News & Views

Citizen Advocacy Center

Fourth Quarter, 2012 - A Health Care Public Policy Forum - Volume 24 Number 24

Upcoming Meetings – Save The Dates!

Citizen Advocacy Center's Public Outreach Meetings will be held in Washington, DC, on April 9 – 10, 2013. More information is at http://www.cacenter.org/cac/public_access_meetings.

Citizen Advocacy Center's 2013 annual meeting will be held in Seattle, Washington, on October 29 – 30,2013. The theme of this meeting will be "Regulation's Impact on Access to Safe Affordable Care." More information will be on our website by mid-year.

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

Although we encourage you to receive our newsletter by becoming a CAC member, ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter.*

CAC offers consulting services. *More information is at http://www.cacenter.org/cac/consultant_services.*

Editorial Note: Once again, the Fourth Quarter issue of CAC News & Views is an account of the plenary sessions at CAC's Annual Meeting. What follows is not a verbatim transcript, but as it is based on an audio recording of the meeting, it is faithful to the speakers' remarks. You may find it helpful to consult the speakers' Power Point slides, which you can find on CAC's Web site (www.cacenter.org).

Jim Oliver, Provost of Seminole Campus, St. Petersburg College welcomed the group to Florida's oldest community college with

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almost 40,000 students and 1700 faculty. He welcomed us on behalf of the Institute for Strategic Policy Solutions, whose mission is "to improve public policy, promote civic engagement, and prepare students for careers in the public sector."

Cassandra Paisley, Bureau Chief of Healthcare Practitioner Regulation, Florida Dept of Health welcomed the group on behalf of the Division of Medical Quality Assurance, which is responsible for licensing and regulating healthcare practitioners through its 22 healthcare boards and councils. The Division licenses practitioners. The Department of Business and Professional Regulation regulates businesses and professions. The Agency for Healthcare Administration regulates hospitals and other healthcare facilities.

She explained that in Florida, there is no division between the roles of licensee and public members. They have the same role and expectations. They are appointed for different reasons. The professional member understands the nuances of the profession and can better judge whether a licensee has violated the scope of practice. The consumer member maintains the human side and makes sure that the patient has a voice. The Division makes a concerted effort to be sure that public members understand their role in the process.

It is important for board members appointed under a governor's watch to understand that governor's view and vision is for the regulation of professions. CAC's mission and vision are aligned with those of the Department of Health.

Becky LeBuhn, Board Chair, Citizen Advocacy Center welcomed the group in behalf of CAC. She noted that attendees came from 23 states and 19 different professions. Twenty-nine public members were present, in addition to licensee board members, board staff, representatives of licensing board associations, attorneys general, specialty certification, health departments, legislators, laboratories, testing companies, facility regulators, federal government, and programs for chemically dependent practitioners. She invited attendees to submit ideas for additional research projects they would like CAC to pursue, and she mentioned that at the request of attendees at the 2011 annual meeting, CAC researched how boards handle minor complaints. This survey report is now available to download from our website: http://www.cacenter.org/files/HowDoesYourBoardResolveMinorComplaints.pdf

KEYNOTE: The Importance of Board Discipline

David Swankin, President and CEO, Citizen Advocacy Center

For the second year in a row, CAC has devoted its annual meeting exclusively to the subject of discipline. As I said when I opened last year's meeting:

> While licensing boards engage in many important activities, it is the disciplinary function that most frequently attracts media attention. This makes discipline the most important determinant of the public's perception of your boards. Whether you like it or not, you don't see many people asking what you do in connection with testing, licensing, education, and other functions. It is discipline that they are aware of.
>
> And, in fact, nothing is more important to a board's statutory mission to protect and promote the public health, safety, and welfare than a well-functioning disciplinary program. The public wants assurance that licensing boards are undertaking appropriate interventions when practitioners fall below minimally acceptable standards of practice.

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In many states, board discipline programs have been reviewed and evaluated – sometimes by state auditors; sometimes by governor-appointed blue-ribbon commissions; sometimes by legislative sunset reviews; sometimes by investigative reporters, and sometimes by all of the above.

The most comprehensive review of healthcare workforce regulation was conducted in 1995 by the Pew Health Professions Commission, on which I served. This review resulted in a report entitled, "Reforming Health Care Workforce Regulation – Policy Considerations for the 21st Century. On the subject of discipline, the Commission recommended that:

> States should maintain a fair, cost-effective, and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.

The Commission framed the problem this way:

> State professional licensing boards are charged with the responsibility of investigating complaints and disciplining health professionals whom they find to have violated statutes, rules, or regulations governing a particular profession. In carrying out their responsibilities, many health professional licensing boards find themselves facing

decreasing budgets and increasing public criticism of how they perform the disciplinary function.

The problems and criticisms fall into four general areas. First, information about the complaint process and disciplined health professionals is not made generally available to the public, making it difficult for aggrieved consumers to determine who can help them resolve their problems with licensed health professionals or make informed choices about who should provide their health care.

Second, members of the public who complain to boards are frequently not informed about the progress of their complaints or allowed to participate in the proceedings.

Third, boards are not seen as vigorously pursuing allegations of health professionals' misconduct or incompetence.

Finally, when boards do act, they are frequently criticized for taking far too long to resolve a complaint and for imposing inappropriate or ineffective sanctions.

So, I pose this question to all of you**:** How does your board measure up against these four areas of concern related to board discipline?

There are best practices out there. One purpose of all of CAC's Annual Meetings is to highlight best practices as they are evolving. Boards would do well not only to adopt best practices, but also to explain them to the public.

One best practice is for a board to self-evaluate its disciplinary program and identify areas for improvement. CAC has a tool entitled, "Evaluating Board Disciplinary Programs" on our Web site at http://www.cacenter.org/files/DisciplinaryPrograms.pdf. This tool advises boards that identify areas needing improvement to determine whether the improvement requires a legislative change, a change in board policy, or an increase in resources.

It is instructive to remember that until the middle of the 20th century, most health professional licensing boards paid little attention to carrying out what the Pew Commission referred to as a "fair, cost-effective, uniform disciplinary process." I highly recommend to all of you a book published this year entitled *Medical Licensing and Discipline in America – A History of the Federation of State Medical Boards*. While this book is about medical boards, I think much of what is written about the disciplinary function (especially in Chapter 6, "The Push for Public Accountability") is relevant to all types of health professional licensing boards. Consider the following short passage from page 156:

It is instructive to remember that until the middle of the 20th century, most health professional licensing boards paid little attention to carrying out what the Pew Commission referred to as a "fair, cost-effective, uniform disciplinary process."

> Historically, state boards operated predominantly as gatekeepers monitoring entrance into the licensed practice of medicine. Much of their disciplinary effort up to that time tended to be exclusionary in nature, often focusing on unlicensed practitioners and defending the physicians' statutory scope of practice against incursions by other health professions. The release of a 1961 report by the AMA Committee on Medical Discipline foreshadowed a growing criticism of the medical profession and state boards for failures both real and perceived in the realm of discipline. Criticism of the former emphasized the profession's role seeking to limit, localize, and veil the outcomes of the relatively few disciplinary measures taken against physicians. State

> medical boards were criticized for their seeming unwillingness to pursue disciplinary matters, particularly in realms that addressed physician competence and the quality of care delivered to patients.

As I said, I think you could substitute for the words "medical boards" virtually any other type of health profession board.

