News & Views

Citizen Advocacy Center

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Save The Dates!

Citizen Advocacy Center's 2013 annual meeting will be held in Seattle, Washington, on Tuesday and Wednesday, October 29-30, 2013.

CAC is now a membership organization *and we invite your board to join. More information is at* http://www.cacenter.org/cac/membership.

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MEDICAL ERRORS AND PATIENT SAFETY

Office of the Inspector General Says Hospital Incident Reporting Systems Fall Short

Editorial Note: This item is based on a report issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services in January 2012. (Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, OEI-06-09-00091). The OIG reports that hospital workers report only about 14% of incidents of patient harm. Why should this concern licensing boards and certifying bodies? It is well known that reports from colleagues in healthcare systems more often lead to disciplinary action than

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consumer complaints or reports from other sources.

Many states have mandatory reporting laws that require hospitals and fellow professionals to report to licensing boards instances of patient harm and adverse actions taken by employers against healthcare workers. But many hospitals never file reports of suspensions or other penalties and regulators are not receiving reports of the volume and quality one would expect. This OIG report shows that even hospital leadership does not know about the vast majority of adverse events in their institutions, so it is not possible for this information to find its way to licensing authorities and other regulators, even if hospitals were dutiful about conforming with reporting requirements. It is noteworthy that this study examines whether incident reports lead first to investigations and subsequently to changes in hospital policy or practices. Hospital authorities interviewed by the OIG were concerned about whether an incident represented a systemic problem within the hospital. The study is not concerned with whether incident reports do or should result in reports to regulatory authorities.

The objectives of the OIG's study were to describe how hospitals use incident reporting systems and incident reports, to determine the extent to which hospital incident reporting systems capture patient harm, and to determine the extent to which accreditors review incident reporting systems as part of their assessments. Hospitals must track and analyze instances of patient harm as a condition of participation in Medicare. OIG research published in 2010 found that 13.5% of Medicare beneficiaries experienced an adverse event during their hospital stay that resulted in prolonged hospitalization or permanent disability, or required life-sustaining intervention. Another 13.5% of beneficiaries experienced adverse events that required treatment, but resulted in only temporary harm. For this report, the OIG returned to the hospitals surveyed in 2010 and interviewed hospital administrators and representatives of accreditors.

These are the OIG's findings:

All sampled hospitals had incident reporting systems to capture events, and administrators we interviewed rely heavily on these systems to identify problems. All 189 hospitals surveyed have systems to capture instances of patient harm. The OIG interviewed risk managers, patient safety officers, and/or quality improvement specialists at 34 hospitals. These individuals (referred to collectively in the report as "administrators") acknowledged that incident-reporting systems fail to reveal how frequently incidents occur, but they still rely on the reporting systems because they value staff accounts of events. Administrators said hospital staff is encouraged to report all instances of patient harm, and is given some instruction as to what that means. None of the hospitals, however, maintains a list of reportable events.

Administrators expressed concern that underreporting can affect patient safety efforts by potentially skewing resources toward prevention of more easily identifiable occurrences

that happen at a point in time (such as patient falls) rather than complex events that occur over a longer period and are more difficult to detect (such as blood clots).

Hospital staff did not report 86% of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm. Reporting systems captured only about 14% of adverse events experienced by Medicare beneficiaries discharged in October 2008. Administrators told the OIG that their staffs failed to report events because they did not perceive them to be reportable (62% of all events), or they neglected to report in this particular case, even though they knew the event was reportable (25%).

…hospital staff reported only 2 of the 18 most serious events in our sample (i.e., those events that resulted in permanent disability or death). Serious events not captured by incident reporting systems included hospital-acquired infections, such as a case of septic shock leading to death; and medication-related events, such as four cases of excessive bleeding because of the administration of blood-thinning medication that also led to death. Incident reporting systems did not capture any of the five NQF (National Quality Forum) Serious Reportable Events and only one of the eight Medicare HAC events in our sample. Medicare does not require hospitals to capture information about these events through incident reporting systems. However, because events on the NQF and Medicare HAC lists are widely recognized among medical professionals as constituting patient harm, many among the public and in the health care community may expect them to be reported by hospital staff.

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Administrators posited several reasons why staff might consider that an event did not need to be reported:

- Event was not caused by a perceptible error
- Event was an expected outcome or side effect
- Event caused little harm and/or harm was ameliorated
- Event was not on hospital's mandatory reporting list
- Event occurs frequently in hospitals
- Event symptoms because apparent after discharge
- Event occurred in patient with a history of similar events

Nurses most often reported events, typically identified through the regular course of care; 28 of the 40 reported events led to investigations, and 5 led to policy changes.

Nurses reported 31 of the 40 reported events. Hospitals conducted investigations into 2/3 of the reported events, although there were few changes in hospital policies or practices.

> The hospital administrators we interviewed reported that they investigated and analyzed 28 of the 40 events for evidence of system failures or medical errors to inform quality and safety improvement activities… Hospital administrators reported that they did not investigate the remaining 12 events because they suspected that the events were isolated incidents unlikely to recur… The most common type of investigation was a clinical review of a single event, but hospital administrators reported that they regularly analyze events in aggregated event reviews… These clinical reviews were similar to root cause analyses but contained less detail and used fewer resources. The most frequently discussed questions during these clinical reviews included whether staff correctly assessed patients before treatment began; whether the attending physicians; and what contributing factors led to the event, such as a medication mislabeling or poor communication during shift changes, met the standard of care.
>
> **Hospitals made few changes to policies or practices as a result of the reported events.** Hospital administrators reported that only 4 of the 40 sample incident reports led to a hospital policy or practice change. Two of these events led directly to changes in hospital policy or practice, and staff included the other three in an aggregate event review that led to changes. According to administrators, the remaining 35 reported events did not result in a policy or practice change primarily because hospitals reviewed the event information and determined that the occurrences did not represent systemic quality problems within the hospitals… In other cases, hospital administrators reported that they may already have procedures in place to avoid a specific type of event. For example, hospitals may use special pressure-reducing mattresses and have rigorous policies and training regarding patient turning, yet still see some pressure ulcers develop.

Hospital accreditors reported that in evaluating hospital safety practices, they focus on how event information is used rather than how it is collected. The three accrediting agencies interviewed by the OIG all indicated that they require hospitals to track adverse events as part of safety improvement efforts. Their surveyors do not, however, evaluate the mechanisms hospitals use for event tracking unless they have reason to believe there is a problem with those mechanisms.

Accreditors cited a number of reasons their surveyors do not scrutinize incident reporting systems or other event detection methods during hospital surveys.

Accreditors cited a number of reasons their surveyors do not scrutinize incident reporting systems or other event detection methods during hospital surveys. Most of the reasons rested on the perception that event detection methods are complex and varied. First, hospitals collect event data from a variety of sources, and it can be difficult to discern which information is from a report and which is from a surveillance record or medical record review. Second, surveyors may not have the expertise to assess the reporting mechanism itself and provide recommendations to improve reporting. Third, officials questioned the value of requiring hospitals to collect event information in a particular way, arguing that a prescribed approach may inhibit innovation. Given this, some officials reasoned

that it was better to focus on the output than on the systems, but they conceded that this lack of focus on how hospitals collect event information meant there was little scrutiny of the reporting systems' event data that hospitals use to inform their patient safety improvement efforts.

The report concludes with two recommendations directed at the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), which are in a position "to provide guidance and incentives for hospitals to more effectively track and analyze adverse events."

The OIG recommends:

AHRQ and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals in using the list.

Hospital administrators reported that the most common reason hospital staff do not report patient harm is that they do not perceive the harm as a reportable event. As such, hospital efforts to improve patient safety may be limited by focusing on only a small subset of events that get more attention because they are more often reported by staff… (T)he list of events would educate hospital staff about the full range of patient harm that occurs in hospitals and should be reported to incident reporting systems. The list should go beyond the fairly rare harm events included in the NQF and Medicare HAC lists and include a comprehensive range of possible patient harm.

CMS should provide guidance to accreditors for assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs.

CMS is testing draft interpretive guidelines for surveyors … including guidance about how surveyors are to assess hospital operations for tracking patient harm… (W)e recommend that this guidance include information about how surveyors should assess hospital event collection efforts, including incident reporting systems, and should include the list of potentially reportable events…CMS should also suggest that surveyors evaluate the information collected by hospitals and compare it to the data elements of AHRQ's Common Format event reporting tools… Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event identification and tracking. *Given the low reporting rates and lack of assessment by accreditors during hospital surveys, CMS should ensure that accreditation survey practices bring about a meaningful examination of systems that identify events, including mechanisms for reporting events, and hospital efforts to address underreporting and use information.* (Emphasis added.)

Given the low reporting rates and lack of assessment by accreditors during hospital surveys, CMS should ensure that accreditation survey practices bring about a meaningful examination of systems that identify events, including mechanisms for reporting events, and hospital efforts to address underreporting and use information.

Editorial Note: State regulatory boards are under criticism for not adequately checking federal databases and / or evidence of disciplinary or malpractice activity in other states. An example is the state of Illinois, which has recently been the subject scrutiny by investigative reporters.

AHRQ Research Finds Hospital Workers Afraid to Report Errors

The Agency for Healthcare Research and Quality (AHRQ) administers a survey periodically to assess the culture of safety in participating hospitals. Survey results released by AHRQ in February 2012 reveal that only an average of 44% of respondents (more than half a million from 1,128 hospitals) feel that "their mistakes and event reports are not held against them and that mistakes are not kept in their personnel file."

In other words, a majority of physicians, nurses, and other health care professionals working in hospitals continue to perceive a punitive atmosphere in their institutions, which discourages reporting of errors and near misses. This is true despite a trend away from a "shame and blame" approach to medical errors. The lack of reporting, according to some observers, has a detrimental effect on patient safety.

Doctors Admit Lying About Mistakes

A survey national conducted by researchers from Massachusetts General Hospital, led by Harvard Medical School professor, Lisa I. Iezzoni, found that many physicians admit lying or withholding information from patients about medical mistakes and their financial relationships with pharmaceutical and medical devices companies. The research was published in the February 2012 issue of *Health Affairs.* The article's abstract explains that:

> **Abstract**
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> The Charter on Medical Professionalism, endorsed by more than 100 professional groups worldwide and the US Accreditation Council for Graduate Medical Education, requires openness and honesty in physicians' communication with patients. We present data from a 2009 survey of 1,891 practicing physicians nationwide assessing how widely physicians endorse and follow these principles in communicating with patients. The vast majority of physicians completely agreed that physicians should fully inform patients about the risks and benefits of interventions and should never disclose confidential information to unauthorized persons. Overall, approximately one-third of physicians did not completely agree with disclosing serious medical errors to patients, almost one-fifth did not completely agree that physicians should never tell a patient something untrue, and nearly two-fifths did not completely agree that they should disclose their financial relationships with drug and device companies to patients. Just over one-tenth said they had told patients something untrue in the previous year. Our findings raise concerns that some patients might not receive complete and accurate information from their physicians, and doubts about whether patient-centered care is broadly possible without more widespread physician

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endorsement of the core communication principles of openness and honesty with patients.

The complete article is at http://content.healthaffairs.org/content/31/2/383.abstract.

New Databases Document Adverse Events for Consumers

Two startup companies, "AdverseEvents" and "Clarimed" are developing online databases containing data on adverse events associated with 4,500 prescription drugs and 130,000 medical devices. These will supplement the Food and Drug Administration's Adverse-event Reporting System (AERS) and Manufacturer and User Facility Device Experience (Maude).

The AdverseEvents database filters duplicate reports in AERS and combines spelling inconsistencies. It enables consumers to search for and compare thousands of conditions and prescription drug side effects from 2004. Access to more comprehensive searches will cost $10 per month. Clarimed also plans to charge for access to its database about medical device adverse events.

Consumer Reports Adds Voice to Hospital Safety Ratings

In the summer of 2012, Consumer Reports issued new hospital safety ratings. These ratings supplement, complement hospital safety ratings issued by some states, the Centers for Medicare and Medicaid Services, the Leapfrog Group, and popular magazines, such as *US News and World Reports*. Because various organizations judge hospital safety according to different variables, their ratings are not always consistent. For example, see http://ideas.time.com/2012/07/11/why-the-best-hospitals-might-also-be-the-most-dangerous/#ixzz20RLequh6.

With characteristic comprehensiveness, Consumer Reports explains its ratings at http://www.consumerreports.org/cro/magazine/2012/08/how-safe-is-your-hospital/index.htm?loginMethod=auto.

Editorial Note: More information is generally desirable, but when ratings like these are inconsistent or contradictory, there is great potential for consumer confusion or mistrust about ratings. We hope that various rating systems can be made more consistent. At a minimum, the various rating entities should explain the basis for their ratings and the reasons for discrepancies with other rating systems.

SCOPE OF PRACTICE

Expanded Scope for Nurse Practitioners Does Not Affect M.D. Pay

Researchers at George Washington University School of Public Health and Health Services analyzed Bureau of Labor Statistics data and concluded that expanding the scope of practice of nurse practitioners does not affect primary care physician pay levels.

Lead researcher Patricia Pittman, PhD said that this study is a first step in the "important (task of) systematically assess(ing) whether there are negative consequences for primary care doctors associated with an expanded role for nurse practitioners."

The research was published in the 2012 edition of *Nursing Research and Practice*. See http://bit.ly/wqS6gU.

More Physicians Dispense Medications

An article posted March 13, 2012, on www.philly.com/checkup by Michael Cohen examines the growing trend of physicians dispensing medications rather than sending patients to pharmacies. Entitled, *When Doctors – Not Pharmacists – Dispense Meds*, Cohen's article discusses the ethics and regulation associated with physician dispensing.

Most states permit physicians to dispense samples, often with a special license or permit, or within a regulatory framework. Utah's legislature recently passed a bill permitting oncologists to dispense cancer medications from their offices.

Most states permit physicians to dispense samples, often with a special license or permit, or within a regulatory framework.

Critics raise concerns about safety, proper labeling, patient counseling about potential side effects, and potential conflicts of interest. The Office of the Inspector General of the Department of Health and Human Services and the National Association of Boards of Pharmacy advocate regulation comparable to the regulation of pharmacies.

New Jersey Supreme Court Limits PA Scope

In a ruling issued in February 2012, the Supreme Court of New Jersey wrote, "the plain language of the governing statute limits performance of EMGs (electrodiagnostic tests) to those who are licensed to practice medicine in this state. PAs do not qualify for, nor do they receive, a plenary license to practice medicine." The ruling was a defeat for neurologist Arthur Rothman, MD, who permitted a PA in his office to use a needle to collect the test data. Rothman contended that the interpretation of the data – which he did – was the important part of the procedure.

The case arose when Selective Insurance Co. of America refused to reimburse for the EMG test in Rothman's office because it was performed by a physician assistant. The court ruled that statutory authorization for PAs to assist MDs does not extend to authorizing PA to perform procedures limited to those licensed to practice medicine.

Missouri Nurses Seek to End Collaborative Practice Requirement

Two nursing specialties – nurse practitioners and certified nurse midwives – are supporting legislation that would eliminate requirements for collaborative practice agreements in Missouri. Currently, advanced practice nurses must pay physicians to review a specified percentage of their charts every two weeks. Physicians may collaborate with only three nurses at a time, and they must be within 50 miles of one another.

Advocates for the legislative change argue that nurse practitioners do not need a collaborative practice agreement to know when to consult and when to refer patients to a specialist. HB 1371 and SB 679 would also allow advanced practice nurses to prescribe controlled substances, give instructions to respiratory therapists, and receive Medicaid reimbursement.

