News & Views

Citizen Advocacy Center

Third Quarter, 2010 A Health Care Public Policy Forum Volume 22 Number 3

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 31 – 32 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 33 of this issue.*

SCOPE OF PRACTICE

Pharmacy Organizations Respond to AMA Scope of Practice Analysis

The American Medical Association's Scope of Practice Partnership (SOPP) has produced a series of "modules" that set forth organized medicine's analysis of the training and preparation on several non-physician professions. The purpose is to arm state medical societies to combat legislation that proposes changes in these non-physician professions' scope of practice.

Per the following April 23, 2010, press release, seven pharmacy organizations have collaborated on a response to the SOPP's pharmacy scope of practice document.

> **Seven Pharmacy Organizations Collaborate on Response to American Medical Association (AMA) Scope of Pharmacy Practice Document**

~ TABLE OF CONTENTS ~

Continued on page 2…

Response addresses document deficiencies and calls for dialogue between pharmacy and medicine

Washington, DC – Seven national pharmacy organizations collaborated on the analysis and response to a document published by the American Medical Association (AMA Scope of Practice Data Series: Pharmacists) for its members. The document describes the scope of practice of the pharmacy profession as viewed by the AMA authors. The pharmacy organizations identified significant opportunities for enhanced understanding by the AMA of contemporary pharmacy practice. Collaborating on Pharmacy's review and response were the American Pharmacists Association (APhA), American Association of Colleges of Pharmacy (AACP), American College of Clinical Pharmacy (ACCP), Accreditation Council for Pharmacy Education (ACPE), American Society of Consultant Pharmacists (ASCP), National Alliance of State Pharmacy Associations (NASPA), and National Association of Boards of Pharmacy (NABP). The letter and accompanying material sent by the pharmacy groups to AMA provides input and clarification on the report. The pharmacy organizations urged the AMA to correct the identified issues noted in the document. The organizations were assured today by AMA that meaningful dialogue will be pursued to examine ways pharmacists and physicians can collaboratively address the healthcare needs of patients.

A copy of the letter and accompanying materials can be viewed at:

Response Letter: AMA Scope of Practice Data Series: Pharmacists

Recommendations: AMA Scope of Practice Data Series: Pharmacists

…Continued from page 1

NOTICE

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Scope of Contemporary Pharmacy Practice

http://www.pharmacist.com/AM/Template.cfm?Section=News_Releases2&Template=/CM/ContentDisplay.cfm&ContentID=23149

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In their letter, the seven pharmacy organizations state in part:

> After reviewing the *AMA Scope of Practice Data Series: Pharmacists* document, the collaborating organizations are deeply concerned with the accuracy and completeness of the information presented. Today physicians and pharmacists are collaborating to enhance patient care in innovative and effective ways. This document is a regression and contrary to the recommendations and policy pronouncements of the Institute of Medicine (IOM), the Patient-Centered Primary Care Collaborative (PCPCC), the Joint Commission, the Association of Academic Health Centers (AHC), and numerous other groups that support more and better inter-professional collaboration to improve patient care.

We have serious concerns about the portrayal within the document of pharmacists' scope of practice, the provision of collaborative drug therapy management (CDTM) services, and the education and training of pharmacists. The suggestion in the document – that the evolving scope of practice of pharmacists serves primarily to "compensate" for increased automation and utilization of pharmacy technicians – is simply wrong. Rather, pharmacy practice is being driven by substantial and important changes in pharmacists' education and training over the past two decades to meet the needs of patients in using medications safely and more effectively. This training allows pharmacists to engage in services for which they have the specific education, training, and regulatory authority to positively impact patient outcomes, especially with regard to the management of medication therapy and the unmet needs of patients.

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For another commentary on the SOPP's pharmacy-related activities, visit the *Pharmacy Idealist* Blog at http://pharmacyidealist.wordpress.com/2010/04/25/turf-wars/.

Nurse Practitioners Seek to Fill Primary Care Practitioner Gap

Editorial Note: The following article appeared in the April 19, 2010, edition of the free online newsletter Impact Lab, published by the DaVinci Institute. The text can be found at: http://www.impactlab.com/2010/04/19/28-states-may-expand-authority-of-nurse-practitioners/.

A Family Nurse Practitioner (FNP) is a nurse who performs many duties commonly performed by a physician.

A nurse may soon be your doctor. With a looming shortage of primary care doctors, 28 states are considering expanding the authority of nurse practitioners. These nurses with advanced degrees want the right to practice without a doctor's watchful eye and to prescribe narcotics. And if they hold a doctorate, they want to be called "Doctor." For years, nurse practitioners have been playing a bigger role in the nation's health care, especially in regions with few doctors. With 32 million more Americans gaining health insurance within a few years, the health care overhaul is putting more money into nurse-managed clinics.

Those newly insured patients will be looking for doctors and may find nurses instead.

The medical establishment is fighting to protect turf. In some statehouses, doctors have shown up in white coats to testify against nurse practitioner bills. The American Medical Association, which supported the national health care overhaul, says a doctor shortage is no reason to put nurses in charge and endanger patients.

Nurse practitioners argue there's no danger. They say they're highly trained and as skilled as doctors at diagnosing illness during office visits. They know when to refer the sickest patients to doctor specialists. Plus, they spend more time with patients and charge less.

"We're constantly having to prove ourselves," said Chicago nurse practitioner Amanda Cockrell, 32, who tells patients she's just like a doctor "except for the pay."

On top of four years in nursing school, Cockrell spent another three years in a nurse practitioner program, much of it working with patients. Doctors generally spend four years in undergraduate school, four years in medical school and an additional three in primary care residency training.

Medicare, which sets the pace for payments by private insurance, pays nurse practitioners 85% of what it pays doctors. An office visit for a Medicare patient in Chicago, for example, pays a doctor about $70.00 and a nurse practitioner about $60.00.

The health care overhaul law gave nurse midwives, a type of advanced practice nurse, a Medicare raise to 100% of what obstetrician-gynecologists make – and that may be just the beginning.

States regulate nurse practitioners and laws vary on what they are permitted to do:

- In Florida and Alabama, for instance, nurse practitioners are barred from prescribing controlled substances.

- In Washington, nurse practitioners can recommend medical marijuana to their patients when a new law takes effect in June.

- In Montana, nurse practitioners don't need a doctor involved with their practice in any way.

- Many other states put doctors in charge of nurse practitioners or require collaborative agreements signed by a doctor.

- In some states, nurse practitioners with a doctorate in nursing practice can't use the title "Dr." Most states allow it.

The AMA argues the title "Dr." creates confusion. Nurse practitioners say patients aren't confused by veterinarians calling themselves "Dr." Or chiropractors. Or dentists. So why, they ask, would patients be confused by a nurse using the title?

The feud over "Dr." is no joke. According to a goal set by nursing educators, by 2015 most new nurse practitioners will hold doctorates, or a DNP, in nursing practice. By then, "the doctorate will be the standard for all graduating nurse practitioners," said Polly Bednash, Executive Director of the American Association of Colleges of Nursing.

Many with the title use it with pride.

"I don't think patients are ever confused. People are not stupid," said Linda Roemer, a nurse practitioner in Sedona, Arizona, who uses "Dr. Roemer" as part of her e-mail address.

What's the evidence on the quality of care given by nurse practitioners?

The best U.S. study comparing nurse practitioners and doctors randomly assigned more than 1,300 patients to either a nurse practitioner or a doctor. After six months, overall health, diabetes tests, asthma tests and use of medical services like specialists were essentially the same in the two groups.

"The argument that patients' health is put in jeopardy by nurse practitioners? There's no evidence to support that," said Jack Needleman, a health policy expert at the University of California Los Angeles School of Public Health.

Other studies have shown that nurse practitioners are better at listening to patients, Needleman said. And they make good decisions about when to refer patients to doctors for more specialized care.

The nonpartisan Macy Foundation, a New York-based charity that focuses on the education of health professionals, recently called for nurse practitioners to be among the leaders of primary care teams. The foundation also urged the removal of state and federal barriers preventing nurse practitioners from providing primary care.

The American Medical Association is fighting proposals in about 28 states that are considering steps to expand what nurse practitioners can do.

"A shortage of one type of professional is not a reason to change the standards of medical care," said AMA president-elect Dr. Cecil Wilson. "We need to train more physicians."

In Florida, a bill to allow nurse practitioners to prescribe controlled substances is stalled in committee.

One patient, Karen Reid of Balrico, Florida, said she was left in pain over a

holiday weekend because her nurse practitioner couldn't prescribe a powerful enough medication and the doctor couldn't be found. Dying hospice patients have been denied morphine in their final hours because a doctor couldn't be reached in the middle of the night, nurses told The Associated Press.