Let me close with the final paragraphs of the Pew Commission report. In a section entitled, "Challenge for the 21st Century," the Commission said:

> Boards should consider implementing processes such as complaint prioritization using established criteria and alternative dispute resolution techniques to move efficiently and effectively resolve complaints. By effectively prioritizing complaints, boards would be able to identify those cases that warrant immediate attention, thereby protecting the public from harm by a substandard practitioner. This would also allow for identification of those cases that are best suited for more informal resolution processes and improve the boards' ability to handle the increasing volume of complaints they receive. In addition, uniform disciplinary processes should appropriately link disciplinary action to the severity of the complaint.
>
> Remembering that boards' primary duty is to protect the public, boards should acknowledge and respond to every complainant in writing. Furthermore, boards should communicate regularly with the complainant about the status of his or her case. Such communication would alleviate increasing criticisms and public perceptions of the boards as ineffectual. Finally, boards should notify the complainant of the outcome or resolution of the case and make all publicly disclosable disciplinary actions available to the public. By providing the public with information about its complaints and disciplinary processes and outcomes, public accountability is greatly improved.

Remembering that boards' primary duty is to protect the public, boards should acknowledge and respond to every complainant in writing.

Thank you.

DISCUSSION: Relating Board Disciplinary Activities to System Safety

Speakers: Kathy Apple, Executive Director, National Council of State Boards of Nursing and Brian Stiger, Director, Los Angeles Department of Consumer Affairs

Moderator: David Swankin, President and CEO, Citizen Advocacy Center

Apology: We regret that because of a technical glitch, the recording of this session was inaudible so the content can not included in these proceedings. We sincerely apologize to CAC News & Views subscribers and to the session's speakers, who generously shared their time and expertise. The session was a wide-ranging informal conversation between Mr. Swankin, Ms. Apple, and Mr. Stiger. While the dynamic and informative discussion has unfortunately been lost, we are able to share the topics that were

addressed. Readers may wish to contemplate these topics themselves or explore them with other board members at a meeting or retreat.

Question: Last summer, the media covered the story of a radiologic technician who diverted fentanyl syringes and then infected at least 31 patients in New Hampshire with hepatitis C from used syringes filled with dummy fluid. Investigators discovered that previously he had done the same thing in seven other states. Medical technicians are not regulated as closely as physicians and nurses, for example, but this case generated calls for a national registry covering all healthcare workers who provide patient care and mandatory disclosure by healthcare facilities of problem workers.

How do we improve communication among facilities and between facilities and regulators? How do we assure that facility regulators and licensing boards share information? Should we have a national registry covering the entire healthcare workforce?

Question: In Ireland, and perhaps other countries, hospitals are expected to handle minor complaints in-house. As a result, licensing boards receive fewer complaints than do boards in the U.S., and the complaints they do receive allege more serious infractions.

Is this a good idea? Would you recommend it here in the U.S.?

Question: Unlike healthcare, the aviation industry is regulated by a single national agency, the Federal Aviation Administration (FAA) and serious accidents are investigated by an independent agency, the National Transportation Safety Board (NTSB). The NTSB looks at people (pilots, air traffic controllers, etc,) places (airports), and equipment (airplanes, etc.). The closest thing to this in healthcare is the root cause analyses conducted by the Joint Commission. Some people have called for a NTSB for health care.

Given our history of state-based regulation of the professions, is this a viable idea? Is it a good idea? How would licensing boards react to such a proposal? Pharmacy boards have jurisdiction over pharmacies as well as pharmacists. Is this a better model?

An executive from a board of nursing in another state said she would not have disciplined the nurses because neither the medical board nor the pharmacy board disciplined the doctors and hospital pharmacists implicated in the incident.

Question: We all remember when a Boston Globe reporter died from a massive overdose of cancer medication at Dana Farber Hospital. The Massachusetts Board of Nursing disciplined the nurses involved in the incident. For that action, it was called a "terrorist organization" by a prominent doctor. An executive from a board of nursing in another state said she would not have disciplined the nurses because neither the medical board nor the pharmacy board disciplined the doctors and hospital pharmacists implicated in the incident.

What is your view of this system of separate bodies to regulate the various professions and healthcare delivery institutions? Do "umbrella agencies" bring some coordination? Could licensing board associations like NCSBN and its counterparts break down the silos that separate regulatory entities? Do you anticipate that regular meetings of the CEOs of the NCSBN, the Federation of State

Medical Boards, and the National Association of Boards of Pharmacy will lead to change? Should other licensing board associations be included?

PRESENTATION: Hospital-Based Discipline

Elizabeth Rezaizadeh, Policy Analyst, Division of Practitioner Data Banks, Bureau of Health Professions, Health Resources and Services Administration

I will start with some basic background information about the National Practitioner Data Bank (NPDB). We also manage the Healthcare Integrity and Protection Data Bank (HIPDB), which collects information about healthcare practitioner licensure actions, criminal convictions, and other civil judgments. I will also talk about our beefed up compliance activities and some of the new features of the banks.

A patchwork of laws went into creating the NPDB. The first is Title IV Public law 99-660 under the Healthcare Quality Improvement Act of 1986. More recently, Section 1921 of the Social Security Act expanded the information collected in the NPDB. Then the Health Resources and Services Administration (HRSA) enacted implementing regulations, which can be found on the Web site.

The NPDB serves primarily as a flagging system, meant to facilitate a comprehensive review of healthcare practitioners' professional credentials. The information is supposed to be used in conjunction with other sources. This is just one tool to help hospitals make hiring and credentialing decisions and boards to make licensure decisions. The bank also collects information on medical malpractice payments. Section 1921 expands the information collected to protect Medicare and Medicaid beneficiaries.

The NPDB serves primarily as a flagging system, meant to facilitate a comprehensive review of healthcare practitioners' professional credentials.

The entities required to report to the NPDB are medical malpractice carriers, state licensing boards, hospitals, Peer Review Organizations, private accreditation entities, and other healthcare entities that have a formal peer review process in place. A memorandum of understanding with the Office of the Inspector General of the Drug Enforcement Agency requires them to report.

The information in the NPDB is not open to the general public, but is available to licensing boards, hospitals, and other authorized healthcare entities, for a fee (currently $4.75 per query). Hospitals are the only entities required to query the NPDB every two years for anyone on staff or granted clinical privileges. Florida is one of the states that use a service called "continuous query" to receive information on licensees. Practitioners can perform a "self-query." Some licensing boards require practitioners to provide their own NPDB query report.

There is an average of 4 million queries a year. Most of those are from health plans, followed by hospitals. Hopefully the two data banks will soon be merged, so that entities will have to pose only one query, rather than two. This was authorized under the Affordable Care Act.

Under very limited circumstances, plaintiff's attorneys can get a Data Bank report. They must show that the hospital failed to query despite the legal requirement, but the

information can be used only against the institution and not against the practitioner. The entities identified under Section 1921 are authorized only to obtain information collected under that authority.

Reportable state licensure actions have to be based on competence and conduct. This applies predominantly to physicians and dentists. Reporting is permissive for other healthcare practitioners. Under Section 1921, state licensure actions against other practitioners are now reportable to the NPDB, whereas previously these actions were reported to the HIPDB. Adverse actions include denial (or withdrawal) of initial application, license revocations, suspensions, summary or emergency suspensions, limitations or restrictions, and reprimands. Also, dismissal of a proceeding because a practitioner surrenders his or her license or leaves the jurisdiction is reportable. Any other loss of license by operation of law would be reportable. States can determine what they consider to be a "negative action or finding," which is also reportable to the NPDB. Some states consider a letter of concern to be a negative action; other states do not. Monetary penalties and modifications to previously reported actions are required to be reported.

Our compliance staff receives many questions about whether provisions in consent orders are reportable. Conditioning a settlement on a promise not to report to the Data Bank would violate the law. Non-reportable licensing board actions include monitoring (proctoring), state actions, and voluntary relinquishment of a license for personal reasons.

Actions are reportable within 30-days. If a hospital were to restrict a practitioner's ability to deliver care, the hospital would send a report.

Hospitals with a pattern of non-reporting may lose their immunity privileges for their peer review panels.

Sanctions for failure to report include fines of up to $11,000 per incident for medical malpractice carriers. Hospitals with a pattern of non-reporting may lose their immunity privileges for their peer review panels. Anyone who discloses information in the NPDB for an unauthorized purpose can be fined up to $11,000 per incident.

