel to the Louisiana State Medical Society, which monitored the state case.

She also observed that some physicians think the Louisiana ruling may be a precedent for other states, including those, such as Indiana, Iowa and Tennessee, where nurse anesthetists have already secured the

legal authority to engage in chronic pain management.

The Kentucky case originated in an unusual manner. The Board of Physical Therapy sued an orthopedic practice, alleging that it was illegal for its members to offer and bill for physical therapy services because they are not licensed physical therapists.

The Kentucky Supreme Court ruled that the physical therapy practice act intends to protect patients from unqualified practitioners, not from physicians, who, the court argued, are trained to provide a wide variety of medical services and are, in effect, exempt from scope of practice restrictions.

Editorial Note: In language that may come to haunt organized medicine, the court wrote that the PT practice act was "not to protect physical therapists against competition from other qualified health care providers." This same comment can be made about medical practice acts, as well. Read the entire post, "Medicine scores legal victories in scope of practice," at: (www.ama-assn,org/amednews, May 11, 2009.

Pharmacists in Maine May Administer Immunizations

As of October 1, 2009, Maine became the fiftieth state to permit pharmacists to give flu shots and other immunizations. This scope expansion was billed as a great boon for residents of rural areas where physicians are in short supply.

Physicians who had previously opposed granting pharmacists this authority didn't oppose this year, given the H1N1 pandemic. Also, pharmacist Joe Bruno told Beth Quimby of the ***Portland Press Herald*** (October 2, 2009) that doctors are busy and reimbursements for giving vaccinations are pretty low.

Confusion over Flu Shots vs. Botox Shots

The Nevada Board of Medical Examiners approved an emergency regulation on September 18, 2009, permitting medical assistants to administer flu shots during the upcoming flu season. County District Judge Kathleen Delaney issued a temporary restraining order barring implementation of the regulation pending a hearing on September 29 because the medical board had cut short the public comment period, denying the representative of a medical spa from testifying on the regulation before it was adopted. Meanwhile, this straightforward attempt to increase access to flu shots became entangled in a scope of practice dispute between plastic surgeons and medical spas.

According to a 1979 law, medical assistants are permitted to work under the direct supervision of doctors who must see each patient before a medical assistant is allowed to provide services. Some interpret the law to prohibit medical assistants from administering Botox injections. However, this law has not been enforced and doctors have allowed medical assistants to perform all the services for which they have been trained. If the supervision regulation were enforced, medical assistants would be prevented from administering any shots, whether flu, Botox, or something else.

Representatives of medical spas contend that plastic surgeons are trying to reclaim Botox business from medical spas by trying to influence the medical board to enforce the supervision regulation.

CERTIFICATION

Study Finds Specialty Certification Matters in Intensive Care

Researchers Deborah Kendall-Gallagher, RN, JD, MS, PhD, and Mary A Blegen, RN, PhD conducted research attempting to

establish a link between specialty certification and competence. Their findings were reporting in March, 2009 in the *American Journal of Critical Care.* The article's abstract is reproduced below, followed by a citation to the entire online article.

Background Adverse events that place patients at risk for harm are common in intensive care units. Clinicians' level of knowledge and judgment appear to play a role in the prevention, mitigation, and creation of adverse advents. Research suggests a possible association between nurses' specialty certification and clinical expertise. The relationship between specialty certification and clinical competence of registered nurses and safety of patients is a relatively new area of inquiry in nursing.

Objective To explore the relationship between the proportion of certified staff nurses in a unit and risk of harm to patients.

Methods Hierarchical linear modeling was used in a secondary data analysis of 48 intensive care units from a random sample of 29 hospitals to examine the relationships between unit certification rates, organizational nursing characteristics (magnet status, staffing, education, and experience), and rates of medication administration errors, falls, skin breakdown, and 3 types of nosocomial infections. Medicare case mix index was used to adjust for patient risk.

Results Unit proportion of certified staff registered nurses was inversely related to rate of falls, and total hours of nursing care was positively related to medication administration errors. The mean number of years of experience of registered nurses in the unit was inversely related to frequency of urinary tract infections; however, the small sample size requires that caution be exercised when interpreting results.

Conclusions Specialty certification and competence of registered nurses are related to patients' safety. Further research on this relationship is needed.

To read the entire article, go to the March, 2009, issue of the American Journal of Critical Care at www.ajcconline.org.

