News & Views

Citizen Advocacy Center

Second Quarter, 2013 - A Health Care Public Policy Forum - Volume 25 Number 2

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 is at http://www.cacenter.org/.

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.*

PATIENT SAFETY

Nurses Question Hospital Safety Programs

A survey conducted by the American Nurses Association and GE Healthcare reveals that nurses in the US, UK and China doubt the effectiveness of their hospitals' patient safety initiatives. Among the findings:

- 90% of respondents believe that nurses are more responsible for patient safety than physicians and patient safety officers;

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- 41% describe the hospital they work in as "safe;"
- 90% say it is important to have a non-punitive culture to encourage reporting of errors and near-misses;
- More than half of respondents believe nurses hold back on reporting for fear of punishment;
- Only 37% consider their hospital excellent at communication with patients;
- Only 31% consider communication among staff to be excellent.

For more about the survey and its findings, see: http://newsroom.gehealthcare.com/articles/patient-safety-challenges-in-nursing-identified-in-global-survey/.

Compounding Pharmacy Oversight Found Insufficient

On April 15, 2013, Representative Edward J. Markey of Massachusetts released a report faulting oversight of compounding pharmacies by state pharmacy boards. The report, entitled, "State of Disarray: How States' Inability to Oversee Compounding Pharmacies Puts Public Health at Risk," is based on a survey of pharmacy boards to ascertain whether board inspections of compounding pharmacies uncover problems like those found at the New England Compounding Center in Framingham, Massachusetts.

Twenty-two pharmacy boards either do not track problems at compounding pharmacies or could not produce historical inspection records.

According to Markey, even states with strong standards are unable to effectively police the pharmacies in other states, which sell across state lines. Meanwhile, the FDA began conducting surprise inspections at thirty-one compounding facilities with a history of problems.

Representative Markey's report can be found at:

http://markey.house.gov/sites/markey.house.gov/files/documents/State%20of%20Disarray-FINAL%20HIGH%20RES%20COVER_0.pdf.

The National Association of State Boards of Pharmacy (NABP) has announced its support for legislation giving the FDA authority to regulate compounders. See: http://www.pewstates.org/projects/stateline/headlines/state-pharmacy-regulators-back-senate-bill-on-drug-compounding-85899475159. However, some consumer advocates criticize the legislation as proposed for covering too narrow a group of compounding pharmacies. See: http://www.washingtonpost.com/national/health-science/senate-panel-approves-tighter-oversight-of-compounding-pharmacies-but-bill-under-fire/2013/05/22/21869ac2-c303-11e2-9fe2-6ee52d0eb7c1_story.html?wpisrc=nl_headlines.

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At the NABP annual meeting in May 2013, delegates from member pharmacy boards adopted several resolutions related to compounding:

- Board of pharmacy will be encouraged to reference the United States Phamacopeial Convention sterile compounding standards in their regulations. In addition, boards will be urged to conduct inspections or surveys of pharmacies engaged in sterile compounding or accept sterile compounding inspections or surveys conducted by a nationally recognized body. Finally, amendments will be proposed to the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy* to address appropriate regulation and require inspection of pharmacies engaged in sterile compounding.
- NABP and the state boards of pharmacy will work with FDA and other stakeholders to establish mutually agreeable definitions for "pharmacy compounding" and "pharmacy manufacturing," and NABP will revise the Model Act to reflect the new definitions.

- NABP will collaborate with the Federation of State Medical Boards and the National Council of State Boards of Nursing to assess the impact on patient safety of the compounding and reconstitution of sterile products for infusion in establishments other than pharmacies and without pharmacists' oversight.

Editorial Note: Boards of Pharmacy are the only state-based regulators of healthcare professionals with the power to oversee and inspect the place of practice as well as the conduct of licensees. However, in the wake of another incident, which exposed thousands of patients to the risk of hepatitis or HIV, the Oklahoma dental board is considering instituting inspections of dental offices, according to a report by the Associated Press on March 29, 2013. After the fact inspections of a Tulsa dental office found rusty and unsanitary instruments used in patient care. See more: http://abcnews.go.com/Health/60-oklahoma-dental-patients-test-positive-hepatitis-hiv/story?id=18991527#.UafuDZXt43b.

ProPublica Publishes Tips for Staying Safe in the Hospital

Investigative journalists at ProPublica have published a guide for consumers on how to stay safe in the hospital. For more information, see: http://www.propublica.org/article/a-patients-guide-how-to-stay-safe-in-a-hospital.

Editorial Note: Note in the article that ProPublica has established a "Patient Harm Community" which collects data on patient experiences – information CAC* News & Views *believes regulatory authorities should want to stay on top of.

AHRQ Issues Primers on Preventing Errors

The Agency for Healthcare Research and Quality (AHRQ) issued the following announcement on June 11, 2013:

> ### Patient Safety Primer Offers Strategies to Prevent Medication Errors
>
> A growing evidence base supports specific strategies to prevent adverse drug events (ADEs), according to a patient safety primer posted online on AHRQ's Patient Safety Network (PSNet). The primer outlines strategies providers can use at each stage of the medication use pathway – prescribing, transcribing, dispensing, and administration – to prevent ADEs. These strategies range from computerized provider order entry and clinical decision support to minimizing nurse disruption and providing better patient education and medication labeling. The primer also identifies known risk factors for ADEs, including health literacy, patient characteristics, high alert medications and transitions in care. To access the full patient safety primer, titled Medication Errors, go to: http://psnet.ahrq.gov/primer.aspx?primerID=23.