The types of actions that are reported to the NPDB include state licensure actions involving a variety of professions. These now constitute more than 50% of reports because of the requirements in Section 1921. Previously, most of the reports came from malpractice insurers and involved largely doctors and dentists.

When Section 1921 went into effect, many new compliance officers were hired to work with state licensure boards. Their focus is to ensure that reporting requirements are met by all entities. Much of their activity is educational. They want to make sure the information collected is accurate, timely, and useful to those who pay to access it. These outreach efforts have reduced the number of state agencies that have "never reported."

The six most queried professions are doctors, dentists, nurses, pharmacists, physician assistants, podiatrists, psychologists, and social workers. We have made sure those boards are aware that they have reporting obligations and most are compliant. We are now looking at other professions, including chiropractors, optometrists, physical therapists, and behavioral therapists.

A new compliance activity is the two-pronged Hospital Compliance Initiative. We want to better understand the credentialing and peer review processes in place at hospitals, and

the barriers to reporting. We are also working with our research staff to study the data and learn how to strengthen the review process.

To help facilitate the sharing of reports, we have a new feature called Report Forwarding. Instead of having hospitals and other healthcare entities print off a copy of the Data Bank report and mail it to licensing authorities, facilities in states that have agreed to participate in Report Forwarding can forward reports electronically.

Instead of having hospitals and other healthcare entities print off a copy of the Data Bank report and mail it to licensing authorities, facilities in states that have agreed to participate in Report Forwarding can forward reports electronically.

Question: Suppose a nurse (or other professional) had a license suspension and an administrative complaint several years ago, but successfully completed a monitoring program and now is doing well with no recurrence of impairment. Is this updated regularly, so the nurse isn't stuck in time?

Rezaizadeh: Yes, this is taken care of by Revision to Action Reports. Also, practitioners are permitted to file a narrative statement to accompany a report in the Data Bank.

Question: You said that initial licensure application denial is reportable.

Rezaizadeh: Yes, if the application denial is for cause, such as failure to disclose something.

Question: I'm with a board of nursing and am pleased to hear about the merging of the two Data Banks. It might prompt agencies such as mine to query more frequently. I think it is unfortunate that stayed actions are not in the Data Bank because a stayed suspension is a serious action in our state and should be viewed as the equivalent of a suspension.

Is there any plan to send the Data Bank information to the OIG because state agencies need to report to OIG separately for potential exclusion? If your agency could report to the OIG, that would be helpful.

Rezaizadeh: There is no plan for that at present. I'm not sure that the content of the reports to the OIG is the same as the content of reports to the Data Bank.

Question: It is my understanding that if a state board takes an action off public access Web sites after a certain period of time, it will never be removed from the NPDB.

Rezaizadeh: That is correct.

Question: What is the difference between the NPDB and the HIPDB?

Rezaizadeh: Federal and State agencies and health plans are required report to the HIPDB. Also, HIPDB is broader in that it collects information on providers and suppliers as well as practitioners. There is a distinction on the type of actions that are reported. HIPDB requires reports of final actions. For an administrative fine to be reportable to HIPDB, it has to be related to the delivery of health care and taken in conjunction with another reportable adverse action. With the NPDB, only one of those two criteria must be met.

PANEL: The Practice Acts

Kathy Thomas, Executive Director, Texas Board of Nursing; Eric Brown, Chief Investigator, Oregon Medical Board; Zeno St. Cyr, Public Member, Maryland State Board of Pharmacy

Thomas: We have been asked to talk about mandatory reporting, whistleblower protections, the value of complaints from healthcare professionals versus consumers, and whether boards should have jurisdiction over facilities as well as individuals.

Texas has had mandatory reporting for nurses since 1987, when the quality assurance act passed. It created mandatory reporting and mandatory peer review. Hospitals that employ ten or more nurses must do peer review and those peer review committees have a duty to report to the board. The law excludes minor incident reporting. In general, the data shows that mandatory reporting laws do cause an increase in reporting. Also, states that don't have mandatory reporting take fewer disciplinary actions per licensee population.

The downside is that there is a significant potential for over-reporting, partly due to fear of liability for not reporting. In Texas, we did receive more minor complaints reports, even though they are exempted from the law. This is balanced by the fact that we receive many more serious complaints than we did before mandatory reporting. Many are cases where employers terminate, and if they don't report, the individual may continue to work at another facility. The bottom line is that the board needs to provide guidance about what constitutes a minor complaint and what should be reported.

The beauty of the peer review process is that it filters complaints. We developed rules for peer review committees to help them decide what is and what is not reportable. They issue a report to the board about their activities. When peer review committees perform well, it speeds up the board's investigative process.

The case involved two nurses who reported a doctor to the Texas Medical Board for substandard practice. He was dispensing something he called oxygenated olive oil out of his car to his hospitalized patients. He sutured a rubber tip on a patient's crushed finger "to protect it from infection."

We had a significant whistleblower case that took place in Winkler County, Texas, with a population 7,000 and one 19-bed critical access hospital, Winkler County Memorial Hospital. The case involved two nurses who reported a doctor to the Texas Medical Board for substandard practice. He was dispensing something he called oxygenated olive oil out of his car to his hospitalized patients. He sutured a rubber tip on a patient's crushed finger "to protect it from infection." He performed surgery in the ER, even though he did not have clinical privileges for surgery. He was also under a medical board order at the time the nurses reported him.

One of the nurses was the hospital's compliance officer; the other was the performance improvement officer. They had been there for a combined forty-seven years. The case illustrates the importance of having adequate whistleblower protections in general, and in particular, in connection with reporting licensees to the appropriate board.

When the physician received notice from the medical board that a complaint had been filed against him, he filed a counter complaint with his golf-buddy, the sheriff, claiming he was being harassed. In June 2009, the nurses were criminally indicted for misuse of

official information, a felony offense in Texas – even though under the Nursing Practice Act, nurses have a duty to advocate for their patients and to report another healthcare provider to the appropriate licensing authority.

How did the sheriff identify the nurses, since complaints are confidential? The sheriff claimed to be a law enforcement officer seeking information in a criminal investigation, which overrides the confidential nature of the complaint. So, he obtained their names and a search warrant, went into their computers, and found the complaint letters.

In 2009, the nurses struck back and filed complaint for illegal termination with the Department of State Health Services, which regulates facilities. They also filed a civil suit in federal court against the hospital, the sheriff, the county attorney, the DA, the hospital administrator, and the physician for retaliation and malicious prosecution in violation of civil rights.

The defendants asserted sovereign immunity and other defenses. The hospital could be fined no more than $1,000 a day because the termination occurred on a single day.

In February 2010, the prosecution dismissed the charges against one of the nurses. The other nurse had a four-day trial. The jury returned a verdict of not guilty within an hour. This was a victory, but it had been a painful process for the nurses who lost their jobs at the only healthcare facility in the community.

In April 2010, the Department of Health Services issued a violation letter to the hospital for wrongful termination and imposed the small fine. In December 2010 and January 2011, the physician, the sheriff, the county attorney, and the hospital administrator were all indicted for retaliation against the nurses and all four were convicted. In August 2010, the federal civil suit was settled for a lump sum of $750,000 to be divided between the nurses and to cover their legal costs. In November 2011, the physician surrendered his license. The nurses' association introduced legislation raising the facility fine to a minimum of $25,000 per day and expanding immunity for nurses to cover criminal liability.

The lessons from this experience are that it is important to look at multiple statutes that bear upon whistleblower protections, and to protect a licensee's duty to advocate for their patients. Licensees need to be educated about this duty because this well-publicized case clearly did scare people. Even though the nurses ultimately prevailed, they paid a high price in the community. The absence of protections can have a chilling effect on reporting.

The lessons from this experience are that it is important to look at multiple statutes that bear upon whistleblower protections, and to protect a licensee's duty to advocate for their patients.