Certified Oncology Nurses' Performance Compared to Non-Certified

Another study aimed at evaluating the clinical benefits of specialty certification compared certified oncology nurses with non-certified oncology nurses. The research team, led by Elizabeth Ann Coleman, PhD, RNP, AOCN, published its findings in the *Clinical Journal of Oncology Nursing*, Vol 13, Number 2, pp. 165-172. The full article is available online at: http://ons.metapress.com/content/q3v32025v71137w8/?p=a8d2002c4838426ea32de63f4c7ec2c3&pi=6. The abstract is reproduced here:

> The study compared certified nurses with noncertified nurses for symptom management of nausea, vomiting, and pain; patient satisfaction; and nurse satisfaction to determine the effect of certification in oncology nursing on those nursing-sensitive outcomes. A total of 93 nurses—35 (38%) of them certified in oncology nursing—and 270 patients completed surveys. Chart audits provided additional data on symptom management. Certified nurses scored higher than noncertified nurses on the Nurses' Knowledge and Attitudes Survey Regarding Pain as well as the Nausea Management: Nurses' Knowledge and Attitudes Survey. The chart audits showed that certified nurses followed National Comprehensive

Cancer Network guidelines for chemotherapy-induced nausea and vomiting (CINV) management more often than noncertified nurses. The study demonstrated that job satisfaction is fairly high for oncology nurses and patient satisfaction is high. In general, cancer pain and CINV were managed well but improvements can be made. Nurses and physicians should be continuously educated on evidence-based guidelines for symptom management of cancer pain and CINV, and a CINV knowledge and attitude assessment tool should be developed.

Pharmacy Technician Certification Spreading

As of March, 2009, only eight states (Colorado, Delaware, Georgia, Hawaii, Michigan, New York, Pennsylvania, and Wisconsin) do not require that pharmacy technicians be certified. A lengthy article by Catherine Redwan in the online version of *Modern Medicine* posted on August 25, 2009, explores the tension between certification by a nationally accredited entity, such as the Pharmacy Technician Certification Board (PTCB) or the Institute for the Certification of Pharmacy Technicians, or by an employer, such as Walgreen's or CVS.

Legislation signed into law in Ohio in January 2009 permits certification by either a national exam offered by a certification body accredited by the National Commission for Certifying Agencies (NCCA) or by an employer exam. In either case, the exam must be approved by the Ohio board of pharmacy.

The National Pharmacy Technician Association (NPTA) and the American Society of Health System Pharmacists (ASHP) favor national over employer-based certification examinations.

"NPTA believes that all pharmacy technicians should be required to be registered, complete a standardized formal training program, pass a nationally accredited certification exam, and complete ongoing continuing education accredited by the Accreditation Council for Pharmacy Education in order to be able to practice as a pharmacy technician," NPTA chairman and CEO Mike Johnston, CPhT wrote in an e-mail to *Modern Medicine's* Redwan.

An ASHP spokesperson told Redwan "By choosing a nationally accredited examination, rather than individual employer-based certification examinations, the public is better assured of a consistent and appropriate measure of skills and competencies. National examinations assess the duties and responsibilities that should be required of all pharmacy technicians regardless of their practice settings."

There is a possibility of federal involvement in pharmacy technician regulation. Last year, U.S. Rep. Steven LaTourette (R-Ohio) introduced the "Pharmacy Technician Training and Registration Act of 2008", which would require states to register technicians and certify them through the PTCB exam, and authorize federal grants to establish state registration programs.

For more information on this subject, read Redwan's entire article at:
http://search.modernmedicine.com/search?qgeneral=pharmacy+technicians&x=21&y=9&searchtype=defLink .

Personal Trainers Face Possible Regulation

Legislation passed in the California Senate and pending in the Assembly would require physical trainers in the state to satisfy educational requirements or earn certification from a certifying agency accredited by the National Commission for Certifying Agencies (NCCA). The International Health Racquet and Sportsclub Association (IHRSA) opposes the bill

opposes the measure, arguing that self-regulation is adequate.

Currently, ten fitness trainer certification agencies are NCCA accredited. Supporters of the legislation point out that there are credential mills that offer a *certificate* (as opposed to a certification) after a couple of hours of class time or an online course.

Text of the Senate bill can be found at: http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0351-0400/sb_374_bill_20090402_amended_sen_v98.html.

LICENSURE

Provisional Licensure Lures Doctors to Texas

A new licensing law in Texas enables doctors who are licensed in good standing in another jurisdiction and are sponsored by a Texas physician to obtain a provisional license from the Texas Medical Board pending approval for a full license. Provisional licenses apply for nine months.

