News & Views

Citizen Advocacy Center

Second Quarter, 2010 A Health Care Public Policy Forum Volume 22 Number 2

Our 2010 Annual Meeting will be held on Thursday and Friday, November 11 – 12, 2010, *in* ***Washington, D.C.*** *The theme of this meeting will be* ***"Scope of Practice, Continuing Competence, and Health Care Reform"****. The Program Announcement and Meeting Registration Form is at* http://www.cacenter.org/files/AnnualMeetingProgram2010.pdf. *We hope that you will be able to attend.*

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 29 – 30 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 31 of this issue.*

SCOPE OF PRACTICE

The Florida Medical Association Legislative Update

Editorial Note: In its April 2010 Legislative Update, the Florida Medical Association congratulated itself for stopping numerous pieces of legislation, including proposals for scope of practice changes for several non-physician professions. Excerpts from the online update appear below:

> The 2010 Florida Legislative Session is finally over, and it was summed up best by Sen. Don Gaetz, who said, "This is the year we averted disaster."
>
> There were an unprecedented number of bills filed this year that, had they passed, would have been harmful to physicians and adversely affected the practice of medicine. From meetings

~ TABLE OF CONTENTS ~

SCOPE OF PRACTICE 1
- The Florida Medical Association Legislative Update 1
- Federal Trade Commission Staff Comments on Proposed Clinic Regulations 4
- Federal Trade Commission Complaint Charges Conspiracy to Thwart Competition in Teeth-Whitening Services 4
- Non-Physicians Assess Resident Competence 6
- Arizona Medical Board Issues Physician Scope of Practice Guidelines 6

IN-DEPTH: OHIO NURSING BOARD LAUNCHES SAFETY INITIATIVE 8

QUALITY OF CARE 15
- Commonwealth Fund Finds U.S. Healthcare System Deficient 15
- Prescription Errors in Emergency Departments 18
- California's Nurse / Patient Ratios Save Lives 19

WORKFORCE 19
- Federal Healthcare Reform Creates Workforce Commission 19
- Center for Health Professions Issues Report on Staffing Patterns in California's Community Clinics 20

PAIN MANAGEMENT AND END OF LIFE CARE 20
- Representatives Launch Caucus on Prescription Drug Abuse 20
- Family Physicians Call for Revolution in Chronic Pain Care 21

Continued on page 2…

that were held months before session began, to amendments that were filed in the session's final days, special interest groups with interests inimical to ours filed a constant barrage of legislative proposals. Through a tremendous amount of work, the FMA Governmental Affairs team was able to defeat or neutralize these proposals, ensuring a successful session.

No issue exemplified the adversity physicians faced this year more than Medicaid reform. With the leadership of both chambers committed to expanding the managed care reform pilot project statewide, a massive change in Medicaid appeared inevitable… The FMA, in concert with the Florida Academy of Family Physicians and other groups, was able to … avert a full-scale managed care takeover, and ensure the preservation of the Medipass system and fee-for-service in Medicaid…

While every session sees an attempt by allied health professionals to expand their scope of practice, the battles were especially fierce this year. Optometrists, ARNPs and physical therapists pulled out all the stops to be able to do what physicians are trained to do, but without first going to medical school for the proper training. I am happy to announce that the FMA was able to defeat all of these proposals, and that not one scope-of-practice bill passed.

Not only was the practice of medicine under assault, but so was the Department of Health (DOH), an entity the FMA fought to create almost 15 years ago. Despite a determined effort, the FMA was able to ensure that the Florida Surgeon General will continue leading a department committed to ensuring the public health, and that the

…Continued from page 1

CONTINUING COMPETENCE 22
EMTs Falsify Recertification Training 22
Certification Board Settles With Test Prep Company 22

DISCIPLINE 23
FSMB Publishes Summary of 2009 Medical Board Actions 23
Delaware Strengthens Medical Board after Pediatrician Scandal 23

PUBLIC INFORMATION 25
Angie's List to Beef Up Health Care Provider Data 25
Nursing Home Quality Reports Improve Post-hospital Care 26

FOREIGN GRADUATES 26
California Medical Board Warns Employers of Foreign Graduates 26
Arkansas Eases Overseas School Restriction 27

SPOTLIGHT 28

PUBLICATIONS OF NOTE 28
Leape Institute Publishes Proceedings of Roundtable on Reforming Medical Education 28

CAC IS NOW A MEMBERSHIP ORGANIZATION 29

CAC MEMBERSHIP ENROLLMENT FORM 30

SUBSCRIPTION FORM 31

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.

Board of Medicine will continue being overseen by the DOH, not the Department of Business and Professional Regulation.

The FMA also defeated the following:

- Legislation that would have prevented physicians from collecting full payment from out-of-network PPO patients;
- Legislation that would have ended the use of binding arbitration agreements by physicians;
- Legislation that would have ensured higher malpractice insurance premiums by repealing the wrongful death exemption;
- Legislation that would have imposed unreasonable reporting requirements on physicians in relation to impaired drivers;
- Legislation that would have provided an unreasonable standard for the treatment of foster children with psychotropic medications;
- Legislation that would have allowed social workers and marriage and family therapists to diagnose autism; and
- Legislation that would have ensured that physicians were paid less in automobile injury cases.

In addition to "averting disaster," the FMA was able to pass its priority legislation for the session. Today, the Senate unanimously approved HB 7217 (by Sen. Carey Baker and Rep. Bryan Nelson), which, if signed by the governor, will exempt medical malpractice insurance premiums from any emergency assessment levied by the Hurricane Catastrophe Fund for three more years…

There were many, many other bills and legislative language that the FMA was instrumental in passing, changing or stopping. A detailed list of all items of interest will be forthcoming in the coming weeks…

The full text is at http://www.fmaonline.org/Council_on_Legislation_Newsletter_04-30-10.aspx.

CAC *News & Views* is published quarterly by the

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Federal Trade Commission Staff Comments on Proposed Clinic Regulations

In a January 2010 letter to the Kentucky Cabinet for Health and Family Services, staff in the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition expressed the opinion that proposed regulations for limited service clinics (LSCs) could reduce competition by applying different requirements for clinic personnel than for personnel in other health care settings. The letter read in part:

> The New Administrative Regulation for LSCs (Proposed Rule) would regulate the operation of LSCs. Numerous provisions of the Proposed Rule – such as the requirement that licensed health care professionals at LSCs operate within the scope of their licensure – mirror basic consumer protection standards that are imposed on competing providers of basic health care services. As such, they do not raise competition concerns. However, several provisions impose costs and restrictions on both LSCs and the health care professionals who practice there, such as physicians and advanced registered nurse practitioners (ANPs), that do not apply in other limited care settings, such as urgent care centers.
>
> Imposing disparate regulations on competitors can reduce competition among them and thereby harm consumers. By reducing competition among providers of basic health care services, the Proposed Rule is likely to raise prices and decrease the availability of health care services for Kentucky consumers. Consumers may conceivably benefit from this disparate regulation only if is necessary to protect consumers' interests. Studies indicate, however, that the quality of LSC care is just as good as that in other clinic settings.
>
> LSCs are operating successfully in more than thirty states, including Kentucky. Thus, the available evidence does not appear to suggest a need for additional costs and limits on LSCs that do not apply in analogous limited care settings. Moreover, the Proposed Rule does not articulate a justification for treating LSCs and other limited care settings differently.
>
> In the absence of a justification, the Proposed Rule appears likely unnecessarily to limit competition from LSCs to provide basic health care services. Therefore, FTC staff recommend that The Kentucky Cabinet for Health and Family Services (Cabinet) eliminate the provisions of the Proposed Rule that would impose greater costs and limits on LSCs (and the professionals who practice there) than on other limited care settings.

Federal Trade Commission Complaint Charges Conspiracy to Thwart Competition in Teeth-Whitening Services

June 17, 2010, the Federal Trade Commission announced that it had issued a complaint charging the North Carolina dental board with improperly excluding non-dentists from providing teeth-whitening services. The FTC's press release is excerpted below. The full text is available at http://www.ftc.gov/opa/2010/06/ncdental.shtm.