On June 14, 2013, the agency followed up with this announcement:

> **Patient Safety Primer Examines Wrong-Site, Wrong-Procedure, Wrong-Patient Errors**
>
> Communications issues are a prominent underlying factor for "wrong-site, wrong-procedure, wrong-patient errors," according to a patient safety primer available on AHRQ's Patient Safety Network (PSNet). Better communication in the form of "timeout" discussions before the medical team begins a procedure, surgical safety checklists, and site marking have been shown to improve surgical safety. To prevent such errors, the primer notes that one must combine these system solutions with strong teamwork and safety culture, and personal vigilance.
>
> To access the full patient safety primer, titled Wrong-Site, Wrong-Procedure, Wrong-Patient Surgery, go to: http://psnet.ahrq.gov/primer.aspx?primerID=18.

LICENSURE

FSMB Considers Interstate Compact Concept

The Federation of State Medical Boards issued the following announcement following its annual meeting in April 2013:

> **Federation of State Medical Boards to Explore Use of Interstate Compact for Physician Licensure**
>
> DALLAS – The House of Delegates of the Federation of State Medical Boards (FSMB) has approved a resolution calling for the FSMB to formally explore the creation of a new system that would utilize an "interstate compact" to increase efficiency in the licensing of physicians who practice in multiple states. The FSMB House passed the resolution unanimously during its Annual Meeting on April 20 in Boston.
>
> Interstate compacts are formal agreements between states that have been successfully utilized to help state governments facilitate a wide range of activities that cross state lines, eliminating the need for federal intervention. Regulation of the health professions is mandated to the states by the 10th Amendment of the U.S. Constitution.
>
> The House resolution calls for the FSMB to convene representatives of state medical boards and other experts by July of this year to study the practical implications of a medical licensing compact. Such an agreement could be used to help facilitate multi- state practice and enable telemedicine, while ensuring that state boards would retain their individual authority for discipline and oversight within the system.
>
> With the expanded use of telemedicine, the practice of medicine across state lines is expected to increase in coming years – especially in rural areas of the United States. Physician licensing is administered separately by each state and U.S. territory, and those who seek more than one license currently must navigate

through multiple licensure processes. These processes could be streamlined through the use of an interstate compact.

"One of the most important consensus points that we continue to hear in discussions of possible models for medical licensure is that they should be state-based," said Humayun J. Chaudhry, DO, President and CEO of the FSMB. "Most policy experts agree state authority ensures the best assurance of patient protection in physician licensing – which remains our number one priority."

"An interstate compact could address the need for efficiency and speed in licensing, while not compromising the inherent value of a state-based system, and most importantly, patient safety," he added.

The House action is the latest in a series of action steps the FSMB has taken in recent years in an effort to better accommodate the needs of physicians who practice across state lines. In January of this year, representatives of 48 state and territorial boards gathered for a special summit meeting in Dallas to discuss various licensing models that could be adopted, with the interstate compact emerging as the most feasible.

Wyoming Board of Medicine Executive Director Kevin Bohnenblust, JD, who participated in the January meeting and whose state sponsored the House of Delegates resolution, called the development "a strong step forward."

"More than 75 percent of the physicians who are licensed in Wyoming are licensed in another state, yet only about 40 percent of our licensees live in Wyoming," he said. "States like ours, with patients who live in small and sometimes remote communities, rely on physicians who do not reside here. We are excited with this development."

IMPAIRED PRACTITIONERS

Consumer Advocacy Organization Suggests Random Drug Testing of Physicians

A California advocacy group, Consumer Watchdog, wrote to the Governor and the legislature on February 6, 2013 to ask lawmakers to consider instituting random drug testing of physicians. This request is in the context of tackling problems of overprescribing the prescription drug abuse.

> "The recent investigation (by the *Los Angeles Times*) and past decades of experience," wrote the advocates, "show that patients are not safe from drug using and drug dealing doctors… Prescription drug abuse by physicians is something the public will not tolerate without a remedy that is reasonable and effective…"

For more about this proposal and a link to Consumer Watchdog's letter, see:

http://www.consumerwatchdog.org/newsrelease/consumer-watchdog-calls-political-response-physician-drug-abuse-scandal-including-mandat.

IN THE COURTS

Court Upholds Medical Board Discipline

According to a February 2013 Iowa medical board press release, discipline taken by the board has withstood a judicial appeal:

> DES MOINES, IA – A Polk County District Court judge has upheld the Iowa Board of Medicine's order to suspend the medical license of a physician who was found to have repeatedly violated the terms of a board order.
>
> Robert F. Tobin, M.D., of St. Joseph, MO, a 71-year-old Iowa-licensed physician who formerly practiced ophthalmology in Council Bluffs and Des Moines, asked the court to reverse the Board's decision, dated March 29, 2012, in which he was sanctioned for violating a board order issued May 6, 2010. The Board determined he did not complete many terms of the order.
>
> Dr. Tobin contended that he was in substantial compliance with the order, that the sanctions meted out by the Board were unreasonable, and his due (process) rights were violated by the deliberative process utilized by the Board.