California Considers New Level Dental Provider

A bill in the California Senate would create a statewide Office of Oral Health and authorize a project to explore new workforce training and delivery models for the purpose of providing oral care for underserved children. The legislation is supported by the California Dental Association, other health professionals, and children's advocacy

organizations. However, the portion that would train new providers is opposed by the California Academy of General Dentistry and the California Association of Oral and Maxillofacial Surgeons who appear to fear that dental therapists will be permitted to perform surgeries. A spokesperson for the Academy of General Dentistry likened the proposal to experimenting on poor children.

The program is intended to address the unequal distribution of dentists in the state [of California], which results in inadequate access to care on the part of children in poor and rural areas.

The sponsor of the legislation says he is asking for "a scientifically based study to explore the possibilities of delivering care in different ways." The program is intended to address the unequal distribution of dentists in the state, which results in inadequate access to care on the part of children in poor and rural areas.

For more information, visit: http://www.californiahealthline.org/features/2012/bill-would-explore-new-tier-of-dental-provider-for-california.aspx.

Legislation Opposes Allergy Treatment by Chiropractors

In January 2012, California's Senate passed legislation prohibiting chiropractors from using lasers and other techniques to diagnose and treat allergies to foods, medicine, and environmental allergies, using lasers and other techniques. The bill was referred to the Assembly for its action.

Oklahoma Medical Board Proposes More APRN Supervision

The Oklahoma Primary Care Association reported in February 2011 that the state's medical board was considering a rule that would add a layer of supervision over nurse practitioners with prescriptive authority:

Board of Medical Licensure Proposes Physician Supervision of Nurse Practitioners (UPDATED)

The Oklahoma Board of Medical Licensure has proposed rules that would require on site physician supervision of nurse practitioners at least 1/2 day per week when a facility is open. A list of proposed rules is available on the Board of Medical Licensure website at http://www.okmedicalboard.org/laws.

The rules also add the following to the list of items considered unprofessional conduct as it related to the Board's ability to revoke a license or take disciplinary action:

—(50) Prescribing Scheduled drugs for pain not associated with malignancy or terminal illness for more than 3 months without documenting access to the prescription monitoring program (PMP) and keeping proper records to reflect medically monitoring the condition of the patient to justify the on-going prescribing of the drugs based on the 435:10-7-11."

Update 03/02/12: The Board of Medical Licensure will continue to take comments until the next public hearing on the rule that would require on-site physician supervision of nurse practitioners (versus the original a 3/5/12 deadline).The Board has postponed a public hearing originally scheduled for March 8th. A date for the next hearing has not yet been determined. However, it is possible it will be held at the May 17th meeting of the Board.

The proposed rule would require a supervising physician to see patients at least a half day a week in the same building where the supervised nurse is practicing. The board says the rationale for the rule change is to curb prescription drug abuse. Nurse practitioners who would be affected claim the rule would cause some clinics to close.

See more at http://www.okpca.org/board-of-medical-licensure-proposes-physician-supervision-of-nurse-practitioners.

California Nurse Anesthetists Don't Need Supervision

In March 2012, a California appeals court ruled unanimously that nurse anesthetists do not need to be supervised by a doctor when administering anesthesia in hospitals. California is one of sixteen states that have opted out of a Medicare requirement linking reimbursements to supervision. In its opinion, the court stated that laws governing the practice of medicine "do not limit the scope of practice of other licensed health care professionals, such as CRNAs." Rather, the nursing board has authority to determine nurses' scope of practice.

The state medical association sued in an effort to overrule a 2009 action by then-governor Arnold Schwarzenegger waiving the supervision requirement. Nurses and hospital organizations agree that supervision is not needed and would add unnecessarily to the cost of care.

Baker Institute Issues Policy Paper on Healthcare Workforce

The James A. Baker, III Institute for Public Policy of Rice University has released a policy report entitled, *Health Reform and the Health Care Workforce* (Number 51, March 2012). It analyzes the impact of the Affordable Care Act (ACA) on the need for increases in the size and changes in the composition of the healthcare workforce. The authors make recommendations on expanding the health workforce, supporting collaboration and improved care delivery, and evaluating the effects of the ACA on the workforce to stay on top of changing knowledge and needs.

Addressing scope of practice regulations, the authors write:

> While discussions of primary care shortages have largely focused on physicians, many researchers and policy analysts argue that non-physician providers can and should play a larger role in the delivery of primary care. About 65% of nurse practitioners enter primary care. Numerous research studies demonstrate that the quality of care delivered by NPs is at least equivalent to that of physicians, and some research had found that NPs have stronger patient communication skills. NPs are more likely to work in underserved settings, including rural communities. However, NPs face barriers to their practice, including scope-of-practice laws that require them to work under physician supervision and limit their ability to prescribe medications, and inconsistent reimbursement policies. Removal of these barriers would enable NPs to practice to their fullest potential to meet health care needs. (Citations omitted).

The entire report can be found at http://bakerinstitute.org/publications/HPF-pub-PolicyReport51-Web.pdf.

Virginia Requires Nurse Practitioners to Practice under Physician "Leadership"

After two years of negotiations, the Medical Society of Virginia and the Virginia Council of Nurse Practitioners agreed on legislation that promotes team practice for physicians and nurse practitioners, under physician leadership.

After two years of negotiations, the Medical Society of Virginia and the Virginia Council of Nurse Practitioners agreed on legislation that promotes team practice for physicians and nurse practitioners, under physician leadership. This replaces a law that required direct supervision of nurse practitioners by physicians. The new law permits physicians to supervise as many as six nurse practitioners, who may now practice in a location separate from their collaborating physician.

The American Academy of Nurse Practitioners opposed the law, in part because it ties a nurse practitioner's license to being part of a team led by a physician. Tay Kopanos, the director of health policy and state government affairs for the Academy told Carolyne Krupa of American Medical News that "Team-based care is a collaboration of various professionals around the needs of a patient and should not be thought of as a physician-led effort or a licensure construct."

The legislation can be found at http://leg1.state.va.us/cgi-bin/legp504.exe?121+sum+HB346.

Editorial Note: According to Greaham McMahon, MD, an internist at Brigham, & Women's Hospital, the team practice approach adopted in that hospital "means trying to dissolve the hierarchical, traditional structure that exists among nursing, physical therapy, pharmacy and medical staff, social work staff and others to empower individual members of the team to contribute equally to the optimal outcomes for the patients." Adopting this model, says McMahon, requires new processes, extensive training, cultural reorientation, and strong support from top administrators. For more on team practice, see:
http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/03MAR2012/0312HHN_Coverstory&domain=HHNMAG**.**

Publications Examine Non-Physician Practice

The growing demand for primary care practitioners has focused attention on the potential of advanced practice nurses and other non-physician providers.

The growing demand for primary care practitioners has focused attention on the potential of advanced practice nurses and other non-physician providers. Online publications expand upon the future of advanced practice nursing and the removal of barriers to practice.

AARP's Public Policy Institute has issued two reports on "Removing Barriers to Advanced Practice Registered Nurse Care." One, written by Andrea Brassard and Mary Smolenski focuses on "Hospital Privileges." It can be found at http://www.aarp.org/health/doctors-hospitals/info-10-2011/Removing-Barriers-to-Advanced-Practice-Registered-Nurse-Care-Hospital-Privileges.html.

A second publication by Andrea Brassard focuses on "Home Health and Hospice Services." It can be found at http://www.aarp.org/health/medicare-insurance/info-07-2012/removing-barriers-to-advanced-practice-registered-nurse-care-home-health-hospice-AARP-ppi-health.html.

A paper by Catherine Dower of the Center for the Health Professions explores the scope of practice of medical assistants in California. The paper can be found at http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=BRQXNI6pgJA%3d&tabid=475&utm_source=September+2012+Center+Newsletter&utm_campaign=Sep+2012+Newsletter&utm_medium=email.

Editorial Note: An article in the Journal of the American Association of Physician Assistants predicts that value-based purchasing for hospitals will expand the role of physician assistants in care delivery. See more at http://www.jaapa.com/pas-roles-expected-to-expand-under-value-based-purchasing/printarticle/256016/**.**

CMS Includes APRNs in "Medical Staff"

In May 2012, The Centers for Medicare and Medicaid Services (CMS) announced that henceforth it considers nurse practitioners and physician assistants to be part of "medical staff" for purposes of the conditions of participation in Medicare and Medicaid. This means that such practitioners will be "granted all the privileges, rights, and responsibilities accorded to appointed medical staff members."

In May 2012, The Centers for Medicare and Medicaid Services (CMS) announced that henceforth it considers nurse practitioners and physician assistants to be part of "medical staff" for purposes of the conditions of participation in Medicare and Medicaid.

See more at: http://www.cms.gov/apps/media/press/release.asp?Counter=4362&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=hospitals+and+health+care+prov&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date.

HMO Sends Pharmacists to Patients' Homes

As reported in Fiercehealthcare on April 16, 2012, the HOM Health New England (HNE) has begun to send pharmacists to the homes of patient at risk for readmission to consult with them about their medications. The result has been fewer hospital readmissions. HNE's Chief Medical Officer told Fiercehealthcare, "Pharmacists are key because medications play such a large role in early and unnecessary hospital readmissions. There's always some level of confusion or lack of understanding when the pharmacist goes into the home."

See more at http://www.fiercehealthpayer.com/story/readmissions-drop-when-pharmacists-visit-patients-homes/2012-04-16.

Maine Expands Scope of Independent Practice Dental Hygienists

In April 2012, Maine's Governor signed legislation permitting independent practice dental hygienists to take x-rays and own radiographic equipment. However, the Dental board's rules pursuant to the legislation placed limits on the extent to which the hygienists can take X-rays.

According to an April 18, 2012, press release from Representative Heather Sirocki's office:

> …The X-rays must be read by a dentist within 21 days.

"Maine has a significant and growing shortage of dental care," said State Rep. Heather Sirocki (R-Scarborough), who co-sponsored the enabling legislation, LD 1891. "In Maine, the primary reason for visits to emergency departments is dental pain. The cost runs into millions of dollars every year. Early detection and referrals for dental disease can help reduce these costs and better serve the patients."

Rep. Sirocki, a registered dental hygienist, said the pilot project authorized by the new law will expand more affordable dental care to underserved parts of Maine, often in rural areas. "All registered hygienists are board certified and licensed to perform radiographs," she said. "Additionally, the independent practice dental hygienist [IPDH] has a minimum of 2,000 hours of practice and is therefore highly qualified to perform all duties within the dental hygiene scope of practice…"

Th(e) bill passed with overwhelming support and was signed by the governor. During rulemaking, however, the Board of Dental Examiners changed the legislative intent by restricting the permissible types of X-rays, which hindered the pilot project.

"The proposed rules significantly weakened the program by allowing two types of bite wing and periapical X-rays," Rep Sirocki said. "They did not permit the so-called 'full mouth series' (FMS), also known as the complete series. This was puzzling, since the FMS is comprised of both periapicals and bite wings, which were permissible. By limiting the radiographs, an IPDH would find it difficult to justify the investment in expensive equipment and this, in turn, would significantly affect the outcome of the pilot…

See more at http://www.maine.gov/legis/house_gop/_news/news_page.php?story_id=20120418_00000231&story_title=Maine%20House%20GOP:%20Independent%20practice%20hygienists%20cleared%20to%20take%20dental%20x-rays.

Minnesota to Certify Community Paramedics

According to a September 11, 2012, report on Minnesota Public Radio, Minnesota is the first state to establish a new designation of healthcare provider: Community Paramedic. Working in conjunction with doctors from ERs and clinics, community paramedics will be permitted to deal with non-emergency healthcare needs, such as visiting patients in their homes, doing basic health assessments, collecting lab specimens, and performing minor medical procedures.

Working in conjunction with doctors from ERs and clinics, community paramedics will be permitted to deal with non-emergency healthcare needs, such as visiting patients in their homes, doing basic health assessments, collecting lab specimens, and performing minor medical procedures.

The Minnesota Nurses Association objected to the early draft of the legislation, expressing fears that community paramedics would compete with public health nurses. Modifications in the law designed to avoid duplication of services and ensuring that paramedics would be integrated with other public health providers partially assuaged the nurses' concerns.

See more at http://minnesota.publicradio.org/display/web/2012/09/10/regional/community-paramedics/.

Pharmacists Learn Literacy-Appropriate Communication

The front-page article in the Agency for Healthcare Research and Quality's (AHRQ) May 2012 *Research Activities* reports that only 12% of U.S. adults have enough health literacy to understand health information effectively. Pharmacists are being trained to help fill that literacy deficiency.

AHRQ launched a health literacy site for pharmacists in 2009, which includes instructions on how to develop pictorial drug cards for patients and telephonic reminder calls, training for pharmacy staff, and more. AHRQ has found that pharmacy students and residents were the people most likely to use the site, so the Agency developed curricular modules with slide decks and activities for pharmacy faculty, students, and residents to learn techniques to can help all patients, not just those with limited literacy. According to Sarah J. Shoemaker, Pharm.D., Ph.D, adjunct assistant professor at Massachusetts College of Pharmacy, "Pharmacists have a real opportunity to provide health literacy-appropriate communication on medications. Not only have pharmacists become more patient-centered in recent years, but Medicare Part D mandates medical therapy management, which is largely provided by pharmacists."

The full article can be found at http://www.ahrq.gov/research/may12/.

Retail Clinics Prepare to Expand Under Affordable Care Act

Anticipating growing demand as currently uninsured Americans acquire insurance under Affordable Care Act reforms, retail clinics are looking for more primary care providers, according to a report posted by Alice Caramenico on FierceHealthcare on July 16, 2012:

Retail clinics prepare for more patients under reform

Assuming that the Patient Protection and Affordable Care Act will go into full effect, *KJZZ* reported that retail health clinics are getting ready for growing demand. For instance, retail clinics in Northern Arizona are expecting a major influx of patients now that the individual mandate has been ruled constitutional. See more at http://links.mkt1985.com/ctt?kn=162&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0

To cope with the oncoming "pent-up demand," such clinics are supporting Medicaid expansion. For example, North Country Health Center largely depends on Medicaid funds, and without expansion, it may struggle to maintain adequate staffing and operations, noted *KJZZ*.

CVS MinuteClinic acknowledged that regardless of the reform ruling, the industry does not have enough primary care physicians to meet urgent medical needs.

Meanwhile, CVS MinuteClinic acknowledged that regardless of the reform ruling, the industry does not have enough primary care physicians to meet urgent medical needs. Retail clinics are well positioned to fill those gaps, Andrew Sussman, M.D., president of MinuteClinic and senior vice president and associate chief medical officer of CVS Caremark, told *FierceHealthcare* in an interview last month. See more at http://links.mkt1985.com/ctt?kn=183&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0.

Higher volumes expected from the reform ruling also are driving the growth of urgent care centers as an alternative to the emergency room, with about 9,000 in operation and 300 more opening each year. Unlike retail clinics, urgent care centers have a physician on the premises at all times and have the ability to diagnose and treat more serious non-emergency illnesses and injuries with X-ray and lab equipment on site, the *FiercePracticeManagement* previously reported.

See more at http://links.mkt1985.com/ctt?kn=146&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0.