On the comparative value of complaints from healthcare practitioners and from consumers, most nursing-related complaints come from facilities, peer review committees, the alternative to discipline program for impaired nurses, and criminal reports. We are receiving a growing number of complaints from consumers. Tort reform passed in 2003, resulting in a cap on punitive damages that suppressed malpractice lawsuits in healthcare. Consequently, consumers feel they have nowhere to go for justice except licensing boards.

We find that consumers are better informed. They can research diseases and treatments on the Internet and come to the board pretty well informed about what they believe should have happened. They are better advocates because it is a loved one who has been

harmed, or killed, in a healthcare situation. Although consumers may not have the same expertise practitioners have, we do see valid complaints from them. Consumers often want severe penalties, even when the violation may not rise to that level. So, consumers may not be happy with the board's choice of disciplinary action. We invite complainants in for a conference if they choose. It is important for families to be able to be heard by an empathetic ear.

Should boards regulate facilities? I won't say they shouldn't, but it would be very hard. I'll keep an open mind. Hospitals would oppose this because they already feel over-regulated.

Brown: Oregon is large geographically, but has a small population. We have twelve board members, two of whom are public members who keep us honest by contributing the non-medical perspective, which is critical for every board. We license about 18,000 practitioners, including physicians, podiatrists, physician assistants, and acupuncturists. Only about 15,000 are actually practicing.

Oregon has strong mandatory reporting laws. The relationships we have with hospitals are primarily informal, but they are required by law to report, as are licensees. Statute 676.150 requires reporting unprofessional conduct. This applies to physicians, nurses, midwives, and most other professions that have a regulatory board. So, a nurse who sees unprofessional conduct on the part of a physician is obliged to report this to the medical board. This reporting requirement used to be restricted to "like" practitioners.

Unprofessional conduct is defined to exclude minor complaints. Unprofessional conduct includes standards of ethics, and incidents for which a hospital might suspend privileges. Licensees have to self-report within 10 days when arrested for a felony or convicted of a misdemeanor or felony. The clerk of the court is also supposed to report a licensee's conviction. Healthcare facilities have numerous reporting requirements, including prohibited conduct, blood alcohol content related to traffic accidents.

The board can refuse to grant a license if it comes to our attention that the applicant had failed to report any adverse action taken against the licensee by another licensing jurisdiction or any peer review body, health care institution, professional or medical society or association, government agency, law enforcement agency or court for acts or conduce that would constitute grounds for disciplinary action. Failure to report a voluntary resignation or practice limitation is also grounds for board action.

Licenses can be automatically suspended for mental illness or imprisonment. Hospital administrators are obligated to report this information.

Licenses can be automatically suspended for mental illness or imprisonment. Hospital administrators are obligated to report this information.

A healthcare facility has an obligation to report within 10 days when an official action is taken on a licensee, such as suspension or withdrawal of privileges. The amount of information supplied will vary. In Oregon, for example, peer review confidentiality is used as protection rather than as a way to report to the board. So, often we will get a very short report saying little more than Dr. Doe has been suspended for thirty days. When we ask the reason(s), we are told it is protected by peer review confidentiality. Eventually, we usually obtain the information we need.

Anecdotally, we have been told that hospitals and licensees have figured out that if they simply wait until someone's contract is up and not renew it, they can get rid of the individual with no official action taken and without informing the board. "Official action" means a restriction, limitation, or loss or denial of privileges of a licensee to practice medicine, or any formal action taken against a licensee by a government agency or health care facility based on a finding of incompetence, unprofessional conduct, physical incapacity, or impairment.

Suicide attempts by minors must be reported and institutions must get social workers involved, but this is just statistical reporting; the individual's identity does not need to be revealed. Hospitals must report restrictions or termination of privileges and explain the facts and circumstances that resulted in the restriction or termination.

In Oregon, the bulk of the complaints we receive come from patients or associates of patients, but fewer than 8% of those complaints result in an official or informal action. Because they tend not to allege violations of the practice act, most patient complaints result in letters of concern rather than disciplinary actions.

The numbers of reports by healthcare practitioners and hospitals is increasing. Forty percent result in some sort of board action because the substance of these complaints is more likely to involve patient safety and professional conduct. Mandatory reporting enables us to remove dangerous doctors and also to correct behaviors and enhance education to improve practice and help the public.

St. Cyr: I will speak about examinations, licensure, discipline, and the Maryland Pharmacy Board's dual jurisdiction over licensees and facilities.

Examinations provide the first line of protection for the public. Independent testing plays a critical role in validating whether healthcare professionals have the critical competencies needed to practice their professions. For the most part, the public has no idea what is tested or who administers the test.

The public perceives that awarding someone a license certifies that the individual has the minimal critical competencies necessary to practice that profession or trade. That is why examinations are required for licensure. Examinations and licensure protect the profession, but more importantly, they protect the public.

Turning to discipline: When I was appointed to the dental board some years ago I asked the board president what we should do with discipline cases. He said our work is not punitive. We are not there to punish practitioners; we are there to protect the public.

Our disciplinary decisions should be consistent, but one size does not fit all because of aggravating and mitigating factors. All complaints should be evaluated on their merits, but some violations call for mandatory sanctions.

Our disciplinary decisions should be consistent, but one size does not fit all because of aggravating and mitigating factors. All complaints should be evaluated on their merits, but some violations call for mandatory sanctions.

Sanctioning guidelines have helped boards be more consistent with their disciplinary decisions. In Maryland, the legislature mandated that all health professional boards have sanctioning guidelines. The pharmacy board recently published its guidelines.

Different viewpoints are represented on the pharmacy board – practitioners, consumers, professional specialties, retail drug store pharmacists vs. hospital-based pharmacists, and so on. The pharmacist members of the board are nominated by the various professional and business groups in their specialties.

Discipline decisions must balance public protection and the practitioner's professional reputation. June 23, 2002, the Virginia Pilot newspaper said:

By dismissing a case behind closed doors, the medical board prevents the public from learning that a doctor was accused of a serious error. In comparison, civil suits and criminal charges are public from the time they are filed, even if a lawsuit is eventually dropped, or if the defendant is found not guilty.

We are not a court of law, but we are there to protect the public and we want the public to know about bad actors. That's why our public orders are made public. This has to be balanced with making sure that we have done our due diligence and investigated all the facts to be sure that before we issue any public orders we know the findings are warranted.

The Maryland Pharmacy Board's vision is "to set a standard for pharmaceutical services that ensures safety and quality health care for the citizens of Maryland." Because the membership represents different specialties and places of work, there are diverse points of view brought to the table, but when we deliberate, everyone on the board is a consumer.

Pharmacy boards have jurisdiction over licensees (pharmacists) and registrants (pharmacy technicians) and pharmacy facilities (pharmacies, drug stores, grocery stores, and wholesale distributors). Disciplinary cases are handled by the board and the compliance staff.

In Maryland, there are about 19,500 pharmacist licensees. There about 1,700 pharmacy permits and 867 wholesale distributors. The bases for discipline are complaints and inspections of pharmacies and wholesale distributors, which occur at least annually.

We had 332 complaints in FY 2011. The largest number was against establishments, then pharmacists, and lastly pharmacist technicians. The majority alleged professional misconduct (64%). Dispensing errors were next (23%), followed by other (8%), customer service (3%) and non-jurisdictional complaints (2%).

Informal, non-public disciplinary actions include letters of education, letters of admonishment, or mandatory CE. Formal, public orders include fines, probation, suspension, or revocation. In FY 2011, about 60% of complaints resulted in an informal or formal action.

Informal, non-public disciplinary actions include letters of education, letters of admonishment, or mandatory CE. Formal, public orders include fines, probation, suspension, or revocation. In FY 2011, about 60% of complaints resulted in an informal or formal action.

