News & Views

Citizen Advocacy Center

First Quarter, 2010 A Health Care Public Policy Forum Volume 22 Number 1

Announcements

Our 2010 Annual Meeting will be held on Thursday and Friday, November 11 – 12, 2010, *in* ***Washington, D.C.*** *Program information will be posted soon on our website at www.cacenter.org. Please mark your calendars.*

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 25 – 26 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 27 of this issue.*

SCOPE OF PRACTICE

California Optometry Board Prepared to Enact Controversial Rule

Legislation passed by the California legislature called for the appointment of a six-person committee (three optometrists and three ophthalmologists) to draft implementing regulations setting forth the requirements optometrists must meet to become certified to treat glaucoma. The controversy arose when it was revealed that the board had hired an optometrist and past president of the California Optometric Association to draft the regulations. The state Academy of Eye Physicians and Surgeons, the American Glaucoma Society and the California Medical Association cried foul. Brian Stiger, the director of the California Department of Consumer Affairs, which oversees the state's licensing boards, sided with the dissidents and asked the board to reconsider the regulation.

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The board held its ground and Stiger has said he will reserve judgment until he sees the regulations the board votes to enact.

Optometrists interviewed by Brian Joseph, Sacramento Correspondent for ***The OC Watchdog*** suggest that ophthalmologists regret having negotiated the legislation authorizing optometrists to treat glaucoma and are trying to backpedal.

For more, see: http://taxdollars.freedomblogging.com/2010/02/04/optometry-board-may-have-violated-intent-of-correas-bill/50573/.

The Board of Optometry published the following initial rationale statement in advance of its December 22 hearing on the proposed regulations:

Specific Purpose:

The proposed regulation will establish the applicable requirements that optometrists in California must meet before the California State Board of Optometry (hereafter Board) will grant a certificate to an optometrist to treat glaucoma.

Factual Basis/Necessity:

On September 26, 2008, Governor Arnold Schwarzenegger signed Senate Bill 1406 (Chapter 352, Statutes of 2008, Correa) amending Business and Professions Code (BPC) section 3041. This became effective on January 1, 2009, and expanded the scope of practice of optometrists to include, among other things, the treatment of glaucoma. BPC section 3041.10 directs the Board to follow certain procedures to develop the certification requirements to ensure that the public is adequately protected during the transition to full certification for all licensed optometrists interested in treating and managing glaucoma patients.

The Board is implementing the changes in the scope of practice with this proposed regulation, which sets forth the requirements that optometrists in California must meet before obtaining certification to treat glaucoma.

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NOTICE

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CAC membership includes a ***free*** subscription to our newsletter for **all** of your board members and **all** of your staff. A membership enrollment form may be found on page 26 of this newsletter.

The proposed regulation is a result of the procedures set forth by section 3041.10, which mandated the Board to implement the findings and recommendations from the Glaucoma Diagnosis and Treatment Advisory Committee (GDTAC) that were subject to review and modification by the Office of Professional Examination Services (OPES). Additionally, a meeting was held with all the California accredited schools and colleges of optometry to ensure that the curriculum guidelines included in the regulation are uniform and incorporate all the necessary minimum knowledge required to effectively and safely treat glaucoma.

Optometrists are usually the first and only health care providers that most people will see when it comes to their vision. Given that there are about 7,000 actively licensed optometrists in California and there are less than 3,000 ophthalmologists, it is only logical to make use of their numbers and geographic distribution to reach the people that need primary care services most.

Also, according to the recommendation by OPES' report, SB 1406 rejected the previous process required for glaucoma certification under SB 929 (Chapter 676, Statutes of 2000, Polanco) because it was too complex and cumbersome for both optometrists and ophthalmologists. There were too many barriers that prevented a timely completion of certification such as:

- A lack of ophthalmologists willing to co-manage with optometrists.
- Insufficient amount of ophthalmologists in a patient's geographic area.
- Patients being required to pay for multiple visits while insurance only covers one visit.
- Ophthalmologists changing diagnosis from primary open angle glaucoma (POAG) to a secondary form not permitted to be treated by optometrist.
- Ophthalmologists refusing to sign forms after co-managing patients.
- Patients moving or changing doctors prior to 2-year encounters required.

Thus only 177 optometrists completed the glaucoma certification requirements from 2001 to the end of 2008 under SB 929. The intent of SB 1406 was to develop a process that would lead to a more appropriate and timely route for certification by resolving some of these problems, while at the same time ensuring the competency of the doctor and not compromising public safety.

For more, see: http://www.optometry.ca.gov/lawsregs/1571_isr.pdf.

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Citizen Advocacy Center
1400 Sixteenth Street NW
Suite #101
Washington, DC 20036
Phone: (202) 462-1174 Fax: (202) 354-5372
Email: cac@cacenter.org

Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Newsletter Layout and Subscription Manager: Steven Papier

West Virginia Optometrists Seek Laser Surgery Authority

In February 2010, the West Virginia Senate passed a bill expanding the scope of practice of optometrists to include three types of laser surgery under a collaborative arrangement with an ophthalmologist located within a 40-mile radius. Ophthalmologists opposed the legislation, raising arguments about the risks of laser surgery and the qualifications of optometrists to perform it.

State Senator Ed Bowman told Mannix Porterfield of the Charleston *Register-Herald* (mannix@register-herald.com) that the ophthalmologists did not deal "in good faith through this whole process." He charged that they were reluctant to negotiate with optometrists. Further, he said they ran a misleading ad suggesting that the Veterans Administration believes it is "bad medicine" to permit optometrists to perform laser surgery. Bowman produced letters from the VA citing an absence of adverse outcomes in laser surgeries by VA optometrists.

The legislation goes next to the House of Delegates.

Michigan's Chiropractors Restore Scope of Practice

Michigan Governor Granholm signed legislation in February 2010 restoring the scope of practice of chiropractors to what is was prior to a revision of the state's health code in 1970. Michigan chiropractors now have a scope of practice more consistent with that of other states.

Chiropractors pointed out the economic arguments in favor of the expanded scope, saying that it would reduce the state's rates of surgery, advanced imaging and inpatient care and reduce lost workdays.

Ohio Improves Advanced Practice Nurse Mobility

The Ohio legislature has made it easier for out-of-state nurses with authority to write prescriptions to do so in Ohio without having to meeting duplicative requirements in the state. The new law does not permit advanced practice nurses to prescribe Schedule II medications, something that is opposed by the medical establishment.

Physicians Press on in Campaign to Stop Scope of Practice Expansions

American Medical News staff writer Amy Lynn Sorrel reported January 18, 2010, that anticipating continuing initiatives to expand the scopes of practice of non-physician health care practitioners, the AMA has adopted new tactics. For more, see: http://www.ama-assn.org/amednews/2010/01/18pr120118.htm.

According to the article, the AMA is promoting model legislation that would create scope of practice review panels to evaluate the implications of requests for scope of practice expansions. Another model law would require non-physicians to identify their credentials and would restrict the use of the term "doctor." The AMA and its allies are also prepared to go to court to question regulations written by regulatory boards to implement legislation or expand scopes of practice via the rulemaking process.

The article includes examples of AMA-sponsored opposition to scope of practice expansions by several professions in several states, many in 2009. More recently, Deborah Yetter (dyetter@courier-journal.com) of the *Courier Journal* reported that the Kentucky Medical Association is organizing its members to lobby against legislation that would

eliminate the requirement that nurse practitioners in the state enter into collaborative agreements with physicians in order to prescribe certain medications. Nurses must have one agreement for controlled substances and another for non-controlled medications.