Related Articles:

Urgent care centers: Compete, collaborate, or join?
http://links.mkt1985.com/ctt?kn=146&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0

What retail clinics are doing right:
http://links.mkt1985.com/ctt?kn=131&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0

MinuteClinic President: Hospital-retail clinic partnerships will expand:
http://links.mkt1985.com/ctt?kn=183&ms=NDIxNzk3NwS2&r=MjQ4NTQ3MjYxMTAS1&b=0&j=MTI3ODg4NTE4S0&mt=1&rt=0

Physician Solo Practice in Decline

Another article posted July18, 2012, on fiercehealthcare.com documents an increase in physician employment by hospitals and a decline in solo practice. What kind of changes will this trend cause in licensure, monitoring, and discipline?

Physician employment could hit 75%, eclipsing private practice

While rumors of the death of private practice have been circulating for some time, a recent survey from recruiting firm Merritt Hawkins suggests it may be no exaggeration that the industry will see 75% of the nation's physicians employed by hospitals in 2014.

"Our projection reaffirms the trend that fewer and fewer doctors are going into solo practice or staying in solo practice," Travis Singleton, senior vice president with Merritt Hawkins, told *CNN*. "It shows that no one wants to hire a solo doctor; no one wants to be a solo doctor. This is a dying breed of physician that is quickly disappearing from the American landscape," he added. See more at http://links.mkt1985.com/ctt?kn=116&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

This prediction, according to the firm, is based on the finding that only 1% of the 2,710 searches it performed for hospitals and physician practices in 2011 were for solo physicians, down from 22% in 2004. See more at http://links.mkt1985.com/ctt?kn=190&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

Merritt Hawkins' *Review of Physician Recruiting Incentives* revealed the following additional trends in the marketplace:

- For the seventh year in a row, family physicians and general internists remained the two most requested physician search assignments. Other high-demand physicians included psychiatrists, general surgeons, emergency medicine physicians, orthopedic surgeons, obstetrician/gynecologists, pulmonologists, urologists, dermatologists, and hematologists/oncologists.

For the seventh year in a row, family physicians and general internists remained the two most requested physician search assignments. Other high-demand physicians included psychiatrists, general surgeons, emergency medicine physicians, orthopedic surgeons, obstetrician/gynecologists, pulmonologists, urologists, dermatologists, and hematologists/oncologists.

- Sixty-three percent of Merritt Hawkins' search assignments in 2011/2012 featured hospital employment of the physician, up from 56% the previous year.
- Only 7% of searches for 2011/2012 featured income guarantees, while 73% offered salary with a production bonus, usually based on a relative value units formula.
- Five percent of 2011/2012 searches offered some form of housing allowance, up from less than 1% two years ago.
- Signing bonuses, relocation and continuing medical education allowances have become more of a recruiting-package staple versus serving as the occasional incentive in years past.

Related Articles:

Fierce Q&A: Beacon Health aims for value over volume in IPA/ACO: http://links.mkt1985.com/ctt?kn=104&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

Thirty-two percent of physicians desire hospital employment: http://links.mkt1985.com/ctt?kn=88&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

Private practices must revisit recruitment strategy to stay alive: http://links.mkt1985.com/ctt?kn=161&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

Selling to a hospital? Three critical questions to ask first: http://links.mkt1985.com/ctt?kn=178&ms=NDIyMzM1OAS2&r=MjYyMDcwMjkzMDIS1&b=0&j=MTI3OTg0MzkzS0&mt=1&rt=0.

Multiple Practitioners Provide Safe Abortion Services

In an article entitled, "Who can provide effective and safe termination of pregnancy care? A systematic review" Renner and Brahmi conclude that a variety of health care professionals can provide safe first trimester pregnancy termination services. (Renner R, Brahmi D, Kapp N. BJOG 2012; DOI: 10.1111/j.1471-0528.2012.03464.x.)

Unsafe termination of pregnancy is a major contributor to maternal morbidity and mortality. Task sharing termination of pregnancy services between physicians and mid-level providers, a heterogeneous group of trained healthcare providers, such as nurses, midwives and physician assistants, has become a key strategy to increase access to safe pregnancy termination care.

Background: Unsafe termination of pregnancy is a major contributor to maternal morbidity and mortality. Task sharing termination of pregnancy services between physicians and mid-level providers, a heterogeneous group of trained healthcare providers, such as nurses, midwives and physician assistants, has become a key strategy to increase access to safe pregnancy termination care.

Objectives: To systematically review the evidence to assess whether termination of pregnancy services by non-physician providers can be performed safely and effectively…

Main results: We identified five controlled studies comprising 8908 women undergoing first-trimester surgical termination of pregnancy (one RCT and three prospective cohort studies) and medical termination of pregnancy (one RCT). The mid-level provider group included midwives, nurses, auxiliary nurse midwives, and physician assistants trained in termination of pregnancy services. Safety and efficacy outcomes, including incomplete termination of pregnancy, haemorrhage, injury to the uterus or cervix, did not differ significantly between providers.

Author's conclusions: Limited evidence indicates that trained mid-level providers may effectively and safely provide first-trimester surgical and medical termination of pregnancy services. Data are limited by the scarcity of RCTs and biases of the cohort studies.

For more, see: http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2012.03464.x/abstract.

QUALITY OF CARE

Board Certification Linked to Fewer Hospital Infections

The Association for Professionals in Infection Control and Epidemiology reported on March 9, 2012, about research findings that infection prevention teams led by people with board certification have higher success rates. According to the APIC release:

Hospitals whose infection prevention and control programs are led by a director who is board certified in infection prevention and control have significantly lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSI) than those that are not led by a certified professional.

Hospitals whose infection prevention and control programs are led by a director who is board certified in infection prevention and control have significantly lower rates of methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSI) than those that are not led by a certified professional, according to a new study published in the March issue of the *American Journal of Infection Control*, the official publication of APIC - the Association for Professionals in Infection Control and Epidemiology.

A team of researchers from the Columbia University School of Nursing surveyed infection prevention and control departments of 203 acute care hospitals in California to determine if there is an association between structure and practices of their programs, and frequency of infections caused by antibiotic-resistant bacteria. MRSA bloodstream infection data for 91 of these hospitals were analyzed to see if there were

factors that were associated with frequency of this infection. Presence of a board certified director and participation in a multi-facility performance improvement project were associated with significantly lower MRSA BSI rates. This is one of the first studies that found an association between specific infrastructure elements, patient care practices, and rates of healthcare-associated infections…

Clinical Trial Results Need Better Dissemination

Editorial Note: The following article appeared in the May 2012 Agency for Healthcare Research and Quality Research Activities. It occurs to CAC one way licensing boards could proactively promote patient safety and healthcare quality by helping to disseminate clinical trial results to licensees and encouraging them to follow evidence-based guidelines and therapies.

Disseminating results from clinical trials to clinicians is critical to bring new guidelines and therapies into practice. This is certainly the case for HIV/AIDS care, where new drugs and treatments can be life-saving to patients. Recently, researchers investigated the diffusion, dissemination, and implementation of findings from an AIDS clinical trial. Their knowledge-transfer initiative resulted in changes in routine clinical practice brought about by active dissemination and implementation from department leaders.

The clinical trial results used in this study were from an AIDS Clinical Trials Group (ACTG) protocol. This trial found that giving antiretroviral therapy (ART) within 14 days after a diagnosis of the opportunistic infection *Pneumocystis jirovecii* pneumonia (PCP) reduced AIDS progression and mortality by 50%. After the findings were released at a major meeting (diffusion), leaders from the HIV/AIDS Division at the University of California at San Francisco undertook a major initiative to get clinicians to adopt this practice. Efforts included establishing guidelines, disseminating educational materials, meeting with opinion leaders, and other activities.

The researchers evaluated 162 patients with PCP to determine time to initiation of ART. Before the clinical trial protocol, the proportion of patients receiving ART within 14 days of their PCP diagnosis was just 7.4%. After trial results were released, this proportion increased to 50%, which rose to 83% following the knowledge-transfer initiative. The researchers noted that, while diffusion is important, targeted information transfer and modification of local conditions were required to ensure maximum change in clinical practice. The study was supported in part by the Agency for Healthcare Research and Quality (HS17784).

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See "The Effect of AIDS Clinical Trials Group Protocol 5164 on the Time from Pneumocystis Jirovecii Pneumonia Diagnosis to Antiretroviral Initiation in Routine Clinical Practice: A Case Study of Diffusion, Dissemination, and Implementation," by Elvin H. Geng, M.D., James S. Kahn, M.D., Olivia C. Chang, M.P.H., C.P.H., and others, in the November 2011 *Clinical Infectious Diseases* 53(10), pp. 1008-1014.

LICENSURE

Virginia Considers Eliminating Some Licensing Requirements

The Governor's Commission on Government Reform and Restructuring in Virginia has recommending ending licensure requirements for hair braiders, mold removers, and interior designers. These three professions are considered to have little impact on public health and safety.

The Virginia Department of Professional and Occupational Regulation received a total of 14 complaints since 1990 for all three professions. One of these complaints led a license revocation when a hair braider failed to report an address change and bounced the check for license renewal.

According to an article by Philip Walzer in the January 8, 2012, *Virginia Pilot*, consumer advocates objected to removing licensing requirements for mold removers and interior decorators. At least one member of the hair braider profession told Walzer that licensure or certification add an aura of professionalism.

DoD to Ease Employment of Veterans

The Department of Defense is working to help troops transition to jobs that require certification or licensure. The objective is to have veterans' training and experience recognized in the credentialing process.

Some troops, including some health care professionals, obtain licenses while they are in the service, but the license may not be transferrable to another jurisdiction once the individual leaves the service. The DoD wants states to facilitate reciprocity or license transfer. For troops who entered the service with a license or other credential which is no longer up-do-date when they leave the service, DoD encourages jurisdictions to allow these individuals to practice under a temporary license while they bring their credentials into compliance.

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Canada Ambivalent About Using NCLEX-RN Exam

Canadian nurses reacted with concern about a decision to bring the National Council of State Boards of Nursing's NCLEX-RN exam to Canada. Several concerns were identified in an article in *Canaca NewsWire Digital Journal.*

A major concern is that an examination developed outside of Canada may not reflect Canadian curriculum, research, cultural sensitivities, and health care system values. Another concern has to do with the potential impact of the USA Patriot Act on the privacy of Canadian nurses. Finally, Canadian nurses worry that use of a U.S. exam will facilitate recruiting Canadian nurses from across the border.

See more at http://www.digitaljournal.com/pr/522136.

Nursing Board Explains Background Checks for Renewal

The April 2012 issue of the Nevada State Board of Nursing's *Nursing News* contains an article intended to clear up misunderstandings among nurses and nursing assistants about the board's decision to conduct criminal history background checks (CHBC) upon licensure renewal. The article says, in part:

> Why is the Board doing this? Simple – public protection. Not everyone is forthcoming about their past criminal history for a variety of reasons. Since starting CHBCs on renewal in October 2010, the Board has initiated 215 investigations based on a renewal applicant's positive criminal background not previously disclosed. This is in addition to the large number of positive criminal histories investigated for initial applicants (See the Board's Annual Report on the website). Criminal histories received by the Board include DUIs, domestic violence, assault, fraud, theft, drug-related charges, child abuse, sexual assault, and attempted murder, to name a few. Every conviction is significant when moral character and the ability to practice nursing safely are crucial to public protection…

The complete article explaining the board's investigative process can be found at http://epubs.democratprinting.com/publication/?i=105082.

California Raises Penalties for Unlicensed Practice of Medicine

In July 2012, Governor Jerry Brown signed AB 1548, which raises fines and increases jail time for the unlicensed practice of medicine in corporate medical spas and similar locations. The primary focus of the legislation is non-surgical cosmetic procedures, such as laser skin resurfacing, cellulite treatments, and dermal fillers performed by physicians not trained in cosmetic procedures, or employees with inadequate training or supervision.

Previous penalties were fines of $200.00 - $1,200.00 and/or a 60-80-day sentence for violating requirements that medical spas be at least 51% physician-owned and that employees be supervised by a licensed physician. The new penalties are a maximum of $50,000 fine or double the amount of fraud, whichever is greater, and a maximum sentence of two to five years in jail.

California Permits Practice by Out-of-State Licensees

On August 29, 2012, the Medical Board of California announced that it would adopt regulations permitting practitioners licensed in other states to provide services in California:

> The Medical Board of California is the first licensing board to adopt regulations for AB 2699, Bass (Chapter 270, Statutes of 2010), which now allows healthcare practitioners, who are licensed in other states, to provide voluntary health care services to uninsured and underinsured Californians on a short-term basis at a sponsored event, without obtaining California licensure. These regulations were needed in order to implement that law…

With the passing of this legislation, physicians who are licensed in states other than California may now volunteer to provide services at health care events in California.

With the passing of this legislation, physicians who are licensed in states other than California may now volunteer to provide services at health care events in California. No California medical license is needed; however, physicians must register with the Medical Board of California and hold

a current valid medical license in good standing in another state, and the practitioner must submit fingerprints for a criminal background check. The out-of-state practitioner must provide the services on a voluntary basis, without charge to uninsured and underinsured persons at a sponsored healthcare event lasting 10 days or less.

See more at http://www.mbc.ca.gov/board/media/releases_2012_08-29_health_fair.html.

New York Court Changes Citizenship Requirement for Licensure

As reported by the Health Care Association of New York State in the September 7, 2012, edition of the online *Health Care Advocacy and Data*:

U.S. Court Overturns Citizenship Requirement for Certain Professions

The U.S. Court of Appeals struck down a requirement that 13 professions must have U.S. citizenship or permanent lawful residence for licensure in New York State. In an advisory notice regarding the court decision, the New York State Office of the Professions in the State Education Department (SED) states that it will now consider license applications from individuals who would have been previously barred from attaining licensure.

However, SED noted that the period for seeking further review from the U.S. Supreme Court has not lapsed.

While the lawsuit was brought in relation to pharmacists, it will apply to all of the 13 professions previously subject to the citizenship and permanent lawful residence requirements, which includes pharmacists, physicians, and other health care professionals such as midwives, dentists, dental hygienists, and chiropractors.

HANYS had previously supported legislation to remove these citizenship requirements and will provide members with additional information when it becomes available

Federation of State Medical Boards (FSMB) Promotes License Portability

The Health Resources and Services Administration (HRSA) awarded a third grant to the FSMB in support of its ongoing license portability efforts. Thirty-six licensing authorities supported the FSMB's grant application and two partner organizations – Administrators in Medicine (AIM) and the American Academy of Physician Assistants (AAPA) – will participate in the three-year grant project plan.

Work began in 2006 on initiatives to streamline the licensure process and reduce regulatory and statutory barriers to telemedicine and multi-state practice. The plan associated with the new grant has these goals:

- Increase utilization and further enhance the Uniform Application for Physician State Licensure (UA);
- Build upon recent improvements in the Federations Credentials Verification Service (FCVS) to reduce credentialing redundancies amongst licensure jurisdictions; and

- Work with state medical boards to develop and test licensure models to facilitate multi-state practice.

See more at http://www.fsmb.org/pdf/pub-nl-summer-2012.pdf.

CONSUMER INFORMATION

Consumers with Good Information Choose Wisely

Research funded by the Agency for Healthcare Research and Quality (AHRQ) found that consumers choose high-value care when given adequate information. Published in the March issue of *Health Affairs*, the study is entitled, "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care."

Research funded by the Agency for Healthcare Research and Quality (AHRQ) found that consumers choose high-value care when given adequate information.

The researchers studied how1400 individuals responded to different presentations of quality and cost information. When providers were clearly identified as high quality, cost had less influence on consumers' decisions, and consumers were more likely to choose a provider with lower cost but better quality than a high-cost provider.