Massachusetts, the model for the federal health care overhaul, passed its law in 2006 expanding health insurance to nearly all residents and creating long waits for primary care. In 2008, the state passed a law requiring health plans to recognize and reimburse nurse practitioners as primary care providers.

That means "insurers now list nurse practitioners along with doctors as primary care choices," said Mary Ann Hart, a nurse and public policy expert at Regis College in Weston, Mass. "That greatly opens up the supply of primary care providers," Hart said.

But it hasn't helped much so far. A study last year by the Massachusetts Medical Society found that the percentage of primary care practices closed to new patients was higher than ever. And despite the swelling demand, the medical society still believes nurse practitioners should be under doctor supervision.

The group supports more training and incentives for primary care doctors and a team approach to medicine that includes nurse practitioners and physician assistants, whose training is comparable.

"We do not believe, however, that nurse practitioners have the qualifications to be independent primary care practitioners," said Dr. Mario Motta, president of the state medical society.

The new U.S. health care law expands the role of nurses with:

- $50 million to nurse-managed health clinics that offer primary care to low-income patients.
- $50 million annually from 2012 – 2015 for hospitals to train nurses with advanced degrees to care for Medicare patients.
- 10% bonuses from Medicare from 2011 – 2016 to primary care providers, including nurse practitioners, who work in areas where doctors are scarce.
- A boost in the Medicare reimbursement rate for certified nurse midwives to bring their pay to the same level as a doctor's.

The American Nurses Association hopes the 100% Medicare parity for nurse midwives will be extended to other nurses with advanced degrees.

"We know we need to get to 100% for everybody. This is a crack in the door," said Michelle Artz of ANA. "We're hopeful this sets the tone."

In Chicago, "only a few patients balk at seeing a nurse practitioner instead of a doctor," Cockrell said. She gladly sends those patients to her doctor partners.

She believes patients get real advantages by letting her manage their care. Nurse practitioners' uphill battle for respect makes them precise, accurate and careful, she said. She schedules 40 minutes for a physical exam; the doctors in her office book 30 minutes for same appointment.

Joseline Nunez, 26, is a patient of Cockrell's and happy with her care.

"I feel that we get more time with the nurse practitioner," Nunez said. "The doctor always seems to be rushing off somewhere."

According to an AMA spokesperson, the twenty-eight states where legislation is pending are: AL, AZ, CA, FL, GA, HI, IA, IL, KS, KY, MA, MD, MN, MO, MS, NC, NB, NY, OH, OK, PA, SD, TN, VA, VT, WA, WI, and WY.

Editorial Note: For a commentary on research into the relative value of non-physician practitioners, go to: http://www.jaapa.com/the-relative-value-and-risks-of-nonphysician-health-care-providers/article/167531/.

Non-Profit Dental Clinic Sues Alabama Dental Society Member for Slander

Sarrell Dental Center, a non-profit Alabama corporation that treats children on Medicaid sued a member of the board of the Alabama Dental Society for slander when the society accused of dental center of providing substandard care. Sarrell claims the dental society is jeopardizing care for poor children by trying to restrict the growth and operations of non-profit clinics.

Meanwhile, the University of Alabama at Birmingham, which has the only dental school in the state, withdrew its students from two Sarrell clinics. Sarrell says the school was pressured by private dentists into withdrawing its students.

This kind of dispute – between non-profit dental clinics and traditional private dental practices is not unique to Alabama. According to U.S. Department of Health and Human Services statistics, twenty-six million children in this country lack dental insurance. Still, only 37% of these children are eligible for Medicaid-funded dental care.

Gastroenterologists Don't Fight Sharing Scope

A study reported in March 2010 in the official journal of the American Gastroenterological Association (AGA) concluded that Propofol use is safe for advanced endoscopic procedures administered by properly trained, non-anesthesiologist professionals. Lead author, Sreenivasa S. Jonnalagadda, MD, at the Washington University School of Medicine said "Perhaps the highest-risk patients should be managed by nurse anesthetists trained in advanced airway interventions, whereas lower-risk patients can be safely managed by professionals with less intensive airway training."

In December 2009, the AGA Institute issued a "Position Statement: Non-Anesthesiologist Administration of Propofol for GI Endoscopy," which affirms the view of four gastroenterology and hepatology societies that administration by non-anesthesiologists is safe.

Editorial Note: It is refreshing to see a medical association say that nurses, in this case, nurse anesthetists, and other professionals can safely provide services physicians usually provide, so long as they have specialized training.

AARP Issues Policy Statement on Nursing Scope of Practice

The AARP Board of Directors has updated its policy document in the aftermath of passage of health care reform:

> The package of health care reforms, signed into law by President Obama in April 2010, identifies nurses as critical players in meeting the changing health care needs of Americans. Unquestionably, nurses, especially advanced practice registered nurses (APRNs), can provide much of the care we need. But first, statutory and regulatory barriers at the state and federal levels that prevent scores of nurses from practicing to the full extent of their licensure must be lifted.

The AARP Board of Directors recognized that these legal barriers are short-hanging consumers and recently approved important changes to AARP policy. The updated policy is below and is no available for you to use as a guidepost in determining where AARP stands on scope of practice issues. This policy change allows us to work together to ensure that our members and all health care consumers, especially in underserved settings such as urban and rural communities, have increased access to quality health care.

The AARP policy on scope of practice is as follows:

March 2010

- Current state nurse practice acts and accompanying rules should be interpreted and/or amended where necessary to allow APRNs to fully and independently practice as defined by their education and certification.

- Require training and demonstrated competency (in both speaking and writing) in English as a second language, as appropriate.

Ohio Enacts Patient-Centered Medical Home Pilot Bill

In June 2010, Ohio's Governor signed into law House Bill 198, which authorizes physician practices and advanced practice nurse primary care practices in the state to undertake pilot medical home programs. The medical home model emphasizes primary preventive care. The legislation calls for designating a minimum of four advanced practice nurse-run medical homes in the pilot, which is described in the law as follows:

Sec. 185.02

(A) There is hereby established the patient centered medical home education pilot project. The pilot project shall be implemented and administered by the patient centered medical home education advisory group.

(B) The pilot project shall be operated to advance medical education in the patient centered medical home model of care. The patient centered medical home model of care is an enhanced model of primary care in which care teams attend to the multifaceted needs of patients, providing whole person comprehensive and coordinated patient centered care.

(C) The pilot project shall not be operated in a manner that requires a patient, unless otherwise required by the Revised Code, to receive a referral from a physician in a practice selected for inclusion in the pilot project under section 185.05 of the Revised Code as a condition of being authorized to receive specialized health care services from an individual licensed or certified under Title XLVII of the Revised Code to provide those services.

Sec. 185.03

(A) The patient centered medical home education advisory group is hereby created for the purpose of implementing and administering the patient centered medical home pilot project. The advisory group shall develop a set of expected outcomes for the pilot project.

Editorial Note: The text of HB 128 can be found at: http://www.legislature.state.oh.us/bills.cfm?ID=128_HB_206. Another piece of

legislation is still under consideration in the Ohio legislature (HB 206), which would expand the authority of advanced practice nurses to prescribe certain medications, provided they have the appropriate education and training.

Texas Medical Association Sues over Chiropractor Scope

The latest in a series of lawsuits filed by the Texas Medical Association (TMA) challenging policies of the states' board of chiropractic medicine seeks to roll back the chiropractic board's opinion that chiropractors may diagnose medical conditions. A legal analysis on the case on the Website of the Texas Journal of Chiropractic at http://texasjournalofchiropractic.eznuz.com/article/Featured_News/News_From_the_TCA/TMA_v_TBCE_Does_it_Affect_Me/22678 says:

> The TMA lawsuit against the Texas Board of Chiropractic Examiners seeks to limit the scope of practice of Doctors of Chiropractic. The TMA contends that DCs cannot:
>
> 1) diagnose medical conditions,
> 2) perform electromyography (needle EMG), or
> 3) perform manipulation under anesthesia (MUA).
>
> The Texas Chiropractic Association (TCA) intervened, joining with the Board to demonstrate that the TMA is wrong on all three counts.
>
> With respect to diagnosis, the TMA flat out asserts that "[u]nder Texas law, *only physicians* can diagnose medical conditions." The TMA relies on the fact that the Texas Chiropractic Act, instead of using the term "diagnose," uses the terms "analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body." The TMA's hyper-technical reading of the word "diagnose" ignores the fact that the term has synonyms and that to "analyze, examine, or evaluate" is synonymous with "diagnose." The TMA's position would make it impossible for a DC to treat patients.
>
> With respect to Needle EMG, the TMA also urges that needle EMG is a *diagnostic* tool, that doctors of chiropractic may not diagnose, and that, therefore, doctors of chiropractic may not use needle EMG. The TMA also bases its argument on a highly strained reading of what constitutes "surgery," a reading that would apply a different definition to different practitioners, allowing PTs, for example, to perform procedures that are prohibited to DCs. Needle EMG is simply not "surgery," no matter who performs it.
>
> With respect to MUA, the TMA urges that chiropractic manipulation is somehow magically transformed into a *surgical* procedure when it is performed under anesthesia, administered by an anesthesiologist. The TMA relies on a term that the TMA asserts applies to *chiropractic* manipulation that is included in the surgery section of the CPT. This would open the door to amendments to the CPT that would potentially limit all health care providers simply because the AMA chose to place the procedure under a particular heading, regardless of the true nature of the procedure.
>
> Even if you do not perform Needle EMG or MUA, your practice would be affected if the TMA prevails. **IF THE TMA PREVAILS, THE TMA'S POSITION WOULD MAKE IT IMPOSSIBLE FOR A DC TO TREAT**

PATIENTS WITHOUT AN ORDER FROM A MEDICAL DOCTOR. (Emphasis in original.)

Study Finds No Need for Supervision of Nurse Anesthetists

Researchers Brian Dulisse and Jerry Cromwell of Research Triangle Institute reviewed Medicare data for 1999-2005 and found that there were no increased inpatient deaths or complications in states that have opted out of the requirement that nurse anesthetists be supervised by a physician. The results of their research were published in the journal, *Health Affairs* in August 2010.

Among the central points made in the article:

- In the U.S., 37,000 certified registered nurse anesthetists (CRNAs) administer thirty million anesthetics each year. CRNAs represent two-thirds of anesthetists in rural areas.

- CRNAs and anesthesiologists experience similar classroom and clinical training in anesthesiology.

- When the Centers for Medicare and Medicaid Services (CMS) allowed states to opt out of the supervision requirement, it did so because of a lack of evidence the supervision requirement.

- Of the sample in the study, CRNAs provided anesthesia in 21% of surgeries in opt-out states, but in only 10% of surgeries in non-opt-out states. Solo provision of anesthesia by CRNAs increased over time by five percentage points in both types of states.

On the basis of their research, the authors recommend that CMS allow nurse anesthetists to work independently of surgeon or anesthesiologist supervision without requiring state governments to formally petition for an exemption. The authors anticipate that this would result in more cost-effective care.

IN DEPTH

Coalition for Patient Rights Responds to AMA Scope of Practice Partnership "Modules"

Editorial Note: The Coalition for Patient Rights is a national coalition of more than 35 organizations, representing more than three million licensed and certified health care professionals committed to ensuring comprehensive health care choices for all patients. According to the coalition, it was formed in 2006 in response to divisive efforts by the Scope of Practice Partnership (SOPP), an alliance of medical and osteopathic physician organizations including the American Medical Association (AMA), which aims to limit the scopes of practice of other health care professionals.

The Coalition is comprised of a diverse array of health care professionals, including registered nurses, naturopathic doctors, psychologists, audiologists, physical and occupational therapists, advanced practice registered nurses (certified registered nurse anesthetists, nurse practitioners, certified nurse-midwives and clinical nurse specialists), optometrists and chiropractors.

In this In-Depth Feature, we reprint the Coalition's statement in response to the SOPP's issuance of "modules" characterizing the education and qualifications of ten non-physician health care professions.

CPR Responds to AMA Scope of Practice Modules

The American Medical Association's Scope of Practice Partnership (SOPP) is a divisive effort to restrict the practice of health care professionals who are not doctors of medicine (MDs) or osteopathy (DOs). This effort would limit patients' abilities to choose their health care providers and limit access to safe, high-quality and cost-effective health care. The AMA Scope of Practice (SOP) Data Series includes 10 modules regarding the qualifications and practice of certain health care professionals who are not medical doctors. The Coalition for Patients' Rights (CPR) strongly urges the American Medical Association to withdraw these modules.

The 38 member organizations of CPR believe that a patient's right to access the health care professional of his or her choice is critical to achieving quality health outcomes. The demand for health care services is growing and all professionals must work collaboratively to meet the needs of patients. As policymakers and regulators seek to overhaul our health care system to provide better quality and lower costs, the role of health care providers other than MDs or DOs becomes increasingly important.

CPR's recommendation to withdraw the SOP Data Series modules is based on many concerns, including those related to conflict of interest, inaccuracies, patient access, redundancies and more:

Conflict of interest – It is a fundamental conflict of interest for one professional group to define the scope of practice of another. It is not reasonable for medical physicians to purport that they are seeking to protect patients when

1) there is no credible evidence to suggest that preventing patients from choosing their health care professional would, in any way, improve patient care, and
2) the economic interests of MDs and DOs are intertwined with scope of practice issues. These efforts amount to protecting "turf," and the needs of patients are lost in the discussion.

Inaccuracies – The modules are rife with inaccuracies and misstatements about the training, education and accreditation of health care professionals other than MDs/DOs. These errors have the potential to misinform lawmakers and regulators across the country and negatively impact patient access to care. Further, the modules inaccurately imply that educational requirements for all other professions are deficient, simply because they vary from the education model for MDs and DOs – without providing any evidence or research for this presumption.

Patient access – If the AMA SOP modules are used as intended, policymakers and regulators may draw inaccurate and inappropriate conclusions about the preparation and practice of each profession. If the AMA's efforts ultimately limit patient access to health care professionals who are not MD/DO providers, patients who wish to rely upon these other professionals will be negatively affected. Research has consistently shown quality health outcomes associated with health care professionals who are not MDs and DOs, who often serve patients with limited geographic or economic access to health care and provide services which MDs and DOs are not qualified or able to provide.

Redundancies with existing resources and mechanisms – Accurate, complete information about the education and credentialing of health care professionals

can already be obtained directly from each autonomous professional organization, the authoritative resource on the preparation and practice of health care professionals who are their members. This makes the modules unnecessary. Policymakers and regulators have ample access to information about each profession's skills and capabilities. Further, each state has an existing regulatory mechanism in place to ensure every health care professional is practicing within an appropriate, legally defined scope of practice. AMA efforts to develop these modules suggest that state policymakers and regulators are inadequate in their role; however, state agencies charged with overseeing scope of practice have been successfully ensuring patient safety for decades.

Divisive spirit – Among the public, policymakers, and providers, there is a clear consensus that our health care system is under stress, the needs of patients are increasing and we urgently need to focus on providing cost-effective care. All health care professionals need to work collaboratively, to share our varied talents and strengths and ensure we can all meet the growing needs of the patient population. Engaging in efforts that divide, rather than unite, the provider community are counter-productive and do not serve our patients' best interests. Patients need the provider community to be united to ensure that, together, we can provide the highest quality care available for the best possible outcomes.

For more information about the Coalition for Patients' Rights, visit www.patientsrightscoalition.org.

PATIENT SAFETY

Lucian Leape on Transparency and Patient Safety

Writing in the March 17, 2010, edition of the Commonwealth Fund's online *Perspectives on Health Reform*, Lucian L. Leape, MD, adjunct professor, Department of Health Policy and Management, Harvard School of Public Health, makes the case that public reporting is an essential ingredient in improving patient safety. His brief is excerpted below. The full text is available at: http://www.commonwealthfund.org/Content/Publications/Perspectives-on-Health-Reform-Briefs/2010/Mar/Transparency-and-Public-Reporting-Are-Essential-for-a-Safe-Health-Care-System.aspx.

Transparency and Public Reporting Are Essential for a Safe Health Care System

What will it take to motivate hospitals to do what we know works to make health care safer? Of the three major approaches to improving patient safety – regulation/accreditation, financial incentives, and public reporting – the most promising is public reporting of performance information and feedback to providers. Transparency is an idea whose time has come and both hospitals and the public will be better off because of it.

Data from a large number of hospitals, gathered by several sources, show wide variations in the incidence of one of the most lethal hospital-acquired complications, central line–associated bloodstream infections (CLABSIs). Compared with the evidence on how to prevent other types of infections – and most other kinds of adverse events – the

evidence on how to prevent CLABSIs is quite strong. Peter Pronovost demonstrated the potential for complete elimination of central line infections in his intensive care unit at Johns Hopkins Hospital seven years ago. In 2005, in a stunning display of generalizability, Pronovost and his team taught staff in over 100 Michigan hospitals to implement his protocol for central line insertion, and 68 hospitals completely eliminated CLABSIs for six months or more.