> The Federal Trade Commission today initiated an action against the state dental board in North Carolina, alleging that it is harming competition by blocking non-dentists from providing teeth-whitening services in the state.

The FTC charged that the North Carolina Board of Dental Examiners (the "Dental Board") has impermissibly ordered non-dentists to stop providing teeth-whitening services, which has made it harder to obtain these services and more expensive for North Carolina consumers. (*In the Matter of* **The North Carolina Board of Dental Examiners** Docket No. 9343 FTC File No. 081 0137.)

According to the FTC's administrative complaint, teeth-whitening services are much less expensive when performed by non-dentists than when performed by dentists. A non-dentist typically charges between $100 and $150 per whitening session, while a dentist typically charges between $300 and $700, with some dental procedures costing as much as $1,000.

Whitening services provided by non-dentists are often available at salons, retail stores and mall kiosks. Dentists in North Carolina offer whitening services in their offices, and also provide take-home kits.

The Dental Board is a state agency created to regulate the practice of dentistry in North Carolina. It consists of eight members, including six licensed dentists, who collectively control the operation of the Dental Board. Any person who wants to practice dentistry in the state must be licensed by the Dental Board. The Dental Board also may ask a state court to deem a particular conduct an unauthorized practice of dentistry and issue an injunction.

Instead of seeking court orders to block non-dentists from providing teeth-whitening services, which the Dental Board believes constitute unauthorized practice of dentistry under North Carolina law, the Dental Board has unilaterally ordered non-dentists to stop providing whitening services. The Dental Board's actions, according to the FTC, are improper and harm competition.

"Without active supervision by a disinterested state authority, a regulatory board whose members have a financial interest in the industry it is charged with regulating cannot exclude its competitors from the marketplace," said Richard Feinstein, Director of the FTC's Bureau of Competition. "The North Carolina Dental Board does not have authority to decide on its own to limit the whitening services available to North Carolina residents, and its actions have decreased competition and harmed consumers."

According to the FTC's complaint, the Dental Board sent 42 letters instructing teeth-whitening providers that they were practicing dentistry illegally and ordering them to stop. In at least six cases, the Dental Board threatened or discouraged non-dentists who were considering opening teeth-whitening businesses. The Dental Board also sent at least 11 letters to third parties – mall owners and property management companies – stating that teeth-whitening services offered in malls are illegal.

The FTC's complaint alleges that as a result of the Dental Board's actions, the availability of teeth-whitening service in North Carolina has been significantly diminished. The complaint charges that the Dental Board's conduct is an anticompetitive conspiracy among the dentist members of the Dental Board in violation of federal law. The FTC seeks to stop the Dental Board's illegal conduct so that North Carolina consumers can benefit from competition

between dentists and non-dentists for teeth-whitening services.

The Commission vote approving the administrative complaint was 4-0-1, with Commissioner Julie Brill recused. It was issued today, and a public version will be available shortly on the FTC's website and as a link to this press release…

Non-Physicians Assess Resident Competence

Research published in the August 2009 issue of ***Academic Medicine*** (pp.1135-1143) concluded that undergraduates, graduate students, and medical and nursing students can be trained to assess medical residents' competence in performing ultrasound-guided insertion of a central venous catheter (CVC). The research was funded by the Agency for Healthcare Research and Quality (AHRQ).

Lead researcher Leigh V. Evans, M.D. of Yale University School of Medicine and his colleagues recruited 49 volunteers who received a 2-hour training session and a 2-hour testing session. Twenty-seven of the volunteers were hired to evaluate the quality of residents' CVC insertions on actual patients. The hired trainees had a 97% agreement with the standard answer on the 50 observed procedural checkpoints.

Evans and colleagues believe similar independent raters can be trained to effectively evaluate other procedural skills of residents and medical students.

Arizona Medical Board Issues Physician Scope of Practice Guidelines

The Arizona Medical Board has issued the following guidelines for physicians considering new procedures or areas of specialization.

Introduction

Medical Boards make basic assumptions when resolving Scope of Practice issues for physicians. Paramount among those assumptions is that the public must be protected from poorly trained or unqualified physicians.

The Arizona Medical Board developed these Scope of Practice Guidelines to assist physicians in assessing their specific qualifications when they make the decision to undertake new procedures, employ new technologies or migrate into new areas of medical practice for which they have not received formal post graduate/residency training.

Preamble

The Arizona Medical Board (Board) recognizes that the practice of medicine is dynamic with respect to scientific and technological advancements. Physician practice patterns are changing with evolving medical knowledge and treatment modalities, new technologies, and fluctuations within health care specialties and the healthcare workforce. Consumer demand has contributed to changes in practice patterns as well.

Laws defining the practice of medicine, in Arizona and nationwide, are broadly defined and do not restrict a licensee from adopting new technologies, employing new procedures, broadening one's scope of practice or even entering into a different area of practice from which he or she was formally trained. While the law may not restrict these changes in practice patterns, the Board does have the obligation to ensure patient safety through the competent practice of medicine.

Prior to licensure, physicians must graduate from an approved medical school, complete an approved residency program and pass standardized tests. Physicians who complete

these necessary requirements are presumed competent to practice within the field in which they received their formal training. Formal training requirements must meet national standards and are heavily regulated and scrutinized. A physician who meets the qualifications for licensure has an unlimited scope of practice. The standard of care, however, requires physicians to be trained, qualified and competent to perform medical procedures before engaging in a particular practice or field of medicine.

Post-formal training and continuing medical education does not receive the same level of scrutiny. While, it is critical for physicians to remain competent and current in the practice of medicine, this training may not be adequate for physicians trying to practice specialty care far afield from their formal post graduate/residency training.

Guidelines

Physicians who practice in specialty areas, whether or not they received formal training, must be competent in all procedures they perform regardless of where they received their training.

For example, internists, who also perform dermatological procedures, must be competent in all procedures that they perform. Likewise, a radiologist practicing radiology for many years may require additional training before being competent to practice emergency department medicine or urgent care medicine.

Areas in which the Board has recently seen physicians expand their scopes of practice include:

- Pain management
- Cosmetic surgery
- Treatment of Erectile dysfunction

While these areas are not inclusive of all the areas in which physicians have expanded their scopes of practice, they represent areas in which physicians have found themselves outside their training and skill levels – at times, to the detriment of their patients. Physicians must be aware of any complications that can arise during the course of a procedure and be prepared to adequately address them. Physicians administering anesthesia during office based surgery must also be aware of the Board's Office Based Surgery Rules, specifically R4-16-702(A)(3)(d), which requires "…the physician and health care professional administering the sedation to rescue a patient after sedation is administered and the patient enters into a deeper state of sedation than what was intended by the physician."

Obtaining Practice Area Expertise and Considerations for an Expanded Scope of Practice

Practice area expertise can be obtained in a number of ways, including: mini-residency programs, informal training by a hospital or group practice, seminars prepared by private organizations, and direct training by medical equipment manufacturers and pharmaceutical companies. Regardless of how expertise is obtained, physicians should consider the following factors before engaging in an expanded practice:

- What competencies (clinical knowledge, judgment and skills) are required in order to provide services safely and competently?
- What are the prerequisites and the core education needed in terms of undergraduate and postgraduate education and clinical experience?
- Will the education received meet the standards and be recognized by an independent and formally accredited educational organization or institution?
- Is the expanded scope of practice appropriate for the education and training received? How does that

education compare to that of other practitioners providing the same service?

- What goals must be established for attaining and retaining competence in that specialty area?

Competence Self-Assessment

Once additional training is complete, and prior to beginning an expanded practice, physicians may elect to obtain an assessment of their skills. Assessment and evaluation programs are available through institutions such as the University of California San Diego Physician Assessment and Clinical Evaluation (PACE) program or the Colorado Center for Personalized Education for Physicians (CPEP). Additional assessment tools may be available through specialty medical societies or through county and state medical associations.

Summary

These guidelines were developed to assist physicians in their understanding of the Arizona Medical Board's position on Scope of Practice issues and the Board's obligation to protect the public through the competent practice of medicine. The Board expects physicians to maintain their educational and technical competencies for their current practices. The Board strongly recommends that these Scope of Practice Guidelines be carefully reviewed by all physicians holding current licenses to practice medicine in Arizona.