See the entire press release at: http://medicalboard.iowa.gov/Board%20News/2013/Court%20upholds%20suspension%20of%20medical%20license%20-%2002152013.pdf.

Court Remands Case to Medical Board

In May 2013, an appeals court overruled a lower court and sent a discipline case back to the Iowa Board of Medicine. The Board imposed a fine and suspension on Dr. Wendy Smoker for alcohol abuse. The court ruled the board had insufficient evidence. The board has asked the Iowa Supreme Court to review the appeals court decision.

For more, see: http://medicalboard.iowa.gov/Board%20News/2013/Appeals%20Court%20overturns%20discipline%20of%20UIHC%20neuroradiologist%20-%2005012013.pdf.

Appeals Court Rules Quorum Need Not Include Specific Board Members

Ruling on a challenge of discipline for unprofessional conduct, an Arizona Court of Appeals rejected the plaintiff's argument that the board was improperly composed when it imposed the discipline. The board position reserved for a nurse was vacant at the time.

> The nurse-member position was vacant when the Board voted to reprimand Kahn. The statutes, though, do not require the presence of any specific member for the Board to conduct business. Eleven Board members attended the August 11, 2010, meeting, and they voted unanimously to reprimand (the doctor).

The decision can be found at: http://www.hortyspringer.com/wp-content/uploads/2013/04/Kahn_v_ArizonaMedicalBoard_March2013.pdf.

California Supreme Court to Rule on Non-Nurses Giving Shots in Schools

Two lower courts have ruled that California's nursing practice act empowers only nurses to administer shots in schools. The American Diabetes Association has appealed to the California Supreme Court, contending that non-nurses may follow a physician's orders, so long as they do not act as a nurse. Furthermore, regulations governing the school system permit non-nurses to help patients with medications.

For details, see: http://www.californiahealthline.org/articles/2013/5/31/supreme-court-weighs-whether-non-nurses-can-give-shots-to-school-kids.aspx.

Medical Board Sued Over Anti-Abortion Law

All fourteen members of the Arkansas medical board have been sued by the state's ACLU in behalf of two abortion doctors who could lose their licenses for performing abortion services after the twelve week deadline in a new law enacted over the governor's veto. The suit contends that the new law violates decades of Supreme Court precedent.

The plaintiffs argue that the ban on abortion services after twelve weeks violates patients' constitutionally guaranteed right to decide to end a pre-viability pregnancy and interferes with the doctors' ability to act on their best medical judgment.

For more, see: http://www.lifenews.com/2013/04/16/aclu-sues-to-overturn-arkansas-law-banning-abortions-at-12-weeks/, and http://articles.chicagotribune.com/2013-04-16/lifestyle/sns-rt-us-usa-abortion-arkansasbre93f187-20130416_1_jill-june-governor-mike-beebe-rita-sklar.

SCOPE OF PRACTICE

AHRQ Expert Interviewed on Changing Role of Nurses

The lead article in the Agency for Healthcare Research and Quality's December 2012 Research Activities is an interview with AHRQ's senior advisor for nursing, Beth Collins Sharp, Ph.D., M.S.N. In addition to growing prominence in "interdisciplinary collaboration with patient-centeredness, which is a longstanding nursing value and well ingrained in nursing practice," Sharp sees a growing role for nurses in research.

Nurses, she observed,

> Bring an on-the-ground perspective – a reality check – to studies. Ideally, nurses are involved from the beginning as questions are developed through to the end when the research gets put into practice. We're often the clinicians collecting data and documenting care or implementing the intervention. We can identify problems during pilot studies or run-in periods in the research protocols. After all, we are experienced in clinical protocols. And, of course, when the study is complete, we're often doing much of the patient education…
>
> I see nurses having an increasing presence on multidisciplinary teams in co-investigator and principal investigator roles. The multidisciplinary approach is such a positive way to go – especially for the patient…

> There was so much buzz in the nursing community when the (IOM) report (*The Future of Nursing: Leading Change, Advancing Health*) was released, you'd have thought the report was only by and for nurses… The report resonated with several sectors of the health care industry and they recognize that the report is actionable… There are provisions (in the Affordable Care Act [ACA]) that speak about both registered nurses and nurse practitioners… Medicare now pays the same reimbursement to certified nurse midwives for a service if the same service (were) otherwise delivered by a physician. The nurse practitioner role is spelled out in several points of the ACA- most often in primary care and the patient-centered medical home, as well as advanced practice education loans and training grants such as geriatric nursing career incentives…
>
> The issues about scope of practice continue to be 'spirited.' Currently, there's a lot of posturing around who should be in charge of medical homes, for example. There are some misperceptions about nurse practitioners – like they're trying to replace physicians or silly things like they're 'physician extenders' or 'mid-level' providers. Be warned – don't use those phrases with your nurse colleagues! All kidding aside, my personal view is that in the current environment where health care demands and deserves a team approach, there's plenty of work for everyone…

The entire interview can be found at http://www.ahrq.gov/research/dec12/1212RA1.htm.

