News & Views

Citizen Advocacy Center

First Quarter, 2013 - A Health Care Public Policy Forum - Volume 25 Number 1

Upcoming Meeting – Save the Dates!

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*.

BOARD AUDITS

Wisconsin State Journal Investigates Medical Board

In a February 21, 2013, article following up on his series of investigative reports published in January, reporter David Wahlberg of the *Wisconsin State Journal* reported the state Medical Examining Board plans to make some changes. A top priority relates to training for board members and staff. The Department of Safety and Professional Services stated its intention to resume a board member training program. A ban on travel by board staff has

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been lifted, making it possible for investigators and other staff to attend national training sessions.

The *Wisconsin State Journal* series faulted the board for using reprimands rather than more serious discipline, even in cases involving patient injury. Board Chairman Sheldon Wasserman said the board should study, and presumably emulate, discipline guidelines followed by boards with more rigorous discipline histories. The board has also been reminded that its members, not the board attorneys, have the authority to determine what discipline is appropriate.

For the article and a link to the investigative series, see http://host.madison.com/wsj/news/local/health_med_fit/medical-examining-board-plans-changes-in-response-to-state-journal/article_253db6cc-7bb0-11e2-9099-0019bb2963f4.html.

See also http://www.fiercehealthcare.com/story/are-state-medical-boards-doing-enough-protect-patients/2013-01-29?utm_medium=nl&utm_source=internal.

University of Maryland Audits Board of Physicians

Under a Memorandum of Understanding effective in April 2012, the University of Maryland conducted an audit and made recommendations to assist the Board in evaluating its complaint resolutions procedures, in preparing a response to the complaint resolution issues identified by the Department of Legislative Services, Office of Policy Analysis, and to provide analysis and advice concerning other issues.

The University of Maryland auditors found that the board was so busy handling complaints that it did not have time for other activities, such as policy analysis and advocacy or public education. Moreover, the board had failed to follow through on instructions from the legislature and sunset review recommendations. As of February 2012, the board has a new Executive Director, Carol Caralfo, who welcomed the opportunity to make board operations more efficient.

The University of Maryland report recommends adding one member to the board and dividing it into two 11-member panels in an effort to reduce backlogs. Other recommendations for the board include:

- Adopting more informal processes for case resolution,
- Including a representative of the allied health professions advisory committee and an ex-officio member for discipline cases involving a member of their profession,

- Establishing timeframes for resolving cases depending on their complexity, and adopting sanctioning guidelines

Recommendations for the legislature include:

- Authorizing the board to use only one peer reviewer in addition to the board's internal medical reviewer in standard of care cases, and
- Consolidating and clarifying the duties and powers of the board.

Another recommendation is that the board and executive director should take proactive steps to increase educational outreach and transparency.

Investigative Report Finds Boards Violate Own Settlement Guidelines

A series of articles by Brian Joseph in the *Orange County Register* in October 2012 uncovered instances of lenient enforcement by several health professional boards in the California Department of Consumer Affairs. Joseph cites independent experts who found systemic weaknesses in the system, including:

- an unusually high burden of proof
- a dramatic imbalance in resources between regulators and defense attorneys
- an institutional disconnect between board investigators and prosecutors in the AG's office

Among other things, the *Orange County Register* found that in 81% of the 76 cases involving serious medical injury or death, the medical board entered into a negotiated settlement and three fourths of those settlements involved lesser penalties than the board's own recommendations. Of the 240 cases handled by the dental board during the period of the investigation, 15 involved death or permanent injury. Ten were settled by negotiation and six of these involved penalties below the board's recommendations.

For more, see http://www.ocregister.com/news/boards-375814-board-cases.html and http://www.ocregister.com/articles/cases-375820-board-recommendations.html.

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CONSUMER INFORMATION

California Pharmacy Board Improves Drug Labels

The California Department of Consumer Affairs reports that:

Californians are finding their prescription drug labels easier to read and understand thanks to the California State Board of Pharmacy. The Board is the first in the nation to require patient-friendly wording on all prescription medicine bottles. Details are in the winter 2013 issue of Consumer Connection, a quarterly magazine from the California Department of Consumer Affairs.

View the magazine online at
http://www.dca.ca.gov/publications/newsletter/winter2013.pdf.

Consumer Reports to Rate Doctors

Consumer Reports' *Consumer Health Choices* service announced the following in a recent email to online subscribers:

Rating doctors, for real

It's easy to find doctor ratings these days. They're all over the web. But typically what do these sites really rate? Punctuality? Personality? How well the doctor answers questions? Don't get me wrong, these are important impressions for patients to share with each other.

But of course, doctors also vary in the quality of the medicine they deliver: how effectively they prevent, treat, and resolve serious conditions. Those factors are much more difficult to measure and report. And today's reality is that your doctor is almost always part of a group, a system, and has other doctors "covering" for him/her.

But we're working on it.

We've just published, in a special issue of Consumer Reports, ratings of 19 Wisconsin medical groups, which combined serve nearly half the state's patients. The ratings were the result of a unique collaboration with the Robert Wood Johnson Foundation (RWJF) and the Wisconsin Collaborative for Healthcare Quality, with whom the medical groups have voluntarily shared their performance data. The ratings included one overall score and seven measures based on data that the groups themselves collect on how well they provide essential care, such as screening for certain cancers and vaccinating against pneumonia, as well as how well they treat people who have heart disease. The 20-page insert was distributed with the magazine in Wisconsin.

Last year, we published ratings of doctors' practices in Massachusetts for patient experience and Minnesota practices for heart disease and diabetes care. The three efforts are the result of a grant from RWJF related to a unique program called Aligning Forces for Quality. That initiative is RWJF's signature effort to lift the overall quality of health care in 16 targeted communities, reduce racial and ethnic disparities, and provide models for national reform.