Consumers were more likely to choose high-value providers when presented with strong, unambiguous quality and cost information. In addition, a check mark indicating "high-value" provider, along with the cost and quality information, also helped consumers use the information and make high-value choices. Given strong quality signals, consumers were also more confident in their choices.

AHRQ believes the study's findings have implications for the design of public report cards that offer consumers information on the quality and cost of health care providers. Although report producers have been adopting strategies to help consumers process and use comparative information on quality and cost, many reporting Web sites still use overly technical information or present other barriers to easy comprehension, according to the study.

See more at http://www.ahrq.gov/path/publicreporting.htm.

Consumers Trust Online Health Information

Research reported by Wolters Kluwer Health found that consumers trust health information they find online. Nearly half of the 1,000 consumers surveyed seek information online, and 67% of those say the healthcare sites they visit have made them better informed patients. Many turn to the Web to become better informed prior to a visit to their doctor. Only 15% say that they sometimes misdiagnose themselves based on information they read online.

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See more at http://www.wolterskluwerhealth.com/News/Pages/Survey-Consumers-Show-High-Degree-of-Trust-in-Online-Health-Information,-Report-Success-in-Self-Diagnosis--.aspx.

Consumers Decline to Disagree with Physicians

Research published in July 2012 in the online version of the *Archives of Internal Medicine* found that patients feel comfortable about asking questions and discussing options with their physicians, but hesitate, in the final analysis, to disagree with physician recommendations. Written by Jared R. Adams, MD, PhD; Glyn Elwyn, MB, BCh, MSc, FRCGP, PhD; France Légaré, MD, PhD, CCFP, FCFP; Dominick L. Frosch, PhD and entitled, "Communicating with Physicians About Medical Decisions: A Reluctance to Disagree," the article reports the following results:

Results

Participants were mostly white, most between 40 and 60 years old, with roughly an even mix of men and women. Survey respondents were highly educated, 42.6% having completed college or graduate study. Many were retired, and only 46.9% were currently employed. Nearly all were currently insured (89.6%), with most having been seen by a physician within the last 6 months (80.3%). Thirty-eight percent had a chronic ailment, and 16% of the sample reported a history of heart disease. A minority held either an autonomous or passive decision-making role preference: 11.1% felt that they should be mostly responsible for treatment decision making, while 19.3% felt that the physician should be mostly responsible. Almost 70% preferred a shared decision-making role, with patients and physicians contributing equally to treatment decision making.

Nearly all patients could envision asking questions (93.1%) and discussing preferences (94.0%); few, however, would voice disagreement with their physician if their preferences conflicted with physician recommendations (14.0%) ($P < .001$). While most felt that they had the ability to disagree (79.0% reported self-efficacy for disagreeing), few thought that disagreement with their physician was socially acceptable (14.0%) or would lead to good outcomes (15.2%) ($P < .001$).

NBCOT on Choosing Providers and Facilities

The National Board for Certification in Occupational Therapy (NBCOT) issued a press release advising consumers to take into account certification and accreditation when selecting a health care provider and facility:

> Nothing is more important than the health of your family. So when it comes to finding the right health care provider or selecting the right rehabilitation or long-term care facility, it pays to do careful research. The following tips are brought to you by the National Board for Certification in Occupational Therapy (NBCOT®) that could be useful as you search for an accredited facility or certified health care provider. Make sure you cover all bases and provide your family with the care they deserve.
>
> **Tips When Searching for a Certified Health Care Provider**
>
> Ask if he/she is certified, and if so, by what board or authority. Certification is designed to ensure that health professionals are qualified, capable and prepared to perform the required services. Request documentation to confirm certification.

Certification is designed to ensure that health professionals are qualified, capable and prepared to perform the required services. Request documentation to confirm certification.

Question the provider about his/her level of education, training, and experience in the desired field. Inquire about any specialty certifications or other skills that might apply to your needs.

Ask for references and perform independent research to determine suitability to provide the care.

Tips When Searching for an Accredited Health Care Facility

Ask management if the rehabilitation or long-term care facility is currently accredited, and if so, by what board or authority. Accreditation means the facility has met certain standards.

Ask to see relevant documentation to confirm the facility's commitment to quality and evaluation. Inquire how the quality of care is measured and monitored by the facility.

Check the benchmarks by which the facility is compared to on the regional and national level. Review client satisfaction surveys and perform independent research on each potential facility.

Reporter Advises Consumers to Check Online Practitioner Profiles

In a September 5, 2012, online column entitled "Find Out If Your Doctor Has Been Disciplined," *MyNorthwest.com* Reporter, Josh Kerns, wrote:

> Every month, the Washington State Department of Health suspends or revokes the license of health care providers, many for drug related offenses. In July and August alone, nearly two dozen lost their licenses, but State Health officials insist there isn't an epidemic.
>
> "It seems like a lot, but when you put it in perspective and actually look at numbers, it's actually about one-third of 1% of all credentialed health care providers are disciplined in a given year," says Donn Moyer, spokesman for the Department of Health.
>
> Moyer says the most recent numbers show about 1,200 health care providers out of over 359,000 faced suspension or revocation as of 2009. The number continues to go up, but the ratio has stayed the same.
>
> Moyer insists health care providers' problems are no different from any other profession's…
>
> So how do you know if your medical provider is in trouble? The state maintains a database of all actions on its website, or you can call the hotline at 360-236-4700.
>
> Moyer says most actions stem from complaints by patients or others, so it's important people bring their concerns to the state…

See more at http://mynorthwest.com/11/732135/Find-out-if-your-doctor-has-been-disciplined.

Joint Commission Resists Disclosure of Accreditation Reports

In September 2011, Health Watch USA and other organizations requested that Congress enact legislation making Joint Commission hospital accreditation reports available to the

"The Joint Commission does not itself provide survey reports directly to the public for the critical reason that we want to maintain an open and honest dialogue with hospitals in the various stages of review over survey findings."

public and subject to the Freedom of Information Act. The response (in a letter dated April 2, 2012) from Mark Chassin, M.D., President of the Joint Commission to Kevin Kavanaugh, M.D. of Health Watch USA pointed out that the Joint Commission makes information about accreditation decisions available to the public and "organizational performance on data-driven metrics required by accreditation. The organization posts information when hospitals fail to maintain accreditation, including identifying the areas that are deficient. He also points out that the Joint Commission communicates with the Centers for Medicare and Medicaid Services. "Nonetheless," Chassin wrote, "The Joint Commission does not itself provide survey reports directly to the public for the critical reason that we want to maintain an open and honest dialogue with hospitals in the various stages of review over survey findings."

Commenting on this exchange between the Joint Commission and Dr. Kavanaugh, former hospital CEO, Paul Levy, wrote in his blog, *Not Running a Hospital*, that

> (T)he Joint Commission fails mightily on the issue of transparency, both in its actions and in its role as an advocate for quality improvement… (T)he Joint Commission persist in holding those useful (survey-based) stories close to the vest, precluding their view by thousands of clinicians and administrators throughout the country, and also from patients and families who might want to engage in collaboration – or activism – with hospitals to encourage adoption of these best practices.

See more of Paul Levy's commentary at http://runningahospital.blogspot.com/2012/04/how-to-alter-flow-of-mississippi.html.

Pharmacy Boards Advocate Consumer Education

At its 108th Annual Meeting in May 2012, the National Association of Boards of Pharmacy approved a dozen resolutions including two that address consumer education:

- Educating the public about pharmacist care services and the pharmacist's role in combating prescription drug misuse and abuse,
- Increasing public awareness of health hazards related to the use of prescription drugs in non-health care settings including, but not limited to, the medical spa industry.

See all of the resolutions at http://www.nabp.net/news/delegates-approve-12-resolutions-at-the-nabp-108th-annual-meeting/.

NCSBN Launches Consumer Education Initiative

On June 4, 2012, The National Council of State Boards of Nursing announced an initiative to educate consumers about Advanced Practice Registered Nurses. The announcement explained:

> The National Council of State Boards of Nursing (NCSBN) has launched a new educational campaign that informs consumers that boards of nursing (BONs) in the U.S. license advanced practice registered nurses (APRNs) as part of their

The National Council of State Boards of Nursing (NCSBN) has launched a new educational campaign that informs consumers that boards of nursing (BONs) in the U.S. license advanced practice registered nurses (APRNs) as part of their mission of protecting the public.

mission of protecting the public. The campaign is designed to explain that BONs are working toward the goal of more APRN licensure uniformity across the country to continue to keep the public safe as health care reform advances.

Forming the centerpiece of this new campaign is a 30-second television spot that was produced in conjunction with the CBS Community Partnership Program. This commercial is currently airing in New York; Chicago; Philadelphia; Detroit; Tampa-St. Pete, Fla.; St. Louis; Indianapolis; Louisville, Ky.; New Orleans; Charleston, S.C.; and Jackson, Miss. on CBS owned and affiliated stations. The spots air within each market during shows such as "The Early Show," the CBS 2 News, the CBS Local Early News, "Entertainment Tonight," and the CBS Local Late News, with occasional rotation into prime time programming. There is also a 60-second radio commercial running in the same markets. Both the television and radio campaigns will air through July 15, 2012… See more at https://www.ncsbn.org/3768.htm and https://www.ncsbn.org/3770.htm.

Consumers will find a wealth of resources about APRNs, BONs, and how to contact a BON by visiting the NCSBN APRN website at https://www.ncsbn.org/aprn.htm.

SPOTLIGHT

Board of Nursing Web Site Compares Board with Professional Society

This Quarter's Spotlight shines on the North Dakota Board of Nursing for including a link on its Web site to a page that compares and contrasts the Board of Nursing (NDBON) and the North Dakota Nurses Association (NDNA). CAC applauds NDBON for including this page to inform consumers about the differences in mission between the two organizations and help dispel the all-too-frequent tendency among consumers to confuse or equate the two entities.

In adjacent columns, the Web site compares the locations, missions, functions, and composition of the NDBON and NDNA. The comparison makes it clear that the NDBON regulates nurses, establishes standards of practice, and disciplines nurses who violate the standards. In contrast, the NDNA influences legislation, promotes continuing professional development, and advances the identity and integrity of the profession.

Kudos to the North Dakota Board of Nursing.

DISCIPLINE

Media Go After Medical Boards for Lax Discipline

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On February 3, 2012, ABC News in Baltimore, Maryland ran a story about delays in prosecuting cases by the Maryland Board of Physicians. Reporter Joce Sterman reported that ABC News investigators examined board records of 49 doctors disciplined since December 2010. Some cases took as long as seven years before the board took formal action. More than 1/3 of the cases took at least two years before an action of suspension or revocation. See more at http://www.abc2news.com/dpp/news/local_news/special_reports/abc2-news-investigation-reveals-huge-lags-in-doctor-discipline.

On February 5, 2012, Glenn Howatt and Richard Meryhew wrote in the Minneapolis *Star Tribune* that the Minnesota Board of Medical Practice often "shies away" from disciplining doctors charged with substandard care and / or patient harm. At least 46 doctors disciplined in other states escaped discipline in Minnesota, as did more than half of the 74 physicians against whom hospitals took an adverse action. The article cites numerous cases of lenience on the part of the board.

Deborah Shelton wrote in the *Chicago Tribune* on February 11, 2012, about the failure of Illinois regulators to query the National Practitioner Data Bank to find out about actions taken against doctors in the state. Shelton writes that "According to the databank, about 215 doctors who have been licensed in Illinois had their clinical privileges revoked or restricted by their hospitals or managed care organizations over a roughly 20-year period, with no apparent action taken by Illinois' licensing authority." See more at http://articles.chicagotribune.com/2012-02-11/health/ct-met-undisciplined-doctors-20120211_1_medical-license-state-medical-boards-national-practitioner-data-bank.

An article by Callum Borchers and Stephen Kurkjian of the Northeastern University Initiative for Investigative Reporting, entitled "Once a Model, State Medical Board Lags Badly" was posted March 19 2012 on *Boston Globe's boston.com*. The article compares data in the Massachusetts Board of Registration in Medicine's public database with records in the federal National Practitioner Data Bank. The investigative reporters fault "physician-friendly provisions" in state law, board policy resulting in purges of records, sometimes in violation of state law, and outdated technology. To illustrate, they found that none of the 35 criminal convictions of Massachusetts doctors since 2002 appear on the board's Web site.

The reporters fault the board for removing the profiles of physicians who lose their licenses or fail to renew, leaving no record if a physician resumes practice in another jurisdiction. The board removes disciplinary and malpractice data after ten years. It fails to post disciplinary orders, which would inform the public of the nature of a violation. The board does not post information about discipline taken in other states. Nor does it post privileging penalties in clinics, outpatient surgical centers, nursing homes and other non-hospital settings. Some of these policies are based on state law. Others are in violation of state law.

See more at http://articles.boston.com/2012-03-18/lifestyle/31208155_1_state-medical-board-public-database-three-female-patients.

Idaho Empowers Board of Nursing to Create Alternative to Discipline

The Idaho Legislature has granted the Board of Nursing authority to "develop and implement alternatives to discipline, including a practice remediation program to educate and rehabilitate a nurse when a practice deficiency can best be addressed without resorting to formal discipline."

The legislative language is available at http://www.legislature.idaho.gov/legislation/2012/S1260.pdf.

Editorial Note: CAC News & Views is pleased to see another state give a licensing board authority to create an alternative to discipline program of the sort CAC promoted in its PreP 4 Patient Safety program. We encourage the Idaho Board of Nursing to write tight eligibility rules to ensure that this non-disciplinary option is not available to licensees who should be in the disciplinary track.

Minnesota Newspaper Calls for Audit of Medical Board Discipline

On March 25, 2012, the *Minnesota Star Tribune* editorial board called on the state's Legislative Auditor to investigate why the state's medical board failed to discipline a majority of the seventy-four physicians whose privileges were revoked or suspended by medical institutions in the past decade. "A key issue," according to the editorial, "(is) whether the board's policy of emphasizing corrective action over discipline – a philosophy that differs from many other states – is the right approach." The editorial mentions that the Federation of State Medical Boards could conduct the review, but advised that "having one medical oversight group investigate a similar group would raise unnecessary doubts about its conclusions."

The entire editorial can be found at http://www.startribune.com/opinion/editorials/144041816.html.

Massachusetts to Change Doctor Discipline Reporting

In March 2012, the Massachusetts House of Representatives approved changes in the way the medical board reports disciplinary actions in order to improve transparency. One important change eliminates the 10-year limit on reporting disciplinary actions.

The House action follows a *Boston Globe* report based on research by the Northeastern University Initiative for Investigative Reporting that showed that the medical board had routinely neglected to post or removed damaging information about physicians during recent years. According to the *Globe* article, the Massachusetts board was one of only three that removes physician profiles when they lose or fail to renew their licenses and one of four that remove disciplinary and malpractice records after ten years.

See more at http://nuweb9.neu.edu/watchdognewengland/featured_articles/mass-board-of-medicine-lacking-in-transparency-for-malpractice-other-disciplinary-actions/.

Ohio Doctor Implants Stents Unnecessarily

Reporter Diane Suchetka reported in the August 31, 2012, online *Plain Dealer* about a doctor with practicing privileges at two Ohio hospitals who was found by St. Joseph Medical Center to have implanted stents unnecessarily in at least 23 patients. The hospital

notified Southwest General Hospital, where the doctor also has practicing privileges, and they are conducting their own investigation.

The doctor, whose name has not been disclosed, intends to appeal the hospital's conclusions, contending that he can prove the stents were appropriate. St. Joseph Medical Center apologized to the affected patients and offered to pay for a follow up appointment with a cardiologist of their choice.