Yet, we still have significant rates of CLABSI in most hospitals, and some are very high. What is going on? What is going on is that the vast majority of hospitals have not implemented the Pronovost protocol because they have not made a meaningful commitment to reducing preventable injuries, much less eliminating them…

What will it take to motivate hospitals to do what we know works to make health care safer? Evidence is available on the effectiveness of three major approaches: regulation/accreditation, financial incentives, and public reporting of performance and feedback to providers.

Regulation and Accreditation

Because regulation is a state function, and there is tremendous variation in state approaches to quality and safety, its use has been spotty. Information from reporting systems, for example, is seldom used by regulators to improve safety. Although licensing functions are usually supported with public funds, state departments of public health seldom have the resources to monitor hospital practices. Given cost constraints and inertia, this situation seems unlikely to change in the near future…

Financial Incentives

Using the reimbursement system to improve quality of care has been in vogue for a decade or more. Incentives are usually positive: payment of a bonus as a percentage of reimbursement – 2% in the Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration – although rewards are sometimes packaged with penalties for underperformers. Rewards tend to be for process improvement, not outcomes. There is some evidence that financial incentives improve compliance with quality indicators (such as use of certain medications following acute myocardial infarction), but little or no evidence of improved outcomes…

Financial incentives for improving safety, on the other hand, are relatively new. In contrast to those for improving quality, which are positive and process-oriented, incentives for safety have been negative and outcome-oriented: instead of receiving a bonus for adhering to a safe practice, providers are penalized for the consequences of not doing so. The focus has been on selected "never events," taken from the list of serious reportable events developed by the National Quality Forum…

Although the stakes for any hospital are small (these are, or should be, rare events), the pushback has been considerable… Evidence that not paying for serious reportable events improves safety is also lacking…

Reporting and Feedback

So far, the most powerful method for reducing preventable injuries has been to require physicians to provide data on their own performance and then provide them with comparisons of their risk-adjusted complication rates with those of

their peers. The Veterans Administration (VA) pioneered this approach in the 1990s with its National Surgical Quality Improvement Program, which has since been adopted and promoted by the American College of Surgeons. Under this program, each hospital's surgical specialty department receives feedback on its risk-adjusted complication and mortality rates, together with a comparison with all of the other (unidentified) surgical departments in the VA system. In response to these reports, below-average units made substantial improvements, leading over several years to system-wide declines in both complication rates and mortality that significantly exceeded the secular trend.

It is reasonable to assume, though as yet unproved, that public reporting of similar types of data would spur hospitals to make greater efforts to reduce adverse events. Hospitals – or the public – can choose the benchmark level they prefer: above average, top decile, or others. But it seems evident that performance reporting works best when all providers participate – as in the VA experience. Thus, reporting has to be mandatory. As Wachter emphasizes, it is essential that the events to be reported are

a) clinically significant,

b) easily measured, and

c) largely if not completely preventable.

Risk adjustment is essential for fair comparisons.

The "benchmark" in safety, of course, should be zero. If it is, then risk adjustment is irrelevant. The hope is that, as it becomes public knowledge that some hospitals are able to eliminate certain types of adverse events, others will be motivated to follow. While a major thrust of the patient safety movement has been to eliminate blaming and shaming of individuals when they make mistakes, for organizations public reporting may be an appropriate use of shaming.

The larger issue here is transparency. From an ethical standpoint, the argument in favor of transparency is straightforward: the public has a vital stake in the outcomes of health care, and therefore it has a right to know how we are doing. (The contrary argument that hospitals and doctors have a right to keep their results secret in order to protect those with bad results is patently untenable.)

From an economic standpoint, Porter and others regard consumer access to full information as a critical element of value-driven purchasing of health care. They contend that consumers can make meaningful choices only if they have complete information. While this formulation is attractive to some economists and policymakers, repeated studies over more than 20 years—going back to the Pennsylvania cardiac surgical scorecards of the 1980s – show that few patients and even fewer doctors pay much attention to this type of information in deciding with whom and where they will receive their medical care.

From the standpoint of improving patient safety, however, transparency is crucial. It is the cornerstone of the cultural transformation that our health care organizations need to undergo to become safe. Transparency is essential within an institution if caregivers are to feel safe in reporting and talking about their mistakes. The free flow of information is essential for identifying and correcting the underlying systems failures. Transparency is also the key to successful

– and ethical – responses to patients when things go wrong. It is the cover-ups that lead to lawsuits. And transparency is essential for accountability, to show the public that the hospital or system responds ethically to its failures. Internal transparency begets external transparency – and vice-versa.

Although most hospitals are still skeptical about being transparent, evidence from a few organizations that have gone public with their bad news shows that it is a win-win. First, transparency motivates caregivers to improve care. Lives are saved. In addition, openness shows that the hospital feels accountable and has nothing to hide, which increases public confidence. Transparency is an idea whose time has come and both hospitals and the public will be better off because of it.

Editorial Note: CAC President, David Swankin, wrote the following letter to Dr. Leape in response to his Commonwealth Fund Brief:

Dear Lucian:

I just read your terrific brief, "Transparency and Public Reporting are Essential for a Safe Health Care System" published online by the Commonwealth Fund. As always, it is well written and makes a convincing case that "…the most powerful method for reducing preventable injuries has been to require physicians to provide data on their own performance and then provide them with comparisons of their risk-adjusted complication rates with those of their peers." I agree completely with your observation that, "The larger issue here is transparency. From an ethical standpoint, the argument in favor of transparency is straightforward: the public has a vital stake in the outcomes of health care, and therefore it has a right to know how we are doing… From the standpoint of improving patient safety, transparency is crucial. It is the cornerstone of the cultural transformation that our health care organizations need to undergo to become safe."

The only quarrel I have with what you wrote is that you dismiss "Regulation and Accreditation" a little more than I think warranted. You write (correctly) "State departments of public health seldom have the resources to monitor hospital practices." While you commend the Joint Commission for being "an effective force for change by requiring hospitals to implement its Patient Safety Goals," you go on to say (correctly) that "However, monitoring safe practices is only a small part of the Joint Commission's activities," and "It seems unlikely that either it (the Joint Commission) or the states will be able to exert pressure to get health care systems to make the quantum changes necessary in hundreds of processes to make health care safe." That leads you to conclude that the best hope for improvement lies in better reporting and feedback.

You may well be correct – certainly that is true in the short run – but as you know better than I do, improving patient safety will take a multifaceted battle plan. So rather than dismiss the limitations of Joint Commission accreditation and regulation by state departments of public health, both need to be *encouraged and pressured* to give monitoring and reporting a higher priority within their existing program responsibilities. Sure it will take more resources; but it will also require both entities to give monitoring and reporting a higher priority *even under* current budget limitations. In many

respects, it is a matter of re-ordering their priorities.

Congratulations again for a much needed commentary.

Pronovost on Patient Safety

Peter Pronovost, the physician Lucian Leape cites in his brief was interviewed in April 2010 by Sarah Klein and Douglas McCarthy of the Commonwealth Fund's newsletter, ***Quality Matters.*** Excerpts from this interview are reprinted below. The full text is available at: http://www.commonwealthfund.org/Content/Newsletters/Quality-Matters/2010/April-May-2010/Q--A.aspx.

Summary: More than 10 years ago, the Institute of Medicine released its landmark report, To Err Is Human: Building a Safer Health System, which estimated that as many as 98,000 people die in the U.S. every year as a result of preventable medical errors. Since then, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, and World Health Organization, among other groups, have actively promoted patient safety. Yet many physicians remain unengaged. Quality Matters asked one of the country's leading experts on patient safety what's holding up progress.

By Sarah Klein and Douglas McCarthy

Introduction

In 2001, Peter J. Pronovost, M.D., Ph.D., a practicing anesthesiologist and critical care physician, outlined a simple protocol to prevent catheter-related bloodstream infections, which kill more than 30,000 patients a year in the U.S. The protocol – which was culled from the recommendations of the Centers for Disease Control and Prevention and other evidence-based literature – became known nationwide as "the checklist" because it suggested physicians follow five steps, including washing their hands, before inserting central venous catheters into patients. Doing so proved remarkably effective. A study of more than 100 Michigan intensive care units that employed the protocol noted a 66% reduction in infections – decline that was sustained over three years. Pronovost estimates that if the same technique were used in every hospital in the U.S., it would save 28,000 lives and $2.3 billion in costs attributed to these infections…

To get results, health care organizations not only have to rigorously measure and report infection rates, they must identify and remove the barriers that prevent clinicians from taking these steps and foster a culture in which nurses feel comfortable questioning physicians who don't follow the protocol. Without an investment in each of these three steps, the protocol is ineffective.