Want to know more about these efforts? You can find all three reports at http://consumerhealthchoices.org/.

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LICENSURE

Legislation Would Change the Composition of Licensing Boards

HB 2316 introduced by Arizona House Representative Farnsworth would amend Title 332, Chapter 45 of the state statutes by adding the following language which would eliminate licensee majorities on regulatory boards:

ARTICLE 1. GENERAL PROVISIONS

32-4501. Definition of board

In this chapter, unless the context otherwise requires, "board" means any body that is responsible for administering the licensing, certification or registration of a profession or occupation under this title.

32-4502. Composition of boards

Notwithstanding any other law, board members whose profession or occupation is regulated by the board may not constitute a majority of the board membership.

32-4503. Board member qualifications and duties

Notwithstanding any other law, board members are appointed by the governor subject to the following:

1. A board member shall have been a resident of this state for at least three years before appointment.
2. A board member must agree that the board member's primary duties, in order of priority, are to:
    a. protect the health and safety of the general public
    b. enforce licensing, certification and registration laws in a manner that is least restrictive to individuals wishing to enter the profession or occupation and that is consistent with subdivision (a) of this paragraph
    c. administer the board in a way that presents the least possible cost to members of the regulated profession or occupation and that is consistent with subdivisions (a) and (b) of this paragraph

3. A board member who is not regulated by the board may not be employed by a licensee, certificate holder or registrant under this title or by an association of licensees, certificate holders or registrants on whose board the member served for three years before and three years after the member's service on the board.
4. One board member may be licensed outside this state in the profession or occupation that the board regulates and shall count toward the limit established in section 32-4502.
5. An individual may be a member of more than one board.

PATIENT SAFETY AND MEDICAL ERRORS

Pharmacy Board Reforms Proposed in Wake of Compounding Tragedy

Massachusetts Governor Deval Patrick proposed legislation in January 2013 to improve oversight of compounding pharmacies. His proposal would require a special license for sterile compounding. In addition, it would:

- Authorize the board of pharmacy to impose fines
- Provide whistle-blower protection for pharmacists and pharmacies
- Require licenses for out-of-state pharmacies that deliver and dispense medications in Massachusetts
- Change the composition of the board of pharmacy

Governor Patrick's proposal would add diversity to the pharmacy board. He recommends an 11-member board with four pharmacists, one nurse, one physician, one pharmacy technician, one quality-improvement expert and three public members.

The Federal Food and Drug administration will also increase oversight of pharmacy compounding. The agency is proposing that "traditional" compounders that make medications to fill a single prescription remain under the jurisdiction of state pharmacy boards. "Non-traditional" compounders that make medications in volume would have to register with the FDA and comply with some of the requirements designed for manufacturers.

For more, see http://www.mass.gov/governor/pressoffice/speeches/0104-compounding-pharmacy-legislation-remarks.html.

Prescription Error Rates High Among Community-Based Providers

Research sponsored by the Agency for Healthcare Research and Quality (AHRQ) found high rates of prescribing errors at ambulatory care facilities in two states, New York and Massachusetts. The biggest problem was illegible prescriptions.

Researchers found an error rate of 36.7 per 100 prescriptions (not including illegibility errors) among ambulatory care facilities using paper prescriptions. They concluded that use electronic prescribing with a basic clinical decision support (CDS) system could have prevented 32% of prescribing errors; an advanced CDS system would have prevented as many as 57%. A CDS system would have prevented all of the legibility errors and 42% of the near misses.

For more, see http://www.ahrq.gov/news/newsletters/research-activities/13jan/0113RA3.html.

IMPAIRED PRACTITIONERS

Study Finds Fault with Addiction Treatment Programs

The Center on Addiction and Substance Abuse at Columbia University published a report in 2012 entitled, *Addiction Medicine: Closing the Gap between Science and Practice.* University researchers estimate that only one in ten people who need addiction treatment receive it. Furthermore, only a small percentage of those who do receive treatment get treatment "consistent with scientific knowledge about what works." The report goes on to assert that:

> Addiction treatment facilities and programs are not adequately regulated or held accountable for providing treatment consistent with medical standards and proven treatment practices.

The report and other information can be found at http://www.casacolumbia.org/templates/NewsRoom.aspx?articleid=678&zoneid=51.

PAIN MANAGEMENT AND END OF LIFE CARE

California Tackles Prescription Drug Deaths

The California legislature is considering a law that would require coroners to report to the medical board all deaths from prescription medications. The Medical Board of California endorsed the legislation.

This legislation was proposed in response to an investigative report in the Los Angeles Times that found that nearly half of the accidental deaths from prescription drugs occurred in four counties and that the deceased had a prescription for at least one of them medications. The paper identified 71 doctors who prescribed to three or more patients who subsequently overdosed.

For more, see http://www.latimes.com/search/dispatcher.front?Query=lisa+girion+scott+glover&target=adv_all.

Florida County Tightens Regulation of Pain Care Clinics

According to a report by Martin Comas in the *Orlando Sentinel* on November 14, 2012, the Seminole County Commission will now require pain clinics to obtain a license and

report monthly on how many prescriptions have been issued for controlled substances. The objective of the new ordinance is to curb over-prescribing and "doctor-shopping."

One pain care specialist quoted in the article predicted the regulations will interfere with practice in such specialties as neurology and rheumatology. He warned that doctors will not set up clinics in counties with strict regulations, or even leave the state.

Maine Prescription Drug Abuse Program Involves Patients

The Maine Board of Licensure in Medicine and Board of Osteopathic Licensure has guidelines that recommend doctors create a controlled substances contract with patients who might be abusers or may be diverting the medications to others. The suggested contract terms include provisions allowing the doctor to count the patient's pills, test a patient's bodily fluids, withdraw prescriptions from patients who violate the contract, and report suspected illegal activity.