The provisional license permits its holder to practice in underserved areas in collaboration with the sponsoring physician. The law was sponsored by state senator Eliot Shapleigh or El Paso, which is experiencing a shortage of physicians and expects the demand for doctors and other health care practitioners to continue to grow. Another piece of legislation calls upon the state to pay 20% of the tuition of doctors for each year they practice in medically underserved areas.

Colorado Reconsiders Licensure for Surgical Technicians

According to an article by Michael Booth in the *Denver Post* on July 19, 2009, Colorado's Department of Regulatory Agencies (DORA) is revisiting the idea of licensure for surgical technicians. Officials have decided to review an earlier decision not to license surgical techs after a technician diverted drugs and exposed as many as 5,000 patients to the risk of hepatitis-C.

Licensure, the argument goes, might have prevented the suspect from obtaining a job at Audubon Surgery Center in Colorado Springs after having been fired by Rose Medical Center. A licensure data base might also have alerted regulators and employers that the same technician had been fired by a New York hospital the previous year before moving to Colorado.

Editorial Note: If only licensure guaranteed that unsafe and incompetent health care practitioners could be identified, disciplined, and/or prevented from moving from job to job. Unfortunately, it is often the case that employers do not report to regulators or other health care facilities when they fire health care workers for cause. Furthermore, even licensing boards may not send a paper trail about disciplined caregivers to their counterparts in other states. If, along with licensure for surgical technicians, DORA were able to institute a more fail-safe reporting and communication system covering both the private and public sectors, it would make a real contribution to public safety.

Oklahoma Licenses Recreation Therapists

After years of trying, the Therapeutic Recreation Association of Oklahoma and Oklahoma State University (which offers the only accredited educational program in the state) celebrated the passage of the Therapeutic Recreation Practice Act which requires recreation therapists to fulfill a state certified licensure requirement.

The legislation creates a Therapeutic Recreation Committee to assist the State Board of Medical Licensure and Supervision in conducting examinations for applicants

and to advise the Board on all matters pertaining to the licensure, education, and continuing education of therapeutic recreation specialists and the practice of therapeutic recreation or recreation therapy. The Committee shall consist of three licensees and two public members appointed by the medical board. The Committee is advisory; the medical board has the power to implement and administer the law.

The Committee's powers are to:

1) Advise the Board on all matters pertaining to the licensure, education, and continuing education requirements for and practice of therapeutic recreation or recreation therapy in this state; and
2) Assist and advise the Board in all hearings involving therapeutic recreation specialists who are deemed to be in violation of the Therapeutic Recreation Practice Act.

The State Board of Medical Licensure and Supervision has the power to:

1) Promulgate the rules and regulations necessary for the performance of its duties pursuant to the provisions of the Therapeutic Recreation Practice Act, including the requirements for licensure, standards for training, standards for institutions for training and standards of practice after licensure, including power of revocation of a license;
2) Determine, as recommended by the Therapeutic Recreation Committee, the qualifications of applicants for licensure and determine which applicants successfully passed such examinations;
3) Determine necessary fees to carry out the provisions of the Therapeutic Recreation Practice Act;
4) Make such investigations and inspections as are necessary to ensure compliance with the Therapeutic Recreation Practice Act and the rules and regulations of the Board promulgated pursuant to the act;
5) Conduct hearings as required by the provisions of the Administrative Procedures Act;
6) Report to the district attorney having jurisdiction or the Attorney General any act committed by any person which may constitute a misdemeanor pursuant to the provisions of the Therapeutic Recreation Practice Act;
7) Initiate prosecution and civil proceedings;
8) Suspend, revoke or deny the license of any therapeutic recreation specialist for violation of any provisions of the Therapeutic Recreation Practice Act or rules and regulations promulgated by the Board pursuant to this act;
9) Maintain a record listing the name of each therapeutic recreation specialist licensed in this state;
10) Compile a list of therapeutic recreation specialists licensed to practice in this state. The list shall be available to any person upon application to the Board and the payment of such fee as determined by the Board for the reasonable expense thereof pursuant to the provisions of the Therapeutic Recreation Practice Act; and
11) Make such expenditures and employ such personnel as it may deem necessary for the administration of the provisions of the Therapeutic Recreation Practice Act.

To be eligible for licensure, applicants must be at least 18 and of good moral character. They must have completed an approved educational program, completed an

unspecified period of supervised field experience, and passed a proctored exam administered by the medical board.

Licensed therapeutic recreation specialists are authorized to perform consultations and evaluations without referral. Prevention, wellness, education, adaptive sports, recreation and do not require a referral. However, initiating therapeutic recreation services to patients with medically related conditions must be based on a referral from a qualified health care professional who is authorized the make such a referral.