The guidelines are online at http://www.azmd.gov/Files/Guidelines/ScopeOfPracticeGuidelines.pdf

IN-DEPTH: OHIO NURSING BOARD LAUNCHES SAFETY INITIATIVE

Editorial Note: The Ohio Board of Nursing is pilot testing a new approach to complaint handling that involves greater involvement by employers and incorporates principles of Just Culture. CAC is pleased to see this development, as we see many aspects of this initiative that echo the principles of CAC's PreP-4-Patient Safety program at which another board of nursing (North Carolina) excels.

This In-Depth Feature consists of excerpts from the Ohio Board of Nursing's explanation of its initiative:

PATIENT SAFETY INITIATIVE
CREATING A CULTURE OF SAFETY AND ACCOUNTABILITY

A JOINT COLLABORATION
THE OHIO BOARD OF NURSING AND NURSING EMPLOYERS

By implementing a more comprehensive approach to practice complaints, the Board believes it will directly address and impact patient safety by increasing employer involvement; creating a state and national patient safety database using TERCAP data; and handling cases incorporating the principles of Just Culture. Considering these objectives, the Board agreed upon a Patient Safety Initiative to be conducted with several acute care facilities as a new approach for practice complaints. If successful, the Patient Safety Initiative will be expanded.

Just Culture and statewide patient safety initiatives are being developed in many health care systems throughout the country, including Ohio. The Ohio Patient Safety Institute, the Ohio Hospital Association, the Ohio Organization of Nurse Executives, and the Ohio Nurses Association are undertaking Just Culture education initiatives. The time is right for nursing organizations, employers and regulators to more closely collaborate for patient safety.

OVERVIEW

PATIENT SAFETY INITIATIVE CREATING A CULTURE OF SAFETY AND ACCOUNTABILITY

A JOINT COLLABORATION
THE OHIO BOARD OF NURSING AND
NURSING EMPLOYERS

Background and Statutory Obligations

The Ohio Board of Nursing is a governmental agency created by Ohio law to regulate the practice of nursing in the state of Ohio for the safety of the public. The Nurse Practice Act (NPA) is set forth in Chapter 4723 of the Ohio Revised Code, and Chapters 4723-1 through 4723-27 of the Ohio Administrative Code contain administrative rules adopted by the Board. The NPA and rules establish requirements for nurses and certificate holders regulated by the Board. A major function of the Board is to safeguard the health of the public by investigating complaints and adjudicating violations. The Board received over 6,200 complaints in calendar year 2009, of which approximately 19% were practice complaints.

Objectives

The Board is collaborating with nursing employers to initiate a Patient Safety Initiative focusing on a new approach to nursing practice issues.

- The goal is to increase patient safety through effective reporting, remediation, modification of systems, and accountability.
- The objectives are to:
    - Increase employer reporting of information related to practice breakdowns
    - Increase employer-sponsored practice remediation
    - Incorporate Just Culture for the review of practice complaints
    - Create a statewide patient safety database
    - Assist with the development of a national patient safety database
    - Increase the use of the Practice Intervention and Improvement Program (PIIP) alternative to discipline program

Components

1) The Practice Intervention and Improvement Program (PIIP) is a confidential alternative to discipline program for eligible licensees. The program establishes a structured remedial education and monitoring program to document that the participant's practice deficiency has been corrected.
2) TERCAP (Taxonomy of Error, Root Cause Analysis and Practice-Responsibility) is a tool used to gather data and track cases involving practice breakdown. TERCAP is an initiative of the National Council of State Boards of Nursing to develop a national database on practice breakdown, and to identify patterns of error, risk factors, and system issues that contribute to practice breakdown. This will assist in the development of new approaches for patient safety.
3) Just Culture, a risk management model pioneered by Outcomes Engineering, Inc., is a systematic method that can be used by nursing employers and the Board to increase

patient safety by recognizing and modifying system flaws, and by holding individuals accountable for reckless behavior or repeated behavior that poses increased risk to patients. Just Culture finds middle ground between a punitive culture that generally does not consider the systems issues that contribute to errors, and a blame-free culture, that does not hold individuals appropriately accountable. Just Culture holds individuals accountable for their performance based on their job responsibilities, but does not expect individuals to assume accountability for system flaws over which they had no control.

Model Design and Responsibilities

Health care facilities will be responsible for choosing to establish Just Culture within their own organizations, i.e., providing training, establishing systems and methods to report practice complaints, providing remediation for a nursing practice deficiency, and resolving systemic issues contributing to practice breakdown. While it is beyond the role of the Board to mandate the use of Just Culture for employers and their businesses, the Board will encourage its use and work collaboratively with employers to promote the principles.

The essential connection between the Board and employers is the initial reporting and communication regarding complaints. Facilities are responsible to report practice complaints and the Board is responsible to investigate, incorporating the Just Culture analysis as part of the investigatory and review process prior to or at the time of recommending disposition of the complaints.

Many complaints do not result in public disciplinary action, but remain confidential and closed unless subsequent violations are reported. However, it is important that complaints are reported. If they are not reported, the risk to public safety is high. For example, the Board may have confidential information from Employer A about a nurse and if Employer B reports a complaint on the same nurse, a pattern could emerge. If Employer B does not report the complaint, it is unlikely the Board could identify a pattern of at-risk behavior.

The public will remain confident that the Board meets its statutory responsibility to protect the public when they know that the Board expects that all complaints will be reported to the Board.

This model illustrates the Board and employers working more closely in conjunction with individual licensees and the health care setting to promote patient safety. The model will enable the Board and the employer to meet their respective legal obligations and assure the public that their expectations for public protection and patient safety are being met. By incorporating the Just Culture principles, we anticipate an increase in employer remediation and in the use of PIIP, the confidential alternative to discipline remediation program, both of which are designed to return the licensee to safe practice…

Processes and Procedures

1) The employer identifies a nursing practice breakdown and notifies the Ohio Board of Nursing by completing the complaint forms. The employer follows their policies and procedures for reviewing/investigating a practice breakdown. If applicable, the employer submits an employer remediation plan to the Board.
    a. If the employer is not sure about reporting a possible

violation to the Board, the employer should report the situation, so the Board can conduct an investigation, review the facts and circumstances, and make a determination regarding whether a violation occurred.

b. While the Board understands that not every practice or medication error needs to be reported, employers need to consider, among other things, the egregiousness of the error and the potential or actual harm. If a one-time error was egregious or had the potential to result in patient harm, the incident should be reported. Further, if the employer is aware of a pattern of errors or concerns, the employer should report the concern. Even if the employer is not sure there is enough evidence to prove a violation, the employer should file a complaint so Board compliance agents can conduct a detailed investigation. The Board may have other investigatory information from the past or from previous employers and the newly reported information may now indicate a more serious problem or a pattern.

2) Board staff reviews the complaint and if additional information is needed to complete the complaint data, consults with the employer. An investigation is opened if the matter involves an alleged violation. The Just Culture analysis is used as part of the investigative process. Board staff enter complaint data in the NCSBN database for TERCAP patient safety data.

3) Board staff present the case to the Board Supervising Member for Disciplinary Matters for review and disposition. The Just Culture analysis is incorporated to assist in distinguishing between human error, risk-taking behavior, and reckless behavior. The Board may close the case, issue a non-disciplinary advisory letter, refer the nurse to the PIIP Program with employer remediation, or impose disciplinary sanctions.

Just Culture Overview and Analysis

Just Culture is a term coined by David Marx, Chief Executive Officer of Outcome Engineering, LLC, an engineer and attorney who is known for his work in patient safety and safe system design. He describes Just Culture as…

> On one side of the coin, it is about creating a reporting environment where staff can raise their hand when they have seen a risk or made a mistake. On the other side of the coin, it is about having a well-established system of accountability. A 'Just Culture' must recognize that while we as humans are fallible, we do generally have control of our behavioral choices.

Scott Griffith, Chief Operating Officer of Outcome Engineering, LLC, wrote a column, "The Growth of a Just Culture" in the *Joint Commission Perspectives on Patient Safety*, (December 2009, Volume 9, Issue 12). The following are highlights from that article.