Nurses testified that physicians are using this requirement to exact fees of as much as $6,000 per year for their signatures on collaborative practice agreements and don't want to give up that income. Sponsors of the bills in the house and senate bowed to pressure from the medical lobby and agreed to retain the requirement that nurse have a signed agreement in order to prescribe controlled substances.

On February 24, 2010, the *Patient Safety Monitor Alert* reported that the California Medical Association and the California Society of Anesthesiologists have sued Governor Schwarzenegger asking him to reinstate a rule requiring that nurse anesthetists be supervised by physicians. Schwarzenegger opted out of the requirement, as allowed by Medicare, for financial and patient safety reasons. He reasoned that patients in rural areas may not be able to wait for a physician supervisor to arrive to supervise a nurse anesthetist. The California Hospital Association agrees with the Governor's position. For more, see: www.hcmarketplace.com/prod-873/Patient-Safety-Monitor-Alert.html.

In striking contrast, the Wyoming Medical Society recently withdrew its years-long opposition to legislation that permits certified professional midwives to practice in the state. Instead of raising fears that home births are unsafe and that midwives are inadequately trained, the medical society decided to cooperate in the drafting of legislation with provisions they believe make home births as safe as possible. These include standards for when a midwife should transfer a mother to a hospital and restrictions on midwives caring for women with certain pregnancy disorders.

For more, see: www.trib.com/news/local/article_a7439f98-6677-576c-aa43-60ba5e7f7693.html

Psychologists, Podiatrists Sue New Jersey Health Plans Over Scope

The New Jersey Psychological Association has sued the state Benefits Commission, Horizon Healthcare Services, and Magellan Health Services claiming that they improperly insist psychologists turn over patient information in violation of the protections in the psychology licensing law. The practice act protects the privacy of confidential communications between psychologists and their patients.

Some months earlier, the New Jersey Podiatric Medical Society sued Horizon Blue Cross/Blue Shield of New Jersey and its contractor, CareCore National, for refusing to reimburse for some diagnostic tests that fall within the scope of practice of podiatrists. Horizon informed its participating podiatrists in August 2009 that it would no longer reimburse for certain diagnostic tests performed at podiatrist offices, but would require patients to have these tests performed at hospitals or general imaging centers. CareCore provides radiology and imaging services.

IN DEPTH

Institute of Medicine Recommends Redesign of Continuing Education

Earlier this year, an Institute of Medicine (IOM) Committee on Planning and Continuing Health Care Professional Education Institute issued a report entitled, Redesigning Continuing Education in the Health Professions. Readers of CAC News & Views are familiar with CAC's position toward continuing education (CE): done right, it can be one useful tool for

professionals seeking to stay up-to-date in their fields, but CE is not a surrogate for current competence. Therefore, licensing and certifying agencies make a mistake to rely solely on CE hours for re-licensure or recertification. CAC is pleased to see the recommendations of this august committee.

Committee Chair Gail L. Warden, President Emeritus, Henry Ford Health System and Professor of Health Policy at the University of Michigan School of Public Health, begins the preface to the report with this blunt statement:

> ***Continuing education (CE) is the process by which health professionals keep up-to-date with the latest knowledge and advances in health care. However, the CE "system," as it is structured today, is so deeply flawed that it cannot properly support the development of health professionals. CE has become structured around health professional participation instead of performance improvement. This has left health professionals unprepared to perform at the highest levels consistently, putting into question whether the public is receiving care of the highest possible quality and safety… (The report) illustrates a vision for a better system through a comprehensive approach of continuing professional development and a framework upon which to develop a new, more effective system.***

This "In Depth" Feature is comprised of excerpts from the report's summary and recommendations. Copies of the full report are available from the National Academies Press at www.nap.edu**.**

…Today in the United States, the professional health workforce is not consistently prepared to provide high quality health care and assure patient safety, even as the nation spends more per capita on health care than any other country. The absence of a comprehensive and well-integrated system of continuing education (CE) in the health professions is an important contributing factor to knowledge and performance deficiencies at the individual and system levels.

To be most effective, health professionals at every stage of their careers must continue learning about advances in research and treatment in their fields (and related fields) in order to obtain and maintain up-to-date, but on a larger scale, the nation's approach to CE for health professionals fails to support the professions in their efforts to achieve and maintain proficiency…

The report provides five broad messages:

1. **There are major flaws in the way CE is conducted, financed, regulated, and evaluated.** As a result, the health care workforce is not optimally prepared to provide the highest quality of care to patients or to meet public expectations for quality and safety.
2. **The science underpinning CE for health professionals is fragmented and under-developed.** These shortcomings have made it difficult if not impossible to identify effective educational methods and to integrate those methods into coordinated, broad-based programs that meet the needs of the diverse range of health professionals.
3. **Continuing education efforts should bring health professionals from various disciplines together in carefully tailored learning environments.** As team-based health care delivery becomes increasingly important, such inter-professional efforts will enable participants to learn both individually and as collaborative members of a team, with a common goal of improving patient outcomes.
4. **A new, comprehensive vision of professional development is needed to replace the culture that now envelopes continuing**

education in health care. Such a vision will be key in guiding efforts to address flaws in current CE efforts and to ensure that all health professionals engage effectively in a process of lifelong learning aimed squarely at improving patient care and population health.

5. **Establishing a national inter-professional CE institute is a promising way to foster improvements for health professionals.** This report proposes the creation of a public-private entity that involves the full spectrum of stakeholders n health care delivery and continuing education and that is charged with developing and overseeing comprehensive change in the way CE is conducted, financed, regulated, and evaluated.

Editorial Note: The committee reviewed the literature about CE and reached the following conclusion:

The literature review of concepts that span academic discipline provides evidence that some methods of CE – including some traditional, formal methods; informal methods; and newer innovative methods – can be conduits for positive change in health professionals' practice. There also is evidence that health professionals often need multiple learning opportunities and multiple methods of education, such as practicing self-reflection in the workplace, reading journal articles that report new clinical evidence, and participating in formal CE lectures, if they are to most effectively change their performance and, in turn, improve patient outcomes.

The evidence is also strong, however, that continuing education is too often disconnected from theories of how adults learn and from the actual delivery of patient care. As a result, CE in its present form fails to deliver the most useful and important information to health professionals, leaving them unable to adopt evidence-based approaches efficiently to best improve patient outcomes and population health. Closing the gap will require defining research problems, using rigorous research techniques, developing "scholarly practitioners," and researching results relevant to practitioners.

Editorial Note: Based on its review of the literature, the committee identified attributes of effective CE, as explained here:

Health professionals face contextual influences when attempting to apply learning in the workplace. Processes, systems, and traditions can facilitate a learner's use of new knowledge in practice. Thus, support for change, resources, and opportunity to apply learning can both positively and negatively affect a learner's application of new knowledge. While practice context can affect education outcomes, so can the ways in which CE is delivered. The committee determined that effective CE activities have the following features:

- Incorporate needs assessments to ensure that the activity is controlled by and meets the needs of health professionals;
- Be interactive (e.g., group reflection, opportunities to practice behaviors);
- Employ ongoing feedback to engage health professionals in the learning process;
- Use multiple methods of learning and provide adequate time to digest and incorporate knowledge; and
- Simulate the clinical setting.