For more, see http://www.sunjournal.com/news/lewiston-auburn/2012/11/18/docs-ask-patients-random-drug-tests/1278223.

Montana Medical Board Retains Assisted Suicide Policy

In November 2012, the Montana Board of Medical Examiners refused a formal request by Montanans Against Assisted Suicide to revoke its policy on the subject. The board's policy merely provides guidance to the state's physicians to the effect that it will take a case-by-case approach to any complaints filed against a doctor for "aid in dying."

The Montana Supreme Court ruled in 2009 that the state constitution does not prohibit assisted suicide, but did not assert that it is a constitutionally protected right. Montanans Against Assisted Suicide claims it is illegal, and may take the fight to the courts.

FSMB Journal Commentary Urges Balanced Approach to Problem of "Pill Mills"

In a guest article in the Federation of State Medical Boards *Journal of Medical Regulation* (V0l. 98, No 2, pp. 7-11), Robert K. Twillman, Director of Policy and Advocacy at the American Academy of Pain Management warns that careless regulation of "pill mills" could reap unintended, undesirable consequences for sufferers of chronic pain. He writes:

> Previous policy efforts to facilitate eliminating pill mills have focused largely on developing new laws, regulations, and rules regarding the standards of practice in pain management clinics. The fact that most pill mills label themselves as "pain clinics" is the primary reason for this. However, the fact that pill mills call themselves pain clinics does not make them such, and as policymakers debate how to eliminate the former, care should be exercised not to harm the latter…
>
> Given that pain clinics currently do not have special standards in most jurisdictions, policymakers are developing new standards that are higher than those expected of other medical practices, sometimes including features that allow for inspections without complaints being filed. While this may be an effective strategy, it is misguided and risks exacerbating a public health problem much greater than the size of the prescription opioid misuse problem – namely, chronic pain…

Twillman suggests eight alternative strategies for regulators to consider, including requiring that all medical practices be owned by a licensed practitioner and designate a medical director, creating the power to perform unannounced inspections, requiring reports to the state prescription monitoring program, encouraging more cooperation between licensing and law enforcement, and so on.

For the complete article, see http://jmr.fsmb.org/search.aspx?search=Twillman.

Board Highlights Pain Management and Prescription Monitoring

The Oregon Medical Board is promoting licensee awareness of appropriate pain management. Its Summer 2012 *Report* features an article entitled, "Prescription Drug Monitoring Program: A Valuable Resource." Its Winter 2013 issue features an article entitled, "The Pendulum of Chronic Opioid Therapy."

The first article encourages licensees to enroll in the Prescription Drug Monitoring Program:

> The Board strongly encourages enrollment and participation in the Prescription Drug Monitoring Program (PDMP), a division of the Oregon Health Authority. The PDMP is a database that allows prescribers of controlled substances to access a patient's prescription history that includes a list of controlled substances prescribed, dosages, and the names and contact information of other prescribers… Since the PDMP launch in 2011, 98% of Oregon Pharmacies report to the program. Comparatively, only 18% of eligible OMB licensees have established a program account…

The article on chronic opioid therapy endeavors to explain apparent changes in regulatory attitudes toward safe prescribing:

> Doctors I speak to about chronic pain management sometimes express confusion or irritation about what they perceive o be a reversal of expectations regarding the prescribing of opioids for chronic non-cancer pain. Indeed, following state laws permitting this practice in the 1990s and the promotion of pain as a "fifth vital sign," physicians met perceived expectations by patients and regulators by learning new skills to safety prescribe these medication. Now many doctors perceive a reversal of expectations by state regulators and struggle to explain a change in prescribing behavior to patients….

For more, see http://www.oregon.gov/OMB/pages/newsltr.aspx.

Medical Board Asks Public to Report Suspected Over-Prescribing

The Medical Board of California (MBC) has appealed to the public to help identify over-prescribing doctors. It is asking families of people who die from prescription drug overdoses to report that information to the board.

For more, see http://articles.latimes.com/2012/dec/29/local/la-me-prescription-reforms-20121229.

Editorial Note: The Los Angeles Times ran a series of articles on prescription drug overdose deaths in California. The main story, with links to other stories in the series, can be found here: *http://www.latimes.com/news/science/prescription/la-me-prescription-deaths-20121111-html,0,2363903.htmlstory*.

DISCIPLINE

CBC News Finds Unenforced Conditions of Discipline

Ontario Healthcare practitioners disciplined for sexual misconduct may be required to post a notice in their offices disclosing the conditions placed on their practice. A CBC News Toronto investigation found at least two instances in which the required sign was not posted, or not "prominently displayed."

For more, see http://www.cbc.ca/player/News/Canada/Toronto/Do+No+Harm/ID/2314438613/ and http://www.cbc.ca/player/News/Canada/Toronto/Do+No+Harm/ID/2314983052/. (Both of these links immediately play audio).

New York Law School Analyses Medical Malpractice Lawsuits

The Center for Justice and Democracy at New York Law School has published a report entitled *Briefing Book, Medical Malpractice by the Numbers*, which makes the case that litigation improves patient safety and may be the best way consumers can protect their rights. The authors' research found that few patients file lawsuits, so when they do their cases are not "frivolous." Malpractice cases are not clogging courts, because most are settled. Also, licensing boards rarely discipline poor performing and dangers doctors. Sometimes it is only a series of malpractice judgments that prompts regulators to revoke a license.

See the report at http://centerjd.org/content/briefing-book-medical-malpractice-numbers.

Injured Patient Turns to Social Media to Stop License Reinstatement

A woman infected with hepatitis C as a result of unsanitary injection practices is using Facebook and a foundation Web site to mobilize opposition to the reinstatement of the doctor who performed the injection. After becoming infected, Dr. Evelyn McKnight established a foundation to promote safe injection practices (http://honoreform.org/about-us/evelyns-story/default.aspx).