- Just Culture strikes a balance, being neither "highly punitive" nor "blame free."
- It is a culture that holds organizations accountable for the

systems they design and for how they respond to staff behaviors fairly and justly. In turn, staff are accountable for the quality of their choices and for reporting both their errors and system vulnerabilities. In an organization with a Just Culture, we focus on our systems yet do not lose sight of physicians, managers, pharmacists, clerks, or nurses as components within our system.

- Rather than assume that a bad outcome has a bad person associated with it, the focus is on the differences between human error, at-risk behavior, and reckless behavior; justice is administered based on the quality of the person's choice.
- Just Culture recognizes that human error is inadvertent, while at-risk behavior and reckless acts are conscious choices, regardless of whether harm was intended. When all three behaviors are managed consistently, a Just Culture shifts to focus on the quality of choices, not on undesired outcomes that may or may not result.

In the *New England Journal of Medicine* (361; 14, October 1, 2009), writers Robert M. Wachter, MD, and Peter J. Pronovost, MD, PhD, wrote "Balancing 'No Blame' with Accountability in Patient Safety"…

> Our failure to create real accountability for patient safety partly represents a fundamental misunderstanding regarding both how other, safer industries carry out their safety activities and the nature of errors. It is true that most errors are innocent slips committed by competent and committed caregivers and are best dealt with by focusing on improving systems rather than people. But as James Reason, the father of modern error theory and "systems thinking" emphasizes, every safe industry has transgressions that are firing offenses. The pilot who neglects to use a checklist before takeoff would not be allowed to fly (not to mention that the copilot would never agree to take off). In most meatpacking plants, workers are monitored by remote video and are held accountable for performance. In these industries, once a reasonable safety rule is implemented and vetted (since some rules create unanticipated consequences or work-arounds and need to be reworked after initial implementation), failure to adhere leaves the work of "no blame" and enters the domain of accountability.

Just Culture focuses on system-wide issues that contribute to practice breakdown, and also examines the behavior and responsibilities of the nurse and holds the nurse accountable for unsafe or reckless choices that endanger patients. Practice breakdown analysis focuses on three origins of errors: (1) human error; (2) at-risk behavior; (3) reckless behavior.

When practice breakdowns are reported to the Board, the Just Culture analysis is used by the Board to distinguish between human error, risk-taking behavior, and reckless behavior. Using the analysis of Just Culture, the Board may close the case, issue a non-disciplinary advisory letter, or consider the options of remediation or disciplinary sanctions. The Board recognizes that each case presents a unique set of factors that warrant individual consideration by the Board.

Outcome Measures

1) Patient Safety Initiative Program employers will provide supplemental practice breakdown information to the Board for 95% of all practice complaints.
2) The Board will investigate and/or review 95% of the practice

complaints using the Just Culture analysis as evidenced by the investigative summary or case review report.

3) The Board will submit the supplemental practice breakdown data for 95% of the reported cases to the national database for TERCAP.

4) Through consultation and collaboration, the Board and employers will establish an increased number of employer remediation plans for practice cases.

5) The number of practice cases considered for and/or referred to PIIP will increase within six months after the implementation of the Patient Safety Initiative.

6) Ohio data will be available for the state and incorporated in the national patient safety database maintained by the National Council of State Boards of Nursing.

REPORTING COMPLAINTS

PATIENT SAFETY INITIATIVE CREATING A CULTURE OF SAFETY AND ACCOUNTABILITY

A JOINT COLLABORATION
THE OHIO BOARD OF NURSING AND
NURSING EMPLOYERS

The public expects that safe nursing care will be delivered and that unsafe or incompetent practice will be addressed. One way to promote safe nursing care is for employers to report practice issues and for the Ohio Board of Nursing to review the practice breakdown and potential violation.

In calendar year 2009, the Board received over 6,200 complaints and allegations of violations of the Nurse Practice Act (NPA) and administrative rules. Based on the evidence obtained during the investigation, the Board may pursue disciplinary action, refer nurses to confidential alternative programs for discipline, issue non-disciplinary advisory letters, or close the complaint with no action taken.

Q) What are the violations I should report?

A) Conduct by a licensed nurse that would be grounds for disciplinary action in Section 4723.28, Ohio Revised Code (ORC), includes, but is not limited to, failure to practice in accordance with safe nursing care standards, violations of maintaining professional boundaries, positive drug screens, diversion of drugs, or impairment of the ability to practice nursing. The employer is required to report even if the nurse has been referred to an employee assistance program or is participating in a remediation program.

If the employer is not sure about reporting a possible violation to the Board, the employer should report the situation, so the Board can conduct an investigation, review the facts and circumstances, and make a determination regarding whether a violation occurred. The law does not require that the employer conduct a full investigation and determine if the nurse has violated the law or rules prior to filing a complaint with the Board.

Q) Should employer-employee issues be reported to the Board?

A) In general, employer-employee issues are not reported to the Board. This includes failure to follow an employer policy. For example, not providing adequate notice of termination of employment, "no call, no show," rudeness with co-workers, refusal to accept an assignment, staffing or work hour issues, etc., are usually

employer-employee issues handled by the employer.

Q) How do I determine if I should refer a medication error to the Board?

A) If in doubt, it is better to report the error to the Board for evaluation. The majority of the Board investigators are nurses who will collect additional information and evaluate if further review for a violation is warranted. Below are guidelines or examples of what to report to the Board:

- Administration of the medication was beyond the nurse's scope of practice
- Administration of the medication was beyond the nurse's knowledge, skills, and abilities
- Errors are repetitive, or a pattern of errors has been identified
- Violation of known medication administration policies and/or procedures resulted in a significant risk to patient
- Recklessly or knowingly caused harm

Q) Under HIPAA, am I permitted to release health care information to the Board?

A) Under HIPAA, the Board is a health oversight and law enforcement agency to whom release of Personal Health Information is a permitted disclosure without patient authorization. 45 CFR 164.512(d); 45 CFR 164.512(f).

Q) How do I make a complaint to the Board?

A) Locate the complaint form on the Board web site at http://www.nursing.ohio.gov and click "Discipline and Compliance." You can download the form, complete it as a Word document, and e-mail it as an attachment to complaints@nursing.ohio.gov, fax it to 614-995-3686 or 614-995-3685, or send it via regular mail to Attention: Compliance Unit, Ohio Board of Nursing, 17 S. High Street, Suite 400, Columbus, OH 43215.

Q) If I make a complaint, what will happen?

A) Complaints are investigated by Board investigators, most are nurses, and all are experienced and have had investigative training. Generally, the investigator contacts the complainant, nurse, and others who can provide information about the allegation. Based on the evidence obtained during the investigation, the Board may pursue disciplinary action or close the complaint.

Q) Is my complaint confidential?

A) Yes. The fact that the Board has received information and is investigating a licensee is confidential and would not be disclosed to the public. The Board keeps complaints and information obtained about those who are under investigation confidential, as required by Section 4723.28(I)(1), ORC. In the interest of protecting patients, always report nurses if you believe there are grounds for disciplinary action.

Q) Does the law provide immunity if I make a complaint?

A) Under Section 4723.33, ORC, a registered nurse, licensed practical nurse, dialysis technician, community health worker, or medication aide who in good faith makes a report to the Board regarding a violation of the NPA or rules, or participates in any investigation, administrative proceeding, or judicial proceeding resulting from the report, has the full protection against retaliatory action

provided by Sections 4113.51 to 4113.53 of the Revised Code.

Q) Why do I need to complete the "Supplemental Information Form for Employers" when I make a practice complaint?

A) The supplemental information is being used to develop state and national patient safety databases. The data will be used to better understand the nature of practice breakdown, identify risk factors, and develop systems to prevent practice breakdown. All facility or patient-specific information will be redacted.

Q) Is Ohio a "mandatory" reporting state?

A) Yes. Ohio law requires mandatory reporting which means that employers must report to the Board those licensees and certificate holders whom they have reason to believe may have violated the NPA or the rules adopted by the Board.

Q) Since the nurse was terminated from employment here, is there really a need to submit a complaint?

A) The Board has many cases where employers did not report nurses to the Board and the nurses went to other employers and repeated their practice errors. It is your responsibility to report potential violations.