Interestingly, there is a provision in the law stating that:

1) No person shall coerce a licensed therapeutic recreation specialist into compromising client safety by requiring the licensed therapist to delegate activities or tasks if the licensed therapeutic recreation specialist determines that it is inappropriate to do so.

2) A licensed therapeutic recreation specialist shall not be subject to disciplinary action by the State Board of Medical Licensure and Supervision for refusing to delegate activities or tasks or refusing to provide the required training for delegation, if the licensed therapeutic recreation specialist determines that the delegation may compromise client safety.

The legislation can be found at: http://webserver1.lsb.state.ok.us/CF/200910%20FLR/.../sb546%20hflr.doc.

IN THE COURTS

Texas Nurses Indicted for Filing Complaint with Medical Board

Two nurses were indicted in July 2009 for filing a complaint about a physician's practice with the Texas Medical Board. The medical board defended the nurses, saying it relies on such complaints to perform its responsibilities. The nurses followed procedures and only after being ignored by the hospital did they file an anonymous complaint with the medical board.

The complaint alleged that Dr. Roland Arafiles encouraged patients in the hospital emergency room to buy his herbal medicines. He was also alleged to have attempted to take hospital supplies to a patient's home to perform a procedure. The hospital chief of staff intercepted the doctor and prevented him from taking the supplies.

When the medical board informed Dr. Arafiles he was under investigation, he filed a complaint with the Winkler County Sheriff's Department alleging harassment. The Sheriff obtained a copy of the complaint and discovered that it was filed by a female over 50 years old. He used this information to identify the two nurses and seek the indictment for "misuse of official information" with intent to harm for a "non-governmental purpose."

The Texas Nurses Association reports about the case on its Website. The latest entry explains in part:

> On Friday, August 28, attorneys for the nurses, Vicki Galle and Anne Mitchell, filed suit in federal court alleging not only illegal retaliation for patient advocacy activities, but also civil rights and due process violations. The lawsuit names not only the hospital, but also the county, hospital administrator, and physician as defendants. Additionally, because the nurses claim violation of their civil rights, the district attorney, county attorney, and sheriff.
>
> Fortunately, Texas has a number of laws that protect nurses who advocate for their patients. The nurses' complaint states their termination and criminal indictment was illegal retaliation in violation of

the Nursing Practice Act, Board of Nursing Rules, and several other Texas laws:

- Health and Safety code provisions prohibiting retaliation for reporting patient care concerns
- Medical Practice Act provision that prohibit retaliation for reporting to the medical board
- The Public Employee Whistleblower Law…

What does the Texas Medical Board say about the case?

The Texas Medical Board wrote a letter to the District and County Attorneys of Winkler County in June 2009. The TMB challenged the notion that information provided to them is for nongovernmental purposes:

> Information provided by an individual to the Board… is information used by the Board in its governmental capacity as a state agency…
>
> …Information provided triggering a complaint or furthering an investigation by the Board is information provided for a governmental purpose – the regulation of the practice of medicine.
>
> Further… under Federal law, the TMB is exempt from the [HIPAA] requirements; therefore, the provision of medical documentation with patient names on them to the Board is not a violation of [HIPAA]. The TMB also expressed concern that the confidentiality of the complaint filed with the Board had been violated: …the Board has a complaint procedure whereby persons may file a complaint against a license holder with the Board…
>
> …Any complaint filed with the Board is considered privileged and confidential and is not subject to discovery, subpoena or other means of legal compulsion for release to anyone other than the Board… The indictments and other documents issued in this prosecution have effectively destroyed the legislatively created confidentiality that a complainant to the Board would have…
>
> Finally, the TMB stated its "grave concern" that the action of the District and County attorneys "potentially created a significant chilling effect" on others who may have been able to provide the Board with information needed in their investigation.

What is the status of the case?

Several pretrial motions had been filed by the nurses' attorneys. As of September 1, 2009, all but two of the motions have been denied; the remaining two motions are a motion to dismiss the case due to prosecutorial vindictiveness and a motion for access to HIPAA protected patient records.

What will happen if they are found guilty?

Under the Texas Penal Code, misuse of information is a third-degree felony that carries the potential for two-to-ten years' imprisonment and upwards of a $10,000 fine.

How could this happen? I thought nurses had whistleblower protections.

They do. However, whistleblower laws provide remedies for individuals who are retaliated against for protected activities. Patient advocacy, specifically reporting concerns about a practitioner's standard of

care, is protected under Texas laws. These include the Nursing Practice Act, the Medical Practice Act for anyone reporting a physician to the Texas Medical Board, the hospital licensing law for all hospital employees, and the Government Code for public employees.