Then, in September, a suit was filed in behalf of nearly 300 patients against Saint Josephs, Catholic Health Initiatives (the parent company), eleven doctors, seven medical practices and a management service alleging massive medical misconduct to get reimbursement from the government and insurance companies.

Editorial Note: Hans G. Poppe, the attorney who filed the class action and numerous previous suits told Kentucky.com that the medical board is investigating the allegations.

See more at http://blog.cleveland.com/health_impact/print.html?entry=/2012/08/patients_at_st_john_medical_ce.html and http://www.kentucky.com/2012/09/06/2326087/hundreds-of-patients-allege-needless.html.

Health Research Group and Federation of State Medical Boards Release Nationwide Disciplinary Data

Public Citizen's Health Research Group released its annual report on medical board discipline on May 17, 2012. The group's press release is reprinted here:

Most States Do Not Protect Patients from Substandard Physicians, Public Citizen's Annual State Medical Board Ranking Finds

South Carolina Is Overall Worst While Wyoming Is Best; Many Large States Are Inadequately Disciplining Doctors

WASHINGTON, D.C. – Most states, including one of the largest – Florida – are not living up to their obligations to protect patients from doctors who are practicing substandard medicine, in part because of budget cuts, according to Public Citizen's annual ranking of state medical boards, released today.

"There is considerable evidence that most boards are inadequately disciplining physicians," said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group. "Action must be taken, legislatively and through public pressure on medical boards themselves, to increase the amount of discipline, and thus, the amount of patient protection. Ensuring that medical boards are adequately funded is an important prerequisite to achieving this, especially because doctors' licensing fees, intended to fund medical board functions, are sometimes taken to fund other state functions, which has recently occurred in California."

"There is considerable evidence that most boards are inadequately disciplining physicians," said Dr. Sidney Wolfe, director of Public Citizen's Health Research Group.

South Carolina was the worst state when it came to disciplining doctors, and, along with Minnesota and Wisconsin, has consistently been among the bottom 10 states for each of the past nine Public Citizen rankings. Connecticut has been in the bottom 10 for each of the past six rankings. For the fourth time in a row, Florida is among the 10 states with the

lowest rates of serious disciplinary actions even though it is beginning to improve. Other large states, such as Texas, Pennsylvania, and Michigan, have been in the bottom half of state rankings for all nine rankings and California has been in the bottom half for the past six rankings. "One likely reason for some medical boards' declining rate of discipline is tighter state budgets," Wolfe said. "The ability of certain states to rapidly increase or decrease their rankings, even when calculated based on three-year averages, can only be due to changes in practices and staffing at the board level. The prevalence of physicians eligible for discipline cannot possibly change so rapidly."

Public Citizen's analysis of medical board data from all states and the District of Columbia found that the rate at which doctors are disciplined by state medical boards has declined significantly over the past seven years, and some of the worst states have been consistently poor performers. Nationally, in 2011 state medical boards took 3.06 serious actions per 1,000 physicians – up slightly (3%) from last year but still down 18% from the peak rate of discipline in 2004 of 3.72 per 1,000 physicians.

The worst states, in order from the worst, are South Carolina; Washington, D.C.; Minnesota; Massachusetts; Connecticut; Wisconsin; Rhode Island; Nevada; New Jersey; and Florida.

Wyoming was the best state when it came to disciplining doctors, taking 6.79 serious actions per 1,000 physicians, a rate five times higher than South Carolina. Three states – Alaska, Ohio and Oklahoma – have been in the top 10 for all nine rankings. Only one of the nation's 15 most populous states, Ohio, is represented among those 10 states with the highest disciplinary rates. The best states when it comes to doctor discipline, in order from the best, are Wyoming, Louisiana, Ohio, Delaware, New Mexico, Nebraska, Alaska, Oklahoma, Washington and West Virginia.

Public Citizen calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions, and probation/restrictions) per 1,000 doctors in each state for each of these three years, and then averaged the rates over the past three years to establish the state's rank.

The annual rankings are based on data from the Federation of State Medical Boards, specifically on the number of serious disciplinary actions taken against doctors in 2009-2011. Public Citizen calculated the rate of serious disciplinary actions (revocations, surrenders, suspensions, and probation/restrictions) per 1,000 doctors in each state for each of these three years, and then averaged the rates over the past three years to establish the state's rank.

Boards are likely to do a better job disciplining physicians if most, if not all, of the following conditions exist:

- They receive adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes). In an era of especially tight state budgets, money allocated to board revenue from doctors' licensing fees frequently has been transferred to fund other parts of state executive branch functions;
- They have adequate staffing;
- They engage in proactive investigations, rather than only reacting to complaints;
- They use all available/reliable data from other sources such as Medicare and Medicaid sanctions, hospital sanctions and malpractice payouts;

- They have excellent leadership;
- They have independence from state medical societies;
- They are independent from other parts of the state government; and
- A reasonable legal framework exists for disciplining doctors (the "preponderance of the evidence" rather than "beyond reasonable doubt" or "clear and convincing evidence" as the legal standard for discipline).

The Federation of State Medical Boards also releases a detailed summary of member boards' disciplinary activity. It can be found at http://www.fsmb.org/pdf/2011-summary-of-board-actions.pdf.

Health Research Group Blasts Texas Medical Discipline

On August 22, 2012, the Health Research Group issued a press release entitled, "Texas Medical Board Failing to Discipline Dangerous Doctors: *459 Physicians Have Been Sanctioned by Texas Hospitals and Other Health Care Institutions But Not Disciplined by the State Medical Board."* The release read, in part:

> Fifty-eight percent of Texas doctors who have been sanctioned for serious offenses by health care entities, mainly hospitals, over the past two decades have never been disciplined by the state medical board. This shows that the state must do a much better job to protect patients from such dangerous doctors, Public Citizen told Gov. Rick Perry today.
>
> In a letter and accompanying report, Public Citizen presented its findings of an analysis of 21 years of data in the National Practitioner Data Bank. The organization found that 459 Texas physicians who have been sanctioned by hospitals, HMOs, or other health care institutions – some multiple times – have yet to be disciplined by the state medical board.
>
> A key problem is that the medical board lacks money and staff to investigate complaints, Public Citizen found. The board receives only a third of the $30 million it collects annually in licensing fees, professional fees, and fines. The state takes the rest and puts it in the general fund…
>
> Some facts contained in the report regarding the severity of the offenses of the 459 doctors who escaped board sanctions include:
>
> - Many of the physicians were disciplined by hospitals and other health care institutions because they were deemed an immediate threat to the health and safety of patients, incompetent or negligent, they committed sexual misconduct or insurance fraud, they abused drugs or alcohol, or they provided substandard care to patients.
> - A quarter of the 459 physicians have been sanctioned by health care facilities more than once.
> - Nearly half of the 459 physicians had one or more medical malpractice reports…

A key problem is that the medical board lacks money and staff to investigate complaints, Public Citizen found. The board receives only a third of the $30 million it collects annually in licensing fees, professional fees, and fines. The state takes the rest and puts it in the general fund…

Public Citizen urges (Governor) Perry to:

1. Allow the medical board to keep all – not just one-third – of the revenue it generates so it can hire more staff and complete more investigations in a timely manner.
2. Appoint an independent medical board enforcement monitor, similar to what California did to address a comparable set of problems. This independent monitor would evaluate the disciplinary system and the board's enforcement procedures, as well as play an active role in maintaining integrity of these processes into the future.
3. Consider instituting random practice audits of physicians, as recommended by the Health and Human Services' Office of the Inspector General. When implemented, these types of random audits have been proven to be effective in identifying practice deficiencies…

See more at http://www.citizen.org/hrg2063.

Nurses Subject to Discipline for After Hours Conduct

August 9, 2012, the California Health Care Foundation (CHCF) ran the following article in its daily online *California Healthline*:

Calif. Supreme Court: Nurses Can Be Disciplined for Off-Job Actions

On Wednesday, the California Supreme Court unanimously denied review of an appellate court ruling that allowed a state board to discipline a nurse for driving under the influence, even though the incident was unrelated to his job, the *San Francisco Chronicle* reports (Egelko, *San Francisco Chronicle*, 8/8).

The California Board of Registered Nursing has the authority to license and discipline the state's 400,000 registered nurses.

About the Board

The California Board of Registered Nursing has the authority to license and discipline the state's 400,000 registered nurses.

In February, Gov. Jerry Brown (D) signed legislation (SB 98) reinstating California's Board of Registered Nursing -- which was disbanded briefly earlier this year -- through 2015.

Board employees investigate about 8,000 cases annually (*California Healthline*, 2/15).

Background on the Incident

In August 2009, a licensed Silicon Valley nurse was arrested after he was involved in a car accident and found to have a blood alcohol level that was twice the legal limit.

The nurse pleaded no contest to the charges, and a judge placed him on probation.

After the incident, the Board of Registered Nursing placed the nurse on probation for three years, which meant he could lose his license for any additional misconduct.

Adam Slote, the nurse's lawyer, maintained that the incident had "no substantial relationship to his qualifications for the profession."

Details of Legal Action

A Superior Court judge overturned the board's action, ruling that licensed professionals only can be disciplined for actions related to their work or qualifications.

However, a state appellate court then reinstated the board's order, saying state law allows disciplinary action of nurses who misuse alcohol on or off the job in a way that endangers other people.

The nurse then appealed to the state Supreme Court.

Implications of Latest Ruling

The state Supreme Court's decision not to review the case leaves the appellate court's decision intact. The ruling will be held as binding precedent for trial courts throughout the state (*San Francisco Chronicle*, 8/8).

See more at http://www.californiahealthline.org/articles/2012/8/9/calif-supreme-court-nurses-can-be-disciplined-for-offjob-actions.aspx?p=1#ixzz26llO9pUi.

CONTINUING PROFESSIONAL DEVELOPMENT

California Considers Continuing Competency Bill for Nurses

On February 15, 2012, Melissa Biel posted the following American Board of Nursing Specialties email blast:

Both California and Georgia are considering bills this year that would require demonstration of competency for professional registered nurses. These bills reflect a trend toward competency-based practice as hospitals and other health care facilities move away from practice hours toward more valid measures of continuing competence.

In California, Senate bill 554 would require every direct care registered nurse to have current demonstrated and validated competency for the specific needs of the patient population in a unit or clinical area before an RN can be assigned to patient care for that unit or clinical area. Current competency may only be demonstrated and validated by observation by another direct care RN who has previously demonstrated current competency in the relevant patient population. Self-assessments are prohibited, and the observing RN must directly observe and assess for a minimum of five standard nursing shifts.

California's bill is sponsored by the California Nurses Association, which cites concerns that despite existing requirements that acute care hospitals validate the competency of their RNs, RNs have been accepted into clinical areas where they are not competent, particularly when hospitals contract with outside agencies for RNs. The bill would require all direct patient care staff, including per diem and temporary staff and new hires, to receive an objective competency assessment, specific to the care unit in which they will be working, before assuming patient care responsibilities.

California's law is opposed by the California Hospital Association, which states that rules already exist to address both the competency of RNs and the orientation of

California's law is opposed by the California Hospital Association, which states that rules already exist to address both the competency of RNs and the orientation of temporary staff.

temporary staff. The hospital association believes that passage of this bill would increase the cost of engaging a traveling or registry nurse by $3,600 per nurse.

In contrast to the specificity in California's bill, Georgia's Senate bill 368 would simply require applicants for renewal of their nursing license to meet such continuing competency requirements as the board of nursing may require by rule or regulation. In Senate bill 368 passes, the Georgia board of nursing would presumably develop continuing competency requirements in its rules and regulations…

Professional Association Questions Maintenance of Licensure

In a press release on its Web site, the Association of American Physicians and Surgeons quotes from an article in its official journal (the Journal of American Physicians and Surgeons) warning that doctors may be driven out of practice by the "testing gurus" of the American Board of Medical Specialties and the Federation of State Medical Boards.

Challenging Maintenance of Certification and Maintenance of Licensure (MOC/MOL, Paul Kempen, M.D., writes in the Journal:

> The requirements for MOC/MOL may be far more intrusive than taking a test. Physicians may have to collect data about how they treat patients, and implement a plan to "improve" certain selected measures – that is to treat patients with a focus on one goal chosen by the authorities, without regard to adverse effects on individual patients…
>
> With a physician shortage at the time that aging Baby Boomers will need more care, MOC/MOL will limit access to care where it is needed most, Kempen predicts. Americans will be forced to rely more on "physician extenders" who have far less education – an ironic consequence of a mandate that is supposed to increase quality.

See more at
http://www.aapsonline.org/index.php/article/special_interests_may_force_your_doctor_to_retire_physician_warns/

CCI Endorses Statement on Continuing Competence for Nurses

On May 23, 2012, the Competency and Credentialing Institute (CCI) board of directors endorsed the *Statement of Continuing Competence for Nursing: A Call to Action*, developed by a Continuing Competence Task Force (CCTF) convened by the National Board for Certification of Hospice and Palliative Nurses (NBCPHN). In a press release, CCI explained:

> NBCHPN created the Continuing Competence Task Force back in 2010 with the aim of achieving three primary goals: Distinguish between competence and competency, define continuing competence, and identify indicators of continuing competence. Members of the Task Force were charged with reviewing the literature and developing a definition that would serve as the foundation for further research and discussion.
>
> As a result, continuing competence has been defined by the CCTF as "the ongoing commitment of a registered nurse to integrate and apply the knowledge, skills, and judgment with the attitudes, values, and beliefs required to practice safely, effectively and ethically in a designated role and setting."

James Stobinski, PhD, RN, CNOR, Director of Credentialing & Education at CCI, presented this statement to the Board of Directors at their Board meeting last March. Stobinski stated, "This topic of competency assessment has been kept very much in the forefront in American healthcare by groups such as the Citizen Advocacy Center. This action reflects the importance of competency assessment in American healthcare. The CCI, along with other nursing organizations, benefits from the work of the Continuing Competency Task Force and this expert work will inform our future strategic planning and provide fuel for thought on the direction of future programs and initiatives."

"The statement of the Continuing Competency Task Force provides a framework for further discussion regarding competency assessment in the perioperative nursing field. We always strive to maintain our leadership in the field, and we will take mindful consideration of this relevant work in our daily business."

Stobinski continued, "The statement of the Continuing Competency Task Force provides a framework for further discussion regarding competency assessment in the perioperative nursing field. We always strive to maintain our leadership in the field, and we will take mindful consideration of this relevant work in our daily business. This work will assist CCI to carry out its stated mission, which is to lead competency credentialing that promotes safe, quality patient care and that supports lifelong learning."

The *Statement of Continuing Competence for Nursing: A Call to Action* is available on the ABNS Web site at http://www.nursingcertification.org.

CCI is the leading provider of certification, competency assessment, and competency-based education to surgical healthcare professionals… See more at http://www.cc-institute.org.

The complete press release can be found at http://www.cc-institute.org/news/2012/04/24/cci-endorses-statement-of-continuing-competence-for-nursing-a-call-to-action.

AMA Urges Flexible Maintenance of Certification and Maintenance of Licensure Requirements

At its summer 2012 meeting, AMA delegates adopted policies advocating that state medical boards enact flexible maintenance of licensure requirements. In particular, they do not want licensure to be dependent on maintaining certification by one of the twenty-four American Board of Medical Specialties voluntary certification boards. Instead, they want medical boards to establish alternative routes to maintenance of licensure for the approximately 200,000 physicians who are not board-certified.

See more at http://www.ama-assn.org/ama/pub/amawire/2012-june-27/2012-june-27-academic.shtml.