Q) Who is to report violations by nurses from a staffing agency?

A) Employers who use nurses from staffing agencies or travel companies need to ensure that complaints are filed with the Board either by the staffing agency, travel company, or by the practice setting where the nurse is working on assignment. The Board is aware of situations where nurses working for staffing agencies or travel companies were not reported and subsequently the nurses continued to practice in other settings repeating the same violations and endangering the public

Q) Who do I contact with questions?

A) Email the Board Compliance Unit at compliance@nursing.ohio.gov.

QUALITY OF CARE

Commonwealth Fund Finds U.S. Healthcare System Deficient

In the third update to its comparison of the performance of the health care systems in seven industrialized countries, the Commonwealth Fund concludes that the U.S. healthcare system "consistently underperforms." Excerpts from the report, written by Karen Davis, Ph.D., Cathy Schoen, M.S., and Kristof Stremikis, M.P.P., are reprinted below. The full report can be found at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?view=print&page=all

Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update

Overview

Despite having the most costly health system in the world, the United States consistently underperforms on most dimensions of performance, relative to other countries. This report – an update to three earlier editions – includes data from seven countries and incorporates patients' and physicians' survey results on care experiences and ratings on dimensions of care. Compared with six other nations – Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom – the United States health care system ranks

last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives. Newly enacted health reform legislation in the U.S. will start to address these problems by extending coverage to those without and helping to close close gaps in coverage, leading to improved disease management, care coordination, and better outcomes over time.

Executive Summary

The U.S. health system is the most expensive in the world, but comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance. This report, which includes information from the most recent three Commonwealth Fund surveys of patients and primary care physicians about medical practices and views of their countries' health systems (2007 – 2009), confirms findings discussed in previous editions of *Mirror, Mirror*. It also includes information on health care outcomes that were featured in the most recent (2008) U.S. health system scorecard issued by the Commonwealth Fund Commission on a High Performance Health System, available at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Jul/Why-Not-the-Best--Results-from-the-National-Scorecard-on-U-S--Health-System-Performance--2008.aspx.

Among the seven nations studied – Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States – the United States ranks last overall, as it did in the 2007, 2006, and 2004 editions of *Mirror, Mirror*. Most troubling, the U.S. fails to achieve better health outcomes than the other countries, and as shown in the earlier editions, the U.S. is last on dimensions of access, patient safety, coordination, efficiency, and equity. The Netherlands ranks first, followed closely by the U.K. and Australia. The 2010 edition includes data from the seven countries and incorporates patients' and physicians' survey results on care experiences and ratings on various dimensions of care.

The most notable way the U.S. differs from other countries is the absence of universal health insurance coverage. Health reform legislation recently signed into law by President Barack Obama should begin to improve the affordability of insurance and access to care when fully implemented in 2014. Other nations ensure the accessibility of care through universal health insurance systems and through better ties between patients and the physician practices that serve as their long-term "medical homes." Without reform, it is not surprising that the U.S. currently underperforms relative to other countries on measures of access to care and equity in health care between populations with above-average and below-average incomes.

But even when access and equity measures are not considered, the U.S. ranks behind most of the other countries on most measures. With the inclusion of primary care physician survey data in the analysis, it is apparent that the U.S. is lagging in adoption of national policies that promote primary care, quality improvement, and information technology. Health reform legislation addresses these deficiencies; for instance, the American Recovery and Reinvestment Act signed by President Obama in February 2009 included approximately $19 billion to expand the use of health information technology.

The Patient Protection and Affordable Care Act of 2010 also will work toward realigning providers' financial incentives, encouraging more efficient organization and delivery of health care, and investing in preventive and population health.

For all countries, responses indicate room for improvement. Yet, the other six countries spend considerably less on health care per person and as a percent of gross domestic product than does the United States. These findings indicate that, from the perspectives of both physicians and patients, the U.S. health care system could do much better in achieving value for the nation's substantial investment in health.

Key Findings

Quality: The indicators of quality were grouped into four categories: effective care, safe care, coordinated care, and patient-centered care. Compared with the other six countries, the U.S. fares best on provision and receipt of preventive and patient-centered care. However, its low scores on chronic care management and safe, coordinated care pull its overall quality score down. Other countries are further along than the U.S. in using information technology and managing chronic conditions. Information systems in countries like Australia, New Zealand, and the U.K. enhance the ability of physicians to identify and monitor patients with chronic conditions.

Access: Not surprisingly – given the absence of universal coverage – people in the U.S. go without needed health care because of cost more often than people do in the other countries. Americans with health problems were the most likely to say they had access issues related to cost, but if insured, patients in the U.S. have rapid access to specialized health care services. In other countries, like the U.K. and Canada, patients have little to no financial burden, but experience wait times for such specialized services. There is a frequent misperception that such tradeoffs are inevitable; but patients in the Netherlands and Germany have quick access to specialty services and face little out-of-pocket costs. Canada, Australia, and the U.S. rank lowest on overall accessibility of appointments with primary care physicians.

Efficiency: On indicators of efficiency, the U.S. ranks last among the seven countries, with the U.K. and Australia ranking first and second, respectively. The U.S. has poor performance on measures of national health expenditures and administrative costs as well as on measures of the use of information technology, rehospitalization, and duplicative medical testing. Sicker survey respondents in Germany and the Netherlands are less likely to visit the emergency room for a condition that could have been treated by a regular doctor, had one been available.

Equity: The U.S. ranks a clear last on nearly all measures of equity. Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick, not getting a recommended test, treatment, or follow-up care, not filling a prescription, or not seeing a dentist when needed because of costs. On each of these indicators, nearly half of lower-income adults in the U.S. said they went without needed care because of costs in the past year.

Long, healthy, and productive lives: The U.S. ranks last overall with poor scores on all three indicators of long, healthy, and productive lives. The U.S. and U.K. had much higher death rates in 2003 from conditions amenable to medical care than some of the other countries, e.g., rates 25 percent to 50 percent higher than Canada and Australia. Overall, Australia ranks highest on healthy lives, scoring in the top three on all of the indicators…

Prescription Errors in Emergency Departments

Research led by William J. Meurer, MD and published by the Society for Academic Emergency Medicine (ACADEMIC EMERGENCY MEDICINE 2010; 17:231–237) reveals a significant incidence of potentially inappropriate medication (PIM) administered to older adults in emergency departments. The abstract of the article, *Potentially Inappropriate Medication Utilization in the Emergency Department Visits by Older Adults: Analysis from a Nationally Representative Sample*, is excerpted below:

> **Objectives:** The objectives were to determine the frequency of administration of potentially inappropriate medications (PIMs) to older emergency department (ED) patients and to examine recent trends in the rates of PIM usage.
>
> **Methods:** The data examined during the study were obtained from the National Hospital Ambulatory Medical Care Survey (NHAMCS). This study utilized the nationally representative ED data from 2000 – 2006 NHAMCS surveys. Our sample included older adults (age 65 years and greater) who were treated in the ED and discharged home. Estimated frequencies of PIM-associated ED visits were calculated. A multivariable logistic regression model was created to assess demographic, clinical, and hospital factors associated with PIM administration and to assess temporal trends.
>
> **Results:** Approximately 19.5 million patients, or 16.8% (95% confidence interval [CI] = 16.1% to 17.4%) of eligible ED visits, were associated with one or more PIMs.
>
> The five most common PIMs were promethazine, ketorolac, propoxyphene, meperidine, and diphenhydramine. The total number of medications prescribed or administered during the ED visit was most strongly associated with PIM use. Other covariates associated with PIM use included rural location outside of the Northeast, being seen by a staff physician only (and not by a resident or intern), presenting with an injury, and the combination of female sex and age 65 – 74 years. There was a small but significant decrease in the proportion of visits associated with a PIM over the study period.
>
> **Conclusions:** Potentially inappropriate medication administration in the ED remains common. Given rising concerns about preventable complications of medical care, this area may be of high priority for intervention. Substantial regional and hospital type (teaching versus nonteaching) variability appears to exist.

The text of the article can be found at http://www3.interscience.wiley.com/cgi-bin/fulltext/123305845/HTMLSTART.