Editorial Note: The committee looked at the regulation and financing of CE and explored some of the consequences flowing from a lack of uniformity and consistency in both areas:

Licensure, certification, and credentialing need to become more consistent, and standardized requirements need to be established to help ensure minimal levels of competence. Efforts to align these processes have begun to occur in small pockets. For example, the nursing community is moving toward greater unanimity around CE requirements for licensure across the states. Therefore, licensure, certification, and credentialing ought to reward improvement of competence, performance, and patient health, instead of focusing merely on rewarding skills, as is now the case.

It will be important for the regulatory system to recognize the inextricable linkage between the continuing education of all health care professionals and health care teams, the quality of patient care, and the quality of system performance. This will require developing linkages among the various regulators of health care and developing new standards and processes. Today's simple credit system, which reinforces the isolated "silo" structure that characterizes regulatory activities, should be abandoned…

Whether continuing education for health professionals should be financed by government, industry, employers, or individuals is still being debated. What is clear, however, is that funding should be directly aligned with the goals of driving improved quality of care and patient safety and should support a mix of activities that are effective both in terms of performance and cost. In this way, funding will help in developing a more comprehensive, broad-based system for professional development, called continuing professional development (CPD)… In addition, strong safeguards need to be put in place to avert the development of education solely for the sake of profit, thus protecting the integrity of the system.

Editorial Note: The committee sets forth its vision for a system of continuing professional development (CPD), described succinctly in the following excerpt:

An effective continuing professional development system would offer significant improvement over today's fragmented approach to continuing education. Whereas the current funding of CE by commercial groups may hold inherent conflicts of interest that shift the focus away from improving health professionals' performance, a CPD system would promote patient-centered care. Moreover, a CPD system would help obviate some of CE's current fragmentation by driving coordination of activities and fostering interprofessional teams. A CPD system would be thoroughly evidence-based in its delivery, innovation, and research, representing a marked change from the current disconnect between CE theory, research, and practice that have resulted in few evidence-based activities to support health professionals' competence and patient outcomes. A CPD system would help clinicians achieve quality improvement, while peer-reviewed studies of CE can claim to support only minimum levels of competence and have infrequently proven effective for improving the quality of care. Although CE has minimally used health information technologies in training and education, a comprehensive CPD system would foster development and dissemination of technology-based approaches.

The structure of the CPD system needs to support the system's goals and deliver systematic and timely information to health professionals based on their learning needs and the challenges they encounter in clinical practice. First, CPD research must be driven by learning theory inclusive of insights and advances from the social, biological, and health sciences. Second, funding for CPD

should be guided by sound economic principles and should set a goal of improving patient outcomes, not promoting a particular product or service. Third, implementing an effective CPD system will require mobilizing the CPD enterprise to promote a culture of learning for patient care. Fourth, the CPD system must be accountable and transparent to the public.

In a comprehensive CPD system, individual health practitioners would be committed to and take control over their own professional development and learning. Achieving this will require making the system learner-driven and more responsive to learners' requirements and flexible enough to adapt to the learning opportunities that present with the ever-changing needs of patients.

CPD needs to facilitate health professionals' learning beyond the classroom and professional conferences. It must be an ongoing process that occurs at the point of care, in conversations with colleagues, and in the many other ways that clinicians resolve daily problems of patient care. A high-performing system would recognize that health professions education is not limited to formal educational activities and must integrate with the learning that health professionals internalize in their everyday practice.

CPD also must be tailored to the various stages of a health professional's career. The learning needs and opportunities of novice health practitioners should be differentiated from those of intermediate and expert practitioners. These stages of expertise, defined by topics and experience, carry important implications for educational design. These processes are much more complex than simply knowing or not knowing. On a finer scale, knowledge of any clinical skill can be broken down into four progressive stages:

1. Declarative knowledge: the learner gains the awareness to identify a problem or to know what should be done;
2. Procedural knowledge: the learner not only understands that there is a problem to solve but also gains knowledge of how to go about solving it;
3. Competence: the learner advances to a stage where he can demonstrate or show how a problem is to be solved; and
4. Performance: the learner identifies the problem, knows how to address it, demonstrates the needed skill, and solves the problem in practice – the learner does what he has learned…

RULEMAKING

CAC Comments in Pharmacy Board Rulemaking

The California legislature empowered the state's Board of Pharmacy to develop rules for consumer-friendly medication labels. In October 2009, the board voted 6-0 with one abstention to propose that labels to be in 12-point type and that pharmacies be required to provide an oral language translation of the prescription's label information for patients with limited English proficiency. Senior and consumer groups supported this proposal.

However, when the proposed rules came up for a final vote in February 2010, the composition of the pharmacy board had changed and the proposal was defeated in a 5-4 vote. The deciding vote was cast by a chain drug store official Governor Schwarzenegger had appointed to the board the day before the vote. The new proposal called for 10-point type labels and provided that translation services be provided "if available."

CAC joined with a San Francisco-based consumer organization, *Consumer Action*, in submitting comments to the Board of Pharmacy asking it to return to its original, more stringent version of the rule. We wrote, in part:

> Both of our organizations are particularly opposed to two changes contained in the February 17, 2010, revised regulations. First, the revision changes the font size on labels from 12-point to 10-point, which is more difficult to read.
>
> Second, and more importantly, the proposed revision changes the language in section (d) that originally read:
>
> > (d) For patients who have limited English proficiency, upon request by the patient, the pharmacy shall provide an oral language translation of the prescription container label's information specified in subdivision (a)(1) in the language of the patient.
>
> The revision replaces that language with:
>
> > (d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.
>
> In effect, the proposed revision makes oral translation in the language of the patient for persons with limited English proficiency optional…
>
> We appreciate that the board is responsible for weighing the cost concerns of the industry – in this case, the cost concerns of chain drug stores – with the public's need to understand their prescriptions in order to reduce medication errors. In drafting the original regulation, the Board of Pharmacy heard from the industry, but wisely decided that making available translation for persons with limited English proficiency was important enough to outweigh the industry's cost concerns.
>
> We urge the board to return to the original regulation. If further justification is needed, the board should make a concerted effort to go into the communities where people with limited English proficiency live and hold well-publicized town hall meetings seeking input from those people and from the organizations that represent them. The opportunity for formal public comment by community groups is not enough. As the board well knows, industry input into this (and all other) rulemakings far outweighs comment from citizens and citizen groups. Informal town meetings are not a replacement for public comment under law, but in this case meeting with the affected communities would help the board arrive at the appropriate balance between the cost concerns of the industry and the needs of the citizenry. Meeting the needs of the public is, after all, the reason for the enactment of the legislation that led to this rulemaking.

PATIENT SAFETY AND MEDICAL ERRORS

Experts Mark 10-Year Anniversary of "To Err Is Human"

On December 1, 2009, the journal *Health Affairs* released a report entitled, *Patient Safety at Ten: Unmistakable Progress, Troubling Gaps*, written by Robert M. Wachter. (See the abstract at: http://content.healthaffairs.org/cgi/content/abstract/29/1/165.) In this, his second review of progress since the seminal IOM report on medical errors, *To Err is Human*, University of California San Francisco Professor Wachter looks as numerous aspects of hospital performance related to patient safety. These include regulation, accreditation, reporting systems, health IT, malpractice, workforce training, research,

patient engagement and involvement, provider leadership engagement, national and international organizational interventions, and payment system interventions.