California to Consider Scope of Practice Expansions for Several Professions

A series of bills have been introduced in the California legislature that would expand the scope of practice for nurse practitioners, optometrists, pharmacists and physician assistants. Details of the proposals will emerge in coming months. For more information, follow bill numbers SB 352, SB 491, SB 492, and SB 493.

For more, see: http://www.californiahealthline.org/articles/2013/3/14/bills-introduced-to-expand-scope-of-practice-for-non-physicians.aspx?p=1 and http://www.sacbee.com/2013/03/14/5261222/ca-lawmakers-look-to-expand-scope.html, and http://www.latimes.com/news/local/political/la-me-pc-doctors-nonphysicians-battle-over-medical-turf-20130326,0,3212596.story.

Oregon Physician Assistants Given Limited Dispensing Authority

Legislation passed in 2012 permits supervising physicians to apply for prescriptive authority for physician assistants under their supervision. This expands on prescriptive authority already available to PAs in medically disadvantaged areas or populations:

> Under the new legislation, PAs are eligible for dispensing authority regardless of practice location. However, an applicant for dispensing authority under the new laws must fulfill additional requirements. To apply, the qualified physician assistant must complete a Drug Dispensing Training Program jointly developed by the (Medical Board) and the Board of Pharmacy, and the supervising physician must:

- Submit a list of drugs or classes of drugs to the Board,
- Submit a drug delivery and control plan,
- Submit an annual report to the Board on the physician assistant's dispensing, and
- Register the practice location(s) as a drug outlet with the Board of Pharmacy.

Massachusetts Cost Control Law Elevates Physician Assistant Role

Legislation signed in August 2013 by Massachusetts Governor Deval Patrick was passed to control healthcare costs in the State. The law requires health plans to list physician assistants in their directories as primary care providers and allow patients to choose a PA as their main provider. Nurse practitioners already have the same status.

For more, see Liz Kowalczyk's article in the *Boston Globe*: http://www.bostonglobe.com/lifestyle/health-wellness/2012/09/16/comparing-training-for-physician-assistants-nurse-practitioners-doctors/g3RYzKuRGbELvYtzZLQGaJ/story.html.

Visit this link for the *Boston Globe's* synopsis of the training and functions of various primary care professions: http://www.bostonglobe.com/lifestyle/health-wellness/2012/09/16/comparing-training-for-physician-assistants-nurse-practitioners-doctors/b4H8GFoA9k2P96D6IXPFVM/story.html.

Specialty Group Opposes Laws Interfering with Medical Practice

On January 17, 2013, the Council of Medical Specialty Societies (CMSS) announced a new policy opposing legislative interference with the practice of medicine and the patient-physician relationship. Specifically, the CMSS opposes laws that:

- Prohibit physicians from discussing with or asking patient about risk factors that affect their families' health
- Require physicians to discuss specific practices that may not be necessary or appropriate, according to the physician's best clinical judgment
- Require physicians to provide patients with diagnostic tests or medical interventions not indicated by evidence and may be performed without the patient's consent
- Limits on the information physicians can disclose to patients or their consultants.

See the CMSS press release at: http://www.cmss.org/DefaultTwoColumn.aspx?id=504.

Dental Professions Conflicted Over How to Improve Access to Care

Two states – Alaska and Minnesota – have authorized practice by a mid-level dental professional called a "dental therapist" to improve access to basic dental care, especially among low-income and underserved populations. Several other states are considering or plan to consider licensing mid-level dental practitioners. These include Connecticut, Kansas, Maine, Massachusetts, New Hampshire, New Mexico, North Dakota, Ohio, Vermont and Washington.

Organized dentistry is opposed to this legislation, in particular to delegating surgical procedures. And in Minnesota, which licenses dental therapists, dentists are lobbying the state to increase the amount it pays dentists to treat patients enrolled in the state's Medical Assistance program.

For more, see http://www.politico.com/story/2013/03/dental-therapists-help-deal-with-access-gap-88664.html and http://www.telegram.com/article/20130310/APN/303109800/0/SEARCH.

Dentists and Nurse Practitioners Collaborate at Virginia Commonwealth University

In a novel practice model, dentists and nurse practitioners at Virginia Commonwealth University collaborate to treat dental health in the context of overall health and disease prevention. The goal is to improve access to care, promote disease prevention, and reduce the cost of care.

For more, see http://www.timesdispatch.com/business/health/vcu-dentists-and-nurse-practitioners-collaborate-on-patient-care/article_393d2de4-3b3a-5d2f-ae2c-c2ad28d24be5.html.

Doctors Encouraged to Learn and Consider Costs of Care

A new movement in medical circles advocates teaching caregivers about the cost associated with medical care and encouraging them to consider the financial consequences for their patients. For example, the organization *Costs of Care* is working with the American Board of Internal Medicine to develop a medical school curriculum to teach students what things cost and how to talk about the cost of care.

The organization advocates:

- Creating a culture where caregivers are responsible for the cost and value of their decisions, take action to avoid waste, and help build the will for change;
- Giving caregivers the knowledge and skills they need to make cost-conscious, high-value decisions with their patients, and;
- Helping caregivers to deflate medical bills by using information technology and decision-support tools to put cost and quality information at their fingertips at the critical moment when medical decisions are made.