Dr. Tahir Ali Javed's Fremont, Nebraska cancer clinic was responsible for infecting at least 99 people with hepatitis C between March 2000 and December 2001. Javed returned to his native Pakistan after the revocation of his Nebraska license and surrender of his New York license in 2003. Now he has applied for a reinstatement of his New York license.

For more, see http://fremonttribune.com/news/local/mcknight-s-group-will-lobby-against-reinstatement-of-doctor-s/article_47b270da-5185-11e2-8d47-001a4bcf887a.html.

Missouri Medical Board Issues First Emergency Suspension

For the first time in memory, the Missouri Medical Board issued an emergency suspension. The doctor in question, Randall Meyer, was alleged to have implanted stents unnecessarily in six patients. He was given an opportunity to defend himself before the board in February 2013. At press time, no information was available about the board's

action after that hearing. Even though this case was covered extensively in the media, a search of Meyer's disciplinary record on the board Web site revealed nothing.

For more, see http://www.stltoday.com/news/local/metro/missouri-healing-arts-board-issues-first-emergency-suspension-of-doctor/article_205eaffd-1825-5d7d-a9de-a289c010fd65.html.

QUALITY OF CARE

"Why Not the Best" Offers Quality Data on Interactive Map

WhyNotTheBest.org, a service of the Commonwealth Fund, provides quality improvement resources for healthcare professionals. They invite professionals and the public to consult an interactive map…

> …to explore performance variation among states, counties, and hospital referral regions on measures of health care quality, safety, outcomes, patient experiences, and more.
>
> Use our newly expanded map overlays to track quality improvement activity across the nation. For example, the Accountable Care Organization (ACO) overlay shows the locations, number of patients served, number of involved physicians, and Web sites of the growing number of ACOs. The physician overlay pinpoints the locations of doctors recognized for providing high-quality care in a number of areas, while the hospital overlay identifies safety nets, teaching hospitals, and other types of facilities.

The map can be found at http://www.whynotthebest.org/maps?omnicid=20#measure=10181&lat=46.10370875598026&long=-98.0419921875&z=5&unit=hrr&n=5&colors=YlGnBu.

Patient Experience Correlates with Quality of Care

A study reported in the January 2013 *British Medical Journal (BML)* by Cathal Doyle, Laura Lennox, and Derek Bell, entitled, "A Systematic Review of Evidence on the Links between Patient Experience and Clinical Safety and Effectiveness" found a close correlation. According to the article's abstract:

> **Primary and secondary outcome measures:** A broad range of patient safety and clinical effectiveness outcomes including mortality, physical symptoms, length of stay and adherence to treatment.
>
> **Results:** This study, summarising evidence from 55 studies, indicates consistent positive associations between patient experience, patient safety, and clinical

effectiveness for a wide range of disease areas, settings, outcome measures, and study designs. It demonstrates positive associations between patient experience and self-rated and objectively measured health outcomes; adherence to recommended clinical practice and medication; preventive care (such as health-promoting behaviour, use of screening services and immunisation); and resource use (such as hospitalisation, length of stay and primary care visits). There is some evidence of positive associations between patient experience and measures of the technical quality of care and adverse events. Overall, it was more common to find positive associations between patient experience and patient safety and clinical effectiveness than no associations.

Conclusions: The data presented display that patient experience is positively associated with clinical effectiveness and patient safety, and support the case for the inclusion of patient experience as one of the central pillars of quality in healthcare. It supports the argument that the three dimensions of quality should be looked at as a group and not in isolation. Clinicians should resist sidelining patient experience as too subjective or mood-oriented, divorced from the 'real' clinical work of measuring safety and effectiveness.

See http://bmjopen.bmj.com/content/3/1/e001570.long.

INTER-REGULATOR COLLABORATION

First Tri-Regulator Symposium Breaks Ground

In October 2012, the National Council of State Boards of Nursing, the National Association of Boards of Pharmacy, and the Federation of State Medical Boards convened a historic Tri-Regulator Symposium in Washington, D.C. Entitled, "Protecting Patients and the Public: A Heritage of Excellence," the meeting was attended by nearly 200 representatives of member boards of the three associations. Featured speakers included Donna Shalala, former Secretary of the U.S. Department of Health and Human Services, Mary Wakefield, Administrator of the U.S. Health Resources and Services Administration (HRSA), Joseph Rannazzisi, Deputy Administrator of the Office of Diversion Control at the Drug Enforcement Administration (DEA), and Edward Salsberg, Director of HRSA's National Health Workforce Analysis. Participants expressed a desire to meet again on a regular basis. For more, see http://www.fsmb.org/pdf/tri-regulator-symposium-media-advisory6.pdf.

CONTINUING PROFESSIONAL DEVELOPMENT

Performance Improvement CME Gains Popularity

Although less than 1% of CME courses conform to this model, Performance Improvement CME (PI CME) is expected to gain in popularity. The concept is to relate continuing education to improvements in practice in the clinical setting. According to an article in *American Medical News*:

> PI CME involves three basic steps: an assessment of the physician's practice using identified evidence-based performance measures, implementation of an intervention, and re-evaluation of those performance measures to gauge improvement, according to the AMA.
>
> A major advantage of the model is that it allows physicians to compare patient outcomes with national benchmarks, said Mindi McKenna, PhD, director of the (American Academy of Family Practitioner's) CME division.

The entire article can be found at http://www.amednews.com/article/20121231/profession/121239977/3/.