To make this point, Pronovost often asks the following question of hospital leaders who tell him they are using the checklist but seeing their infection rates remain high: "If a brand-new nurse in your hospital were to see the senior-most doctor placing a catheter and not complying with this checklist, would the nurse speak up and would the doctor listen?" The most common response he gets: "I am laughed at, truly laughed at. They say, 'Are you nuts? Of course that wouldn't happen," Pronovost says. "In what other industry would this happen? We have an indisputable standard. Failing to comply with it kills people. Yet we are not comfortable having one worker question another about it? These infections kill more than 30,000 people – the equivalent of a 747 crashing every few days. If the U.S. public knew these

were needless deaths, there would – and should – be a public outcry."

For Pronovost, conversations with hospital leaders about the nature of medical culture help to explain – at least in part – why the U.S. has not made more progress in achieving patient safety goals more than a decade after the Institute of Medicine published *To Err Is Human: Building a Safer Health System*, which suggested as many as 98,000 people die in the U.S. every year as a result of preventable medical errors. *Quality Matters* asked Pronovost what other barriers he's identified as he's traveled the country helping hospitals implement strategies for improving safety and what he thinks it will take to surmount them.

QM: What's your assessment of the country's patient safety efforts to date?

Pronovost: We're not getting very far. I think the reason is our efforts have been competitive rather than cooperative. They have been independent rather than interdependent. And they have been focused on efforts rather than results…

The topic itself is less important than learning how to work together as a U.S. health system to solve a problem. We need to learn how to work together and apply that learning to other areas.

QM: How is the lack of cooperation problematic in your work?

Pronovost: I see it in my work on health care–acquired infections… I'm not alone in that. When the U.S. House of Representatives held hearings on health care–acquired infections last year they noted one of the problems was the federal agencies don't work together. It is striking. It almost takes a broker to get different agencies to work together. We've played that role to some extent when working with the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services, all of which are working together under the leadership of the Dept. of Health and Human Services… Within the states we ask that the quality improvement organizations, the state health departments, and the state hospital associations work together… In some states, this is the first time these groups have talked together, even though they are all working on health care–acquired infections. ***Editorial Note: Notice that he does not mention health professional licensing boards.***

QM: How else does collaboration help combat health care–acquired infections?

Pronovost: When we started this work there was this tension, if you will, about how to measure quality and safety at the national level. There was a difference of opinion about whether we could use different measures than clinicians use at the bedside…

Through the collaboration we came to the conclusion that using central-line associated bloodstream infections as a measure is a better approach (than using discharge data). Everyone is going to use it.

QM: Are there other ways collaboration has advanced your work?

Pronovost: Yes. There was also tension about whether to take a centralized (regulatory) or a free market approach to solving these problems. It's the same tension that we [as a country] are facing with financial reform or education reform. And one of the "aha moments" we had was that is a false choice. It is not an either-or. What we ought to do is

centralize those pieces of this project that are most efficient and effective to do in a centralized way and leave to the market – in other words the individual hospitals and clinicians – to do what they do best, which is innovate. So we said we will centralize the way we measure infections (the CDC did that) and the evidence on how to reduce these infections, but we will encourage local innovation based on local culture. That approach has been remarkably well received.

QM: And how do you encourage interdependence among health care providers, insurers, and others when it is appropriate?

Pronovost: We're working with the Blue Cross and Blue Shield Association to create common incentives for reducing infections… The incentive plan would most likely be modeled on what we did in Michigan, where hospitals were first rewarded for submitting data and then rewarded for demonstrating improvement. Hawaii was the first to pilot test this approach and they loved it. Their CEOs and medical directors are financially incentivized for the infection rates in the hospitals in their states. We also have interdependence within and among hospitals. Clinicians share best practices and implement what works in their area.

QM: What about the third piece? You said you're also concerned that the country has been focused on efforts rather than results. Can you give us some examples of this?

Pronovost: When the U.S. House of Representatives held its hearings they looked at hospital efforts to combat catheter-related bloodstream infections state by state. All 50 states reported that hospitals were using the checklist, but only 11 states reported the hospitals were formally measuring infection rates and none were anywhere near as low as the rates of infection achieved in Michigan. I think it shows, in my own belief, a complete accountability failure. The public does not care whether checklists are used or not; they care about not getting infected.

QM: What else is slowing progress on patient safety?

Pronovost: The lack of a scientific approach to quality improvement. In most quality improvement projects, they average about 60 to 80% missing data. You don't need to be a statistician to say about the only thing I can conclude when I have that little data is that I have a heck of a lot of missing data.

QM: How do you address this in your improvement work?

Pronovost: In Michigan, we sent the hospital CEOs a letters that said, in effect, "If you don't get missing data down, you will be kicked out of the collaborative. Don't waste your or our time."…

QM: So what's the next step in improving patient safety?

Pronovost: I think the public needs to tell us what is of most concern to them. For that we will need research. I wish we had a forum where we could do focus groups around the country, or the ability to get public opinion data or some broader consumer input. But right now, I think the best we can do is to focus on where the preventable harm is occurring. We know how to measure and we have good models for ventilator-associated pneumonia. There are probably 30,000 people that die needlessly from that annually. Catheter-related bloodstream infections and ventilator-associated pneumonia together account for the vast

majority of preventable deaths in the hospital…

I think there ought to be an agency that develops outcomes measures and makes them public. The state-of-the-art of outcome measures is woefully inadequate; most of them are misguided and they are going to misinform the public. That is not a limit of science but a limit of our investment. We have put no money into measurement development. The National Quality Forum (NQF) validates measures but they have little money to develop new measures. The National Committee for Quality Assurance (NCQA) also has measures, and both organizations have helped improved quality and advance measurement. Yet I think we need an organization similar to the U.S. Securities and Exchange Commission that is solely responsible for measuring outcomes. The private sector sets the rules, has accountability, publicly reports outcomes, and encourages private sector analysis. I think NCQA and/or NQF can be that private sector entity, yet I think it needs to be housed in a federal agency with accountability…

QM: What is your opinion of the regulatory agencies, especially at the state level? Are they effective and how does their role need to change?

Pronovost: Regulation is needed in our society because there are some health care organizations that go awry. We need wise regulation to ensure markets compete on truth. Because regulation focuses on finding the bad apple, it is only going to assure the minimum level of quality. Alone it will never produce the high level of quality that the U.S. public wants and deserves. We need regulation, yet we need more.

QM: What about public reporting?

Pronovost: My fear is that the politics of demanding transparency has exceeded our investment in the science of measurement. We are putting data out there now that isn't very informative. Clinicians are, I believe, justifiably pushing back because they are concerned about the accuracy of the data…

National Healthcare Quality Report Shows Few Gains in Safety

The Agency for Healthcare Research and Quality (AHRQ) reports that improvements in patient safety continue to lag. The *National Healthcare Quality Report* and the *National Healthcare Disparities Report* for 2009 released in the spring by AHRQ show little progress in eliminating health care-associated infections.

Rates of post-operative pneumonia improved, but all other indicators either remained the same (bloodstream infections associated with central venous catheters) or became worse (post-operative sepsis increased 8%; catheter-associated urinary tract infections increased by 3.6%; selected infections due to medical care increased 1.6%).

QUALITY OF CARE

Communication Key to Quality Teamwork

Research supported by the Agency for Healthcare Research and Quality (AHRQ) has identified barriers to communication between physicians and nurses in the long-term care setting, which have implications for patient safety. The researchers questioned 375 nurses working in 26 long-term care facilities in Connecticut about collaboration, logistical challenges, professional respect and understanding, and language comprehension.

Twenty-eight percent of the nurses said they felt hurried by the physician while talking on the phone. One fourth of the nurses said it

was difficult to find a quiet location for making a call to a physician. Twenty-one percent said it was difficult to reach the physician they wanted to talk to. Most of the sample of nurses who were interviewed after filling out the questionnaire said it was important to be prepared before placing a call to a physician. They also said that physicians are not always receptive to their calls.

Physician-Pharmacist Teams More Effective Lowering Blood Pressure

Researchers from the University of Iowa found that clinics utilizing physician-pharmacist teams are three times more likely to control patients' blood pressure than clinics that do not have physician-pharmacist teams. Sixty-four percent of the patients at clinics with physician-pharmacist teams were able to achieve blood pressure control compared with 30% of patients at clinics without such teams.

Physicians in the study accepted 96% of the 771 recommendations made by the pharmacist member of the team. The authors conclude that health systems that want to control patients' blood pressure should consider involving clinical pharmacists more closely in managing patients. The research was sponsored by the Agency for Healthcare Research and Quality (AHRQ).