Editorial Note: Dr. Meurer, et. al. noted that Beers Criteria and other tools pharmacists use to identify and avoid potentially inappropriate medication use in nursing homes would be applicable to

treating older patients in emergency departments, if physicians were aware of their existence.

An article in the Los Angeles Times (in 2009) entitled, Pharmacists are a Vital, if Under-Used, Part of Healthcare, quotes Julie Donohue, associate professor of health policy and management at the University of Pittsburgh as saying, "In terms of the number of hours spend studying drug effectiveness, pharmacists are better trained than physicians." Dr. Paul Gregerson, chief medical officer for the JWCH Institute in Los Angeles told the LA Times "Pharmacists know more about medications than anybody else in the healthcare system. That's what they went to school for… They're like walking encyclopedias."

California's Nurse / Patient Ratios Save Lives

A study published in the journal Health Services Research (available at http://www.hsr.org/hsr/abstract.jsp?aid=45274535150) concludes that better nurse patient ratios could save thousands of lives annually. Written by Linda H. Aiken, Douglas M. Sloane, Jeannie P. Cimiotti, Sean P. Clarke, Linda Flynn, Jean Ann Seago, Joanne Spetz, Herbert L. Smith, the study compares mortality rates in California with rates in Pennsylvania and New Jersey in 2006. According to the abstract:

> **Implications of the California Nurse Staffing Mandate for Other States**
>
> **Objectives:** To determine whether nurse staffing in California hospitals, where state-mandated minimum nurse-to-patient ratios are in effect, differs from two states without legislation and whether those differences are associated with nurse and patient outcomes.
>
> **Data Sources:** Primary survey data from 22,336 hospital staff nurses in California, Pennsylvania, and New Jersey in 2006 and state hospital discharge databases.
>
> **Study Design:** Nurse workloads are compared across the three states and we examine how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workloads across the hospitals in these states.
>
> **Principal Findings:** California hospital nurses cared for one less patient on average than nurses in the other states and two fewer patients on medical and surgical units. Lower ratios are associated with significantly lower mortality. When nurses' workloads were in line with California-mandated ratios in all three states, nurses' burnout and job dissatisfaction were lower, and nurses reported consistently better quality of care.
>
> **Conclusions:** Hospital nurse staffing ratios mandated in California are associated with lower mortality and nurse outcomes predictive of better nurse retention in California and in other states where they occur.
>
> You may download this article from http://www3.interscience.wiley.com/cgi-bin/fulltext/123346354/HTMLSTART.

WORKFORCE

Federal Healthcare Reform Creates Workforce Commission

The Patient Protection and Affordable Care Act establishes a number of boards and commissions. Among them is the National Health Care Workforce Commission (Sec. 5101).

The Commission's purpose is to serve as a national resource on health care workforce issues. To develop and request evaluations of education and training activities to determine whether the demand for health care workers is being met. To review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration concerning national health care workforce priorities, goals and policies. There are specific topics and high priority areas delineated in the Act. There is a grant program and studies to be performed under the direction of the Commission.

The Commission will have 15 members appointed by the Comptroller General, and will include at least one representative of:

- health care workforce and health professionals;
- employers;
- third-party payers;
- individuals skilled in the conduct and interpretation of health care services and health economics research;
- representatives of consumers;
- labor unions;
- State or local workforce investment boards; and
- Educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2- and 4-year institutions, or registered apprenticeship programs).

Center for Health Professions Issues Report on Staffing Patterns in California's Community Clinics

Tim Bates and Susan Chapman of the Center for the Health Professions at the University of California, San Francisco prepared a report in February 2010 on staffing patterns in California's licensed community clinics.

An earlier report analyzed the use of Medical Assistants (MA) in clinics. The report includes data on the use of Registered Nurses (RN) and Licensed Vocational Nurses (LVN) during 2005-2008.

The authors found essentially no change in the proportion of clinics reporting utilization of RNs and LVNs, while the use of MAs has steadily expanded. LVNs are more widely used in clinics in rural areas. The most common staff pattern is the RN-MA together, or an MA alone.

The full report is available at http://www.futurehealth.ucsf.edu.

PAIN MANAGEMENT AND END OF LIFE CARE

Representatives Launch Caucus on Prescription Drug Abuse

On June 12, 2010, two Members of Congress announced the creation of a bi-partisan coalition on prescription drug abuse. Their press release is excerpted below. The full text is available at http://www.americanchronicle.com/articles/view/160643.

> Today, Representatives Mary Bono Mack (CA-45) and Hal Rogers (KY-05) launched a bi-partisan Congressional Caucus on Prescription Drug Abuse. As the Co-Chairs of the Caucus, Bono Mack and Rogers are long-time advocates for multi-tiered solutions to the ever-growing epidemic that has wrought havoc on communities large and small throughout the United States. The new Congressional Caucus on Prescription Drug Abuse aims to unite like-minded policy-makers to raise awareness of abuse, and to work towards innovative and effective policy

solutions incorporating treatment, prevention, law enforcement and research. Representatives Bill Delahunt (MA-10), Stephen Lynch (MA-09) and Connie Mack (FL-14) are also original caucus members.

"Prescription drug abuse is on the rise, threatening the lives of more and more of our young people every day," said Bono Mack. "Far too many Americans have the misconception that prescription drugs are ´safer´ because they´re prescribed by a doctor, but the fact is that prescription drugs, when abused, can be just as addictive and as deadly as street drugs. Like millions of people across our country, I have seen firsthand the devastation that prescription drug abuse can cause, and I am proud to launch this Caucus with some of my colleagues who share my passion and dedication to ending this cycle of abuse that is destroying the lives and futures of too many of our young people."…

"Prescription drug abuse is overwhelming our local law enforcement community, challenging our health practitioners and worst of all, is an easy predator on our young people," stated Rogers. "In Kentucky, we´ve employed a three-pronged approach to combat the scourge of abuse – law enforcement, treatment and education – and today we´re applying this strategy, with the input of research, to tackle drug diversion. I look forward to collaborating with these and other colleagues who are similarly dedicated to tackling prescription drug abuse from the bottom-up and the top-down."

"Prescription drug abuse across America can only be described as an epidemic," said Delahunt. "Between 2002 and 2007, my home state of Massachusetts lost 42 times as many residents to opioid-related overdoses than in the Iraq and Afghanistan wars, and the Commonwealth is currently seeing two deaths per day…" The Prescription Drug Caucus will help raise awareness of this terrible epidemic while developing effective policies to combat abuse.

According to the National Institute on Drug Abuse, nearly 7 million people are utilizing prescription drugs for non-medical purposes. Nearly one-third of individuals who began abusing drugs in the past year reported their first drug was a prescription drug, and one out of every five new drug abusers is initiating use with potent narcotics, such as oxycodone, hydrocodone and methadone. The Drug Enforcement Administration (DEA) indicates illegal prescription drug diversion is the fastest growing drug threat nationwide. The Caucus will conduct periodic events to educate Members of Congress, congressional staff, relevant government officials and the general public about the dangers of prescription drug abuse and policies aimed at reducing the diversion and misuse of these drugs.

Family Physicians Call for Revolution in Chronic Pain Care

The American Academy of Family Physicians issued a report in November 2009 entitled *A Call to Revolutionize Chronic Pain Care in America: An Opportunity in Health Care Reform*. The committee that prepared the report found that 25% of Americans suffer from chronic pain. This problem is attributable to numerous factors, including inadequate education in pain diagnosis and

management. Another problem is difficulty accessing specialized care. A full description of the report is available at http://www.aafp.org/online/en/home/publications/news/news-now/health-of-the-public/20091111chronic-pain.printerview.html.

CONTINUING COMPETENCE

EMTs Falsify Recertification Training

On May 27, 2010, *Boston Globe* staff writer Donovan Slack reported that at least 200 emergency medical technicians and paramedics in Massachusetts and New Hampshire were practicing with illegitimate credentials. One company in particular was charged with permitting EMTs and paramedics to sign attendance rosters for training courses and receive credentials without actually attending the courses.

Massachusetts' Commission of Public Health promised to take disciplinary action against offenders. Firefighters in Boston and elsewhere receive extra pay if they have an EMT certification.