The pharmacy model has advantages. One is that our inspections allow the board to review and take action against not only people, but also places. Facility policies and procedures are subject to board review, but the board has to walk a fine line between its regulation of establishments and board intrusion into business practices. For example, we can require pharmacies to do something as simple as posting licenses, permits, or hours of operation. We require many pharmacies to operate six days a week, and to have an 800 number to facilitate patient contact. We also regulate such

things and short- and long-term dispensing. Sometimes, an investigation into a complaint reveals that the problem was not with a licensee, but with the policies and procedures of the establishment. We can also limit the number of hours or shifts pharmacists work without a break, but we cannot limit the total hours per day, even when we believe extended hours contribute to medication errors.

Question: My question is about enforcing sanctions against licensees for failure to report. How often does this happen? How are these individuals discovered? What sanctions are involved?

Brown: They can be discovered many ways. Sometimes another individual or a hospital informs us; sometimes we learn it from the Data Bank or the Federation of State Medical Boards. If failure to report was due to ignorance of the requirement, we issue a letter of concern. Often failure to report turns out to be part of a larger problem.

Thomas: Enforcement is not as good as it could be. Part of the problem is that we may not get a report from someone else, so we don't know there is a failure to report. Facilities do a better job of reporting than do licensees, who have to go on practicing with these other people and are afraid of attack or ostracism.

Question: Kathy Apple spoke this morning about collaboration at the national level between medicine, nursing, and pharmacy. Here we have a representative of a board in each of these professions. Do you experience that kind of collaboration within your own states?

Thomas: Recently, we have had an outbreak of pill mills that involve doctors, pharmacists, advanced practice nurses, and physician assistants. We have a joint initiative for investigating and doing onsite, unannounced inspections. We invite DEA to come in with us. This inter-board collaboration has been successful and has resulted in several prosecutions already.

Brown: The federal government DEA agents in Oregon transmit reports about misconduct. In addition, the executive directors of the pharmacy, nursing, medical, and dental boards meet as a group every couple of months to talk about issues they have in common related to prescribing.

St. Cyr: In Maryland, a meeting takes place regularly within the Department of Health and Mental Hygiene of all the board executive directors, regulation officers, and attorneys to discuss common issues. Some of the boards have had contentious meetings. For example, the pharmacy board and the medical board have met regularly for a long time to hammer out agreements about drug therapy management.

In Maryland, a meeting takes place regularly within the Department of Health and Mental Hygiene of all the board executive directors, regulation officers, and attorneys to discuss common issues.

The pharmacy board, medical board and dental board have come together around a law that applies to patients who do not live within a reasonable distance of a pharmacy. In those areas, physicians and dentists are allowed to dispense medications from their offices. The issue is how to conduct inspections of the offices to be sure the medications are stored properly, and so on. There have been conflicts over jurisdictional authority, with the pharmacy board offering to do the inspections and the doctors and dentists saying they will do it themselves. The Division of Drug Control is a neutral bystander

and some have wanted them to do the inspections. But the Division doesn't have the resources to conduct additional inspections.

Question: Please talk about discipline of acupuncturists in Oregon. Is it handled differently than physician discipline?

Brown: Acupuncture discipline goes through the same investigative process. We get very few complaints about acupuncturists. Typically, they involve substance abuse and boundary violations rather than professional competence.

PANEL: Relating to the Criminal Justice System

Daniel Hernandez, Prosecutor, Florida Department of Health Prosecution Services Unit, Mike Fasano, Florida State Senator and Chair of Budget Subcommittee on Criminal and Civil Justice Appropriations, Rebecca Marshall, Chief Enforcement Attorney, State Medical Board of Ohio

Hernandez: Conventional wisdom says that it is impossible for boards to work with law enforcement. In my experience, this is not true. The biggest hurdle facing departments of health is communicating what we do. Once law enforcement understands what regulators can bring to the table, the resources we possess, how we can help them, they understand that there can be a symbiotic relationship.

In Florida, we work with the FBI, the DEA, the Florida Department of Law Enforcement, local sheriffs, and police departments. We also work with the Agency for Healthcare Administration, the Department of Insurance, and the Department of Children and Families. So, we have positive experience with many state agencies and with federal and state law enforcement.

In 2010, we had about 106 collaborative investigations with law enforcement and other state agencies. We had twice that many in 2011. In 2012, we will have surpassed the 2011 numbers. What accounts for this increase?

In 2010, we had about 106 collaborative investigations with law enforcement and other state agencies. We had twice that many in 2011. In 2012, we will have surpassed the 2011 numbers. What accounts for this increase?

First, in June 2011, we established an Emergency Action Unit that I operate. It consists of six attorneys and five staff. We focus on cases involving an immediate serious danger to the public, such as pill mills, sexual misconduct, drug diversion, battery, and murder. Emergency actions include suspension and restriction orders. Our caseload is about 4,000 cases that have been investigated and brought to the department for prosecution. On average, we review 30 - 40 new cases per week. When they don't require emergency action, we refer them to another section so we can focus on the high-profile cases where there is the potential for harm to the public. When a complaint comes in, it goes to an investigator and to an attorney in my unit. They work together from the beginning, so the attorney can give guidance to the investigator in complex cases. As a result, we now complete cases in about 45 days (as opposed to about 135 days in the past).

Second, we increased communication between law enforcement and other agencies. We reached out, met with law enforcement, and explained what we do and how we can contribute to their investigations. We work on coordinating with law enforcement on a

continuous basis. We increased our participation on task forces, where we share information with law enforcement and others. We, in turn, learn from investigations other agencies are conducting.

Most of our cases involve an investigation by another agency because they typically involve fraud or some other illegal act. The Emergency Action Unit provides one point of contact for law enforcement and other outside agencies.

We prioritize investigations. The consumer unit that triages complaints has four priorities. The first two priorities are cases that involve immediate danger and are referred to my unit. Priority three cases are candidates for suspension. Priority four cases don't involve immediate or serious danger, but allege a violation.

We further triage the priority one and two cases that come to my unit. If, for example, an arrest is pending, we give the case priority so we can be ready when law enforcement is ready. We made it a priority not to jeopardize law enforcement's efforts. After investing time and effort in an investigation, the last thing law enforcement wants is for an agency that knows nothing about law enforcement and undercover investigating to come along and mess it up. We have made mistakes in the past, and when we have, we show law enforcement what measures we have taken to be sure it doesn't happen again.

When possible, we gather our evidence independently of law enforcement. So, while we collaborate with them, we send our own investigators alongside law enforcement. This is important because law enforcement does not want to testify in our cases. This creates potential inconsistency between their testimony in our case and their case. They are much happier to have our investigators go in and gather our own evidence.

Fasano: I am frustrated when I read in the newspaper or hear from a constituent about a bad doctor, because it is difficult to suspend or otherwise discipline the doctor. The Board of Medicine appeared before the Criminal Justice Appropriations Committee and explained why it takes so long. My colleagues and I don't understand why a physician is not immediately suspended after having been found guilty of a crime. The legislature is going to look at the obstacles the board faces and see if we can pass legislation that allows the board to take action more promptly.

We have a pill mill crisis in Florida. Seven people die each day from an overdose of prescription medication. It took almost twelve years to pass legislation calling for a prescription drug database, which is making a difference. Along the way, we learned how difficult it is to discipline doctors and pain clinics that are over-prescribing. We passed legislation barring felons from owning pill mills and requiring licenses and inspection of these establishments. It is getting better because law enforcement is working with regulators. Also, pharmacists have helped identify over-prescribers.

We have a pill mill crisis in Florida. Seven people die each day from an overdose of prescription medication.

Marshall: People don't understand why there would be friction when law enforcement and the medical board seem to have the same goal. Law enforcement has an undercover operation and don't want it to be exposed. There are turf battles over control of evidence. In Ohio, the administrative process usually moves faster than law enforcement, so it is hard to coordinate.

The board's concern is patient protection. In Ohio, the board cannot act on an indictment; it must have a conviction. This is hard to justify to patients and the media. Boards are under pressure from the public and the media. Political agendas – known and unknown – are part of life.