LICENSURE

Governor Vetoes Licensure Legislation

In June 2010, Rhode Island Governor Donald L. Carcieri vetoed two licensure bills. One would have licensed the 13 genetics counselors practicing in the state. The governor vetoed the legislation because it did not contain "conscience protections" for genetics counselors who object to abortion.

The second bill called for a one-year moratorium on new licenses for home care, nursing home and hospice providers. The objective of the legislation was to re-distribute care toward more home and community-based care compared with nursing home care. In his veto message, the governor said he feared the legislation could jeopardize the quality of care.

PAIN MANAGEMENT AND END OF LIFE CARE

Researchers Recommend End of Life Discussion Protocol

Research published in the *Archives of Internal* Medicine (2010; 170(12):1057-1063) recommends systematic measurement of end of life care planning and communication. Lead researcher Anne M. Walling, M.D. and her associates explain in the article's abstract:

> **Background:** Patients in American hospitals receive intensive medical treatments. However, when lifesaving treatments are unsuccessful, patients often die in the hospital with distressing symptoms while receiving burdensome care. Systematic measurement of the quality of care planning and symptom palliation is needed.
>
> **Methods:** Medical records were abstracted using 16 Assessing Care of Vulnerable Elders quality indicators within the domains of end-of-life care and pain management designed to measure the quality of the dying experience for adult decedents (n= 496) hospitalized for at least 3 days between April 2005 and April 2006 at a university medical center recognized for providing intensive care for the seriously ill.
>
> **Results:** Over half of the patients (mean age, 62 years; 47% were women) were admitted to the hospital with end-stage disease and 28% were 75 years or older. One-third of the patients required extubation from mechanical ventilation

prior to death, and 15% died while receiving cardiopulmonary resuscitation. Overall, patients received recommended care for 70% of applicable indicators (range, 25% – 100%). Goals of care were addressed in a timely fashion for patients admitted to the intensive care unit approximately half of the time, whereas pain assessments (94%) and treatments for pain (95%) and dyspnea (87%) were performed with fidelity. Follow-up for distressing symptoms was performed less well than initial assessment, and 29% of patients extubated in anticipation of death had documented dyspnea assessments.

Conclusion: A practical, medical chart-based assessment identified discrete deficiencies in care planning and symptom palliation that can be targeted to improve care for patients dying in the hospital.

CONTINUING COMPETENCE

Physical Therapy Board Association Publishes Model for Continuing Competence

In its April 2010 issue of *Federation Forum*, the Federation of State Boards of Physical Therapy published a "Model for Continuing Competence." The model has two requirements:

- Each licensee must obtain a minimum of 30 Continuing Competence Units (CCUs) from either certified or approved activities in a two-year renewal period.
- At least 15 CCUs must be obtained by taking certified activities.

The model has four guiding principles:

- Continuing competence should be self-directed
- Licensees should use the results of an evaluation or assessment to select appropriate development activities
- There is no one "right way" to demonstrate competence
- Licensees may choose either certified or "approved" activities, but the number of approved activities is limited because the approval process for them is not as rigorous as it is for certified activities.

Explaining the rational for shifting from continuing education to continuing competence, the model says:

> Most people would argue that there are a number of ways to maintain competence in the field of physical therapy. Truthfully, there are probably as many different pathways to professional continued competence as there are professionals. Currently, however, most jurisdictions approve, based solely on the parameter of time, just a few activities. Any states just have one approved option, traditional continuing education. Continuing education has a place in a continuing competence plan. It is an option; it's just not, and should not, be the only option. Making the leap from CEUs to CCUs is an opportunity for jurisdictions to have more meaningful continuing competence requirements while allowing the licensee to reflect on a career path, self assess strengths and weaknesses, and develop a personalized plan of achievement.

Two key differences between continuing education and continuing competence are the way value is measured and the breadth of activities that qualify. In a traditional continuing education model, value is measured by the time spent attending the course. A continuing competence model calls for valuing activities on a variety of factors beyond time. In a traditional continuing education model, the only activities that are approved are those that follow standard classroom or online classroom structures. A continuing competence model allows for a number of activities including residencies, fellowships, assessment tools, specialty exams, and research, as well as traditional continuing education opportunities. Paired with self reflection and assessment by the licensee, a host of different activities can be linked together to create a comprehensive plan for continued competence.

The entire text can be found at: https://www.fsbpt.org/download/Forum_Spring2010_CCModel.pdf.

Occupational Therapy Self-Assessment Tools Online

The National Board for Certification in Occupational Therapy (NBCOT) offers a series of free online self-assessment tools "to empower certificants of all levels of experience to engage in critical self-reflection with the ultimate goal of assessing current levels of proficiency within the domains of occupational therapy practice." As explained in the Spring/Summer issue of *NBCOT Certification Matters*, each self-assessment tool corresponds to a validated domain and task statement from NBCOT's practice analysis.

There are self-assessment tools for seven practice areas: general practice, geriatrics, physical disabilities, mental health, pediatrics, orthopedics, and community mobility. Upon completing the tool, certificants receive a score report and links to applicable professional development resources.

More information is available at www.nbcot.org.

DISCIPLINE

Beefed Up Enforcement Legislation Defeated in California

Legislation intended to address criticisms of California regulatory boards, especially the Board of Registered Nursing which lost its executive director and several board members last year in the wake of an expose by *Pro Publica* and *The Los Angeles Times* died in committee in April, 2010. The legislation would have standardized the disciplinary process beefed up investigative staff for the state's health professional licensing boards.

Opposition to the legislation was led by the California Nurses Association and the Service Employees International Union which objected especially to a provision common in other states that would have required employers to report to boards when they fire or dismiss employees for wrongdoing. Only two members of the legislative committee considering the bill actually voted. The bill's sponsor voted aye; one other legislator voted nay; the other four legislators who were present declined to vote, effectively killing the bill.

Florida Posts Some Complaints Online

The Florida Department of Health began in April posting the information online about complaints against health care professionals. Complaints remain confidential during the investigation phase, but ten days after a board committee finds probable cause, a complaint becomes public.

PUBLIC INFORMATION

California Physicians Required to Tell Patients They Are Licensed by the Medical Board

March 29, 2010, the California Medical Board approved a regulation requiring doctors to notify their patients that they are licensed and how to contact the board. The board's announced its decision in a press release:

Sacramento – Effective June 27, 2010, physicians practicing in California must inform their patients that they are licensed by the Medical Board of California, and include the Board's contact information. The information must read as follows:

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

This requirement is the result of a regulation (Title 16, California Code of Regulations section 1355.4) approved by the Medical Board, as mandated by Business and Professions Code section 138. The purpose of this new regulation is to inform consumers where to go for information or with a complaint about California medical doctors.

"The Medical Board's mandate is public protection, and this new requirement will assist patients by directing them to our Web site and our call center, where they can access very basic yet important information about our public services," said Medical Board President Barbara Yaroslavsky. "And it will take very little effort for physicians to comply."

Physicians may provide this notice by one of three methods:

- Prominently posting a sign in an area of their offices conspicuous to patients, in specified type.
- Including the notice in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file.
- Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in specified type.

The three options are designed to serve a multitude of practice settings, including emergency departments, skilled nursing facilities, and surgical settings.

Editorial Note: CAC News & Views finds it unfortunate that the board included the second option in the regulation because there is a strong chance that patients will overlook or forget the message that is placed in their file at the physician's office. We fear that for this reason, most California physicians will choose option two.

Congress Considers *Health Care Transparency Act*

In May 2010, the *Healthcare Truth and Transparency Act* (H.R. 5295) was introduced by Congressman John Sullivan (R-OK) and David Scott (D-GA). The bill would require healthcare practitioners to include their full credentials in advertising and prohibit non-physician healthcare practitioners from misleading their patients about their credentials.

In support of the measure, the AMA and its Scope of Practice Partnership (SOPP) commissioned a survey which found that 93%

of the public supports having medical professionals clearly state their education, training and licensing in advertisements. The survey also found confusion about who is and who is not a doctor.