ARBO White Paper Advocate Accreditation of CE Courses

On June 18, 2012, the Association of Regulatory Boards of Optometry (ARBO) sent a white paper entitled, "The Council on Optometric Practitioner Education: The Importance of Valid Accreditation of Continuing Education for Maintenance of Licensure and the Public Welfare" to all of its member boards. The abstract to the white paper explains:

Regulatory entities are charged with protecting the public welfare by assuring the continued competency of licensed health care providers. This is primarily accomplished via required continuing education attendance for license renewal. To address inefficient and inconsistent approval of courses across the jurisdictions, the Council on Optometric Practitioner Education (COPE) was formed and a standardized method of course qualification and accreditation was developed utilizing certified course reviewers. In response to federal and state regulatory concerns of bias and industry influence, Standards for Commercial Support (SCS) were also developed and implemented. This process meets the definition of accreditation, the needs of regulatory boards, and addresses the concerns of both the governmental agencies charged with oversight and the public utilization of standards for commercial support, content review for bias prior to course presentation, timely corrective actions, and on-site review. The unmanageable conflicts of interest created by trade associations or trade association committees self-accrediting affiliated continuing education providers or events would be indefensible and unwise for the profession of optometry. Optometrists and the optometric regulatory agencies should zealously protect the integrity of continuing education accreditation for the public welfare.

The unmanageable conflicts of interest created by trade associations or trade association committees self-accrediting affiliated continuing education providers or events would be indefensible and unwise for the profession of optometry. Optometrists and the optometric regulatory agencies should zealously protect the integrity of continuing education accreditation for the public welfare.

See more about the COPE at http://www.arbo.org/index.php?action=cope.

ABMS Boards Affirm Maintenance of Certification

On August 9, 2012, the American Board of Medical Specialties (ABMS) announced that three more of its member boards will require continuous involvement in their maintenance of certification programs. According to a press release:

> Ongoing certification with each Member Board is contingent upon meeting the Maintenance of Certification requirements for the specific Member Board, which are part of the ABMS Maintenance of Certification® (ABMS MOC®) program. As a result, each of the three Member Boards listed below have eliminated specific "end dates" for their participating Board Certified physicians. The American Board of Family Medicine (ABFM), American Board of Psychiatry and Neurology (ABPN) and American Board of Radiology (ABR) have joined the American Board of Pediatrics (ABP) in emphasizing the continuous nature of the ABMS MOC program.
>
> "A robust and comprehensive Maintenance of Certification program is a powerful and valuable tool for physicians to demonstrate commitment and leadership to improve the quality and safety of health care," said Gary J. Becker, MD, ABR Executive Director.
>
> Piloted by ABP during 2010, this approach supports better care through physician participation in the rigorous ABMS MOC process, which continually assesses and helps enhance a physician's medical knowledge, judgment, professionalism, clinical care, and communication skills. "Research shows that, in general, over time, knowledge deteriorates and practice habits and patterns fail to change in response to medical advances. Physicians participating in lifelong learning demonstrate their focus on constant improvement efforts and staying current in their medical practices," stated James C. Puffer, M.D., ABFM President and Chief Executive Officer…

To keep pace with continuous advances in the medical field, ABMS and its 24 Member Boards developed the ABMS MOC program, an assessment of physicians based on six core competencies: professionalism, patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice. Competencies are assessed by a four-part process: licensure and professional standing, lifelong learning and self-assessment, cognitive expertise and practice performance assessment.

See the complete press release at http://www.abms.org/News_and_Events/Media_Newsroom/Releases/release_AdditionalABMSMemberBoardsDropEndDate_08062012.aspx.

PAIN MANAGEMENT AND END OF LIFE CARE

Doctors Ask for Changes in Pain Medication Rules

The Washington State Medical Association (WSMA) and the Washington Osteopathic Medical Association (WOMA) are asking regulators to change the regulations written to implement a 2010 law that tightens pain medication prescribing in the state. A legislative committee looking into the situation was told in February that the new rules are causing some doctors to cease prescribing for fear of discipline.

Carol Ostrom, writing in the *Seattle Times* on February 10, 2012, reports that WSMA wants the regulations to be amended so that the detailed patient examination and documentation requirements apply to patients using large doses of medication or who have serious pain problems. The association also wants the word "shall" changed to "should," which would lessen fears of discipline for not conforming precisely with every detail of the rules.

Supporting the rules, Dr. Jeff Thompson of the state's Medicaid program told Ostrom that doctors need help interpreting and following the new rules. He also supported the state's Prescription Monitoring Program and efforts by the Department of Health to administer rules for narcotic pain medication use in emergency departments.

Delaware Creates Panel to Develop Balanced Policy for Safe and Appropriate Drug Use

Delaware's Prescription Drug Action Committee began work in March 2012 trying to find a balance between controlling the abuse of prescription medications and making sure patients with severe or chronic pain receive adequate pain care. The committee is chaired by the director of the Department of Public Health and includes representation from the department that licenses health care practitioners.

Delaware's Prescription Drug Action Committee began work in March 2012 trying to find a balance between controlling the abuse of prescription medications and making sure patients with severe or chronic pain receive adequate pain care.

On the one hand, opiates are thought to have contributed to the deaths of 354 Delaware citizens in 2010 and 2011. On the other hand, many Delaware doctors have simply stopped prescribing controlled substances to eliminate the risk of discipline or avoid the obligation to undergo additional training in safe and appropriate prescribing. The new committee is charged with finding the right balance between these two challenges.

See more at http://dhss.delaware.gov/dhss/pressreleases/2012/prescriptiondrugs-031512.html.

Iowa Medical Board Issues Sample Pain Meds Agreement

On July 9, 2012, the Iowa Board of Medicine released the following announcement:

> Board offers new agreement for physicians who prescribe to patients with chronic pain
>
> DES MOINES, IA – The Iowa Board of Medicine is offering a new sample agreement for physicians to use when prescribing controlled substances to patients with long-term chronic pain.
>
> The agreement between the physician and the patient specifies the use of the pain control medications and the consequences for misuse. It is intended to prevent misunderstandings about these high-strength opioid painkillers, which can be highly addictive if they are not managed properly.
>
> The board's administrative rules, which have the weight of law, encourage physicians to use pain management agreements if they believe a patient is at risk of abusing or diverting medications. The sample agreement is offered as a tool to help physicians strengthen their chronic pain management practice, and is available on the board's website.

Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices.

> Physicians should not fear board action for treating pain with controlled substances as long as the physicians' prescribing is consistent with appropriate pain management practices. These practices, which are delineated in administrative rules, include a comprehensive examination of the patient, a treatment plan, and a periodic review of the drug therapy. In addition, if the physician believes the patient is at risk of drug abuse or diversion, then there should be a pain management agreement and periodic drug-testing to ensure the patient is receiving appropriate levels of the prescribed medications.
>
> Also, the Board encourages physicians to use to the Iowa Prescription Monitoring Program database, which contains a patient's controlled substance prescription history.
>
> The abuse, misuse, and diversion of prescription painkillers are at epidemic levels in the U.S. More than 36,000 people died from drug overdoses in 2008, and 14,800 of them involved prescription painkillers, according to a recent report from the Centers for Disease Control. In addition, for every prescription painkiller death, there are 32 emergency room visits for misuse or abuse.
>
> The Iowa Department of Public Health's Bureau of Vital Statistics reports the drug overdose death of at least 130 Iowans over the past three years due to prescription pain relievers such as oxycodone, hydrocodone, and methadone.
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> ##
>
> For more information about the Iowa Board of Medicine, please visit www.medicalboard.iowa.gov, or contact Mark Bowden, Executive Director, at mark.bowden@iowa.gov or (515) 242-3268

NABP Prescription Monitoring Program Celebrates First Year

On August 16, 2012, the National Association of Boards of Pharmacy (NABP) celebrated the one-year anniversary of its prescription monitoring program (PMP) InterConnect program. The program allows authorized persons in participating states to request patients' prescription records and receive information from other states. The program has proven to be a useful tool for reducing prescription drug abuse and doctor shopping for the purpose of diversion and prescription drug abuse.

See more at http://www.nabp.net/news/nabp-pmp-interconnect-celebrates-one-year-of-connecting-prescription-monitoring-programs-to-combat-p/.

FDA Requires Opioid Makers to Fund Caregiver Training

In July 2012, the Food and Drug Administration (FDA) announced that makers of opioid painkillers will be required to fund training programs for healthcare practitioners and consumers to help reduce fatal medication overdoses. The courses will be low-cost or free and will be designed by continuing education providers and not the drug companies.

The courses for caregivers must be available by March 2013, but they will be voluntary pending Congressional legislation making them mandatory. Brochures for patients will explain risks and instruct patients to seek emergency care in the case of an overdose

IMPAIRED PRACTITIONERS

Licensee Successfully Fights Summary Suspension for Substance Abuse

After a seven-month saga of accusations, license suspension, and missed evaluations, Florida doctor, Christina Paylan's license was restored in March 2012. She was declared fit to practice by an addiction psychiatrist and clinical psychologist.

The Florida Department of Health suspended Paylan's license in August 2011, alleging that she and her boyfriend illegally possessed Demerol, Valium, and Xanax and were trafficking in hydrocodone. Although she regained her license to practice, Paylan faces criminal charges for fraudulently acquiring controlled substances and using personal information.

Fifteen Percent of Surgeons Show Signs of Alcohol Use Disorder

An article entitled, "Prevalence of Alcohol Use Disorders Among American Surgeons," appeared in the February 2012 issue of *Archives of Surgery*. Based on research by a team led by Michael R. Oreskovich, MD, the article estimates that 15.4% of respondents to a survey show signs of alcohol abuse or dependence. According to the article's abstract:

> **Results:** Of 25,073 surgeons sampled, 7,197 (28.7%) completed the survey. Of these, 1112 (15.4%) had a score on the Alcohol Use Disorders Identification Test, version C, consistent with alcohol abuse or dependence. The point prevalence for alcohol abuse or dependence for male surgeons was 13.9% and for female surgeons was 25.6%. Surgeons reporting a major medical error in the previous 3 months were more likely to have alcohol abuse or dependence (odds ratio, 1.45; $P < .001$). Surgeons who were burned out (odds ratio, 1.25; $P = .01$) and depressed (odds ratio, 1.48; $P < .001$) were more likely to have alcohol abuse or dependence. The emotional exhaustion and

depersonalization domains of burnout were strongly associated with alcohol abuse or dependence. Male sex, having children, and working for the Department of Veterans Affairs were associated with a lower likelihood of alcohol abuse or dependence.

Conclusions: Alcohol abuse and dependence is a significant problem in US surgeons. Organizational approaches for the early identification of problematic alcohol consumption followed by intervention and treatment where indicated should be strongly supported.

Alcohol abuse and dependence is a significant problem in US surgeons. Organizational approaches for the early identification of problematic alcohol consumption followed by intervention and treatment where indicated should be strongly supported.

See more at http://archsurg.ama-assn.org/cgi/content/abstract/147/2/168?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=alcohol+use&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT.

Nursing Board Proposes to Clarify Chemical Dependency Program

The Oregon Board of Nursing held a hearing on June 19, 2012, in a rulemaking action intended to clarify the parameters of its Health Professional's Services Program. Specifically, the amendments would:

- Clarify that the program is for four years for substance abuse disorders;
- Clarify that the program is two years for a mental health disorder; and,
- Clarify that monitored practice is to be supervised in the work setting.

PUBLIC MEMBERS

Advocacy Groups Urge Governor to Fill Public Member Seats

On July 12, 2012, representatives of six advocacy organizations wrote to Governor Jerry Brown urging him to fill public member vacancies on the Medical Board of California (MBC). The groups are Consumers Union, AARP, California Pan-Ethnic Health Network, CALPIRG, The Center for Public Interest Law at the University of San Diego School of Law, and the Latino Coalition for a Healthy California. The letter said:

With currently high levels of concern among patients about medical errors and patient safety in general, it is particularly important that the public feel assured that the Medical Board of California's (MBC) members place the highest priority on the health and safety of California Consumers.

With currently high levels of concern among patients about medical errors and patient safety in general, it is particularly important that the public feel assured that the Medical Board of California's (MBC) members place the highest priority on the health and safety of California Consumers. Yet, nearly half of the MBC public seats are vacant and awaiting your appointments. During your first terms in office as Governor, you were a strong champion of putting public members on California boards to correct imbalances of representation and lend independent voices to the discussion. We urge you to fill these MBC seats soon and to consider the attached criteria in doing so.

The MBC has a total of fifteen seats. The law requires that seven of these be filled by public members; the remaining eight are physician seats. At the moment, unfortunately, there are seven physicians on the MBC and only four public members. A relationship that should have been close to 50/50 is now askew with nearly twice as many physicians as public members. This creates a dramatic imbalance on the MBC. We are concerned about the implications this has for priority-setting and policy and process decisions being made by the MBC now. Certainly, the legislature envisioned a balance of viewpoints on the MBC when it assigned seven of 15 seats to public members.

Of the four unfilled gubernatorial MBC appointments, three are for governor-appointed *public* members. These seats have been vacant for over two years, and two additional public seats that are gubernatorial appointments expired in June. Since the appointees holding these expired seats have already served two terms, it is our understanding that they must leave the board after a 60-day grace period at the end of July. **This will leave the MBC with seven physician seats filled and only two public seats filled at the end of this month.** (Emphasis in the original)

There are many important matters before the MBC now, including issues related to: safety for patients who have surgeries in physician-owned outpatient surgery centers; consumer teleconference access to MBC board meetings; clearer communications with consumers about the MBC's complaint process; and the importance of comprehensive data collection regarding physicians. All of these issues, and many more, deserve the attention of a full and balanced MBC.

The mission of the MBC is to "…protect health care consumers … and, to promote access to quality medical care…" By law, the MBC's highest priority is to protect the public (Business and Professions Code section 2001). As the responsibilities of the MBC grow, and as the MBC prepares to come before the legislature in 2014 for its sunset review, it is especially important that health care consumers feel assured that members of the MBC hold the public interest as their highest priority.

The MBC's public members have the responsibility to bring the public perspective into the MBC's work, rather than the health care provider perspective. We believe the MBC needs public members who have demonstrated an historic commitment to working on behalf of consumers and who have no conflicts of interest. Attached are criteria for appointment of public members to the MBC, which we previously sent to your office. We urge you to aggressively reach out to fill the MBC public seats as promptly as possible, with these criteria in mind…

The MBC's public members have the responsibility to bring the public perspective into the MBC's work, rather than the health care provider perspective.

Criteria for Appointment of *public* seats to the Medical Board of California

These criteria are designed to increase the likelihood appointees to public seats on the Medical Board of California (MBC) are effective representatives of a consumer point of view. Public appointees to the MBC should each demonstrate an historic commitment to working on behalf of consumers and should have no conflict of interest. Appointees to public seats should:

- have a demonstrated consumer orientation including a track record of consumer/public service with an emphasis on experience doing advocacy on behalf of the public interest;
- have an interest and knowledge of health care issues including issues of access and quality/patient safety;
- have an awareness of the health care concerns of California's diverse populations and connections to grassroots organizations representing consumers and diverse population groups;
- have skills gained from experience serving on not-for-profit boards, including a proven ability to get things done in a board situation.
- have demonstrated communication and negotiation skills;
- have familiarity working with the political process, the legislature and the media;
- have a willingness and ability to commit the time necessary to fully participate in board activities;
- have no significant related financial or other interests and an ability to be impartial on issues that will come before the MBC; Appointees, and their spouses and family members, should not be registered lobbyists for a profession or an entity regulated by the MBC; Potential appointees should divulge if they are a registered lobbyist for the health industry;
- not be a health care provider; and
- not be a spouse or family member of a person whose profession is regulated by the Medical Board.