For more, visit http://www.costsofcare.org.

South Dakota Rejects Student Midwife Attendance at Births

In South Dakota, licensed nurse midwives are allowed to perform home births under a waiver from the Board of Nursing. Midwives certified by the North American Registry of Midwives may not practice legally in the state. Advocates for certified professional nurse midwives contend that they offer a service for families wanting a natural birth that is not available from nurse midwives, most of whom practice in hospitals.

House Bill 1065 would permit student midwives to participate in live births under the supervision of a midwife certified as a trainer by the North American Registry of

Midwives. Based on concerns about liability and training, the House Health and Human Services Committee voted to defer the proposed legislation. Gloria Damgaard, Director of the Board of Nursing, said the legislation raises scope of practice concerns that might undermine the waiver permitting nurse midwife to perform home births.

For more, see reporter John Hult's coverage of this issue in the Sioux Falls, South Dakota Argus Leader at http://www.argusleader.com/apps/pbcs.dll/article?AID=2013130127001&nclick_check=1.

Mississippi Considers Rules for APRN Practice

In the wake of an investigation of the G.V. Montgomery Veterans Affairs Medical Center and the arrest of its associate director for patient care services, the board of medicine is considering stricter regulation governing nurse practitioners. The facility has been charged with permitting nurse practitioners to prescribe controlled substances without valid DEA licenses and without physician supervision. The facility had been operating under federal regulations that permit nurses in VA hospitals to prescribe under the hospital's DEA license.

Regulations under consideration would reduce the number of APRNs a doctor can supervise to four. It would also require that the supervising physician be no more than 40 miles from the nurses' place of practice. Some questioned whether the medical board has the authority to enact rules that regulate nurse practitioners.

For more, see columns by reporter Jerry Mitchell in the Jackson Mississippi Clarion-Ledger at http://blogs.clarionledger.com/jmitchell/2012/11/.

Massachusetts to License Naturopaths

The Massachusetts legislature approved licensure of naturopathic doctors in December 2012. The law will require naturopaths to complete approved educational preparation and meet any other requirements imposed by a newly created board of naturopathic medicine.

Canadian Provinces Expand Scopes of Practice

According to the Commonwealth Fund International News Briefing,

> In certain Canadian provinces, non-physician health care professionals are being allotted greater responsibility. In October, the Ontario government expanded the scope of practice for pharmacists, giving them the authority to renew most prescriptions and offer some services previously provided only by doctors. Regulations were changed to allow pharmacists to renew nonnarcotic prescriptions, provide advice to people with chronic conditions, and give flu shots.
>
> Both Ontario and British Columbia have increased the capacities of nurse practitioners, granting them the authority to admit and discharge patients without having to wait for the approval of a doctor or supervisor. According to the B.C. Health Minister Margaret MacDiarmid, expanding the role of nurse practitioners

will help fill some of the gaps in the health care system and will improve efficiency, saving doctors, nurses, and patients time.

Sources: http://www.theglobeandmail.com/news/british-columbia/more-powers-givento-nurse-practitioners/article4607995/ and http://www.theglobeandmail.com/news/politics/pharmacists-in-ontario-can-give-flu-shots-and-renew-non-narcotic-prescriptions/article4598872/

For more, see http://www.commonwealthfund.org/Newsletters/International-Health-News-Briefing/2012/December-2012/Canada/Premiers-Health-Care-Report.aspx?omnicid=11.

Texas Medical Board May Waive Supervision Requirements

In its December 2012 *TMB Bulletin*, the Texas medical board explains its criteria for waiving supervision requirements for prescriptive authority:

Prescriptive Delegation Waiver Requests

The board has authority to waive or modify any of the site or supervision requirements for a physician delegating prescriptive authority to advanced practice nurses or physician assistants. But the board's rules state that the board may grant a waiver *only if it determines good cause exists to grant a waiver*.

So what factors does the board take into account?

- Whether the existing prescriptive delegation requirements cause an undue burden to the patient population (not only to the requestor) without corresponding benefit to patient care.
- The quality and viability of safeguards that are proposed to ensure continued quality of patient care.
- The quality and viability of safeguards that are proposed to foster a collaborative practice between the physician and the physician assistant or advanced practice nurse.
- The requestor's type of primary practice and the type of practice conducted at the site for which a waiver is requested, including the populations served by the practices and duties as- signed to mid-level practitioners.
- Whether the proposed frequency and duration of time the physician is on-site when the advanced practice nurse or physician assistant is present is sufficient for collaboration to occur, taking into consideration the other ways the physician collaborates with the advanced practice nurse or physician assistant at other sites.

For more information, please visit the Prescriptive Delegation Waiver Requests page on our website at http://www.tmb.state.tx.us/professionals/np/pdwreqs.php.

ETHICS

Physician Groups Offer Guidance for Use of Social Media

The Federation of State Medical Boards (FSMB) and the American College of Physicians have issued guidance for physicians in the use of digital communications and social media in patient care. A paper published online and in the *Annals of Internal Medicine*, contains recommendations regarding the influence of social media on the patient-physician relationship. For details, see http://www.acponline.org/pressroom/online_medical_professionalism.htm and http://www.healthleadersmedia.com/print/PHY-291079/ACP-FSMB-Issue-Stern-Guidance-on-Social-Media.