Non-physician health care professions see this legislation as part of the AMA's and SOPP's efforts to thwart their ability to practice to the full extent of their training and qualifications. (See the SCOPE OF PRACTICE section in this issue). The Coalition for Patient Rights, representing several non-physician professions, posted this on its Website:

> **Coalition for Patients' Rights Opposes Unnecessary Regulation of Valuable Health Care Providers**
>
> ***Proposed Legislation Creates More Bureaucracy and Fails to Address Underlying Issue of Patient Education***
>
> WASHINGTON – The Coalition for Patients' Rights (CPR) today announced its opposition to the Healthcare Truth and Transparency Act (H.R. 5295) which would needlessly impose federal trade laws on qualified health care professionals and add another layer of bureaucracy to the health care system.
>
> "This is bad legislation wrapped in feel-good language," said Karen Howard, a spokesperson for CPR. "As health care professionals, we want patients to understand who is providing their care and what their qualifications include. But H.R. 5295 doesn't accomplish this; instead it would only create another obstacle to prevent patients from obtaining the quality health services they need."
>
> This legislation is considered by many care providers to be unnecessary and duplicative, as laws already exist in every state making it illegal for health care professionals to misrepresent their licensure, credentials, training, education, or clinical expertise to patients. "With so many other priorities in health care, it's wasteful for Congress to be working to pass a law that already exists across the country," said Howard.

Furthermore, Coalition experts warn that many provisions in this bill are vague and could easily be used as a political tool against specific health care professionals who are fully licensed and educated to provide important care for patients. Unfortunately, efforts are underway by organized medicine to restrict the services provided by health care professionals who are not doctors of medicine (MDs) or osteopathy (DOs). This legislation is a likely output of a movement coordinated by the Scope of Practice Partnership (SOPP), a group of medical and osteopathic physician organizations established by the American Medical Association (AMA) and other medical groups, that aims to limit other health care professionals' scopes of practice. Scope of practice refers to the range of health care-related activities and services that professionals are educated, licensed and/or certified to provide.

The Coalition for Patients' Rights – which consists of professional organizations representing providers such as naturopaths, occupational therapists, advanced practice registered nurses and psychologists – believes that a cooperative effort to educate patients about their health care providers is the key to reducing confusion over whether they are or are not MDs or DOs. To that end, CPR is working to help consumers understand who they can turn to for various health concerns. Additionally, information about every provider group in the Coalition, including training and licensing, is freely available on the

website of each CPR member organization.

"We're proud of our skills and the care we provide, and believe patients are able to choose the professionals who best meet their personal needs. Putting the Federal Trade Commission in the middle of communications between health care professionals and their patients doesn't do anything to enhance patient care," said Howard.

Health care providers who are not MDs/DOs have extensive training and complete years of education in their respective specialties. Additionally, they meet rigorous licensing and certification standards, and care for tens of millions of patients each year in the United States.

The text can be found at: http://www.patientsrightscoalition.org/Media-Resources/News-Releases/Transparency-Act.aspx.

Editorial Note: Legislation under consideration in California would require physicians to inform patients whether they are certified and by which specialty board. This legislation was inspired in part by problems with cosmetic surgery, including liposuction, which any licensed physician is authorized by law to perform, regardless of specialty.

Update: California Pharmacy Board Ignores Comments by Patient Advocates

The California Board of Pharmacy acceded in April 2010 to the wishes of industry by allowing pharmacy labels in smaller type. Consumer organizations and advocates argued for larger type – sending in more pages of comments than on any other proposed pharmacy board action.

Editorial Note: See CAC News & Views 1st Quarter 2010 - Volume 22 Number 1 for CAC's comments on the proposed rule.

IMPAIRED PRACTITIONERS

California Stiffens Rules on Chemically Dependent Practitioners

In the aftermath of a newspaper expose of the failings of the Board of Nursing's impaired practitioners' program and the decision by the Medical Board of California to terminate its program for chemically dependent physicians, the legislature created a committee to develop tougher standards for impaired practitioner programs operated by all of the state's health professional boards. The new standards were announced by press release in November, 2009:

Stronger patient protection efforts were launched this week by the Department of Consumer Affairs (DCA), which continued to follow the Governor's directive to overhaul healthcare boards' investigations and professional practice programs by announcing key standards to monitor substance-abusing licensees, and dedicating a senior executive to improve and strengthen all of DCA's enforcement programs.

Established by SB 1441, the DCA created a Substance Abuse Coordination Committee, charged with developing consistent, uniform standards to monitor and regulate licensees with substance abuse problems to ensure the highest standards of consumer protection. The committee, chaired by DCA Director Brian Stiger, was comprised of representatives of all healthcare related boards, and a representative of the California Department of Alcohol and Drug Programs. The Committee's standards will be submitted to the

Legislature, per statutory requirement, before the end of 2009. SB 1441 requires all healing arts Boards to adopt the standards through their own regulatory processes, regardless of whether a Board already operates a substance abuse diversion program.

The new standards:

- Allow the quick removal from practice of licensees who pose a danger to consumers;
- Require that any substance abuse treatment vendor report licensee noncompliance within one day;
- Institute worksite monitoring for licensees who are in a diversion program but who are deemed safe to practice;
- Allow employers and the public to know if a diversion program participant's license is inactive or possesses restrictions; and
- Grant Boards the ability to communicate with a licensee's employer regarding their diversion program participation.

Implementation of the standards will be overseen by Paul Riches, who has been named Deputy Director for Enforcement and Compliance. Riches most recently served as Executive Officer of the Board of Behavioral Sciences, where he has used innovative strategies to cut the amount of time Board staff required to complete an investigation by more than 50%. The Deputy Director will partner with DCA Director Brian Stiger to oversee all enforcement programs for all of the department's boards and bureaus, with a focus on reducing enforcement timeframes for all healing art boards.

"These new standards, and Paul's new role as Deputy Director for Enforcement and Compliance, are major components of the enforcement reforms I have initiated," said DCA Director Brian Stiger. "These standards will go a long way towards creating substance abuse diversion programs that are consistent, effective, and will ensure the public is protected, not the licensee."

Other standards developed by DCA's Substance Abuse Coordination Committee address specific substance abuse testing requirements, ensuring that licensees who are confirmed to be drugs and/or alcohol abusers, and who pose a risk to the public, are not diverted from an enforcement action or public disclosure of that action.

Nursing Journal Reports on Chemical Dependency Programs

Volume 1, Issue 1 of the *Journal of Nursing Regulation (April 2010)*, the official journal of the National Council of State Boards of Nursing, includes an article entitled "Nurses with Chemical Dependence: Successful Treatment and Reentry." Written by Daniel Angres, M.D., Kathy Bettinardi-Angres, MS, APN, RN, CADC, and Wally Cross, Rph, MHS, CADC, the article looks at experience in each phase of chemical dependency treatment: identification and intervention, post-intervention referral options and practices, treatment, contracts with employers, continuing care, and reentry into the workplace.

The authors conclude that, "Treatment is more likely to bring long-term success if the nurse enters a specialized program for health care professionals, followed by a strict aftercare program."

ROLE OF THE PUBLIC MEMBER

The Public Member: A Significant Presence in Professional Licensing

Editorial Note: The following article by public member, Reverend O. Richard Bowyer, appeared in the West Virginia Board of Medicine Quarterly Newsletter, vol. 14 No 1:

> Although generally common today, the phenomenon of selecting public, lay or consumer members to serve on professional licensing boards is a rather recent reality. In many cases the initial appointments were often virtually mere tokens, usually one layperson on a board of perhaps as many as 12 or more. As the value of such persons became increasingly known, the number of such appointments also tended to increase.
>
> During the dynamic decade of the 1960s various social movements began to clamor for consumers to serve on various boards of directors, especially in the non-profit arena. Federal agencies and other funding bodies began to require such inclusiveness as a condition of grant recipients. But for professional licensing boards, the inclusion of laypersons was often legislatively driven.
>
> My personal experience has been in two areas: The Board of Medicine and the Lawyer Disciplinary Board. In West Virginia, the Board of Medicine is established by State Code, while the Lawyer Board is appointed through the State Bar and its disciplinary actions enforced by the Supreme Court. In both instances, those who serve as public or lay members play a very significant role. Even so, a newly appointed layperson often is unsure of her or his role and opportunities to make special contributions to the process of licensing and discipline.
>
> It must be recognized that the status of a layperson is the same as that of any professional person on the board. Certain things are, or should be, obvious. Most important is the fact that a layperson is not and should not be expected to be qualified to offer judgments on matters that require professional knowledge and competence. There will be matters that have technical implications that the layperson need not know nor understand. However, many of the matters before the board will benefit from other competencies and experience. I have found that with both lawyers and doctors there are issues that appear differently to the eye and from the experience of a layperson. A layperson may perceive waiting time or what the professional may consider to be an appropriate comment quite differently. Quite often there are ethical questions and considerations or matters of common courtesy that need to be addressed.
>
> A layperson may or may not bring experience in dealing with the particular profession in any capacity than as a recipient of services. But she or he may have experience serving on other boards and therefore have clear understanding of procedural protocols such as parliamentary rules. When the particular professional board has concerns to be presented to the Legislature of a State, the lay voice may carry particular weight and influence.
>
> It is very important for the layperson to understand the public tendency to view professional licensing boards to be protectors of the profession. Although in agencies established by legislation, such as a Board of Medicine, it is clearly articulated that its primary responsibility

is to protect the public; there are those who assume that with a majority of the board being members of the profession, they will think first of its well being. But professionals in any field who understand the role they play in society know that the public or the patient should be and must be their primary consideration. It is essential for a layperson to know and understand the primary role of the board and to challenge any situation that might in reality or perception stray from that purpose.