Public Members Retain Seats on Florida's Medical and Osteopathic Boards

Bills that passed in the health regulations committees of the Florida House and Senate would have given one of the public member seats on the medical board and one on the osteopathic board to physician assistants.

Bills that passed in the health regulations committees of the Florida House and Senate would have given one of the public member seats on the medical board and one on the osteopathic board to physician assistants. This would have reduced the number of public members on the medical board to two and on the osteopathic board to only one.

One of the consumer members on the medical board, Donald Mullins, protested the proposed legislation, arguing that reducing the number of public members would affect public perceptions of the board, even if it did not affect board decision-making. Mullins pointed out that Florida already has fewer public members (20%) than many other states, such as California (47%), Texas (37%), and New York (28%).

In the face of opposition to reducing the number of public members, the Florida Academy of Physician Assistants withdrew that part of the pending legislation.

Editorial Note: CAC News & Views believes it would be appropriate for the two licensing boards to have at least one seat for physician assistants, since they regulate that profession. However, reducing the number of public members is the wrong way to go about it. It makes more sense to increase the size of the boards or reduce the number of physician seats to make a place for physician assistant representation on the boards.

IN THE COURTS

Illinois Supreme Court to Decide Case on Error Reporting

A suit by the Illinois Department of Professional and Financial Regulation against a Walgreens pharmacy raises questions about confidentiality protections in the federal Patient Safety and Quality Improvement Act. The 2005 law encourages reporting of errors to patient safety organizations by physicians, hospitals, and pharmacies.

The case was explained in a January 26, 2012, post on the *Findlaw KnowledgeBase* by Elgin, Illinois personal injury firm Brady & Jensen:

> The Patient Safety and Quality Improvement Act is a federal law that took effect in 2005. Under this law, the mistakes of hospitals, physicians, and pharmacists are reported to patient safety organizations (PSOs) that are charged with the review of these incidents. Recommendations can then be made for improvements to health care services to prevent future errors and medical malpractice. In order to encourage the free flow of information, PSOs do not disclose reported incidents to the public.
>
> A case scheduled to be heard by the Illinois Supreme Court, however, could help unveil that secrecy. The case, which will begin this January, deals with the confidentiality of three Walgreens pharmacists who were accused of medication negligence.
>
> In 2010, the Illinois Department of Professional and Financial Regulation was investigating the mistakes made by the drug store's pharmacists and issued subpoenas to obtain information about the incidents from Walgreens. When the store refused to provide the information, stating that it should remain confidential under the Patient Safety Act, the state sued Walgreens and lost – precipitating the state Supreme Court case.
>
> **Impact on Patient Safety**
>
> According to those who support the drug store's position in this case, if the Supreme Court rules against Walgreens, patient safety may actually be at risk. Mistakes may not be reported to PSOs if health care professionals know that the information has the potential to be made public.

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> "If that becomes public and used for discipline, people are going to be very reluctant to participate in that system," Dr. Wayne Polek of the Illinois State Medical Society told American Medical News.
>
> The state of Illinois, however, argues that the Act is being applied too broadly, and questions whether all Walgreen's medication error information is protected by the federal law.
>
> Since this is the first case to consider the protections of the Patient Safety and Quality Improvement Act, whatever decision the court reaches in the Illinois case will impact future rulings across the country.

The post can be found at http://knowledgebase.findlaw.com/kb/2012/Jan/503496.html

Tennessee Supreme Court Remands Case to Medical Board

In October 2011, the Tennessee Supreme Court upheld an appeals court ruling that the Tennessee Board of Medical Examiners erred in disciplining a doctor because the board did not articulate the standard of care that had been violated. The court wrote:

> This is an appeal from an administrative hearing wherein the Tennessee Board of Medical Examiners suspended a physician's medical license for one year and imposed other conditions after finding that, among other things, the physician had violated Tennessee Code Annotated sections 63–6–214(b)(1),(4), and (12) (2010). Upon review, the trial court affirmed the Board's ruling; however, because the Board failed to articulate the applicable standard of care in its deliberations, the Court of Appeals reversed the Board's ruling. We agree with the Court of Appeals that the Board was required to articulate the standard of care in its deliberations. Therefore, we vacate the ruling of the trial court to the extent that it affirms the Board's decision that the physician violated Tennessee Code Annotated sections 63–6–214(b)(1), (4), and (12). However, rather than reversing the Board's decisions, we are remanding the matter to the Board and instructing it to conduct deliberations based on the existing record and articulate the applicable standard of care as required by the statute.

See more at http://caselaw.findlaw.com/tn-supreme-court/1582255.html.

Court Overrules Finding of "Neglect"

The Supreme Court of Delaware ruled against the state's Department of Health and Human Services in September 2011, saying that the Department had not proven that a nurse was guilty of patient neglect.

The Supreme Court of Delaware ruled against the state's Department of Health and Human Services in September 2011, saying that the Department had not proven that a nurse was guilty of patient neglect. In the courts words,

> The Delaware Department of Health and Social Services appeals from a Superior Court order reversing a DHSS Administrative Hearing Officer's decision to place Madhu Jain on the Adult Abuse Registry for three years, because Jain had "neglected" a patient as defined by 11 Del. C. § 8564(a)(8) and 16 Del. C. § 1131(9).1 On appeal, DHSS claims that the Superior Court erroneously concluded that DHSS had failed to show that Jain neglected the patient within the meaning of those two statutes, because Jain's conduct breached basic, fundamental nursing standards. The facts do not support a finding that

Jain committed an act of neglect recklessly, knowingly, or intentionally. Therefore, we affirm the Superior Court's judgment for the reasons below.

See more at http://caselaw.findlaw.com/de-supreme-court/1579303.html.

TELEMEDICINE

Telemedicine Association to Develop Certification

The American Telemedicine Association announced on September 5, 2012, that it will develop a certification program for providers of online medical consultations to consumers. The announcement said in part:

> The program will be based on guidelines codifying best practices and quality metrics and confer an official seal of approval to providing organizations who meet the high standards set in the guidelines. Virtual doctor consultations are transforming the delivery of primary health care. Through online visits, consumers are able to access care for routine and urgent health problems without having to leave home or work. With projected physician shortages, increasing wait times and rising healthcare costs, online consultations are a tool to improve the delivery of healthcare. A growing number of private payers and employers are providing online services as a way to safely and efficiently expand access to primary care and relieve pressure on hospital providers…
>
> ATA is assembling a broad group of stakeholders—including independent researchers, clinicians, payers, representatives from governmental agencies and executives from industry including online medical service providers – to be involved in the development of the proposed guidelines. The effort will be supported by an evaluation of validated, impartial research on the effectiveness and quality of such services and an assessment of practices by existing providers…

See more at http://www.americantelemed.org/i4a/pages/index.cfm?pageid=1.

Editorial Note: CAC News & Views urges the ATA to include consumer and patient advocates in the group it is assembling to develop its certification standards.

USA Today Posts Feature Article on Popularity of Telemedicine

In the Moneyline section on May 7, 2012, and in an online post on May 10, 2012, *USA Today*, Phil Galewitz of *Kaiser Health News* wrote about the growing popularity of online doctor visits. Insurers, such as UnitedHealth Group (NowClinic is available in 22 states) and corporations, such as General Electric and Delta Airlines are promoting telehealth as an efficient, cost-effective way of obtaining health care services. Online healthcare services are popular among the uninsured.

Many medical boards limit computer-based healthcare to situations in which the doctor (or a referring doctor) has examined the patient in-person. But some states have loosened such restrictions, including Tennessee, Nevada, and New Mexico. Some drug store chains offer

a computer terminal where patients can consult a physician who can call in a prescription to the pharmacy, if needed.

See more at http://www.usatoday.com/money/industries/health/story/2012-04-27/virtual-doctors-telemedicine/54791506/1.

Legislation in Michigan Encourages Telemedicine

The Governor of Michigan has signed legislation that would encourage the use of telemedicine in the state as a less expensive alternative to doctor visits. House Bills 5408 and 5421 make reimbursement more consistent in an effort to encourage insurers to use telemedicine.

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See more at http://www.legislature.mi.gov/(S(qgdims45jptjdi55p32vkcjj))/mileg.aspx?page=getobject&objectname=2012-HEBS-5408&query=on&highlight=telemedicine and http://www.legislature.mi.gov/(S(qgdims45jptjdi55p32vkcjj))/mileg.aspx?page=getobject&objectname=2012-HEBS-5421&query=on&highlight=telemedicine.

IN DEPTH

CAC's President Discusses History and Future of Regulatory System

Editorial Note: CAC's President and CEO, David Swankin, delivered the keynote address at the 2012 annual meeting of the Federation of Associations of Licensing Boards (FARB). The title of this talk was "Regulation of the Professions: Where Have We Been? Where Are We Going?" This quarter's In-Depth Feature consists of the concluding section of his talk, "Changes That Could Improve the System." The first two sections of Swankin's remarks, "How Did the Current Regulatory System Evolve?" and "Problems and Flaws in the Current Regulatory System" appeared in the previous issue of CAC News & Views, Second Quarter, 2012.

Regulation of the Professions: Where Have We Been? Where Are We Going? *(continued)*

Changes that Could Improve the System

I began this address with a quotation from Ben Shimberg's 1980 book, "Occupational Licensing: A Public Perspective."

Let me begin this "look ahead" section with the opening sentences from Ben's book -- must reading, I believe, for everyone interested in occupational and professional regulation. Thirty-two years ago, he wrote:

"An important debate is under way between the professions and the public about the future of occupational regulation in America. The air is filled with charges and countercharges about who benefits the most from licensing – the public or the occupational group. However, at bottom, the controversy concerns the extent to which regulatory power will remain primarily in the hands of the occupational groups or be shared with others, including representatives of the public."

I don't fancy myself a particularly skilled prognosticator – I can hardly select the winners of professional football games each week, nor have I ever correctly predicted the teams that will in the NCAA final four every March!

What follows, therefore, is what I think *should* be in our future, as we strive to achieve what I know is our common goal – a regulatory system as fair, effective, efficient, and timely as possible. The goal is to fulfill the given mission – to protect and promote the public health, safety, and welfare.

First, I will discuss some basic, systemic changes that I believe would strengthen and improve the ability of the regulatory system to fulfill its public protection mandate. These will be the hardest to achieve, because they involve structural change, which is never easy to accomplish.

Second, I will recommend changes that can be accomplished within the framework of the existing system. You may disagree with some or all of my suggestions; that is your prerogative. As for me, they are all on my fervent wish list!

Structural Reforms: Do Away With Comprehensive, All-Inclusive, Unlimited Licenses Where They Exist

In some professions, including medicine, law, engineering, and architecture, the initial license is unlimited, allowing the licensee to practice any or all activities associated with the profession. Of course there are some restraints on practice (including exposure to malpractice lawsuits, or violation of a practice act based on incompetence or unprofessional conduct), but legally, the license is unlimited. We live in an age when most licensees' actual practice is specialized. Licensing should reflect this reality. Imagine a system that was similar to Boy Scout merit badges – a practitioner would initially be licensed in his or her area of practice; over time, that licensee would earn the ability to practice in additional specialty areas by demonstrating current competence in that new subject matter. The public would be better served by this kind of more limited licensing system, since the license would attest to specific areas of competence. In some professions (for example, in medicine), well-established voluntary certification programs award certifications that are specific to specialty areas. This is not the case in other professions (law, for example). Many professions would likely vigorously oppose a move in this direction, but such a change would enhance the ability of regulatory boards to monitor the marketplace, and to protect the public health, safety, and welfare. Such a licensing system would be of great assistance to consumers trying to locate a practitioner who has demonstrated competence in dealing with a particular issue or problem. Significantly, a system like the one I am envisioning would authorize any practitioner who demonstrates a particular competence to provide that service, regardless of the professional's title. In other words, just like Boy Scouts who earn varying combinations of merit badges, licensees would have overlapping scopes of practice based on their demonstrated competence rather than an exclusionary legislative construct.

In some professions (for example, in medicine), well-established voluntary certification programs award certifications that are specific to specialty areas.

Affirmative Criteria for Selecting Public Members

In the great majority of cases, state laws requiring the appointment of one or more public members to licensing boards contain disqualifiers, but set forth no positive criteria a

prospective public member appointee must meet. Current laws often prohibit appointing a public member who is or has been a member of the professions being licensed by a particular board, or someone whose spouse or child is licensed in that profession.

Some nongovernmental specialty certification boards have begun to establish affirmative criteria for the public members appointed to their boards. In addition, the Center for Medicare and Medicaid Services (CMS) now requires public members appointed to Medicare Quality Improvement Organizations (QIOs) to meet the affirmative criteria.

Not everyone is cut out to be an effective public member of a licensing board. Over the years, a consensus has emerged as to the most important qualities to look for when selecting public members for health regulatory boards. The following list of attributes reflects the views of both governors' appointment secretaries and people who have experience serving as public members:

- a track record of consumer and/or public service advocacy;
- communication and negotiating skills;
- a willingness to commit the time necessary to fully participate in all board activities;
- an interest in health care, including access and quality of care issues;
- an awareness of the health care concerns of diverse population groups within their community;
- connections to, or a willingness to cultivate connections to grassroots organizations representing diverse population groups; and
- "boardsmanship" skills gained from experience serving on civic, educational, benevolent, or other organizations.

Similar criteria can and should be developed for public member appointments to non-health occupational and professional licensing boards.

Remove Statutory Requirements That Governors Appoint Only Those Individuals Nominated By a State Professional Association to Serve As Licensee Members of a Licensing Board

In some states, the Governor is given no discretion in appointing licensee members to particular licensing boards.

In some states, the Governor is given no discretion in appointing licensee members to particular licensing boards. The Governor must appoint the nominees of the state professional association. The North Carolina Dental Board is a case in point. I believe such a requirement is a case where the concept of "self-regulation" under color of law has gone too far. Accountability requires that the Governor be given discretion in making appointments.

Abandon Exclusive Funding Of Licensing Boards by Licensing Fees

Boards, especially boards with relatively few licensees, are often too poor to effectively perform their assigned functions. While funding from general revenues has drawbacks, they pale when the alternative is insufficient operating funds. Inadequate funding prevents some boards from being able to hire sufficient staff. It sometimes impedes the ability of boards to operate an effective disciplinary program, making them hesitant to pursue formal

disciplinary hearings, turning instead to negotiated settlements and taking the chance that attorneys for licensees will succeed in negotiating terms more lenient than those that might be achieved at a formal hearing. Sometimes, underfunded boards don't have the resources to appeal lower court decisions adverse to the board. They may be hesitant to impose and administer continuing competence requirements that can be more costly than simply monitoring compliance with mandatory continuing education requirements. Even boards with relatively large staffs and high licensing fees are insufficiently financed if they are dependent on fees to cover their expenses. The California Medical Board's budget, for example, is about one-tenth the size of the budget of the Medicare Quality Improvement Organization (QIO), which is federally funded to oversee the performance of only that portion of physicians in the state who provide services to Medicare beneficiaries. Of course, at a time when states struggle to balance their budgets, providing at least some funding to finance licensing board operations is not easily accomplished. What is absolutely clear, however, is that exclusive reliance on user fees too often provides inadequate resources for effective administration and compromises the ability of boards to carry out their public protection mission as well as they could if more funding were available. I know some of you do not agree with my point of view.