However, nothing in current Texas law, or laws in any other state (to Texas Nurses Association's knowledge), prohibits a local prosecutor from pursuing criminal action as the Winkler County District Attorney has done in this case. It may be an abuse of prosecutorial discretion, and the nurses may ultimately have an action (lawsuit) for malicious prosecution, but no one anticipated the need to try to limit the discretion of local prosecutors. No one ever imagined that a nurse would be criminally prosecuted for reporting a patient care concern to a licensing agency.

For more on the nurses association's coverage of the case, visit: http://www.texasnurses.org/displaycommon.cfm?an=1&subarticlenbr=509

DISCIPLINE

Health Research Group Asks HHS to Strengthen Disciplinary Data Banks

In separate letters to Secretary Kathleen Sibelius of the U.S. Department of Health and Human Services, the Health Research Group urged the department to correct deficiencies in the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

In a letter dated May 27, 2009, HRG asked HHS to implement recommendations made by stakeholders and its own Office of the Inspector General to address under-reporting by hospitals to the NPDB. Appended to the letter was a 25-page report entitled, ***Hospitals Drop the Ball on Physician Oversight***. The letter reads in part:

In the 17-plus years since it began, the National Practitioner Data Bank (NPDB) has not received a single report from almost half of U.S. hospitals who are required to report doctors whose hospital admitting privileges have been terminated or restricted for more than 30 days. This means that thousands of hospitals (with, collectively, hundreds of thousands of doctors who have admitting privileges) have never disciplined and reported a single doctor in the 17 years since there has been a requirement that such actions be reported.

Prior to the opening of the NPDB, the Department of Health & Human Services (HHS) estimated that 5,000 hospital clinical privilege reports would be submitted to the NPDB each year. However, the average number of hospital reports per year has been 650. As of December 2007, there were a total of only 11,221 such reports.

Thirteen years ago (1996), by which time it had become clear that the number of doctors reported by hospitals was significantly short of the above estimates, the Health Resources & Services Administration (HRSA, the part of HHS that manages the NPDB) sponsored a national conference of all major NPDB stakeholders (including medical and hospital associations). The conference concluded that "the number of reports in the NPDB on adverse actions against clinical privileges is unreasonably low, compared with what would be expected if hospitals pursued disciplinary actions aggressively and reported all such actions." HHS has done almost

nothing since then to alter this alarming situation.

The enclosed report documents two categories of "reasons" for this dangerously low number of hospital based disciplinary reports: inadequate hospital discipline and loopholes in reporting discipline even when it occurs.

- The actual amount of discipline of doctors is extremely low because of lax hospital peer review that could result in such action. For example, a July 2008 study for the California legislature found problems in hospital peer review that resulted in "physicians continuing to provide substandard care (at times for years) impacting the protection of the public."
- There are reporting loopholes wherein even doctors who have been disciplined have actions that are arranged to evade the reporting requirement. For example, a 1994 study of 144 rural hospitals by HRSA found that 20 percent of hospitals reported an increase in certain activities, such as imposing disciplinary actions less than 31 days (below the reporting threshold). In addition, a state medical board official told us that hospitals avoid reporting by
  1) changing by-laws, and
  2) giving doctors leave of absences in lieu of suspensions.

Although multiple HRSA funded studies, two Office of Inspector General (OIG) reports (1995 and 1999) and the aforementioned HRSA-sponsored national conference on the issue in 1996 made numerous recommendations to address hospital under-reporting, the recommendations for the most part have not been implemented. It is noteworthy that the 1996 national conference, which included the American Medical Association and American Hospital Association, reached agreement that many hospitals were not complying with the NPDB reporting requirement. Since the majority of recommendations from these reports and activities have not been implemented, it is not surprising that the level of reporting has not improved.

From the perspective of state medical boards, hospital reports are an important source of data for regulatory oversight. In New York State, for example, 31 percent of hospital complaints, compared to only 10 percent of consumer complaints to the Board, result in a medical board action. Failure of hospitals to discipline or report therefore deprives the boards of critical information and creates the potential for patient harm.

The entire letter (HRG publication # 1874) can be found on the Health Research Group Website: http://www.citizen.org/publications/release.cfm?ID=7660&secID=1158&catID=126. The Hospitals Drop the Ball report is HRG publication # 1873:

http://www.citizen.org/publications/release.cfm?ID=7659&secID=1158&catID=126.