DISCIPLINE

Board of Nursing Advises Licensees on Avoiding Unprofessional Conduct Complaints

Editorial Note: The North Carolina Board of Nursing published the following article by Angie Matthes, RN, MBA/MHA in its Fall 2012* North Carolina Nursing Bulletin. *We reprint it here as an illustration of a board reacting to complaint trends by advising licensees how to avoid problem behaviors.

Avoiding Unprofessional Behavior Allegations

Have you ever been treated poorly or received poor customer service? What was your impression of the person or business?

What do you consider rude and unprofessional behavior? We can all recognize these behaviors in someone else, but can we recognize this within our own behavior?

The Board of nursing has been receiving a growing number of public complaints about nurses who are "perceived" as unprofessional, rude, uncaring, condescending and impatient.

For example, have you ever heard or made comments like these? "That patient is such a pain." "I am so sick of that patient calling me every 5 minutes." Consider how this would make you feel if this were said about a loved one. While most of the time comments like these are said out of frustration and not meant for the patient to hear, you never know when you may be overheard.

Nurses seem to be under more pressure today due to higher patient acuity, fewer staff and resources, and increased demands. In response to these stressors, nurses may react abruptly and convey a negative attitude without meaning to. However, patients and their loved ones rightfully expect to receive appropriate quality nursing care in a timely manner by caring and professional nurses. It is important to remember that it is how nurses present themselves to patients that can frame how patients view their entire healthcare encounter. Consider the following scenarios:

Scenario #1

Shortly after coming on duty, a patient lashes out at the nurse because he had not received his medication when he requested it. The nurse responded, I just got here. We are short of staff and you are not our only patient." What kind of impression do you think this made on the patient? Did this demonstrate care and concern for his wellbeing? What if instead, the nurse responded with, "I am sorry for the delay; is the pain medication effective in relieving your pain or are you beginning to have pain before your next medication dose is allowed?" How would you expect the patient receiving this response might feel? Did the nurse show empathy and a desire to help?

Scenario #2

A confused patient is yelling at the nurse telling her to stop hurting her the nurse responds, "Quiet. I am tired of listening to you whine all the time." A visitor overhears this interaction and reports that the nurse was disrespectful and abusive.

Consider how you might feel if someone said this to your loved one. Do you think you would feel comfortable leaving your loved one with someone that seemingly demonstrated no concern?

Everyone wants to feel like they have been heard when they share concerns or needs no matter how exceptional the nursing care is, a nurse that has been perceived as rude or uncaring may end up being the nurse that the patient or family remembers the most.

Most nurses report that the very reason they became a nurse was to help people in order to do this effectively, nurses have to consider how they react and respond in stressful situations. The time it takes to respond positively and professionally is much less than the time it will take to respond to complaints down the road.

There will always be a difficult day or a challenging situation, but it is worth the effort when a nurse remains professional and carries out his/her role to the best of his/ her ability in the most caring and compassionate manner. Remember, when patients experience anxiety and fear, these feelings can often be displayed as frustration and anger. Nurses must recognize this and display compassion and understanding.

When all is said and done, patients and their loved ones will not likely remember every health care provider involved in their care, but they usually will remember their best and worst experiences. Only you can control in which group you will be placed. Few kind words and sincere compassion will leave your patients with a positive experience and perception of their nursing care. Attitudes are contagious: let yours be positive!

Newspaper Article Questions Reach of Licensing Board Authority

Editorial Note: A thought-provoking article posted February 9, 2013, on the Austin, Texas statesman.com reviews a number of actions taken in recent years by the state's board of nursing involving legal or ethical lapses by nurses while off-duty. American-Statesman staff reporter Eric Dexheimer interviewed the parties involved and experts

around the country to assemble a balanced discussion of the appropriateness of licensing boards taking disciplinary action for unprofessional conduct outside the workplace. The article, entitled "Off duty, under scrutiny: How much off-the-clock behavior can the state regulate?" can be found here:

http://www.statesman.com/news/news/state-regional-govt-politics/off-duty-under-scrutiny-how-much-off-the-clock-beh/nWKyr/.

Secretary of State Strengthens Penalty Imposed by Medical Board

Delaware's Secretary of State intervened to suspend Dr. Muhammed Niaz's license for three years for unlawful prescribing practices. The physician was the subject of 55 malpractice allegations. The discipline imposed by the medical board was two years of probation.

For more, see: http://news.delaware.gov/2013/03/07/delaware-imposes-three-year-suspension-and-5000-fine-on-dr-muhammed-niaz-for-unlawful-prescribing-practices/.

CONSUMER INFORMATION

Seventy-two Percent of Internet Users Seek Health Information Online

According to an online article in *FierceHealthIT*, a growing number of consumers seek health information online. Seventy-two percent of Internet users sought health information online in the last year. Fifty-nine percent of these were seeking information about a particular condition for themselves or a family member or friend. Yet, sites run by doctors and hospitals typically are more like advertising brochures. For more, see: http://www.fiercehealthit.com/story/doc-websites-often-little-more-bios-general-info/2013-02-04.