Connect the Regulation of Persons to the Regulation of Facilities

Currently, we have a non-system of regulation, understandable for historical reasons, but deficient at a time when system regulation is needed. A serious medical error occurring in a hospital may have been caused by a system flaw, or it may have been caused by the actions or inactions of a licensed professional providing service in that hospital. Or, as is often the case, the error may have been partly a systems error and partly the fault of an individual's inappropriate actions. It is unnecessarily difficult to investigate and implement corrective action when separate agencies oversee facilities and individuals. Coordination among different government oversight agencies may be a goal, but nothing assures it will, in fact, occur. The Pew Health Professions Commission recommendation mentioned earlier didn't go far enough – it called on regulatory boards "to understand" the impact and responsibilities of other types of oversight agencies, but understanding is not enough. We need to rethink the way we organize the regulatory oversight system, and legally institutionalize connections between the various parts. The results speak for themselves in airline regulation, where we have an integrated oversight system. And the results speak for themselves in the case of financial institutions, were there is no integrated oversight system. Witness what happened on Wall Street in recent years.

I am not advocating abandoning the state system of occupational and professional regulation and federalizing the system. But I am advocating integrating the various oversight activities, and doing so by law. Hoping interagency cooperation will occur is not good enough – we need to require it to occur.

Broaden the Membership of Licensing Boards

Most state occupational and professional regulatory boards are composed of two categories of individuals: members of the profession, and public members. The reasons for this are historical, as I described earlier. Contrast this with, for example, the composition of a board of directors of a community hospital, which typically includes individuals

Most state occupational and professional regulatory boards are composed of two categories of individuals: members of the profession, and public members.

representing a wide variety of stakeholders – hospitals, insurance companies, bankers, managed care systems, and others. Imagine state licensing board membership that included a variety of stakeholders, moving beyond the current two-dimensional model (i.e., licensees and public members). It most certainly would give a different meaning to the term "self-regulation." It could result in a much broader understanding by interested parties of the important work of these licensing boards, and could lead to broader support when boards seek legislative improvements to their practice acts. Controversial issues would not go away under such a model, but broadly based boards would become the initial forum for resolution of many controversial issues. It could become a more successful model for conflict resolution among stakeholders, such as scope of practice disputes between professions. Stakeholder participation on licensing boards would be in keeping with the emerging expectations of a new generation, one that is not as accepting of command and control type regulation at any level of government as were previous generations, including my own. Undoubtedly a controversial idea, it would be interesting, to say the least, to have one or more of the 50 states experiment with such a regulatory model, in keeping with the American tradition of states acting as the testing arenas for bold new concepts.

In its 1989 report entitled "Allied Health Services: Avoiding Crises," The Institute of Medicine (IOM) recommended that:

"Licensing boards should draw at least half of their membership from outside the licensed occupation; members should be drawn from the public as well as from a variety of areas of expertise such as health administration, economics, consumer affairs, education, and health services research."

Improving What We Have Now

I offer six recommendations that I believe would make the current system more effective and help boards carry out their public protection mission.

Require Demonstrations of Current Competence as a Condition of Maintaining a License

The current approach, where state legislatures impose mandatory continuing education requirements on many professions, is inadequate.

The current approach, where state legislatures impose mandatory continuing education requirements on many professions, is inadequate. In a 2009 report issued by the Institute of Medicine (IOM) entitled "Redesigning Continuing Education in the Health Professions," the Committee Chair wrote:

"Continuing education (CE) is the process by which health professionals keep up to date with the latest knowledge and advances in health care. However, the CE "system," as it is structured today, is so deeply flawed that it cannot properly support the development of health professionals. CE has become structured around health professional participation instead of performance improvement. This has left health professionals unprepared to perform at the highest levels consistently, putting into question whether the public is receiving care of the highest possible quality and safety… Refocusing the lens from CE to a system of continuing professional development supports health professionals in achieving the goal of high quality, safe health care."

Read the quote again, leaving out the words "health" and "health professionals," because the comment is equally valid and applicable to all occupations and professions. Some licensing boards in some professions, and some state legislative bodies, recognize the need to bring this change about. But we are only at the beginning of this journey. We have talked about it long enough. The time for bold action is now!

Assure Timely Reporting To Licensing Boards When There Is Unacceptable Behavior by Licensees

Earlier in this talk I said that marketplace monitoring is typically complaint driven. We have learned that exclusive dependence on complaints is inadequate. That is why some professions have laws requiring mandatory reports from third parties to inform licensing boards of actions they have taken in response to poor performance by licensees. For example, federal and state laws require hospitals and other institutions to inform state medical boards when an adverse action is taken against a licensee for substandard performance. The executive director of one state medical board reported that a mandatory report from a hospital is twice as likely to lead to a licensing board disciplinary action than is a complaint from a consumer. But numerous studies over the years have shown how few such reports have, in fact, been filed.

Boards need to ask themselves this question: Which third parties (individuals and institutions) are in a position to know which licensees are practicing in an unethical or substandard manner? Once these third parties have been identified, they should be required to report adverse actions to the licensing board. If such a requirement already exists, are the third parties fulfilling their obligation? If not, what are the consequences? For example, if a building inspector finds work so shoddy that he or she refuses to issue a certificate of occupancy, does the contractor licensing board receive notice of that fact? Shouldn't they?

An alternative approach to assuring effective marketplace monitoring is to enact a variation of the structural change I recommended above: that is to expand the jurisdiction of professional licensing boards to include the physical locations where licensees work – in other words, the model that exists today for pharmacists and pharmacies. If we go this route, it will be even more important to assure adequate funding for licensing board operations.

One way or another, I believe we need to move beyond being 100% reliant on complaints as a method to monitor the marketplace. There is no substitute for good, timely marketplace information, and we should assure that this information flows into all occupational and professional licensing boards.

There is no substitute for good, timely marketplace information, and we should assure that this information flows into all occupational and professional licensing boards.

Overcome the Silo Mentality

Many boards are totally independent agencies, and those that are value their independent status. But many activities today are characterized by interaction and interdependence. I recall a conversation I once had with a board of nursing executive, after a tragic medical error occurred in a hospital. A so-called "root cause" analysis indicated that a physician, a nurse, and a pharmacist all had some culpability, as did the hospital itself for some serious system flaws. I asked the board executive what actions her board had taken, or planned to

take, regarding disciplinary action against the nurse's license. She said to me, "We don't plan to do anything. The medical board has taken no action against the physician involved; the pharmacy board has taken no action against the pharmacist involved; heavens knows what, if anything, the hospital has done to address and correct the system flaws. So we think it would be unfair to move against the nurse when all the others have been untouched."

This might sound to you like an isolated case, but it has stuck in my mind, because to me it is an illustration of the consequences of operating with a silo mentality. From a public protection perspective, silos don't work. Public protections in this case required all the oversight entities to work together, with the goal of preventing a similar occurrence in the future. It is an example of why I support the idea of all licensing boards being located in an umbrella agency with policy oversight powers. Understand, I am not a supporter of the "umbrella" concept when its purpose and function is primarily to save money! I understand the hostility to umbrella agencies, especially in states where the umbrella has no oversight of policy. But policy oversight makes great sense to me, and in those states where it occurs, I believe the occupational and professional licensing system is improved.

Give Complainants More Status

In 1993, CAC published a report entitled "Should the Public Have a Right to Comment on Proposed Licensing Board Consent Orders?" We identified the report as "An Issue for Debate." We said in the preface:

"This paper puts forward for debate and discussion the suggestion that the general public should be given a legal right to comment on proposed settlements between health licensing boards and licensees who choose to settle a disciplinary action rather than go through a disciplinary hearing. To accomplish this, we propose that states enact public right-to-comment laws, similar to the right-to-comment laws governing many federal agencies. These laws would require state health licensing boards to publish proposed consent orders or stipulations and establish a comment period during which interested parties could support or object to the proposals. At the end of the comment period, the board could withdraw its consent if public comment generated an objection that was convincing to the board. To our knowledge, no state licensing board currently operates under such a law.

There are at least three valid reasons interested individuals may wish to have the right to be heard by a disciplinary board before a proposed settlement is made final.

There are at least three valid reasons interested individuals may wish to have the right to be heard by a disciplinary board before a proposed settlement is made final. First, they may want to urge that the board be more or less severe in its proposed settlement, depending on the circumstances of the particular case. Second, they may have a legitimate concern that the practitioner represents an ongoing threat to others. Third, they may want the board to realize the impact of the alleged violation on the public and the precedential implications of inappropriate disciplinary action."

We distributed the report widely and asked for comments. I can't say I was surprised when almost all of the board attorneys who responded thought it was a terrible idea. Perhaps it is!

Many and in some cases nearly all disciplinary cases are settled by consent order or other named process used to mean negotiated settlement. Should that process be more

transparent, including some method of participation by the complainant? I'd be interested in hearing your views on this.

One final comment on this issue: Recently, a Federal judge rejected a proposed negotiated settlement between the Federal Securities and Exchange Commission (SEC) and Citibank; one of his main reasons for rejecting the negotiated settlement was the SEC did not insist that Citibank admit it had violated the law. The negotiated settlement contained language whereby Citibank neither confirmed nor denied the charges brought against it by the SEC. I have seen licensing board negotiated settlements that do not require the licensee to admit a violation of the practices act. In my opinion, that is horrible public policy. Interestingly, on January 6, 2012, the SEC announced a policy change, at least in criminal cases, where it would no longer agree to negotiated settlements that did not contain an admission of violation.

Make the System More Transparent

We wrote that report as part of our long-standing effort to make the regulatory system more transparent. Last October, at CAC's annual meeting, 18 years after we published the report, one of our speakers, the Director of the Safe Patient Project for Consumers Union (publisher of Consumer Reports) said:

"Are regulatory agencies in the healthcare field doing a good job? I have no idea. The system is not transparent enough for me to determine the answer. It is sad but true that it is easier to make a decision about cars or refrigerators than about healthcare providers, but that is the case.

The regulation of healthcare professionals is among the most secretive processes in government today. From the outside, it looks as if the culture is more oriented to protecting the licensees than protecting patients. We know that regulatory boards are strapped for resources and often have to face well-resourced, savvy lawyers on the other side.

Still, boards have the information, consumers don't. Making that information public would be an essential step toward rooting out the small percentage of licensees who threaten harm to patients."

Improve Consumer Education

How many consumers know the difference between a physical therapist and an occupational therapist? Between an RN and an LPN? Between an OD and an MD? Between a real estate agent and a real estate broker? Between a building inspector and an appraiser? Between a psychologist and a psychiatrist? Between an ophthalmologist, an optometrist, and an optician? Between a financial planner and a stock broker? Between an architect and a general contractor?

How many consumers know the kinds of complaints a licensing board has jurisdiction to address? Can they deal with fee disputes? If not, who can?

How many boards believe they have some responsibility to educate consumers on questions such as these? We have examined many board websites, and very few that we have looked at answer these questions.

How many boards believe they have some responsibility to educate consumers on questions such as these?

It is one of the reasons the public is so uninformed about what you do. Too often, we pay a high price for this lack of knowledge and understanding when we seek a legislative amendment to our practice act that would allow us to do a better job. In too many cases, there is no citizen support for our efforts. Much of this lack of support is based on lack of understanding. Imagine if we had public support for our proposals. I know it would make a difference.

LETTERS

Dear CAC:

I wanted to let you know that your suggestion about including the complainant in the conversation with the North Dakota Board of Pharmacy while considering the adoption of a stipulated settlement, or agreed order, was taken up by our board and is now included as one of the tenets of our complaint resolution policy, which can be found at http://www.nodakpharmacy.com/complaints.asp.

From our agenda of March 15, 2012:

Discussion on changing our procedure to share proposed stipulated settlements with the complainant before approval by the board. Should we invite them to the meeting, after the pharmacist or pharmacy has signed the stipulation, to participate in the discussion before a vote on approval?

After discussion of the topic:

Executive Director Anderson asked the Board Members to consider a variation in our complaint resolution process. When an actual formal complaint is brought by the Board of Pharmacy as a result of a complaint received from a member of the public, and a hearing is scheduled, but a signed Stipulated Settlement is reached before the hearing, we offer the complainant an opportunity to discuss the stipulation with the Board, before we make the decision on that Stipulated Settlement. The Board Members felt that this was a reasonable accommodation, and by consensus our complaint resolution process will be changed.

Sometimes advocacy makes changes.

Sincerely,

Howard C. Anderson, Jr., R.Ph.
Executive Director
North Dakota Board of Pharmacy

Colleagues:

I am sending you two unsolicited papers because a) I think you will find them of interest, and b) they are being published in a journal you may not routinely see, Academic Medicine.

Perspective: A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians: http://journals.lww.com/academicmedicine/Fulltext/2012/07000/Perspective___A_Culture_of_Respect,_Part_1___The.10.aspx, and

Perspective: A Culture of Respect, Part 2: Creating a Culture of Respect: http://journals.lww.com/academicmedicine/Fulltext/2012/07000/Perspective___A_Culture_of_Respect,_Part_2__.11.aspx.

Sincerely,

Lucian Leape

Dear CAC:

There are fascinating developments in Montana at the BME in the wake of the decision of the Montana Supreme Court in *Baxter v. Montana* (2009).

To briefly recap:

The Court held that the policy of the State, as reflected in the advance directive statute, is to empower citizens w/autonomy over medical and end of life decision making, such that it would be consistent w/the public policy of the state for physicians to provide aid in dying (i.e., a prescription for medication to a mentally competent terminally ill patient which the patient may ingest to achieve a peaceful death). Accordingly, there is no basis for criminal prosecution of a physician who provides aid in dying. This provides protection from criminal exposure. The decision did not address disciplinary exposure.

Compassion & Choices (C & C) asked the MT BME to express its policy on how it would handle a complaint for aid in dying. The BME sought public comment and received a great deal. It issued a Position Statement in January, but in face of aggressive response by those opposed to aid in dying, it issued a shorter revised Position Statement in March, posted to the BME website. The BME Position is that it will handle a complaint re this practice as it would any other. We at C & C were pleased with this appropriate Statement. Opponents are engaging in aggressive bullying of the BME to force it to rescind.

Under this Position Statement should a complaint be filed involving a physician providing aid in dying, the BME would assess whether the care provided met the standard of care. As you probably are aware, there is growing support for the option of aid in dying. A short article of mine citing and discussing policies of national medical and health policy groups supportive of the practice is in the Vol. 10, No. 1, Spring 2009 issue of the Harvard Health Policy Review. This sort of support buttresses the case that providing aid in dying can be appropriate and within the standard of care.

I would be pleased to speak about the trend toward expanding end of life choice at an upcoming CAC conference, possibly the 2013 annual conference. It would be good to speak w/Board members about the importance of Board's being sensitive to the need to respect physicians who provide this compassionate end of life care option.

Sincerely,

Kathryn L. Tucker, JD
Director of Legal Affairs
Compassion & Choices
Adjunct Professor of Law
Loyola Law School/Los Angeles

See more at
http://bsd.dli.mt.gov/license/bsd_boards/med_board/pdf/physician_aid_in_dying.pdf.

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

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
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

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:		
Name of 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:

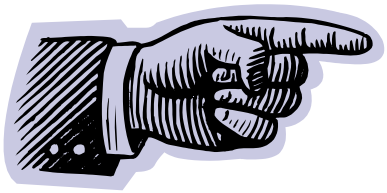
or

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.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2013 and back-issues for $240.00.**

Name of Agency:	
Name of Contact Person:	
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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:

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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.