Ohio is also experiencing problems with pill mills. And, with the weak economy, we have seen an increase in healthcare fraud. Sadly, there has been a spike in sexual misconduct involving patients. There has been a string of child porn cases in Ohio. We have the ability to immediately suspend a license at the moment of conviction for certain things, including physician rape and trafficking of drugs.

How do we use criminal records checks to weed out bad licensees? The most leverage you have is before you have issued a license. I have been surprised that it is not the content of the records check, but what information has been omitted from an application form. The applicants who try to hide their backgrounds tend to be problems.

When we do a records check, we look at patterns, how old they were when they committed an offense, whether there has been rehabilitation, whether it was before or after they started their training. Most significantly, was the offense directly related to their practice?

We have used criminal records checks since 2008. We require a state and a federal check of individuals applying for an initial license. Sometimes they reveal different information. There are federal regulations related to criminal background checks, so be careful. In our office, applications are public, but records checks are not.

We ask licensees on renewal if they have been arrested or convicted of anything. We wanted criminal background checks at every renewal, but could not get that through the legislature because of pushback by the medical association.

Clean records are not a guarantee that the person will be a good licensee. Physicians are smart, so the few who have a criminal bent are evil geniuses. They are hard to catch. Watch for substance abuse and psychological problems. If you do fingerprints, do digital prints.

One of the problems with enforcement against pill mills is that the patients are not complaining about the volume of drugs they are getting. In Ohio, we are seeing an increase in heroin-related deaths as we get a handle on the pill mills.

One of the problems with enforcement against pill mills is that the patients are not complaining about the volume of drugs they are getting. In Ohio, we are seeing an increase in heroin-related deaths as we get a handle on the pill mills. Most of our prescribing actions against physicians result in immediate suspension or permanent revocation. We have an aggressive remediation program for people who are poor prescribers, but not criminals.

We have a very cooperative relationship with law enforcement. We have field investigators in every county and every investigator is on at least one local drug task force. It takes a lot of PR to convince law enforcement that it is worthwhile to work together. We have a good electronic drug database and a law mandating physicians to check it. We also have a collaborate agreement with neighboring states.

These are the things that require a prescriber to check the database in Ohio: If someone is selling drugs, a conviction for altering a prescription, drug screens inconsistent with a person's treatment plan, and clean urine screens that are inconsistent with prescription

records. There is also a list of situations in which it is considered a best practice to check the database, but not a requirement. We identified large-volume prescribers we shouldn't worry about, such as hospice, physician practices owned by a hospital, ambulatory surgical facilities, and accredited entities.

Sometimes it is hard to build a disciplinary case. We now think about intermediate steps if we can't reach full discipline. We have developed consent agreements under which the licensee agrees to suspension pending the completion of a criminal case. Another is an agreement not to practice pending an administrative hearing or criminal process. We will agree to a continuance while the criminal case works its way to conclusion if the licensee agrees not to practice in the meantime. Consent orders may require a chaperone, or limit the kinds of exams that can be performed or the types of patients who can be seen. We have made doctors post the citation from the medical board in the lobby.

How do you get the doctor to agree? Sometimes the alternatives are giving up the license or going to prison. We will soften the statement of offenses in return for giving up the license. We will accept license surrender in return for not going to court.

The main message is to stay on the cases. Doctors assume the medical board is lazy and overworked and will go away if ignored long enough. So, we are persistent in high profile cases. Let the licensee know the board is not going away.

Question: Is there enough information in your consent agreements to allow another state to take summary action?

Marshall: Yes, licensees have to agree to something that is a violation. The amount of information in an agreement is case by case. We put in as much information as possible.

Hernandez: Our cases always involve an emergency suspension or restriction order that is public. There is also a public administrative complaint.

Question: Sometimes boards have to go around professional associations. Here is what the Nevada nursing board said in its newsletter about criminal background checks for licensure renewal:

Why is the board doing this? Simple. Public protection. Not everyone is forthcoming about their past criminal history, for a variety of reasons. Since the start of our renewal program in October 2010, we have 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 for initial applicants.

Publishing this in the newsletter was a tactic to get around opposition from the professional association. Have any other boards tried to go directly to licensees?

Hernandez: I don't know, but I can tell you about a legislative change in Florida that I think will be very helpful. Beginning in 2013, all licensees will be fingerprinted and there will be a central repository. Periodically, the fingerprints will be compared with the FBI's database. So, any arrests will be reported to regulatory agencies when they happen, rather than waiting until renewal time.

Beginning in 2013, all licensees will be fingerprinted and there will be a central repository. Periodically, the fingerprints will be compared with the FBI's database. So, any arrests will be reported to regulatory agencies when they happen, rather than waiting until renewal time.

Fasano: This is something that the Attorney General advocated. It is an illustration of how problems could be dealt with if the

professions would agree to it. The Florida Medical Association and Osteopathic Association are encouraging their members to use the database, but they don't want this to be mandated. It is very concerning that there are still physicians in the state who do not know the database exists.

Hernandez: Law enforcement likes the database as an investigative tool, as does my unit.

Question: In Ohio, are the federal and state criminal background checks just for doctors, or for other professions, too?

Marshall: I don't know about nurses, but I believe they have something. Our board requires background checks for MDs, DOs, DPMs, and PAs. We do not require it for massage therapists or acupuncturists at this time.

Question: One of CAC's board members, Julie Fellmeth of the Center for Public Interest Law in California was appointed the Enforcement Monitor for the California Medical Board. In her report, she emphasized the importance of attorneys and investigators working together from the start of a case. Mr. Hernandez talked about that happening in Florida. Does it happen in Ohio?

Marshall: In Ohio, attorneys and investigators work together on high profile cases, but we have so many complaints, we cannot put an attorney with every investigator on every case. However, investigators are encouraged to call attorneys for guidance.

The New Mexico legislature passed a law in 2012 requiring all healthcare boards to use a prescription database whenever they issue a prescription of opiates.

Comment: The New Mexico legislature passed a law in 2012 requiring all healthcare boards to use a prescription database whenever they issue a prescription of opiates. The nursing board has completed implementing rules and the medical board will soon do so.

Fasano: We are frustrated when boards drag their feet on rulemaking, so I would prefer that statutes have implementing language rather than relying on boards to do a rulemaking.

Comment: The Florida Board of Medicine looks forward to the legislature streamlining the board rulemaking process so we can implement legislation more quickly.

Someone asked whether consent orders contain language that would allow other jurisdictions to take action. In Florida, the law does not allow us to look at an action in another jurisdiction; it simply asks whether there was an action. In a recent case we were taking reciprocal action on discipline that originated in a state with a bifurcated regulatory system under which a state agency does all the DEA-type cases. We missed being able to take a reciprocal action because of this bifurcated system.

Comment: Nevada has had a prescription database for 15 years. There was tremendous pushback, but checking the database has become a best practice. Physicians check because they do not want their names to appear on the list in connection with patients who doctor-shop. A companion piece of legislation makes it a felony for patients to deceive a healthcare provider in order to obtain narcotics.

Comment: The Wyoming Board of Pharmacy has had a prescription database program since 2004. As soon as doctors realize that this is a tool they can use, its popularity will grow. I'm not sure we will need a mandate, because we distribute stickers that say, "We

use the Wyoming Prescription Drug Monitoring Program," and doctors can post these stickers in their offices. Doctors began requesting extra stickers to post in each treatment room, and doctors can use the system to get their own prescribing profile to discover whether one of their patients has been involved in a forgery.

Question: What about interstate sharing of prescription drug monitoring data, and do federal agencies have access to this data?

Hernandez: Legislation passed in 2011 allows Florida to share with other state boards. We share with federal and state law enforcement.

Fasano: Florida's database is paid for by a private foundation because there wasn't money appropriated from the state budget. Including language about sharing allowed us to apply to additional grant sources.