Writing to Secretary Sibelius again on August 26, HRG urged the Department to complete implementation of the HIPDB regulations. The letter begins:

> This letter is to urge you to immediately implement Section 1921 of the Social Security Act. This would significantly reduce the chances that patients will be injured or killed by any of the more than 100,000 non-physician health professionals (e.g., nurses, pharmacists, physician assistants) and other health workers with disciplinary records who may be employed in hospitals or nursing homes. The adverse action reports concerning these health professionals are contained in the federally run Healthcare Integrity and Protection Data Bank (HIPDB). Federal hospitals and a few nursing homes have access to these reports. However, the failure to implement Section 1921 keeps the data from more than 5,000 U.S. hospitals and approximately 700 nursing homes. This secrecy ensures that though they have been disciplined one or more times, many in multiple states, such healthcare workers can get jobs at hospitals or nursing homes because their employers lack awareness of their previous unsatisfactory records.
>
> As of December 31, 2007, the HIPDB contained the following data:
>
> - Names of more than **40,000** nurses sanctioned for health care-related violations including unsafe practice or substandard care (23,551 reports), misconduct or abuse (10,930 reports), fraud/deception/misrepresentation (3,437 reports), and improper prescribing/dispensing/administering drugs (7,526 reports).
> - Names of more than **49,000** LPNs and nurse aids sanctioned for health care-related violations such as unsafe practice or substandard care (16,110 reports), misconduct or abuse (12,197 reports), fraud/deception/misrepresentation (4,247 reports), and improper prescribing/dispensing/administering drugs (4,634 reports).

The much-needed action to immediately make this important information available to over 5,000 hospitals and about 700 nursing homes from which it is currently being kept secret is clearly within your authority.

Twenty-two years after Section 1921 was enacted, the Department of Health and Human Services (HHS) has still not published the final Section 1921 regulation needed to implement the legislation. Publication of the final regulation would expand the National Practitioner Data Bank (NPDB) to allow hospitals and nursing homes access to the following adverse action reports, which have already been collected by the Health Resources and Services Administration (HRSA).

The entire letter (HRG publication # 1888) can be found on HRG's Website at: http://www.citizen.org/publications/release.cfm?ID=7703&secID=1158&catID=126.

Board Shifts Burden of Proof to Oft-disciplined Doctor

Des Moines Register reporter Tony Leys reported on October 2, 2009, the long saga of Dr. Narinder Kumar's interactions with the Iowa Board of Medicine. The pediatrician was first disciplined in 2006, when the board required him to have a female chaperone present when he treated female patients. The board was criticized at the time for keeping the allegations against the doctor confidential in return for his promise to comply with the chaperone requirement.

The board suspended Kumar's license in 2007 for breaking his agreement to have a chaperone present and because of allegations that he had improperly touched female patients. The suspension was rescinded four months later when the board wasn't satisfied that the allegations had been proven.

Kumar was charged again in 2008, this time for allegations of alcohol abuse. His license was again suspended indefinitely in 2009 for failure to comply with a drug-testing requirement, for improperly prescribing medication, and fabricating medical notes.

Kumar was fined $10,000 in addition to the license suspension. Furthermore, his license won't be reinstated unless and until Kumar shows that the grounds for suspension no longer exist and that is would be in the public interest to permit him to practice.

Texas Medical Board Discipline Called Lax

In a lengthy article in ***The Dallas Morning News*** on October 11, 2009, staff writer Brooks Egerton takes stock seven years after the newspaper published a "scathing series of stories" about the state medical board. At that time, the board promised more stringent and consistent discipline. Egerton writes that seven years later, the promise hasn't been kept.

Instead, the reporter found "a broader pattern of tolerance for misconduct." In a harsh analysis of the board's August meeting, Egerton wrote:

> After its last meeting, in late August, the board announced decisions on four sex-related cases. Two involved doctors whom judges had already sentenced for crimes against children. Two involved psychiatrists found to have had affairs with adult patients – potentially sexual assault under Texas law, but they've not been charged.
>
> The child abusers were allowed to go on practicing medicine, though not with kids. The other two are working without restrictions.
>
> It's all part of a broader pattern of tolerance for misconduct, a *News* analysis shows. Others who kept their licenses after the August meeting include two doctors convicted of lucrative federal crimes that put patients in harm's way; a neurosurgeon who operated on the wrong body part four times; a cardiologist found to have performed dozens of invasive procedures with little or no cause; and at least seven physicians linked to a death.
>
> In all, 131 doctors were disciplined at the meeting. Only two had their licenses revoked, and then only because they quit contesting the cases against them. A handful of others were suspended or surrendered their licenses rather than fight.
>
> The rest carry on with lesser penalties. For the neurosurgeon, it's 10 hours of continuing medical education. For one of the federal convicts, it's 22 hours plus passing a test on legal issues. For an ER doctor who was too drunk to intubate a

> patient – a patient who then died – it's therapy and urine tests.