Certification Board Settles With Test Prep Company

The American Board of Internal Medicine (ABIM) has sanctioned 140 certificants for cheating on certification exams, sharing exam questions with a test preparation company and/or purchasing test questions. ABIM also reached a settlement in June 2010 with the test preparation company, Arora Board Review RESUME

> Philadelphia, PA, June 17, 2010 – On June 10th, the American Board of Internal Medicine (ABIM) reached a settlement with Arora Board Review and Rajender Arora, MD, owner and operator of Arora Board Review.

Under the terms of the settlement agreement:

- Dr. Arora is not Board Certified.
- Arora Board Review and Dr. Arora are permanently enjoined from copying, distributing or selling any materials that incorporate the content of ABIM Examinations.
- Arora Board Review and Dr. Arora are permanently enjoined from collecting, soliciting or encouraging others to collect ABIM Examination content.
- Arora Board Review may not offer a live test-prep course at any time in the future.
- Arora Board Review is paying damages to ABIM.

The permanent injunction was signed by Judge Curtis Joyner of the US District Court of Pennsylvania on Thursday, June 10 and orders that Arora Board Review is permanently enjoined from "creating, reproducing copying, distributing, offering for sale, selling and/or publicly displaying any materials of any kind and in any medium that infringe ABIM's copyrights in its Certifying Examinations." The injunction also ordered that Arora is prohibited from "collecting, soliciting or encouraging third parties to collect and/or share the content of ABIM Examinations."

"We are pleased that our efforts to protect the integrity of our examinations have been successful," added Christine Cassel, President and CEO of the American Board of Internal Medicine. "While the damages we have received can not begin to cover the costs of replacing the questions compromised by Arora Board Review, they send an important message that we will do what

it takes to protect the examination process."

DISCIPLINE

FSMB Publishes Summary of 2009 Medical Board Actions

Each April, the Federation of State Medical Boards issues a *Summary of Board Actions*. The summary contains data about disciplinary actions taken by member medical boards plus information about each board's disciplinary processes, including standards of proof required when prosecuting cases and the health care professions regulated.

This year's report includes disciplinary data for each board from 2005-09. During 2009, state medical boards took 5,721 actions against physicians, an increase of 342 actions over 2008. Summaries of board action reports from 1990 – 2009 are at http://www.fsmb.org/fpdc_basummaryarchive.html.

The Federation says this about the disciplinary data:

> Because states operate with different financial resources, levels of autonomy, legal constraints and staffing levels, the FSMB discourages using data from this report to compare or rank states. The *Summary of Board Actions* is most useful in tracking trends in physician discipline within each state over time. To assist in tracking disciplinary trends, the report includes the Composite Action Index. Designed by the FSMB, the CAI is a weighted average of disciplinary actions taken against physicians practicing in a state, as well as all physicians licensed by that state. Actions affecting physicians' licenses, such as revocations and suspensions, are weighted more heavily in a state's CAI…
>
> The CAI is a barometer that can signal significant changes in a medical board's disciplinary activity level. Changes in a board's funding, staffing levels, changes in state law and many other factors can impact the number of actions taken by a board. Please note the validity of the CAI is limited in states that have total in-state physician licensee populations of less than 1,000.

Editorial Note: The Health Research Group's annual ranking of states based on the Federation's data is at http://www.citizen.org/hrg1905.

Delaware Strengthens Medical Board after Pediatrician Scandal

How did it happen that a pediatrician in Lewes, Delaware was able to continue in practice and molest more than 100 young patients over a decade and a half, despite suspicions and complaints by colleagues and patients? The state medical society failed to report allegations it received to the medical board. The medial board failed to act when the doctor was under investigation in 1994 for improper conduct in Pennsylvania. Nor did it act on a police complaint in 2005 alleging improper touching of a three-year old patient.

Delaware Governor Jack Markell retained Widener University School of Law Dean Linda Ammons to research the case and recommend actions to fix the system. She told the Delaware State News, (May 23, 2010) that the failure of so many parties to report Dr. Bradley to the medical board could be because there was little confidence the board would take meaningful action.

On June 30, 2010, Governor Markell signed nine bills intended to prevent a similar regulatory breakdown in the future. Senate Bill 296 reorganizes the medical board. The official synopsis explains:

This act reorganizes and renames the Board of Medical Practice to better reflect the Board's responsibilities and improve public understanding of the Board's role. The act also expedites resolution of emergency cases, improves the investigatory authority of the Board, clarifies the protections for persons reporting unprofessional conduct, and allows for greater input by persons who are not medical professionals.

Section 1 changes the name of the "Board of Medical Practice" to the "Board of Medical Licensure and Discipline," which will better reflect the responsibilities of the Board.

Sections 2 and 3 change the composition of the Board of Medical Licensure and Discipline to increase the number of public members and add the Director of Public Health.

Section 4 eliminates a provision of the code dating to the 1990 expansion of the board that is no longer applicable and clarifies that appointments following a Board member's resignation are for the duration of the remaining term.

Sections 5 and 6 create an expedited process for emergency suspensions of licenses to practice medicine. The sections would allow the Board to temporarily suspend a license on the joint determination of the Board President and the Secretary of State that the person's continued practice is a clear and immediate danger to public health.

Section 7 enables the Board of Medical Practice to obtain information concerning peer reviews without regard to the outcome.

Section 8 eliminates the ability of the Board to enter into agreements with other entities, including the Medical Society of Delaware, to facilitate its duties under the Medical Practice Act.

Section 9 grants the Division of Professional Regulation the ability to retain independent, third party treatment providers to provide services to licensees.

Section 10 also requires the Division of Professional Regulation to provide complainants access to a Division investigator to discuss issues or concerns regarding a report or complaint.

Section 10 of the bill clarifies that the protections for reporting conduct to the Board extends to all reports of violations of the Medical Practice Act.

Section 11 provides that the changes to the composition of the Board can occur by attrition through term expiration, and that the actions of the Board are not invalid during the transition period.

Other legislation requires health care institutions, including hospitals, nursing homes, and the medical society to report suspected neglect or abuse to the Department of Services for Children, Youth and their Families, which in turn must report to the Division of Public Regulation. The medical board's powers are strengthened and law enforcement entities must communicate with each other about alleged physician misconduct. The Division of Professional Regulation is re-defined as a criminal justice agency, giving it access to the state criminal information database. Doctors working in outpatient settings must have another adult in the room when treating a patient younger than 15. All physicians must be fingerprinted every ten years.

The legislation is at http://legis.delaware.gov/LIS/lis145.nsf/Signed%20Legislation?OpenView&Start=1&Count=30&Expand=2#2.

Dean Ammon's full report is at http://law.widener.edu/NewsandEvents/Articles/2010/~/media/Files/BradleyReport/FINAL%20REPORT.ashx.

PUBLIC INFORMATION

Angie's List to Beef Up Health Care Provider Data

In its May 2010 online newsletter, Angie's List posted the following announcement about its plans for enhancing its information on health care providers:

> As this month's cover story demonstrates, there are no hard and fast rules when it comes to licensing for health care providers.
>
> Licensing requirements and enforcement vary significantly from state to state, making it difficult for consumers to find consistent and comprehensive information.
>
> In some states, licensing information is easy to access. In others, it's a jumbled array of data spread across many regulatory sites that the consumer must scour to glean any useful information.
>
> At a minimum, you should always make sure your health care provider is licensed, if required, within the state he or she is practicing. However, licensing alone doesn't confirm the provider is a good one. You need to dig deeper.
>
> That's where Angie's List comes in. You already come to our site to read reviews on health care providers and learn about their accessibility, bedside manner, effectiveness of treatment, billing process and office environment.

But we want to offer you a more comprehensive resource.

To that end, last fall we began requiring that all health care providers on the List attest to their compliance with state licensing laws. This year we'll be going even further and performing random audits of the license numbers of health care providers to help ensure our information is accurate and up-to-date.

In addition, you'll soon have access to licensing details and past disciplinary actions for health care providers. We plan to offer a breakdown of state health care licensing requirements and a guide to resources where you can easily access all the information you need to make informed decisions.