Question: North Carolina has a prescription database, but access is limited to the regulatory boards, the state bureau of investigation, and the DEA. We do not allow local law enforcement to have access because of fears that they would target patients rather than practitioners. Have you experienced this problem?

Hernandez: No. Typically, law enforcement is not interested in the patients. They will sometimes ask patients to provide evidence, but they are targeting doctors or the clinic that is trafficking on the doctor's license.

PANEL: Revisiting Negotiated Settlements

David Swankin, President and CEO, Citizen Advocacy Center, William Miller, Supervising Attorney, Boards of Nursing, Osteopathic Medicine, Pharmacy and Podiatric Medicine, Florida Department of Health

Swankin: Most discipline cases never get to a hearing. Most are settled by a negotiation. In the public interest community, "negotiated settlement" translates to mean "plea bargain," and plea bargain means someone has copped out. I think this is unfortunate because, in my view, the only way to determine whether a negotiated settlement is any good is to evaluate its contents. Some negotiated settlements are so strong they are better than a result that would be possible from an administrative hearing.

In the public interest community, "negotiated settlement" translates to mean "plea bargain," and plea bargain means someone has copped out.

A public member once told me he always votes "No" to a negotiated settlement. He said that in his state he feels like a rubber stamp because all he gets is a one-page summary of each case and the staff's recommended settlement. In his view, a one-page summary isn't enough to reach a decision. I agree.

Here are some of the things I would like to know before making a decision about a proposed negotiated settlement:

- If the agreement has conditions, what are they?
- If there is probation, what is the rationale for the length of time?
- How have similar cases been handled by this board?
- If this case were to go to hearing, would we be likely to get the same or a similar outcome?

- Has this individual had other violations? If so, what were the facts? What were the interventions?
- Will this settlement be public? Reportable on our Web site? In what detail?

CAC produced a publication in 1993 entitled, "Should the Public Have the Right to Comment on Proposed Licensing Board Consent Orders?" We took the position that complainants have a vital stake in their case and should be permitted to be involved, especially when there is a settlement negotiation. After all, every federal agency posts proposed settlement agreements and other actions for public comment. Our proposal was that at least the complaining party should have an opportunity to comment on a proposed settlement. We asked board attorneys to comment and none of them liked this idea.

The North Dakota Board of Pharmacy wrote us recently to say:

> Dear CAC,
>
> I wanted to let you know that your suggestion about including the complainant in conversation with the North Dakota Board of Pharmacy while considering the adoption of a stipulated settlement was taken up by our board and it is now included as one of the tenets of our complaint resolution policy…. 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 a decision on the settlement whether to approve it or not. The board members felt that this was a reasonable accommodation, and by consensus, our complaint resolution process will be changed to allow this to happen.

Why doesn't every board permit this to happen?

Miller: Florida has over a million licensees in 17 different professions. The big five are nursing, medicine, massage therapy, pharmacy, and dentistry. The Prosecution Services Unit is divided into three sections: medical, allied health, and nursing (which handles nursing, podiatry, pharmacy, and osteopathic physicians).

The unit has prosecuted more than 10,000 cases in the last five years, 4,500 by settlement agreement. Licensees agree they don't dispute the allegations of material fact. In Florida, boards have final order authority. ALJs issue recommended orders, which boards can change, but rarely do.

The average cost for prosecuting a case is about $2,500. The least expensive way is informal hearings and determinations of waiver when facts are not disputed. Next are voluntary relinquishments, followed by settlement agreements. A formal hearing before an administrative law judge averages $34,000. So, there is an economic incentive for respondents to settle cases.

The average cost for prosecuting a case is about $2,500.

Most of my experience is with the board of nursing, which is by far the fastest-paced, highest volume practice in prosecution services. We review between 160 and 200 or more cases each bi-monthly board meeting for final disciplinary action.

How can we be successful with settlement agreements? The answer is "consistency with flexibility." How do we do this with no recorded history? The medical board does maintain a history. In the nursing section, we rely on institutional memory, but we try to follow the trends. If the board enters a type of discipline for a particular type of offense, we will offer the same discipline in settlement agreements.

Of course, every case is different and we look at the specifics and may change some component of the discipline. There are standard templates for many settlement situations. The language in final orders for an informal hearing is exactly the same language that is in our settlement agreements. In terms of what is reported to the National Practitioner Data Bank, my understanding is that a report is based upon the discipline that is entered, not whether or not the licensee has admitted the allegations.

The board of nursing's probable cause panel recommends a penalty at the time it authorizes the issuance of the administrative complaint. This becomes my prosecutor's first offer of settlement. The panel is made up of a current and a former member of the board, which helps with institutional memory.

The most important thing in being successful in settling cases is responsibility. As a section manager, I am the only one who presents cases to the boards. I would recommend that you give boards one point of contact. It is clear that I am the person responsible for the work product.

Total buy-in for all players is important. This includes board members, board counsels, prosecutors, and even the respondents and their attorneys. This is not something where you will see a bright line and but you will know it when a majority of your settlement agreements are accepted. It is common for us to have the board approve every settlement agreement.

As to Mr. Swankin's concern, our boards see the entire disciplinary file, whether it is an informal hearing or a settlement agreement. If it is an electronic agenda, we have to publish anything provided to the boards within a week of the hearing. We excise what is confidential – patient records – but everything else is on the Web site. It was a challenge to get used to, but we are accustomed to it now.

I monitor what my staff attorneys are recommending, and intervene if I think the settlement is too mild. If we use disciplinary guidelines and trends, the boards know what to expect.

I monitor what my staff attorneys are recommending, and intervene if I think the settlement is too mild. If we use disciplinary guidelines and trends, the boards know what to expect.

The boards have final order authority. Entering into a settlement agreement does not bind the board to anything. If the board rejects an agreement, they cannot enter some other discipline, they can only make a counter offer, which the Department or the respondent may not accept. If I were a defense counsel, I would always choose a settlement agreement over an informal hearing.

If your settlement agreements are rejected, it is really an opportunity because it tells you the board isn't satisfied with that particular discipline for that offense. Eventually, counsel understands what the board wants.

In Florida, complainants get regular updates about the progress of their complaint. If they want to come before the board to comment on a settlement agreement, they have the option to do that.

Question: Do I understand it correctly that in Florida, if a nurse is referred to the program for impaired nurses (IPN) they are suspended, and if they sign a monitoring contract, they are on probation for the length of the contract? In my state, licenses are not suspended but revoked when someone enters treatment, to avoid a situation in which a person can continue to practice under a stayed suspension even if they are not in compliance with their monitoring contract.

Miller: Suspensions are stayed initially in most cases until the individual is evaluated. If IPN says they need treatment, they have to follow through with that treatment. IPN has the power to require them to withdraw from practice as part of their contract. If IPN terminates the nurse, this generates a new complaint to the Department of Health.

We don't do stayed revocations any more in Florida because there is a concern with denial of due process rights. Sometimes there is good cause for terminating monitoring contract, such as entering military service. They have a right to challenge whether termination was justified.

Any time an administrative complaint is filed in Florida, it is tied to the licensee's profile on the Web site. We believe the public has a right to know that an administrative complaint is pending.

Comment: Any time an administrative complaint is filed in Florida, it is tied to the licensee's profile on the Web site. We believe the public has a right to know that an administrative complaint is pending. A PDF copy of the administrative complaint with all the allegations is posted. If the complaint is dismissed, the documentation is promptly removed from the Web site. The entire investigative file is available on a public agenda when the case goes to the board, minus confidential material.

ROUNDTABLE DISCUSSION: A Consent Order

The board has responsibility for final approval of a negotiated settlement. How do you do that in a responsible way? Do you have enough information? Did you have time to review it? What do you want to know?