Wachter gives the overall effort to respond to patient safety concerns a grade of B-, although he did write that "(E)ven our missteps…have yielded valuable lesions… (Had) I been asked in 1999 how much change in patient safety-related areas would be possible within a decade, I would have substantially underestimated our actual accomplishments." Wachter sees other reasons for optimism, including the fat that previously unaddressed issues, such as diagnostic errors and prioritizing safety interventions, are now being addressed.

Wachter gives his highest grade of A-to interventions by national and international organizations. He found that much stronger engagement by the Agency for Healthcare Quality and Research, the National Quality Forum, Joint Commission, Accreditation Council for Graduate Medical Education, World Health Organization, Institute for Healthcare Improvement, and others, better dissemination of tools, training and requirements, some wide-scale change efforts (including checklist studies) have illustrated capacity for broad engagement and measurable progress. Regulation and accreditation receive a grade of B+, largely as a result of efforts by the Joint Commission. However, Wachter believes that most of the "low-hanging fruit" have been plucked so advancements as a result of regulation and accreditation will be more difficult in the future. Reporting systems also receives a B+. Key developments, in Wachter's view, were the adoption of the National Quality Forum checklist to support error reporting and improvements in analytical abilities at provider organization and governmental levels.

Areas receiving the lowest grade, C+, are health information technology, malpractice system and accountability, patient engagement and involvement, and payment system interventions. The remainder receive grades of B or B-. These categories are workforce and training issues (where "few organizations are adopting robust teamwork, culture change, or simulation programs"), research, and provider organization leadership engagement.

Taking a more pessimistic view of progress toward patient safety during the previous decade, Consumers Union's *Safe Patient Project* issued a report entitled, *To Err is Human – to Delay is Deadly*, which "give(s) the country a failing grade on progress in select recommendations we believe necessary to create a healthcare system free of preventable medical harm.

The report can be found at: www.safepatientproject.org/safepatientproject.org/pdf/safepatientproject.org-ToDelayIsDeadly.

The Safe Patient Project finds that there is little information available to gauge how well the county is addressing patient safety issues. "(W)e don't know if we've made any progress, and efforts to reduce the harm caused by our medical care system are few and fragmented. With little transparency and no public reporting (except where are fought state laws now require public reporting of hospital infections), scarce data does not paint a picture of real progress.

Based on their review of what evidence is available, the authors conclude that there are still more than 100,000 preventable deaths each year, and that is likely a conservative estimate, since the CDC estimates 99,000 deaths from hospital-acquired infections alone.

The report's failing grade is based on an analysis of progress toward four major goals, all recommended by either the IOM,

or the U.S. Food and Drug Administration. The authors write that:

- **Few hospitals have adopted well-known systems to prevent medication errors and the FDA rarely intervenes.** While the FDA reviews new drug names for potential confusion, it rarely requires name changes of existing drugs despite high levels of documented confusion among drugs, which can result in dangerous medication errors. Computerized prescribing and dispensing systems have not been widely adopted by hospitals or doctors, despite evidence that they make patients safer.
- **A national system of accountability through transparency as recommended by the IOM had not been created**. While 26 states now require public reporting of some hospital-acquired infections, the medical error reporting currently in place fails to create external pressure for change. In most cases hospital-specific information is confidential and under-reporting of errors is not curbed by systematic validation of the reported data.
- **No national entity has been empowered to coordinate and track patient safety improvements.** Ten years after *To Err is Human*, we have no national entity comprehensively tracking patient safety event or progress in reducing medical harm and we are unable to tell if we are any better off than we were a decade ago. While the federal Agency for Healthcare Research and Quality attempts to monitor progress on patient safety, its efforts fall short of what is needed.
- **Doctors and other health professionals are not expected to demonstrate competency.** There has been some piecemeal action on patient safety by peers and purchasers, but there is no evidence that physicians, nurses, and other health care providers are any more competent in patient safety practices than they were ten years ago.

The Safe Patient Project recommends three "Next Steps:"

> Patients, consumer organizations, and advocates alarmed by the lack of public accountability surrounding patient safety have issued a Patient's Call to Action to underscore the need for implementing the IOM's key recommendations, including:
>
> - effective action by the FDA, drug manufacturers, hospitals, doctors, and other healthcare providers to prevent medication errors;
> - increased accountability through mandatory, validated and public reporting of preventable medical harm; and
> - better training in patient safety for doctors and nurses.

OIG Says Patient Safety Jeopardized by Hospitals' Failure to Report Adverse Events

On January 5, 2010, Deputy Inspector General for Evaluations and Inspections Stuart Wright delivered a Memorandum Report entitled, *Adverse Events in Hospitals: Public Disclosure of Information about Events*, OEI-06-09-00360 to both the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS). The memorandum, which is available at: http://www.oig.hhs.gov/oei/reports/oei-06-09-00360.pdf, asserts that public disclosure of information about adverse events in hospitals can educate healthcare providers

about the causes of events, potentially leading to improvements in patient safety and assisting patients in making decisions about their care. There is concern that such disclosures could undermine patient privacy, but all of the entities reviewed in the memorandum (17 state adverse reporting systems and 8 Patient Safety Organizations overseen by AHRQ and CMS) protect patient privacy though policies, practices and legal provisions. The study focused on 12.3 million Medicare beneficiary inpatient admissions to acute care hospitals in 2007.

For purposes of the memorandum, the OIG defines an adverse event as harm to a patient as a result of medical care or harm that occurs in a healthcare setting. While an adverse event often results in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality care, and they may not always be preventable.

The OIG's review of reporting policies and practices revealed that public disclosure of information about adverse events is limited. Of the 17 state reporting systems in the study, seven disclose more extensive information about the causes of adverse events and prevention strategies. These state systems are in Maryland, Massachusetts (two systems - the medical board and the Department of Health), Minnesota, New Jersey, Oregon, and Pennsylvania. Three state agencies report less extensive information (Colorado, Maine, and Rhode Island), and seven systems disclose no information to the public (Utah, Florida, Nevada, New York, South Carolina, South Dakota, and Vermont).

AHRQ is required by the Patient Safety Act to issue two public reports, one containing trend analyses of adverse events and the other reporting on the effectiveness of strategies for reducing medical errors. AHRQ has additional plans to collect root-cause analysis data about the causes of adverse events and to expand data collection beyond hospitals to include nursing homes and other healthcare settings.

CMS is considering public disclosure of hospital-acquired conditions on its *Hospital Compare* Website, which currently includes other hospital quality measures. CMS is currently evaluating the effects of hospital-acquired conditions on reimbursement, utilization, quality and patient safety and will determine how much of that information will be publicly disclosed after the findings are known.

The OIG chose not to make any recommendations in the memorandum, leaving state agencies and other reporting entities to emulate the policies and practices of the seven state systems with the most extensive reporting.

These systems disclose analysis of the causes of events, evidence-based guidance for reducing occurrences, and information about demonstrated improvements by hospitals. This type of information, if disseminated by other state systems and entities that receive adverse event information, could help improve patient safety.

Editorial Note: A second OIG report entitled, Adverse Events in Hospitals, Method of Tracking Events, concludes that the methods used to detect adverse events in hospitals fails to identify a large percentage of hospital-caused incidents resulting in Medicare overpayments and lost opportunities to prevent recurrence of the adverse events. For details, see http://oig.hhs.gov/oei/reports/oei-06-08-00221.pdf.