Iowa Medical Board Tests Maintenance of Licensure

One of several state medical boards that are testing components of a Maintenance of Licensure (MOL) program, the Iowa Board of Medicine has begun communicating about the project to its licensees:

> The Iowa Board of Medicine is participating in a national initiative aimed at strengthening patient care by requiring licensed physicians to provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development that is relevant to their areas of practice, measured against objective data sources and aimed at improving performance over time.

For more, see https://medicalboard.iowa.gov/practitioners/mol.html.

UK Outpaces US in Doctor "Revalidation"

Beginning in December 2012, doctors in the UK will be appraised annually, with a decision made at five-year intervals about whether they are qualified to continue practice, under new procedures enacted by the General Medical Council (GMC). The "revalidation" process will begin with senior medical leaders, including national and regional medical directors. Starting in April, the general physician population will be phased in to the revalidation system of annual assessments and feedback by colleagues and patients. By April 2016, the most doctors in the UK will have been through the process.

National Health Service organizations at hospitals and physician networks and elsewhere in the system will have a medical director or other individual who will evaluate annual assessments and feedback and make a recommendation every five years to the GMC. Minor issues may lead to delayed revalidation or to discipline. When the system was pilot-tested, about 4% of doctors caused concern. In more than half of these cases, the concerns were considered minor. Problems that could jeopardize patient safety were found in about 0.7% instances.

For more, see http://www.gmc-uk.org/doctors/revalidation.asp.

Editorial Note: The Medical Board of Australia is moving in the same direction, according to an announcement in a Communique issued after its December 2012 meeting that it is "starting the revalidation conversation in Australia:"

Internationally in medicine and medical regulation, there is active discussion about revalidation for medical practitioners and how it can support patient safety. The International Association of Medical Regulatory Authorities (IAMRA), defines revalidation as "…the process by which doctors have to regularly show that they are up to date, and fit to practise medicine. This will mean that they are able to keep their license to practise. Sometimes called 'Recertification.'"

The Board has decided to formally begin this conversation in Australia. It has not yet made any decisions or set a strategic course. It is committed to working with the profession, the community, and other stakeholders about its approach, which will be informed through careful analysis of Australian data, our regulatory context, and international research.

The Board expects to develop an initial discussion paper in 2013 and to consult widely with all interested stakeholders as the conversation about revalidation develops.

Hospitals Test Older Physicians

According to an article by Alicia Caramenico in the December 11, 2012, online *Fierce Healthcare* newsletter, between five and ten percent of U.S. hospitals are testing older physicians for competence. Doctors over a certain age are being evaluated for physical and cognitive acuity as a condition of renewing privileges.

Some hospital administrators believe such policies constitute age discrimination. They recommend evaluating physicians on a case-by-case basis.

For more, see http://www.fiercehealthcare.com/story/more-hospitals-test-older-docs-competency/2012-12-11?utm_medium=nl&utm_source=internal.

IN THE COURTS

Court Rules Supervising Physician Not Liable for Assistant's Conduct

The Vermont Supreme Court ruled in December 2012 that a physician is not liable for the misconduct of a physician assistant, so long as the physician's supervision was appropriately performed. Physician organizations say that supervisory relationships and residency programs would have been put in jeopardy had the court ruled differently.

For more, see http://www.amednews.com/article/20121227/profession/121229981/8/.

Government May Enter Hospital to Investigate Hepatitis C Outbreak

A New Hampshire court has ruled that the state Department of Health and Human Services (DHHS) may enter Exeter Hospital and access its HER database to investigate an outbreak of hepatitis C. The hospital had sought a protective order to protect its files,

citing privacy concerns. The hospital also objected that DHHS would not share the information it obtained with the hospital, citing its HIPAA confidentiality obligations.

This case is of interest to readers of **CAC *News & Views*** because the hepatitis outbreak allegedly originated when a drug-seeking employee infected patients. See: http://www.fiercehealthcare.com/story/drug-abusing-hospital-employee-may-have-spread-hepatitis-c/2012-06-12. It is unclear from newspaper reports whether the employee is under investigation by the appropriate licensing board.

The attorney general's press release is here: http://doj.nh.gov/media-center/press-releases/2012/20121101-exeter-hospital-order.htm. The court's opinion is here: http://doj.nh.gov/media-center/press-releases/2012/documents/exeter-hospital-order.pdf.

Court Ruling Questions Confidentiality of Information Reported to PSOs

Two lower court rulings in Kentucky (Norton Hospitals Inc. v. Cunningham and Phillip Tibbs, MD, et al., v. Bunnell) limit discovery protections contained in the federal Patient Safety and Quality Improvement of 2005. This federal law protects hospitals and other providers against legal discovery for safety or error information collected within the framework of a Patient Safety Organization (PSO).

The two court opinions would limit discovery protections to "self-examining analysis," which would mean peer review discussions involving an error, near miss, or other safety issue. Attorneys for the Kentucky Hospital Association claim this ruling would mean sentinel events reported to the Joint Commission would not be protected. The American Hospital Association will join the Kentucky Hospital Association in an appeal to the state's Supreme Court.

ETHICS

GAO Finds More Imaging Performed by Self-Referring Docs

The U.S. Government Accountability Office (GAO) found that advanced imaging using MRI and CT technology increased between 2004 and 2010 and that the increase was greater among self-referred services. Self-referring providers ordered about twice as many images as those who did not self-refer.

See the report (GAO-12-966, Sept 28, 2012, *Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions*) at http://www.gao.gov/products/GAO-12-966.

Payments to Doctors to Become Public

Starting in September 2014, the Centers for Medicare and Medicaid Services (CMS) will require public reporting of payments to physicians by drug companies and device manufacturers. Rules implementing the Physician Payments Sunshine Act were announced March 13, 2013.

Under the rules, companies will be required to report consulting and speaking fees, research grants, gifts, food and entertainment, honoraria, royalties, licensing fees, and other payments. Doctors will have an opportunity to check the accuracy of the data reported by the companies to CMS before it is made public.