For purposes of discussion, here are the basic elements of a consent order signed by the Florida Board of Nursing:

- Case No. 2011-15131
- May 23, 2011, respondent forged a physician's name and signature on two patient records
- May 24, 2011, respondent was interviewed by NWMC (employer) at which time she acknowledged that she forged the physician's signature on two patient records
- Section 464.018(1) (h), Florida Statutes (2010), provides that unprofessional conduct as defined by board rule constitutes grounds for disciplinary action.
- Rule 64B9-8.005(6) provides that unprofessional conduct includes falsifying records or altering patient records, etc.
- Respondent neither admits nor denies the factual allegations contained in the Administrative Complaint
- Respondent admits that she is subject to the provisions of Chapters 456 and 464, Florida Statutes, and the jurisdiction of the Department and the board
- Respondent admits that the stipulated facts, if proved true, constitute violations of laws as alleged in the Administrative Complaint

- Respondent admits that the Agreement is a fair, appropriate, and reasonable resolution to this pending matter
- Respondent must pay investigative costs not to exceed $2,115.08 within 3 years (cost $1.286.56)
- License was placed on probation for 1 year and is subject to conditions, including:
- Agreement not to violate the law and to report change of employment and any subsequent violations
- Agreement to submit written reports to the compliance officer
- Agreement to inform employers of probationary status.

Discussion Questions:

Would you vote to:

- Approve
- Disapprove
- Ask for more information before voting

If Disapprove, why?

If ask for more information, which of the following?

- Why just one year probation?
- How were similar forgery cases resolved previously?
- What would we expect the result would be if this case went to hearing?
- Were there previous cases of forgery by this licensee? If so, what resolution?
- Were there previous disciplinary actions for other types of violations?
- Other?

Is this case reportable? To whom?

Is this consent agreement posted on the Web site? How much detail is posted?

Comments: There really isn't enough information here to be comfortable signing this. What orders did the licensee sign? Treatment orders? Medication orders? Is she stealing drugs? The resolution is curious because there is such a financial component. My state imposes a lot of remedial education in such things as medication administration, ethics, and so on.

What orders did the licensee sign? Treatment orders? Medication orders? Is she stealing drugs?

I agree there isn't enough information to make a determination. What did she sign off on? What would be the effect on the patient? Was she pressured by a doctor who was doing something else? Was it the first time she did it, or the first time she got caught?

I like the process my board uses. I am relatively new, but I have an experienced board member who is my coach. I was encouraged to ask questions. At a licensee hearing, we have one board member and the staff member who has done the investigation and an attorney from the AG's office and the licensee and perhaps his or her attorney. The staff person typically leads off asking questions. The session is tape-recorded. The board member and the assistant AG can ask questions. The session takes at least an hour and sometimes longer. It is good for the board and the licensee, who gets to explain the circumstances. The licensee leaves and the panel deliberates. The deliberation process is open and candid. As the public member, I feel very free to ask questions and offer

opinions. I often ask what was done in similar cases. The licensee is brought back in and told the decision. At the board meeting, we have all the information that the board member and staffer had prior to the hearing. Sometimes the licensee comes in with information the day of the review panel. I don't recall an occasion since I have been a member when a settlement agreement was rejected by the board.

There was a situation in which a licensee signed a stipulation and consent order, and that is the point at which it would be put on the agenda for an upcoming board meeting. Apparently, she signed because that enabled her to get beyond the review panel and get an audience in front of the full board. Then she expressed some ambivalence about the agreement she had signed, so the board held off on adopting the order because there was no agreement.

My board allows nurses who come before the board to hear the board's discussion of their cases and what the board plans to do because it is an open meeting. The licensee can either agree to the order or contest it.

The respondent is present in Florida, often with an attorney.

On our board, we don't conduct formal hearings. We receive the agenda in advance with all the background material. We have an opportunity to pull any of the cases that have negotiated settlement agreements if we are not in agreement with the attorneys' recommendation. Often, small changes are suggested. Our board meetings are public, so anyone can be there.

As a staff person, I believe it is our job to get the right information so the board members can make informed decisions. Board members tell us what they consider to be sufficient information. We work with board members to be sure what we consider is relevant.

Sometimes my board does not agree completely with a consent order, but feels that if they don't sign it, the licensee can be out there practicing.

PANEL: Licensing Board Responsibilities to Address Patient Abuse and Human Trafficking

Eric Brown, Chief Investigator, Oregon Medical Board

I will talk about abuse cases involving practitioners, and Oregon's child abuse statutes, which require reporting by many parties. Then, I will talk about human trafficking.

In Oregon, our board members see an entire case; the respondent's reply, letters from the respondent's attorney, support letters, the investigative file, patient records, and so on. We have only one attorney, so either he or I conduct negotiations. When our board issues the charging document, we ask how they want to settle the case, which we view as our marching order.

Patient abuse in Oregon includes inappropriate relationships. These cases are difficult to prove because typically it is a "he said, she said" situation.

Patient abuse in Oregon includes inappropriate relationships. These cases are difficult to prove because typically it is a "he said, she said" situation. When we are able to build a case, it is often because this was not the first incident; several patients may come forward, or we reopen an old case we couldn't do anything with before. The serious cases result in serious

discipline – suspensions, revocation, mandatory chaperones. Orders like these make it very difficult to be employed. These cases come through reports from hospitals, police, patients, victim advocates, and occasionally self-reports.

The child abuse statute is extensive. Child abuse is defined to include rape, sexual abuse, sexual exploitation, contributing to sexual delinquency, negligent or maltreatment of a child, buying or selling a person, and more. The problem is getting practitioners to identify one of these offenses and be willing to report. The mandatory reporters include physicians, interns, residents, DHS workers, teachers, and more. The biggest source of complaints is educational institutions.

Similar statutes relate to elder abuse and nursing home issues. Typically, complaints allege negligent care. Many are because of poor communication. These statutes require mandatory reporting.

In this country, human trafficking typically is sex-trade related or agricultural. There does not appear to be good evidence to show how big a problem this is. It is difficult to identify human trafficking. Law enforcement and physicians miss it because they aren't looking for it.

Many of the victims are from another country. They don't understand that they have rights as a victim. They may not speak English; they are often isolated and lack freedom of movement. The Stockholm syndrome is often in play because the victims are solely dependent on the trafficker for their wellbeing.

Who may identify victims? Often it is law enforcement, typically based on a report from a healthcare worker or social service person. Sometimes it is a street prostitution arrest. Healthcare providers are not a common source because people who are trafficked rarely get healthcare, unless it is an emergency. What is the evidence? Trauma, fractures from old injuries that weren't treated, repetitive motion injuries, malnutrition, exhaustion, frostbite, burns, etc. Another indicator is when the trafficker won't let the victim answer questions for themselves, and won't let them be interviewed alone.

What should a healthcare practitioner do? Try to isolate the person and have a conversation. Ask general questions, such as "Are you free to go?" "Do you get paid for your work?" "How did you get here today?"

Call law enforcement if possible. It is possible that there isn't enough evidence and reporting a situation ends up making it worse for the victim.

Realize that the person may never come back, so think about giving a prescription that will help the person long term. Think about temporary splints that can be removed. Think about what kind of care they need for 30 days as opposed to seven days.

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Is this an area for a board to get involved in? That's depends on the available time and resources. In Oregon, we are having a big problem with opioid prescribing, so sometimes we have to pick our fights. But, it is useful to educate boards so they are at least aware of the problem.

Question: Where do these issues come up in Oregon? Often the problem is seen in massage therapy.

Brown: Being on the I-5 corridor, we see it a lot in agriculture, which is dependent on migrant or illegal labor. In urban areas, it is seen in prostitution.

Question: Who does a healthcare provider report to?

Brown: Child abuse reports go either to DHS or local law enforcement. They will then work together on the case. Usually the victim is given shelter and healthcare and the perpetrator is prosecuted.

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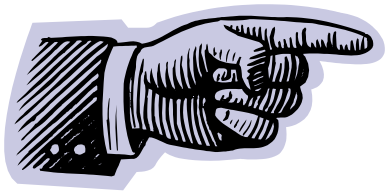

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