California Hospitals Report Increased Number of Errors

California hospitals reported a total of 1,538 serious and preventable events during the fiscal year ending June 30, 2009, according to a January 8, 2010, report in the

Sacramento Business Journal at www.sacramento.bizjournals.com. This was an increase over the previous year when hospitals reported 1,224 events. Reports are required under a reporting law enacted in 2006, but the *Business Journal* obtained the data under a freedom of information request. No data, according to the article, has yet been reported to the state legislature as reports are being investigated by the Department of Health.

The most commonly reported preventable event was stage three or four ulcers. Other incidents ranged from medication errors to wrong-site surgeries to death.

Nurses Critical to Preventing Medical Errors, Study Says

Research into how the practice environment and nurse staffing affect medication errors funded by the Robert Wood Johnson Foundation and reported during an Interdisciplinary Nursing Quality Research Initiative (INQRI) Webcast October 7, 2009, found that the vast majority of potential medication errors that are caught before they occur are caught by nurses. There are about 7,000 deaths each year attributed to medication errors. There would be far more except that 50 percent of potential medication errors are caught before they occur, and 87 percent of those potential errors are caught by nurses.

Study leader Linda Flynn, RN, PhD, associate professor at the University of Maryland School of Nursing, told Heather Comak of *HealthLeaders Media* that

"Nurses are the safety net that keeps patients safe from experiencing a medication error. Our question was, what are the factors that impact the nursing safety net – what are the factors that help nurses in doing their job to intercept medication errors before they reach the patient, and what are the factors that serve as barriers to this safety net?"

The researchers found that, in addition to a supportive staffing environment, four actions routinely taken by nurses are most closely associated with preventing medication errors. These are:

- Conducting independent review of the medication administration record in comparison with the medication order,
- Questioning the rationale,
- Encouraging patients and families to be the last line of defense for a medication error, and
- Clarifying orders and handwriting with physicians.

Failure to Order Tests Blamed for Diagnostic Errors

Research funded in part by the Agency for Healthcare Research and Quality (AHRQ) found that the leading causes of diagnostic errors are failure to order tests, failure to report results to patients and failure to follow up on abnormal test results. The data is based on a survey of nearly 300 patients from 22 hospitals conducted by a team from Brigham and Women's Hospital Center for Patient Safety Research and Practice led by Gordon Schiff, MD. The physicians surveyed were asked to report three cases of diagnostic errors and describe their perceived causes, seriousness and frequency.

Diagnostic errors occurred most frequently during the testing phase and resulted from failure to order, report or follow up on tests (44%). Clinician assessment errors accounted for 32%, inadequate history taking 10%, incomplete physical examination 10%, and referral or consultation errors and delays 3%. Nearly one-third of the diagnostic errors were considered to be major, resulting in death, disability or a near life-threatening event. The most common missed or delayed

diagnoses included pulmonary embolism, drug reactions or overdose, lung cancer, colorectal cancer, acute coronary syndrome, breast cancer and stroke.

See AHRQ Research Activities, Number 353, January 2010, p. 4. at www.ahrq.gov.

Patients Responsible for Reporting Prescription Errors, According to Pharmacy Board

A story posted by KCRA TV News at www.kcra.com on November 2, 2009, documented the record of the California Board of Pharmacy's recent history disciplining pharmacists for prescription errors. Investigators from the station reviewed seven years of cases. In 2007 and 2008, the board issued 43 fines and citations related to prescription errors in Northern California alone. The report noted that more than 350 million prescriptions were filled in California in 2008, but only 400 medication errors were reported that year and no licenses were revoked for medication errors. Suspecting that there are errors that go unreported, investigators interviewed Virginia Herold, Executive Director of the pharmacy board, who told them that pharmacies are not required to report errors. Rather, the board relies on reports from patients who have been the victims of errors. According to Herold, when the board receives a patient complaint, the board gives pharmacies two days to file a quality assurance review consisting of documentation of the error, its cause, and prevention methods to be implemented.

CONTINUING COMPETENCE

NCC Announces Continuing Competency Initiative

The National Certification Corporation (NCC) has announced a major change to its certification maintenance program to begin in June 2010. The new program will include the use of "specialty assessment evaluation to identify targeted individual-specific continuing education needs to address knowledge gaps and provide a learning plan that the certified nurse can follow to meet certification maintenance requirements."

A brochure announcing the new program explains its rationale:

> The changes in the maintenance program are being made in recognition of the expanding knowledge base needed to function in an increasingly complex health care environment. This approach also brings greater accountability and transparency to the certification maintenance process while providing employers and the public a valid measure of assurance regarding the ongoing competency of nurses certified by NCC.
>
> It also aligns NCC with other professions who have added continuing competency components to their maintenance processes including physicians, pharmacists, physical therapists and nurses in Great Britain, Australia and Canada. Many state boards of nursing are also introducing continuing competency measure for nursing re-licensure…
>
> In many cases, health care professionals may expand their role or perhaps narrow their practice in a subspecialty area over time resulting in the evolution of new competencies or a shift in competency focus to meet the individual practice role. While these changes are appropriate, maintenance of the NCC certification requires that the certified nurse demonstrate maintenance of the core certification specialty knowledge competencies as they are currently outlined and tested for their certification specialty. Since regulators, employers and other interested parties use certification to identify and validate the knowledge competencies and clinical expertise in the identified specialty, it is the responsibility of each NCC certified nurse to maintain the stated core certification specialty knowledge competencies through active participation in the Professional Development Certification Maintenance Program.

The new program will be phased in over a period of three years, during which the current requirement of 45 continuing education hours will remain in place. The new element is a requirement that each certificant undergo a specialty assessment evaluation consisting of 125 questions related to the core certification specialty knowledge competencies. This assessment gives the nurse feedback about his or her strengths and gaps in specialty knowledge and provides a basis for selecting the amount and nature of continuing education (CE) needed to maintain certification.

The assessment is a Web-based, no-cost, one-time only, two-hour and fifteen minute evaluation. After taking the assessment, nurses will be provided with a specialty index report for each major core knowledge area. This will be the nurse's individualized learning plan. Continuing education will be required in only the areas the assessment indicates need updating. So, it is anticipated that many, if not most certificants will find their CE obligation decreasing from 45 hours.

Other activities may be substituted for some of the CE obligation. These include authorship of a journal article or book, presentation of an accredited CE course, editing a book, or precepting students in the same specialty area.

Editorial Note: CAC congratulates NCC for introducing the assessment component into its certification maintenance program. We are concerned, however, that the structure of the program leaves room for certificants to "game" the system. The assessment is offered online and can be taken at any time, on any computer, and in any setting. How will NCC verify the identity of the individual actually taking the test? This is a serious matter because the results of the assessment determine how much CE an individual is required to take – ranging from a 15 to 50 hours. Individualized assessment is a step in the right direction, since it will provide an evidence basis for selecting professional development activities targeted to enhance a particular certificant's knowledge and skills. We hope that this is just a first step in strengthening NCC's certification maintenance program and that eventually they will both introduce safeguards to ensure the integrity of the assessment process and go beyond CE and require certificants to actually demonstrate current competence. Such demonstrations could include peer review, practice monitoring, follow-up assessments and other methods, such as those being adopted by the American Board of Medical Specialties physician certification bodies.

Architects Back Repeal of Colorado Continuing Competence Law

The Colorado chapter of the American Institute of Architects (AIA) initiated a bill in the state House of Representatives to repeal legislation enacted during 2008 requiring a demonstration of continuing professional competence as a condition of relicensure. The following "Fact Sheet" issued under the names of sponsors of the legislation sets forth the architects' rationale for repeal.