Egerton goes on to criticize the secrecy of the system which makes it impossible to analyze the board's rationale for choosing penalties. He writes that penalties are generally negotiated between a handful of board members and the physicians' attorneys. Board spokespersons defended this approach, saying that doctors fight for years when the board attempts to revoke licenses, continuing to practice in the meantime. Revocation cases also sap limited board resources.

Egerton's example-filled article can be found at the following link: http://www.dallasnews.com/sharedcontent/dws/news/healthscience/stories/101109dnpromedboard.42491dd.html.

Nursing Board Investigates Nurse Managers

A nurse filed a complaint in July 2009 with the Nevada State Board of Nursing against five nurse managers working in the emergency department of Renown Regional Medical Center in Reno. The complain alleged that the hospital's policies endangered nurses and patients and violated wage and hour laws. The hospital told the ***Reno Gazette Journal*** that the complaint was filed by a disgruntled former employee.

A nurse who was fired in July for failing to attend a class alleged that his firing had more to do with his union activities than with his failure to attend the class. The retired complainant had also been a union leader at the hospital.

The complaint filed with the nursing board alleges:

- That nurses were required to draw blood from patients without proper protection from blood-borne diseases and in ways that might render lab tests invalid.
- That nurses were required to make blood draws from multiple patients, which delayed testing and put patients at risk.
- That patients were transported from the emergency room to hospital rooms before their conditions were fully evaluated, and patients were being misplaced or put into "inappropriate" rooms.
- That an "unreported patient" was admitted during the day and unexpectedly discovered by a night nurse.
- That nurses aren't given enough time to write charts for patients and are forbidden to do the work on their own time or put in for overtime.
- That decreased nursing staff and high patient loads routinely put endanger patient lives.

Texas Dental Board Compared Unfavorably to Medical Board

The Texas State Board of Dental Examiners is less likely to take disciplinary action and less likely to impose severe penalties than it the state medical board, according to a review by Mary Ann Roser, staff writer for the ***Austin American-Statesman***. The board took 158 disciplinary actions in the past two years, nearly one-third of which were probated suspensions and 65 were warnings. Probated suspensions were given for such offenses as videotaping female employees undressing, misprescribing narcotics, and abusing drugs. Even dentists whose licenses had been revoked in another state were given probated suspensions in Texas.

In August, 2009, the Texas State Auditor issued an audit report about the dental board. Its overall conclusion was:

> The Texas State Board of Dental Examiners (Agency) reported unreliable results for 8 (67 percent)

of 12 key performance measures tested for fiscal year 2008. It reported reliable results for 4 (57 percent) of 7 key performance measures tested for the first quarter of fiscal year 2009. A performance measure result is considered reliable if it is certified or certified with qualification.

Inaccurate, incomplete, and inconsistent data in the Agency's automated systems continues to weaken its ability to appropriately regulate licenses and to report accurate licensee information to the public. The Agency does not have adequate controls to prevent or detect errors and inconsistencies within its automated systems. Improvements are also needed in the controls over system access and changes made to automated systems.

The State Auditor's Office previously reported issues of unreliable and inaccurate data in June 2002 and August 2005. After the 2005 audit, the Agency reportedly spent $118,000 to implement a new Enforcement System with the intention of addressing prior audit recommendations. That system became active in September 2007, but it is not fully functional or reliable, and a number of weaknesses continue to exist. The Agency indicated that the weaknesses are due, in part, to the inability of the system developer to deliver an information system that worked as the Agency intended.

The Agency has indicated that, along with other regulatory agencies, it plans to purchase a new automated system that will replace all of the automated systems it currently operates. The cost of the new system is approximately $644,000. Given the difficulties the Agency has had in the past in designing, implementing, and maintaining automated systems, it will be imperative that the Agency use a systematic process for installing, customizing, testing, and implementing the new system to ensure that the existing problems do not occur in the new system.

The inadequacies in controls over data integrity contributed to unreliable performance measure reports. Auditors communicated other less significant issues to Agency management in writing.

The link to the full report is: http://www.sao.state.tx.us/Reports/report.cfm/report/09-047.