Until now, this type of information was available only through ProPublica's Dollars for Docs." In 2009, ProPublica published data obtained from 12 company Web sites. It plans to publish data from 15 companies in the near future.

Doctor Gets Slap on Wrist for Writing Unnecessary Prescriptions

The Oklahoma Board of Medical Licensure and Supervision issued a reprimand and required Dr. Gary Dickinson to perform 200 hours of community service for writing numerous unnecessary prescriptions to help pharmaceutical company sales representative Tara Linville earn bonuses from her employer. Dickinson wrote numerous prescriptions for Linville and her family members and friends from March – August 2010. The board found probable cause to charge Dickinson with "prescribing violations, medical records violations, procuring/aiding/abetting a criminal operation, and dishonorable or immoral conduct likely to deceive/defraud/harm the public."

A hearing was held in March 2013. Board Member, Chuck Skillings, CEO of Shawnee Regional Hospital, expressed surprise that Dickinson was not charged with a felony.

For more, see http://newsok.com/edmond-doctor-got-off-light-for-role-in-fraud-board-member-says/article/3763527.

ADMINISTRATION

Georgia Law Targets Undocumented Medical Workers

According to an article by Carole Fleck in the January – February 2013 *AARP Bulletin*, more than 1,500 health care professionals in Georgia are unable to work because of difficulties enforcing a new licensure renewal law. In order to renew their licenses, healthcare workers must now prove they either are citizens or have permission to work. The state is having trouble keeping up with the paperwork. Consequently, 500 doctors, 450 physician assistants and respiratory therapists, and 600 nurses have been unable to work. So far, the state has not found any healthcare professionals working without proper documentation.

Pennsylvania Cuts Licensing Fees

Pennsylvania's board of medicine voted in the summer of 2012 to waive the $360.00 license renewal fee for physicians and lower fees for other professionals. The board has built up a $31.8 million reserve, enough to last about two years, according to official estimates.

Editorial Note: In December 2012, the Illinois Department of Financial and Professional Regulation warned that it would have to lay off 18 employees in its medical discipline unit because of lack of funds. The department claimed a "structural

deficit" of $6 million. They have tried unsuccessfully to raise the $342 three-year renewal fee since 1997. See this warning from the Secretary of the Department of Financial and Professional Regulation: http://www.idfpr.com/News/newsrls/01092013LetterToDoctors.pdf.

SPOTLIGHT

CAC shines the Spotlight this quarter on the Missouri State Board of Nursing and its Executive Director, Lori Scheidt for peppering its Nov – Dec 2012, Jan 2013 Newsletter with data about board accomplishments and, significantly, data about the nursing workforce in Missouri. Colorful charts in Scheidt's Executive Director's Report present detailed information about the types of complaints received in FY 2012 and the sources of complaints closed by the board during FY 2012.

County-by-county maps indicate where Missouri's LPNs, APRNs, and RNs are employed. A table shows the number of nurses licensed by examination, endorsement, and renewal during the FY and the total number of nurses in practice by category. Another table compares the average age of nurses by category from FY 2004 to FY 2012.

CAC believes demographic information of this sort is essential for statewide planning for workforce needs, allocation of resources for public health activities, and decisions about the scopes of practice of the professions. Congratulations to the Missouri State Board of Nursing for collecting and reporting this information.

IN DEPTH

2012 Ben Shimberg Memorial Lecture, by Paul Grace, CEO National Board for Certification in Occupational Therapy

Mr. Grace was presented with the Ben Shimberg Public Service Award "for his outstanding leadership at the National Board for Certification in Occupational Therapy (NBCOT) in embracing and implementing many of the public interest goals that Ben Shimberg promoted and that CAC has long pursued."

Thank you. I am honored and grateful to receive the Ben Shimberg Public Service Award. The previous recipients of this award are distinguished leaders in the realm of regulation, competency, and public protection. To join this distinguished group as the 2012 recipient is both humbling and terrific.

There are three individuals who are with me tonight that I want to recognize. From the NBCOT Board of Directors is General Mack Hill. General Hill is retired from the US Army Medical Corp and serves as a public member of our Board of Directors. Mack brings to our Board the reality of the world through his experiences in military health care delivery, be it from a hilltop base in Vietnam or as commander of several US military hospitals, and now as a civilian consultant to private industry. When our board discusses topics like professional conduct, competency assessment, and standards, his exceptional career and life experience have proven to be an invaluable asset to the Board in its decision making process.

Dr. Jim Henderson is my closest friend. Jim is Vice President and Senior Psychometrician at Castle Worldwide in Raleigh, North Carolina. He has had many volunteer leadership positions throughout his career that added to the credentialing industry's body of knowledge on such topics as accreditation, standard setting, and continuing competency. He is one of the few who has mastered the art and science of psychometrics with a constant focus on fairness and quality. Most recently, he has chaired the research committee of the Institute for Credentialing Excellence.

Denise Fandel is the Executive Director of the Board of Certification for Athletic Trainers. In addition to being a trusted colleague, she is the consummate credentialing executive. She is the incoming president of the Institute for Credentialing Excellence.

Used as an adjective, crazy is defined as intensely enthusiastic, passionately excited, and intensely impatient. These are characteristics that have been used to describe individuals like Steve Jobs, Ben Shimberg, Albert Einstein, and the executive director of the Citizen Advocacy Center, Dave Swankin. Who among us would argue that David's passion for the involvement of the public in the credentialing industry isn't crazy?

"How Can the Credentialing Industry Fail?" Some may consider this question crazy. However, those who work in different aspects of the industry would not consider the question crazy; hopefully they, as I do, consider the question seriously. And often.