FACT SHEET: HB 10-1148 Concerning the Repeal of the "Continuing Professional Competency" Requirement in Architect's Licensing Statute

By Representative Gerou and Senator Tapia

Vote YES on HB 10-1148 to repeal the continuing competency requirement in the architects licensing statute

Background

During the 2008 session of the General Assembly, the Colorado Component of the American Institute of Architects (AIA Colorado) asked Senator Peter Groff and Representative David Balmer to carry a bill requiring Continuing Education for architects. During discussions with DORA, the department agreed to support SB 08-029 only if it also contained a provision for the eventual additional requirement of a Continued Competence process.

Architects agreed under these terms: (1) no retake of the Architect's examination would be required; (2) architects could help draft the requirement. NO TIME FRAME FOR THE IMPLEMENTATION OF THIS PROVISION WAS SET IN THE BILL. Architects seek repeal of only the Continued Competence portion of the original bill before the system goes into effect.

A workgroup composed of AIA Colorado members and DORA representatives has met for more than a year in an attempt to reach agreement. They have yet to reach an agreement. Because of that and the overwhelming negative response from our members Statewide, the AIA Colorado Board has directed us to seek repeal of the provision.

Rep. Gerou and Sen. Tapia - an architect and an engineer - are carrying this bill for their two professions because architects want it out of the law and engineers fear that they will be next and they do not want Continuing Competency to be part of the Engineer's Licensing Statute. Nor do the Land Surveyors who are governed by the same joint board which regulates the three professions.

Following a meeting with Governor Ritter's staff, AIA Colorado has received assurance that the Governor has no problem with the repeal of this portion of the bill and that he will direct DORA to be neutral on the bill.

Why "Continuing Professional Competency" Does NOT Work for Architects

1. The process suggested by DORA works from the premise that an architect is not competent unless he/she can prove otherwise as a condition of renewal. Of course, every licensed architect has already been deemed competent by DORA based on education, experience and examination.
2. The model suggested by DORA is a self-evaluation one. An architect seeking license renewal would go online and respond to a series of prompts evaluating his/her own competency. It is a time consuming, non-comprehensive, and largely meaningless exercise. In addition, the professional must then create a learning plan, and further execute, document and defend that learning plan. All of which is in addition to and separate from current Mandatory Continuing Education requirements.
3. It calls into question an architect's ability to get liability insurance. Let's assume that during the self-assessment process, an architect indicates that he/she needs or wants more work in a particular area. That information is discoverable in the event of a claim against an architect. Additional liability issues are raised if an architect does not identify a given subject area. INSURANCE COMPANIES ADVISE US THAT THEY MAY NOT ISSUE LIABILITY POLICIES IF SUCH A SYSTEM IS IN PLACE.
4. The concept raises "restraint of trade issues." Colorado would be the only State to have such a system in place. Architects from other states who seek reciprocity would encounter

major roadblocks to licensure in Colorado. Colorado architects fear retaliation from other states.

5. It is not an overstatement to observe that AIA Colorado leadership and staff have received a "firestorm" of criticism over this requirement. It also would come at the worst possible time for architects. It adds a burdensome requirement and has almost tripled the cost of license renewal during a period when as many as 25% of architects report that they have no work. The profession is in a serious economic slump.
6. The State of Colorado should not be spending money to hire consultants and add outsourced, elaborate, and unproven data systems and software to track new requirements at a time when money is needed for schools, highways and higher education. The cost/benefit of money spent on this program is questionable. Funds would be better spent elsewhere.

Please Vote YES on HB 10-1148

A copy can be found at: http://b76ee10b57134367ebd46545bd5d972cbf6f36d1.gripelements.com/pdfs/finalfactsheet-repealcontinuedcompetency.pdf.

Washington State Nursing Board Drafts Continuing Competence Rules

In November and December 2009, the Washington State Nursing Commission held rules writing workshops related to a rule requiring documentation of continuing competence. The rule defines the components of continuing competence as

1. Active practice. A minimum active practice requirement is 576 hours for the past thirty-six month period. Each nurse shall attest annually awareness and compliance with the active practice requirement. Each nurse shall attest in writing every three years completion of 576 practice hours for the previous thirty-six month period. Active practice may include working as an administrator, quality manager, policy director, public health nurse, home health nurse, nursing educator, nursing consultant, nursing regulator, or any practice that requires nursing knowledge and a nurse license.
2. Continuing nursing education. A minimum of 45 hours in the previous thirty-six month period. Each nurse shall attest annually awareness and compliance of the continuing education requirement. Each nurse shall attest in writing every three years completion of 45 hours of continuing education. The education hours should be related to the nurse's area of professional practice or areas identified through reflection and self assessment for professional and development.

There will be a random audit of the documentation supplied by licensees.

Editorial Note: It may be a good idea to specify the nature of documentation that a board will accept to establish conformance with a continuing competence requirement. But documentation doesn't do much to protect the public if the actual requirement continues to rely heavily on continuing education, which even the Nursing Commission acknowledges is not, in and of itself, sufficient. In an effort to compensate for the weaknesses of continuing education, the Nursing Commission added the active practice requirement and makes passing mention of the idea of reflection and self-assessment. Assessment of practice weaknesses and learning needs could add value to the CE requirement if the assessment is the basis

for choosing CE activities. However, neither the rule drafting exercise nor the Demonstrating Continuing Competence conceptual model which the rule is intended to implement appears to explain the reflection and self-assessment component, nor are nurses expected to document that they have engaged in self assessment and applied it to their CE choices.

CERTIFICATION AND ACCREDITATION

Accreditation Body Punts on Doctoral Requirement for Licensure

The Accreditation Commission for Acupuncture and Oriental Medicine will develop standards for doctoral programs, but has decided not to take a position on the controversial question of whether a doctorate should be required as a prerequisite for licensure. The ACAOM posted the following statement online in February, 2010:

> **FEBRUARY 2010 ACAOM DECISION ON FIRST PROFESSIONAL DOCTORAL STANDARDS**
>
> At its February 2010 meeting, the Commission considered the public comment submitted in response to its August 2009 resolution in which ACAOM extended the comment period for seeking information and input regarding the development of first professional doctoral standards until January 15, 2010. For more, see: http://www.acaom.org/PdfVersion/ACAOM%20Reconsiders%20Resolution%20on%20FPDx%2009.pdf.
>
> The Commission received approximately 3000 letters and petition signatures on the subject, including from individual practitioners, students and patients, the Presidents of state and national AOM organizations such as the Council of Colleges of Acupuncture & Oriental Medicine (CCAOM), the American Association of Acupuncture & Oriental Medicine (AAAOM), a significant number of state AOM professional organizations, an AOM organization promoting a unique business model for professional practice, and from virtually all of the Asian AOM organizations in the US. Collectively, the organizations that submitted commentary represent the AOM educational community and a significant percentage of all AOM practitioners in the US.
>
> Based on this review the Commission, in its exercise of professional judgment, is satisfied that there is sufficient support to justify the further development of first-professional doctoral standards. Accordingly, the Commission voted to authorize the ACAOM Doctoral Task Force to complete its work in developing standards for accrediting first-professional doctoral programs in AOM for the Commission's review and consideration. In taking this action, the Commission does not take any position on whether or not the first- professional doctorate should be the required educational requirements for professional practice in AOM, which is the prerogative of state legislative and AOM regulatory authorities.
>
> In the coming months the Commission will be reconvening the ACAOM Doctoral Task Force to refine the first draft of first-professional doctoral programs, http://www.acaom.org/pdfversion/ACAOM%20Draft%20First%20Professional%20Doctoral%20Standards.pdf, based on the public comment previously received on that draft. A second draft of the standards to be developed by the Task Force will be submitted to the AOM communities of interest for public comment pursuant to the Commission's public comment and hearing protocols. For more, see:
>
> http://www.acaom.org/PdfVersion/ACAOM%20First%20Professional%20Doctoral%20Standards%2010.pdf

Article Documents Benefits of Certification

Misty D. Watts, MSN, RN writes in the current issue of ***Critical Care Nursing Quarterly*** about the benefits of certification and clinical ladders for critical care nurses.