Besides ensuring a level of education and training, there are other reasons why health care licensing is so important. For instance, an unlicensed doctor would be ineligible to carry malpractice insurance, thus posing a huge liability to any patients under his or her care.

One way to protect yourself is to avoid seeing providers who aren't affiliated with insurance companies, hospitals or health care organizations, which check licensure routinely.

"Those are red flags," says Lisa Robin, senior vice president of advocacy and member services for the Federation of State Medical Boards.

While 91% of Angie's List members who took our online poll believe health care licensing is crucial, only 20% say they check licensing prior to making an appointment, whether it be with a doctor, nurse practitioner or another type of provider.

Ellen Purpus of Malvern, Pa., is one member who is adamant about doing

her own background check before visiting a doctor. She says in addition to making sure they're licensed by the state, she won't see anyone who isn't certified by a reputable board.

Several members also told us they believe a referral from another health care professional guarantees the provider is licensed. Don't assume that's the case.

And don't expect to become an expert on your doctor just by visiting a website. Set up an initial consultation to get more information after you've completed a background check.

Ultimately, as a prospective patient, you can never just take a provider's word that they're licensed. Protect yourself, be diligent and always research prospective health care providers before you're under their care.

Doctors' reviews and ratings are at http://www.angieslist.com/angieslist/companylist/doctor.info.aspx.

Nursing Home Quality Reports Improve Post-hospital Care

A study of the impact of *Nursing Home Compare*, the Website that publicly rates the performance of nursing homes on quality measures, revealed an improvement in two of three post-acute care performance measures, but no significant decrease in potentially preventable rehospitalizations. Using national data from 1999 – 2005, Rachel Werner, M.D., Ph.D., of the University of Pennsylvania and colleagues compared data for 10 quality measures before the launch of *Nursing Home Compare* and after. The number of patients with moderate to severe pain improved 0.6 percent. There was a 0.7 percent improvement in the number of patients with improved walking, but no change in the number of patients without delirium.

The study was supported by the Agency for Healthcare Research and Quality (AHRQ) and was published in the periodical, *Health Services Research*, (44 [4], pp. 1169-1187, 2009).

FOREIGN GRADUATES

California Medical Board Warns Employers of Foreign Graduates

Editorial Note: The following article appeared in the July 1, 2010 issue of the Medical Board of California newsletter:

WARNING to physicians and program directors

Don't assist the unlicensed practice of medicine

The Medical Board continues to receive complaints alleging physicians are allowing international medical school graduates to work in their offices treating patients. This practice is only lawful if the scope of the work is no more than a medical assistant would perform.

After individuals graduate from medical school, the law requires them to enter accredited residency training programs to qualify for a California medical license. These training programs are generally in large teaching hospitals, and are accredited by the American Medical Association's Accreditation Council of Graduate Medical Education. Before the trainees qualify for licensure, they cannot "moonlight" or gain experience by participating in an "externship" by working in a physician's private office or clinic. If graduates are unable to gain admission into an accredited training program, they cannot gain clinical experience by working in a physician's private office or clinic performing any duties other

than those routinely fulfilled by a medical assistant. They cannot perform as a trainee (in a residency program), nor a physician assistant. International graduates may be employed as medical assistants in a physician's office if they do not represent themselves as medical doctors nor exceed the duties specified in Business and Professions Code section 2069-2071 and Title 16, California Code of Regulations, sections 1366-1366.4.

A recurring problem seen at the Board is physicians writing letters of recommendation for unlicensed international graduates that extol their hands-on clinical patient skills, with the hope of impressing future training program directors. International graduates desire a letter to present to prospective postgraduate training program directors describing their clinical experience in the United States. If the Board advises them that they have to limit their hands-on activities to those that a high school graduate medical assistant can do legally, those activities will not impress future program directors. Inevitably, many international graduates choose to violate the law and engage in the unlicensed practice of medicine, thus putting the supervising physicians at risk of being charged with aiding and abetting the unlicensed practice of medicine.

While the Board understands the desire to assist the international graduate, letters written by physicians that indicate they have allowed the unlicensed international graduate to perform examinations and assist with patient care activities in their offices can result in a charge of aiding and abetting the unlicensed practice of medicine. It is common for recommendation letters to be referred to enforcement to determine whether the author of the letter has allowed an unlicensed individual to treat his or her patients. This could result in either a citation for "aiding and abetting" unlicensed practice, or the author acknowledging that the letter embellished the description of duties performed by the trainee. Neither outcome is desirable.

International graduates, not licensed in California nor formally enrolled in an ACGME-approved postgraduate training program, may not perform any clinical activities beyond the scope of a medical assistant. Unfortunately, individuals seeking clinical experience to enhance their ability to obtain an ACGME-approved postgraduate training program will need to seek such clinical experience outside of California.

The above holds true for U.S. and Canadian graduates not licensed in California nor formally enrolled in an ACGME-approved physician assistant training program. Supervising physicians should be aware not to embellish letters of recommendation that portray the graduates as performing duties above and beyond those that are legally allowed.

Arkansas Eases Overseas School Restriction

Beginning June 1, 2010, the Arkansas medical board will evaluate applications from foreign medical school graduates on the basis of their performance during residency and test results rather than the school they attended. Since 2008, the board had been using California's list of disapproved foreign medical schools to decide which applicants were ineligible to obtain a license to practice in the state.

The board had been sued by graduates of the American University of Antigua, a school

which had been on the board's list of banned educational institutions. The board also took into consideration the shortage of primary care physicians in the state and determined that it would make more sense to evaluate students on a case by case basis rather than by the school they attended.

SPOTLIGHT

Editorial Note: CAC News & Views is pleased to acknowledge the Missouri Board of Nursing for collaborating in the production of a video encouraging consumers to be active partners in protecting the safety of the care they receive. Lori Scheidt, Executive Director, sent us the following information about the video:

Our Board partnered with the Missouri Center for Patient Safety whose vision is a health care environment safe for all patients, in all processes, all the time to make this video to help consumers be more comfortable and confident in asking questions and speaking up. This video is told with real Missouri patient stories and providers.

You, as the patient, play a vital role in making the care you receive safe. You must be an active, informed, and vocal member of your health care team. **Speak up if you have questions or concerns about your care. If you don't understand, ask again. You have a right to know!**

See the Partnering for Safe Care Video link at http://www.pr.mo.gov/nursing.asp. Please let me know your thoughts, and feel free to link to it on your websites!

Lori Scheidt, Executive Director
Missouri State Board of Nursing
lori.scheidt@pr.mo.gov

PUBLICATIONS OF NOTE

Leape Institute Publishes Proceedings of Roundtable on Reforming Medical Education

Unmet Needs: Teaching Physicians to Provide Safe Patient Care reports on the discussions and recommendations of the Lucian Leape Institute Roundtable on Reforming Medical Education. The Lucian Leape Institute is located at the National Patient Safety Foundation.

The report's executive summary points out that:

> Health care delivery continues to be unsafe despite major patient safety improvement efforts over the past decade. The Roundtable concluded that substantive improvements in patient safety will be difficult to achieve without major medical education reform at the medical school and residency training levels. Medical schools must not only assure that future physicians have the requisite knowledge, skills, behaviors, and attitudes to practice competently, but also are prepared to play active roles in identifying and resolving patient safety problems. These competencies should become fully developed during the residency training period.

The full report may be downloaded from the National Patient Safety Foundation Website at http://www.npsf.org.

CAC is Now a Membership Organization

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) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
3) A **$20.00 discount** for **CAC** webinars.
4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
5) **Discounted rates** for **CAC**'s **on-site** 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 fees as follows:

Individual Regulatory Board	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organization	$375.00
Association of regulatory agencies or organizations	$450.00

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;
3) Provide us with a purchase order number so that we can bill you;

Or

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

Name:	
Credit card number:	
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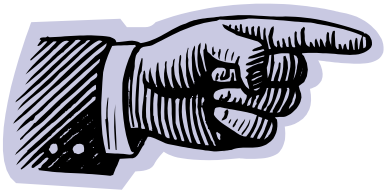
Security Code:	

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.

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

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

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Our Federal Identification Number is 52-1856543.