If we do not commit, as individual credentialing entities and as an industry, to address (and answer) this question with a focus on the end user – the public – in mind, we will have no one to blame but ourselves for a collective slow decline towards systematic irrelevance in the healthcare marketplace.

I believe it to be a safe assumption that those of us who work in this industry, regardless of our roles, have specific issues, concerns, or tipping points about the industry's health and sustainability. If left unattended, I believe issues related to leadership, governance, accreditation, and scope of practice will shorten the timeline when our question will be answered with some finality.

I want to take this opportunity to offer some thoughts about leadership, governance, accreditation, and scope of practice, all topics pertinent to the crazy question. A certainty that we should all always be mindful of is that the private and public credentialing industry is the consequence of a political process. This process is a cradle-to-grave proposition for the individual organizational entity as well as the industry. Tip O'Neill, the former Speaker of the US House of Representatives, made the following statement famous: "All politics is local." For me, the statement sums up my view of how, for the most part, our industry operates. A leader's success is directly tied to his ability to understand and influence the issues of his constituents, or stakeholders: the simple, even mundane and everyday concerns. For credentialing organizations, leadership means understanding who the stakeholders are and how the credential can serve their needs. Leadership means monitoring the stakeholders and developing an understanding of the influences in their environments that drive their needs. Leadership then means positioning the credential so that it satisfies stakeholder needs concerning access to and

the affordability of quality care. Steven Jobs, the late leader of Apple, observed and understood the needs and interests of the computing public and then developed products that we didn't even realize we needed.

That credentialing operates in a political environment is not necessarily a bad thing; however, it is a reality that can sometimes be challenging when we advocate for the fundamental reasons we credential individuals.

Why do we regulate the professions? The uniform response is, of course, public protection. If that is right, where and to what degree is the public included in the process before, during, and after a certification or licensure program is launched? I understand the need to establish standards for eligibility, assessment, discipline, and practice, but where is the public invested in this equation? How does the leader of a credentialing organization gain understanding of the current needs of the public and predict its future needs?

Since the early 1980's it has become popular to add a public member to a certification or licensing board. Their role? To represent the public's interest. For many organizations, a single public member was appointed. Think about this for a second; if one of the key roles of regulation is public protection, then why limit the public's participation in the process to a single individual? In an industry that has a market basket full of policies and requirements and if the industry primary purpose is to serve the public's interest, why has the industry been relatively silent on the public's role and participation in the process? It's safe to state the Citizen Advocacy Center has been the single most powerful voice on advocating for public members. Why have the credentialed professions been reluctant on this key issue, other than acting on minor changes to some bylaw language?

An argument that I've heard is that if the decisions made by the credentialing board are good for the profession, then they must be good for the public as well.

In the governing documents of credentialing bodies – be they certification or licensure – the composition of the board is delineated: what the make up the board should be in terms of the types and qualifications of individuals who should fill certain designated positions. Why is there no specificity, for the most part, for public members? Could the public's interests be marginalized if there is only one public member serving on a board of 10, 12, or 15 members of the regulated discipline? Is leadership for the credential able under this arrangement to gain adequate insight into the influences that drive the public's needs and interests?

Although having a member represent the public is a requirement for accreditation of certification programs through the National Commission for Certifying Agencies and ISO 17024, there is no accreditation requirement that public members have to have the same rights and privileges as professional members of the governing body. More often than not, public members are not permitted to hold office or chair a committee, and they are often eligible to serve only on certain committees.

Why is our industry hesitant to engage the public in a meaningful way? Isn't it worthwhile having members of the public serve on practice analysis study task groups?

After all, they are the primary consumers of the practitioners' services. Would public protection be enhanced if credentialing entities regularly promoted awareness to the community on how to assess practitioner's credentials or file a complaint? Will our industry ever realize the inherent power of an engaged public that can be a powerful ally in helping credentialing bodies satisfy their mission? Without industry-wide leadership that advances a proactive agenda that includes the public, this will not happen.

A cornerstone of practitioner credentialing, be it certification or licensure, is how candidates become eligible within the program. For a majority of the regulated professions, graduation from an accredited professional education program is the most significant requirement a future certificant or licensee must satisfy. At first glance, this is reasonable and promotes a common standard for all to attain. However, most of the accreditation entities for these professional education programs are linked in some way to their respective professional association. Members of the profession make up the majority of the accrediting bodies' membership. Remember, they say – if it's good for the profession, it must also be good for the public. As I noted previously the political process has a lot of influence on how a profession credentials itself – local politics in action.

I am not aware of a single credentialed profession that was the result of anyone other than the profession's members initiating and leading the effort. I have no issue with that, but what is a bothersome fact is that usually the certification or licensing board cannot fully exercise its public protection role because of the profession's influential role in the eligibility standards. The reason for this is that eligibility standards are usually included in a practice act's language – and very specific to graduation from an accredited program.

Let's get specific with an example. We are experiencing today in health care what some have labeled "degree creep." What was once a bachelor's degree, entry-level qualification is now quite often a professional doctorate? What is the evidence that the public required such a shift in educational eligibility? Were bachelor-educated practitioners found to be incompetent? Were patients' outcomes so poor that only an advanced degree could correct the situation? Or was the driving impetus to reposition the profession among similar disciplines that share turf boundaries? What is the cost of these changes for patients and third-party payers? And was the leadership of credentialing organizations acting on a robust understanding of the public interest when considering changes to the entry-level requirement?

I am not speaking about advanced practice that might rightly require advanced education and training. I am speaking about entry-level. The change in eligibility became a reality when the profession, and subsequently the profession's accreditors, decided a change would be beneficial. I once sat in a meeting of educational program directors debating if the profession's entry level should be advanced from the master's level to professional doctorate. One educator took the floor and announced, "We all know it has to be the doctorate – we'll have the students in class for at least an extra year and that will boost our FTE numbers!" I turned to the executive director of this group and asked him if he had a good anti-trust attorney on retainer.