Editorial Note: CAC convened a meeting in April 2013 focusing on outreach by regulatory boards and voluntary certification organizations. One day of the meeting concentrated on Web sites. Background research in preparation for this meeting revealed that few regulatory and certification Web sites contain information about health conditions (or links to other authoritative sources) and information about what a given profession is trained to do in the way of diagnosis and treatment. Consumer advocates in attendance at the meeting agreed that members of the public want to see this kind of educational information online.

Medical Board Pressed to Reveal More Disciplinary Information

Under pressure from the *Boston Globe*, the Massachusetts medical board agreed to post information on doctors whose licenses have been revoked or who have been disciplined for negligent care. Currently, these individuals do not appear on the board's searchable database. As of February 2013 the board had been unable to make good on its promise.

For details, see http://www.bostonglobe.com/lifestyle/health-wellness/2013/02/19/medical-board-late-adding-information-about-troubled-doctors-its-website/u6IFGGncPCZuN9HjxluVkO/story.html?s_campaign=8315.

Online Doctor Rating Sites under Criticism

Writing in the March 2013 issue of *Medicine on the Net*, Doug Desjardins explores critiques of online sites that rate doctors. One problem with the data on these sites is the small sample size. Another problem is that practitioners are evaluated on variables that do not address quality of care and patient outcomes.

For more, see coverage in HealthLeaders Media: http://www.healthleadersmedia.com/print/MAR-289689/Beware-Flaws-in-Online-Physician-Rating-Sites.

CONTINUING PROFESSIONAL DEVELOPMENT

Poll Shows Consumers Support Lifelong Learning

Editorial Note: The following press release explains the findings from a public opinion survey conducted on behalf of the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) and CAC.

Chicago – Large majorities of Americans want the healthcare professionals who treat them to be required to keep up with developments in their professional fields and want their skills assessed by independent bodies. Seventy four percent of American consumers believe that healthcare providers should not be excused from lifelong learning regardless of years of practice. Sixty six percent believe that they should not be excused from being periodically evaluated on their qualifications and their ability to practice their profession safely by the professional agency that originally certifies their competence. These findings come from a national survey conducted on behalf of The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) and Citizen Advocacy Center (CAC) by Harris Interactive, one of the world's leading market research firms. The NBCRNA and CAC sought to gain a better understanding of the public's perspective about the credentialing standards required of their healthcare providers. The NBCRNA also was interested in ensuring that nurse anesthetists' commitment to quality care aligns with the expectations of the patients they serve.

Americans' replies indicated that the public prefers healthcare providers to adhere to a multimodal recertification program. For example:

- 91% of U.S. adults think it is very important/important that a health care professional who is going to treat them has passed an examination on their profession's specific knowledge.
- 89% believe it is very important/important that health care professionals who are going to treat them attend educational programs throughout their career to refresh their knowledge and learn about the latest scientific evidence and new technologies.
- 85% believe it is important that health care professionals who are going to treat them have an independent body of health professionals evaluate their skills/knowledge to certify them as competent.

The NBCRNA recently introduced the Continued Professional Certification (CPC) program for nurse anesthetists. The CPC program requires a commitment to learning, mastering skills, and being assessed at regular intervals. The survey results demonstrated that the public's perspective is aligned with many of the best practices in certification and recertification, and supports the key elements of the NBCRNA's Continued Professional Certification program.

"As a healthcare certification body, the NBCRNA has the responsibility to ensure our certification and recertification programs reflect the ever evolving and complex demands of the healthcare environment to include the expectations of the patients we protect," said Dr. Charles Vacchiano, president of the NBCRNA Board of Directors. "Nurse anesthetists appreciate the critical role they play in healthcare, and are committed to demonstrating that they deserve the trust their patients place in them."

The survey's findings also indicate that the majority of Americans disagree with the concept of grandfathering when new recertification requirements are introduced. When asked specifically the number of years a healthcare provider should practice in order to be excused from new requirements of periodic testing, training and evaluated continuing education, the majority of respondents selected that providers should not be excused from any requirement, regardless of time in practice.

David Swankin, president and CEO of the Citizen Advocacy Center, called the survey findings "extremely valuable." He said it was critical that healthcare credentialing bodies work to understand the public's perspective in their decision making process. "The CAC commends the NBCRNA for supporting the measurement of this valuable information and for its leadership in this area. The nurse anesthesia profession is offering a good example to other nursing professions in its commitment to a rigorous continuing competence program."

For questions about the NBCRNA, please contact Danielle Burian at 708-667-0107, or dburian@nbcrna.com.

About the NBCRNA

The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) is a not-for-profit corporation dedicated to promoting patient safety by enhancing provider quality in the field of nurse anesthesia. The NBCRNA accomplishes its mission through the development and implementation of credentialing programs that support lifelong learning among nurse anesthetists. For more information, please visit http://www.nbcrna.com.

About the CAC

Since 1987, the CAC has served the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. The CAC offers training, research and networking opportunities for public members and for the health care *regulatory, credentialing,* and *governing* boards on which they serve. For more information please visit http://www.cacenter.org.