Nursing Home Board Accused of Delays and Inaction

An expose in the ***Des Moines Register*** published September 13, 2009 reveals that the Iowa Board of Nursing Home Administrators disciplined only nine nursing home administrators since 2001, some of whom were already retired from the profession or incarcerated. The board failed to take action even after state nursing home inspectors found that an administrator neglected to report to the state when she became aware of allegations of sexual abuse by one of her employees.

Staff writer Clark Kauffman reported that the board chairperson is a former nursing home administrator who resigned from his last position for a confidential personal reason. Board Chairman Daniel Larmore told Kauffman that, “We’re only meeting quarterly and we’re there for about four hours. There are piles of these fine-and-citation reports that we have to look at. To read every one of them, well, we pretty much have to depend on the board executive to give us information on those that are concern issues.”

The board operated for more than a year with only one of its two public members. The other, Audrae Zoeckler, resigned in 2008, saying that she was marginalized by the board. Unlike her public member counterpart who had a poor attendance record, Zoeckler had been excluded for five years from the three-member committee that reviews complaints and discusses potential discipline. When she requested to join the disciplinary committee, Board Chairman Larmore "scoffed" at the suggestion. Commenting on her resignation, Zoeckler wrote to the Iowa Department of Public Health that "I have never felt like anything by a token member. I rarely received copies of the minutes or agendas and I had to call before each meeting to see what time I should be there."

The article documents numerous complaints that resulted in no action by the board. A subsequent article on September 17 reported that state officials were considering changes to the operation of the board. Eventually, on October 10, 2009, Kauffman wrote that Larmore had resigned. His resignation came at the request of the Governor's chief of staff who had been appalled by the newspaper reports showing Larmore's indifferent reaction to allegations of sexual abuse by a nursing home worker. Larmore was also occupying a seat on the board designated for a practicing nursing home administrator, which he was not.

ADMINISTRATION

Texas Medical Board Announces New Efficiencies

On April 10, 2009 the Texas Medical Board issued a press release announcing that the average time to issue a Texas medical license had gone down about 30 days. When the average time to issue a license reached a peak of 100 days in September, 2007, the Legislature mandated that TMB reduce licensing time to 51 days. The addition of staff and resources, along with the implementation of the LIST system, which improves communications between applicants and TMB staff, enabled the board to meet and then exceed the legislative mandate.

Arizona Regulatory Boards Sue Over Seizure of Funds

To balance the 2008 – 2009 state budget, the Arizona legislature "swept" licensure fees from health-related regulatory boards into the state's general fund. Previously, 10% of the fees collected by the boards went to the general fund, and the remaining 90% stayed with the boards to pay for their operations. In their suit, the boards contend that turning their fees over to the general fund amounts to illegal taxation. They further claim that the move was improper procedurally, because a two-thirds vote is required to enact a new tax.

Digital Recordings of our Annual Meeting in Orlando

Individual sessions cost $45.00 each.
All day Wednesday costs $95.00.
All day Thursday costs $95.00.
Both Wednesday and Thursday costs $175.00.

Wednesday:	**Thursday:**
Maintenance of Competence	Report On "Chemically Dependent Healthcare Practitioners" Meeting
Keeping the Public Informed	Implementing Legislation through Rulemaking
Relationships between Certification and Regulation	Discipline Issues

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CAC is Now a Membership Organization

As you may know, **CAC** is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings and services are of as much value **to the boards themselves** as they are to the public members. Therefore, the **CAC** board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

(1) A **free** electronic subscription for **all** of your board members and **all** of your staff to our highly regarded quarterly newsletter, **CAC *NEWS & VIEWS***;

(2) A **10% discount** for **all** of your board members and **all** of your staff who register for **CAC** meetings, including our fall annual meeting;

(3) **Free** electronic copies of all available **CAC** publications;

(4) A **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;

(5) **Discounted rates** for CAC's **onsite** training of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;

(6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fee as follows:

Individual Governmental Agency	$275.00
Governmental Agency responsible for:	
2 – 9 regulated entities/professions	235.00 each
10 – 19 regulated entities/professions	225.00 each
20+ regulated entities/professions	215.00 each
Association of regulatory agencies or organizations	450.00
Non-Governmental organization	375.00

Please complete the following **CAC Membership Enrollment Form** if your board or agency is ready to become a member of **CAC**. Mail the completed form to us, or fax it to (202) 354-5372.

CAC Membership Enrollment Form

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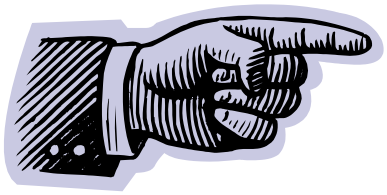

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