I understand change is inevitable and often helpful, but what evidence should the credentialing body that represents public interests require that an accrediting body have to produce and defend when it argues for a change in entry-level eligibility to practice? Will the public be underserved by this change? What will the impact be on workforce issues, diversity, and access to care?

Much has been written about scope of practice. A rich discussion about scope of practice issues is beyond the intent of this presentation. However, discussions about public protection or public access to affordable services are, in part, about scope of practice. The scope or boundaries of practice are an integral part of the credentialing/regulatory scheme. Scope of practice defines the array of services, tools, or skills a practitioner can provide and the context where these can be provided.

In other words, it delineates the make-up and boundaries of the sand box and provides direction on who is eligible to play in their respective box.

The scope of practice model works well until another profession seeks its own sand box or wants to expand its existing box to include some of the play activities of another. In the regulatory system, this dispute is usually addressed through the political process – a process that at times appears to favor one profession over another.

In an effort to provide objectivity to the scope of practice decision making process, six health credentialing organizations came together in 2009 and published a monograph titled Changes in Healthcare Professions Scope of Practice: Legislative Considerations. The monograph presents questions and other factors that should be considered when determining a profession's scope.

Reasonable people can at times be unreasonable when it comes to what they consider encroachment into their profession's body of knowledge and skill or task sets. Forgotten for the most part in this process is the public.

What may not be available to the public at the end of the day may be access to efficient and cost effective care due to a turf battle between providers.

Today in various trade publications the scope of practice of nurse anesthetists in relation to that of anesthesiologists being debated. Is the debate about any lack of education for these advanced practice nurses, inadequate training, or unreliable assessment of their knowledge and skill, or is the debate about maintaining the status quo for physicians? Again, if it is good for the profession it must be good for the public.

With the coming changes in health care delivery, credentialing bodies and the credentialing industry need to be an independent and objective voice in helping the system work through challenges inherent to scope of practice, governance, and accreditation. There are other issues that require leadership: professional discipline, telemedicine, continuing competency, and funding. Lack of an industry-wide focus to these and other issues can marginalize our impact on influencing health care delivery If the public and private entities that make up this industry are to be successful in their public service mission, the number one need is focused, informed, and courageous leadership. We all know when an organization has it, and unfortunately, we may all suffer when it doesn't.

In our lifetime, there may not have been an individual who has made a greater impact on how we live and work than Steve Jobs – that crazy guy who founded Apple Computer. He invented the future for us in the development of devices that we might not even have imagined were possible, and as a result, he gave us access – affordable access to the world of information to a degree that has improved our lives.

Most, if not all of us have used or watched someone use the Apple iPhone or iPad. With one touch of a colorful icon or swipe of the screen we are now able book a flight, make a reservation, play poker, and try to win at Angry Birds. In his HBR article, Jobs biographer Walter Isaacson describes some specific leadership applications that Jobs used to lead Apple. We would be crazy not to consider these and their potential impact and changes to the way we approach our credentialing business. I want to discuss a few of these leadership characteristics.

In preparation for this presentation, I did a search of Steve Jobs quotes about life and business, drawing significantly on Isaacson's work. All, I believe, all have a common element: leadership.

So now, I'd like to ask my crazy question another way, "How would Steve Jobs have led the credentialing industry?"

Focus – deciding what not to do is more important than deciding what to do. As Jobs said to the CEO of Google, "Figure out what Google wants to be when it grows up." For our industry, our focus is public protection. We need to figure out what the needs of the public will be in a continually evolving health care service environment and to set standards and credentialing policy that supports the public's need for quality, access, and affordability. What are we doing to stay focused on this goal? What forces do we need to stand up against to achieve it?

Simplify – Jobs' ability to focus was accompanied by his related instinct to simplify. "It takes a lot of hard work to make something simple," he told Isaacson. Are our rules and regulations too complex, resulting in confusion or misinterpretation by those we credential? Think about the instructions you receive when you purchase an Apple product: connect the device to a power source and begin. Can the public understand our systems and guidelines?

Push for Perfection – During the development of every product, Jobs at a certain point "hit the pause button and went back to the drawing board because he "felt" it wasn't perfect. How often do we hear that we can work on the corrections to a product, process, or policy at a later date? What message is an organization sending, especially a credentialing one, if it appears to be routinely issuing correction or interpretation announcements to its credential holders and related communities?

Engage Face-to-Face – Jobs was a believer in face-to-face meetings. There is temptation in the networked age to think that ideas can be developed by e-mail, he told Isaacson. "That's crazy. Creativity comes from random discussions. You run into someone and ask what they are doing, you say 'Wow,' and soon you are cooking up all sorts of ideas."

Unfortunately, today's financial challenges may limit or eliminate a board's (or its key committees) ability to meet face-to-face. However, engaging with others face-to-face is for me is like setting the stage for a play or movie. We will never know what our industry would be like today or tomorrow if Steve Jobs were its leader. I am certain it would not fail under his leadership.

For us, today's leaders in credentialing, to develop answers to the question, "how can we fail" is the collective responsibility of credentialing bodies and meaningful public participants to address.

Through respectful leadership, it requires a commitment to serve our primary customer, the public, a commitment to base decisions and actions on evidence, and collaboration may change the question from failure to success. I don't consider that to be too crazy an idea.

Thank you.

Upcoming Meeting – Save the Dates!

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*.

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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

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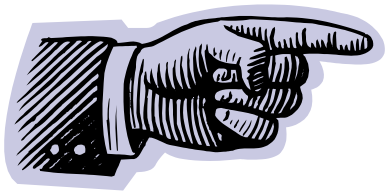

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