She writes about the history of certification in this specialty, documents studies of the value of certification, explores barriers and incentives for nurses to seek certification, explains clinical ladders and makes the case for the benefits of certification to patients and employers. The article's abstract reads:

> With today's healthcare challenges of nursing shortages and financial instability, it is imperative that healthcare organizations retain clinically competent nurses at the bedside. Professional development and recognition are key motivators to increase nursing job satisfaction, thus reducing shortages and turnover. Implementation of specialty certification and clinical advancement programs is of benefit to the public, employers, and nurses alike. Clinical ladder and Magnet recognition are often the impetus for specialty nursing certification in healthcare institutions. Clinical ladder history, purpose, models, perceptions, and satisfiers are discussed. Certification statistics, types, impetus, benefits, incentives, and barriers are highlighted, as well as a facility's innovative strategy to increase specialty certification. Certification and clinical ladder programs demonstrate commitment of healthcare organizations and nursing staff to provide high-quality care and professional nursing development, an investment that hospitals cannot afford to overlook.

The article is available for purchase online at:
http://journals.lww.com/ccnq/pages/currenttoc.aspx#464513691

DISCIPLINE

Expose' Prompts Improvements in Nurse Board Discipline

Following an investigation conducted in 2009 by the *Los Angeles Times* and independent newsroom, *ProPublica*, the California Board of Nursing made dramatic changes in its disciplinary procedures. (See **CAC News & *Views***, Third Quarter 2009). To reduce the time it takes to process cases, the board began prioritizing complaints so it investigates more serious cases first; it acquired subpoena power and hired staff investigators to handle less complicated cases that won't result in criminal prosecution; took over some responsibilities from the Attorney General's office.

Then, in December 2009, the *Times* and *ProPublica* uncovered additional problems. Tracy Weber and Charles Ornstein of *ProPublica* wrote on December 5, 2009, that firms supplying hospitals with temporary nurses fail to conduct adequate background checks. The result is that some temporary agencies "have become havens for nurses who hopscotch from place to place to avoid the consequences of their misconduct." (www.propublica.org/feature/termporary-nurses-danger-iinadequate-oversight-1206).

On December 26, 2009, the reporters wrote in the *Times* that implementation of a new fingerprinting requirement resulted in the discovery of dozens of registered nurses who had been convicted of serious crimes, including murder, sexual misconduct, robbery and assault. (www.latimes.com/news/local/la-me-nurses-fingerprints26-2009dec26,0,3288465.story). The board had referred more than a dozen cases to the Attorney General's Office. Of 1900 conviction reports, 1300 were closed because of the nature or age of the offense.

Governor Schwarzenegger's budget submitted in January 2010 proposes a $12.8-million appropriate to hire investigators for the Board of Nursing and other health professional boards. The investigators would work directly for the boards. Only more serious cases would continue to be referred to a central pool of sworn investigators within the Department of Consumer Affairs.

Delaware Authorities Review Failures in Doctor's Child Rape Case

The widely publicized case involving Lewes, Delaware pediatrician Earl B.

Bradley is being formally reviewed by an expert in government ethics and health policy to determine why the doctor was allowed to continue in practice despite a decade of complaints alleging inappropriate conduct. The parents of his patients and his co-workers complained as long ago as 1998 about inappropriate touching. In 2009, Bradley was charged with raping nine girls, aged 3 months to 13 years.

Central to the investigation is to find out why Bradley was not reported to the medical board. The medical society, health care practitioners and institutions, and law enforcement agencies are under a mandate to report to the medical board and subject to a fine of $250 to $5,000 for failure to do so. The Division of Professional Regulation says it never received a complaint. Law enforcement officials say they contacted licensing authorities by phone in 2005 to report allegations against Bradley but the board refused the complaint, saying (incorrectly) that complaints must come from the victim or the victim's parents.

It is anticipated that the formal review of the case will be submitted to the Governor and the legislature in early spring.

More information on the case can be found at: ***http://www.delawareonline.com/***.

Dallas Paper Says Texas Medical Board Tolerates Misconduct

On October 11, 2009, Brooks Egerton wrote in the *Dallas Morning News* that the Texas Medical Board has not lived up to its promise to go after bad doctors after an earlier expose in the newspaper. Egerton recounts that at the conclusion of its August meeting, the board had decided to impose minor, if any discipline on two doctors convicted of crimes against children who may continue to practice on adults, two psychiatrists who had had affairs with patients, two doctors convicted of federal crimes that exposed patients to harm, a neurosurgeon who four times operated on the wrong body part, a cardiologist who performed numerous invasive procedures with questionable justification, and at least seven doctors linked to a patient death. A total of 131 physicians were disciplined at the meeting; only two were revoked because they stopped contesting the charges and a few surrendered their licenses.

Egerton expressed frustration that the board's confidentiality rules make it impossible to know why discipline is so lenient. Many cases are settled by "agreed orders" negotiated by the board and the defendant's attorney. The board's Website reveals little about these orders.

Board spokespersons told Egerton that the goal of the discipline process is remediation. It is to protect the public while allowing the physician to continue to practice if possible.

For more, see: www.dallasnews.com/sharedcontent/dws/news/healthscience/stories/101109dnpromedboard.42491dd.html.

NCSBN Issues Analysis of Disciplinary Data

The National Council of State Boards of Nursing has published *A Report of Findings from an Analysis of NURSYS Disciplinary Data From 1996-2006.* The introduction explains that:

There have been few studies examining disciplinary actions by state boards of nursing (BON). Researchers have mainly studied disciplinary actions as they apply to the incidence of medication errors or drug use among nurses. Nurses incur disciplinary action from BONs for many reasons. Grounds for discipline include fraud and deceit, criminal acts, substance abuse, mental incompetence, unprofessional conduct, incompetence due to negligence, and inability to practice nursing with reasonable skill and safety. The BON may also discipline nurses for willful misconduct, such as diverting narcotics, misjudgment, or

inappropriate action stemming from a lack of knowledge of a lapse in vigilance.

Extensive data and tables are organized around the following topics:

- Demographics
- Violations
- Actions
- Incidents
- Recidivism
- Criminal Convictions
- Education
- International Training
- Drug Related Violations
- Medication Errors

Copies of the report are available from the National Council of State Boards of Nursing, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277.

Disciplinary Records Missing from Federal Data Bank

The Healthcare Integrity and Protection Data Bank (HIPDB), the federal data base of disciplinary actions against practitioners other than doctors and dentists which was made available to hospitals on March 1, 2020, has serious omissions, according to reports by the *Los Angeles Times*, *ProPublica*, and other media. The problem is that licensing boards have not been reporting to the data bank.