There are, or there are likely to be, situations in which members of the profession perceive a given matter as being in the public's best interest, when the layperson has a different view. It is essential that the layperson speak up and articulate his or her experience, knowledge or personal perception. In a recent training session of the board of directors of a community mental health agency provided by an auditor, the auditor stressed that the most important thing a board member can do is ask questions. That may not necessarily be the case in professional licensing and disciplinary matters, but appropriate questions can be very helpful in making decisions or recommendations. In fact, there may occasionally be a professional member of the board who is not accustomed to having his or her views questioned especially by someone outside the profession. A timely and intelligent question from a layperson may be a significant teaching moment for both parties. Especially in matters of discipline the layperson may offer an insight into the complaint and raise a question that reflects his or her personal experience in a similar situation.

There are other situations in which a clear statement or thoughtful question can be very helpful. Even with legal documents and procedures, the layperson may offer a perspective that can be quite beneficial. In formal or official letters or statements, a lay viewpoint may be quite significant. When reviewing drafts of documents or formal statements, the eye less familiar with the technical language may very well catch a spelling or grammatical error.

It is essential that the layperson, no less than any professional member, recognize that all statements and public expressions of the board must be made only by the person or persons authorized to speak on behalf of the board. Actions are board actions and whatever has been decided or deter- mined by the majority of the board is the official action or position of the board. Disagreement may be quite appropriately expressed in the process of reaching a decision or determining an action. But once made, that action is official and disagreement is seldom appropriate to express outside the board. In most cases, board meetings are likely to be conducted in public or open session.

No less than professional members of the board, a layperson may occasionally have a conflict in a matter. For example if it involves a professional who has provided services to the layperson in normal circumstances, or if the professional happens to be employed or engaged by an agency for which that layperson is a board member, a conflict should be declared and the layperson recused from the action.

Membership on a professional licensing board is not only a notable honor, it is an opportunity to con- tribute significantly both to the profession the board represents, and even more to the public that profession exists in order to serve.

SPOTLIGHT

Physical Therapy Boards Respond to Security Breach

This Quarter's Spotlight shines on the Federation of State Boards of Physical Therapy (FSBPT) for taking decisive action to deal with a security problem affecting the National Physical Therapy Examination (NPTE). The following excerpts from an FSBPT *Newsflash* explain the situation and the corrective actions that were taken. ***CAC News & Views*** congratulates the FSBPT for acting decisively to protect the integrity of its exam.

> **Federation Newsflash:**
>
> **FSBPT suspends NPTE Examination for all graduates of certain overseas programs**
>
> **July 12, 2010**
>
> In response to pervasive, ongoing security breaches by significant numbers of graduates of physical therapy schools from certain foreign countries, the Federation of State Boards of Physical Therapy (FSBPT or Federation) will suspend National Physical Therapy Examination (NPTE) testing for all graduates of schools located in those countries, pending the development of a separate, secure exam for those graduates (to be called the NPTE-YRLY). The affected individuals will include all graduates of physical therapy schools in Egypt, India, Pakistan and the Philippines…
>
> Testing will resume once development of the NPTE-YRLY has been completed. The Federation expects to launch the NPTE-YRLY in or about the fall of 2011. Currently, the Federation intends to offer the NPTE-YRLY once per year, at select test sites to be identified at a later date…

This necessary security measure is in response to compelling evidence gathered by the Federation reflecting systematic and methodical sharing and distribution of recalled questions by significant numbers of graduates of programs in the affected countries, as well as several exam preparation companies specifically targeted to these graduates. This evidence was obtained through extensive forensic analyses of exam performances, as well as a variety of legal actions brought by the Federation in the United States and abroad… (T)he Federation is pursuing criminal copyright prosecution against St. Louis Review Center and its owners, has invalidated the scores of several individuals believed to have unfairly benefitted from advance access to test questions, and has removed the compromised items from the exam.

The Federation's ongoing investigative efforts have revealed that the sale and sharing of recalled test questions extends beyond this single test preparation company, and that the sharing of test items has continued despite its past efforts to ensure the security of the exam. "The National Physical Therapy Examination is a key element in assisting jurisdiction licensing boards and the Federation in assuring the public that licensed physical therapists and physical therapist assistants are competent and safe practitioners. We view the security of the NPTE as the highest priority in our mission of public protection and, therefore, have used the best forensic and investigative techniques available to identify the problem and the perpetrators. Given the pervasive and continuing use of electronic technologies by graduates of these schools and some examination preparation companies – in spite of the harsh penalties imposed by the Federation – we believe that the NPTE-

YRLY is the best solution to ensure the validity of all NPTE test results," stated Federation President E. Dargan Ervin. "The Federation recognizes the significant consequences of this policy decision, but feels that it needs to be made clear to all candidates that the Federation will not tolerate security breaches. We will continue to use and add security measures to protect against possible future breaches and will not hesitate to add other groups to the list restricted to the NPTE-YRLY if we obtain sufficient evidence that members of additional groups may be obtaining an unfair advantage on the NPTE or otherwise jeopardizing the integrity of the exam."…

LETTERS

Editorial Note: CAC received the following communication from Board Member, Carol Cronin. We are pleased to share it with readers of CAC News & Views because we think you will be interested in checking on the consumer information publications on the IPI Website.

Dear Colleague,

Given your involvement in consumer quality issues, I thought you would be interested in recently completed work that addresses what patients and family members should do if they have a concern about quality. The following three briefs are available both online and as pdfs in the "What's New" section of the Informed Patient Institute (IPI) website at www.informedpatientinstitute.org:

- What to Do if You Have a Concern about Quality in a California Hospital
- What to Do if You Have a Concern about Quality in a California Nursing Home
- What to Do if You Have a Concern about Quality in a California Physician's Office

The California HealthCare Foundation funded the development of the briefs which includes both California-specific and national information. The Foundation will be integrating this information separately into their consumer-facing websites. IPI is planning to replicate this work in other states and eventually to provide nationwide information about what patients, consumers and family members should do if they have a concern about quality.

Also available on the IPI website is information about the best nursing home and physician report cards in every state.

Please feel free to link to this information or pass it on to others that might be interested.

Thank you.

Carol Cronin
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Informed Patient Institute
Annapolis, MD
410-268-0189
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www.informedpatientinstitute.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.

MEMBERSHIP ENROLLMENT FORM

TO BECOME A CAC MEMBER ORGANIZATION, PLEASE COMPLETE THIS FORM AND SEND IT TO:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

Name:		
Title:		
Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

PAYMENT OPTIONS:

1) Mail us 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;

Purchase Order Number:

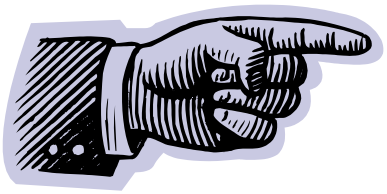
Or

4) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

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

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

Name of Agency:	
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1) Make a check payable to **CAC** for the appropriate amount;
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4) Complete the following form if paying with Visa, MasterCard, or American Express:

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Expiration date and Security Code:	
Billing Address:	
City, State, Zip:	
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Our Federal Identification Number is 52-1856543.

REGISTRATION FORM

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". TO REGISTER, PLEASE COMPLETE THIS FORM AND SEND IT TO:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

Name:		
Title:		
Organization or Board:		
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PAYMENT OPTIONS:

1) Mail us 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;

Purchase Order Number:

Or

4) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

	Early Bird (before Oct. 11, 2010)	**(after Oct. 10, 2010)**
Registration fee:	☐ **$345.00**	☐ **$395.00**
Registration fee for CAC Member Organizations:	☐ **$295.00**	☐ **$325.00**

(If you're not sure whether you are affiliated with a CAC member organization, please refer to our 2010 member list at http://www.cacenter.org/files/members.pdf.)

CANCELLATION POLICY

100% refund if cancelled before October 11, 2010.
50% refund if cancelled between October 11, 2010, and October 26, 2010.
NO REFUND if cancelled after October 26, 2010.