Reporters Tracy Weber and Charles Ornstein of *ProPublica* found numerous states that have either not reported or made incomplete reports about nurses, psychiatric technicians, pharmacists, and other practitioners.

Acknowledging that information is missing from the HIPDB, Health Resources and Services Administration (HRSA) Administrator Mary Wakefield took steps to remedy the problem. The agency plans to begin in the summer to publicly list licensing agencies that do not report properly.

For more, see: http://www.latimes.com/nurses and http://www.propublica.org/nurses.

IN THE COURTS

Nurse Who Reported Unsafe Practice Acquitted by Jury

On February 11, 2010, a jury in West Texas acquitted nurse Anne Mitchell of third-degree felony charges for "misuse of official information" when she and a colleague reported a physician associate to the state medical board. The nurses had expressed concerns to their hospital employers about the safety of Dr. Rolando Arafile's practice, but to no avail, so they submitted an anonymous complaint to the medical board.

The local sheriff, a friend of Arafile's, discovered who had filed the complaint and told the hospital to fire the nurses. Prosecutors alleged that Mitchell had reported Arafile in bad faith. The jury took only an hour to reach its decision.

The fallout from the case has prompted comment from many sources. Alice Bodley, general counsel for the American Nurses Association, told *Medscape Medical News* (www.medscape.com) that the nurses shouldn't be thought of as "whistleblowers" but as contributors to a culture of safety. On February 10, 2010, The *New York Times* editorialized that the case should never have reached the courts. Rather, it should have been evaluated by the medical board first, before the ability to acquire evidence was compromised by the publicity around the prosecution. Nurse Toni Inglis commented in *statesman.com* that it is a nurse's duty to report as part of the professional code of ethics, not a felony. For more, see: www.statesman.com/opinion/inglis-nurses-win-but-still-bear-burdens-of-233158.html.

LETTERS

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

The brief article in the Third Quarter 2009 issue of **CAC** ***News & Views***, entitled "Long Hours, Lack of Sleep Dangerous for Attending Physicians" says there was "a nearly 3% increase in complications…" for physicians who didn't get enough sleep. The sleep deprived had a 6.2% complications rate compared to the 3.4% rate for the non-sleep deprived. While this is, indeed, nearly 3% in absolute terms, calling it a nearly "3% increase" severely understates the actual increase in the danger of complications. In fact, the sleep deprived were 83% more likely to have complications. [6.2 is 83% more than 3.4.] The article could have had a lot more impact to the casual reader if it had cited an 83% greater risk of complications.

Sincerely,

Robert Oshel, Retired

Formerly Associate Director of Research and Disputes, Division of Practitioner Data Banks, U.S. Department of Health and Human Services

CORRECTION

In the Third Quarter 2009 issue of ***CAC News & Views***, we incorrectly reported that licensing boards in Arizona had sued to recover funds removed from them by the state legislature. In fact, the suit was filed by a coalition of professional associations, and not by the boards themselves. Thanks to Kevin Earle, Executive Director of the Arizona Dental Association, for finding this error and sending us the coalition's press release which is reprinted here:

Professional Health Associations Look to Recover Funds, File Suit Against State of Arizona

Swept funds vital in protecting health and safety of Arizonans

PHOENIX – A coalition of thirteen Arizona health associations representing licensed health professionals in numerous fields filed suit in Maricopa County Superior Court today to recover more than $13.2 million in funds "swept" from various licensing boards.

These funds were taken by the Arizona Legislature in April and June 2008 and transferred to the State's General Fund. The funds consist entirely of fees paid by licensees in each profession. There are several strong legal arguments that the "transfers" are unconstitutional and in violation of state law.

The taking of these funds has left the boards extremely weakened, creating excessive delays in both licensing and disciplinary actions. As a result of the licensing delays, some healthcare businesses and individual providers may choose not to expand or locate in Arizona, which in turn would further exacerbate the existing shortage of physicians and nurses and some other licensed health professionals.

Along with licensing, these boards protect the health and welfare of Arizonans by investigating allegations of misconduct. Without adequate funding, these boards may be forced to lay-off staff and compromise their critical regulatory responsibilities. Some boards, including the Pharmacy Board, will have to cease operations as soon as July 2009.

"As health professionals, the regulation of safe practices and compliance is crucial to ensure the health, safety and welfare of the patients our members serve," said Mindy Rasmussen, RPh, the Executive Director/CEO of the Arizona Pharmacy Alliance. "Ensuring quality health care that is accessible to all Arizonans should be a top priority. Taking money from the licensing boards compromises the integrity of health care in Arizona."

By law, the funds must be used for the purpose of running the individual boards. "Our members pride themselves on being trusted care-takers of their patients' health," said Arizona Dental Association Executive Director, Kevin Earle. "A vital and effective regulatory structure provided by the boards adds confidence to patients and the public at large. These boards need funding to survive."

"This suit is crucial to the immediate and on-going operation of these regulatory boards," said Roger Morris with the law firm of Quarles & Brady, LLP, one of the attorneys representing the associations. "The associations brought suit because they recognize that protecting the public health and safety is of paramount importance and have joined together in an effort to force the State of Arizona to do the same."

The associations participating in this action are: Arizona Athletic Trainers Association, Arizona Association of Chiropractic, Arizona Dental Association, Arizona Medical Association, Arizona College of Emergency Physicians, Arizona Nurses' Association, Arizona Occupational Therapy Association, Arizona Optometric Association, Arizona Osteopathic Medical Association, and Arizona Pharmacy Association.

The following is a breakdown of the funding swept by the state:

Dental Board	$5,689,000.00
Pharmacy Board	3,049,700.00
Medical Board (Physician Assistant Board)	1,375,800.00
Nursing Board	1,079,000.00
Osteopathic Board	791,100.00
Veterinary Board	609,500.00
Occupational Therapy Board (Athletic Trainers Board)	239,500.00
Optometry Board	185,600.00
Chiropractic Board	166,800.00
Physical Therapy Board	100,000.00
	$13,286,000.00

Editorial Note: Charging that he was in effect taking licensing fees intended to fund the medical board, doctors in California sued Governor Schwarzenegger for imposing a three-day per month furlough on government workers in an effort to ease the state's budget crisis. The lawsuit also challenges the governor's move last year to transfer $6 million in medical licensure fees to the state's general fund. The California Medical Association lost the first round of its court fight but may appeal.

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

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

PAYMENT OPTIONS:

1) Make a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card (including American Express);
3) Provide us with a purchase order number so that we can bill you;

Or

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

Name:	
Credit card number:	
Expiration date and Security Code:	
Billing Address:	
City, State, Zip:	
Security Code:	

Signature Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of **CAC**. Membership includes a subscription to our newsletter for **all** of your board members and **all** of your staff, as well as many other benefits. But if you decide **not** to join **CAC**, we encourage you to subscribe to **CAC** ***News & Views*** by completing and returning this form by mail or fax.

SUBSCRIPTION FORM

Please select how you want to receive your copies:

Downloaded from our website: ____ **Calendar year 2010 (and back-issues) for $240.00.**

Delivered by mail: ____ **Calendar year 2010 for $275.00.**

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

PAYMENT OPTIONS:

1) Make a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card (including American Express);
3) Provide us with a purchase order number so that we can bill you;

Or

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

Name:	
Credit card number:	
Expiration date and Security Code:	
Billing Address:	
City, State, Zip:	
Security Code:	

Signature Date

Our Federal Identification Number is 52-1856543.