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Survey Methodology

This survey was conducted online within the United States between May 14th and 16th, 2013 among 2,052 adults (aged 18 and over) by Harris Interactive via its Quick Query omnibus product. Figures for age, sex, race/ethnicity, education, region and household income were weighted where necessary to bring them into line with their actual proportions in the population. Propensity score weighting was used to adjust for respondents' propensity to be online.

All sample surveys and polls, whether or not they use probability sampling, are subject to multiple sources of error which are most often not possible to quantify or estimate. These include sampling error, coverage error, error associated with nonresponse, error associated with question wording and response options, and post-survey weighting and adjustments. Therefore, Harris Interactive avoids the words "margin of error" as they are misleading. All that can be calculated are different possible sampling errors with different probabilities for pure, unweighted, random samples with 100% response rates. These are only theoretical because no published polls come close to this ideal.

Respondents for this survey were selected from among those who have agreed to participate in Harris Interactive surveys. The data have been weighted to reflect the composition of the adult population. Because the sample is based on those who agreed to participate in the Harris Interactive panel, no estimates of theoretical sampling error can be calculated.

PAIN MANAGEMENT AND END OF LIFE CARE

FSMB to Offer Opioid Training

The Federation of State Medical Boards has announced a new online CME course on opioid prescribing:

> Dear State Medical Board Executive Directors,
>
> The FSMB and the FSMB Foundation are pleased to announce a partnership with the Boston University School of Medicine CME office to provide free, online education on the new *Safe and Competent Opioid Prescribing Education (SCOPE) of Pain* program.
>
> As you may know, the FDA recently mandated that manufacturers of extended release/long-acting (ER/LA) opioid analgesics, as part of a Risk Evaluation and Mitigation Strategy (REMS), make available comprehensive prescriber education in the safe use of these medications. Boston University School of Medicine (BUSM) was recently awarded an unrestricted educational grant by the manufacturers of ER/LA opioid analgesics to provide this education. Launched on March 1, 2013, with the first phase – an online educational activity – the program addresses many key elements of the physician component of the Obama Administration's prescription drug abuse prevention plan on prescriber education released in April 2011.
>
> During last month's Annual Meeting in Boston, we hope you had an opportunity to explore the *Safe and Competent Opioid Prescribing Education (SCOPE) of Pain* program, which was being demonstrated by representatives from Boston University. The program, which is available at www.scopeofpain.com, is a free, educational program that has been accredited for a maximum of 3.0 AMA PRA Category 1 Credits™. It is comprised of three (3) educational modules that must be completed in order for the learner to earn their online certificate of credit. We believe this program will satisfy current risk management and opioid education CME requirements in many states.

In the months since http://www.scopeofpain.com launched it has been accessed by thousands of clinicians, and their feedback has been overwhelmingly positive. Educational initiatives such as this collaboration are crucial in raising awareness with physicians of the risks opioids pose, while providing a framework to ensure physicians who prescribe opioids do so responsibly and safely.

We ask that you please promote and publicize this free, online CME program to your licensees, and we appreciate your efforts to date in helping to educate physicians on safe and effective opioid prescribing. Should you have any questions or need assistance, please contact Ms. Kelly Alfred, Director of Education Services, at (817) 868-5160 or kalfred@fsmb.org. You may also contact Ilana Hardesty, SCOPE Program Manager at hardesty@bu.edu.

Sincerely,

Kelly C. Alfred, M.S.
Director, Education Services
Federation of State Medical Boards

In March 2013 the Food and Drug Administration issued a plea to prescribers to obtain training in the safe and appropriate use of opioid medications. See more in FDAVoice: http://blogs.fda.gov/fdavoice/index.php/2013/03/fda-joins-with-health-professional-organizations-in-encouraging-prescribers-to-seek-training-to-safely-prescribe-opioid-pain-medicines/.

Oregon Medical Board Newsletter Features Pain Management

The winter 2013 issue of the Oregon Medical Board *Report* features two articles on pain management. In an article entitled, "The Pendulum of Chronic Opioid Therapy," Barry Egener, MD, Medical Director of the Foundation for Medical Excellence addresses the perceived "reversal of expectations by state regulators" about prescribing opioids for non-cancer pain. He discusses approaches to reduce risks of overdose and suggests explanations doctors can give to patients when prescription patterns change. The second article consists of the medical board's "Statement of Philosophy: Pain Management."

Read both articles at http://www.orecon.gov/OMB/newsltr.shtml.

IN DEPTH

Chemically Dependent Practitioners: What Should Licensing Boards Know and When Should They Know It?

Editorial Note: In this quarter's In-Depth Feature we reprint remarks by Arthur Levin, Director of the Center for Medical Consumers and member of CAC's Board of Directors to begin a one-day conference convened by CAC in 2012 to revisit the regulatory management of chemically dependent healthcare practitioners.

Mr. Levin:

This is not a new topic for CAC. And this is not the first time I have spoken at a CAC meeting on the topic of health care professional impairment. But in truth, over the past decade, there has been little change and little progress, at least in my view, in dealing some of the concerns of merit that have been raised in CAC meetings over the years about the "rightness" or "wrongness" of a lack of full transparency as far as state licensee oversight agencies are concerned.

My aim today is to help stimulate a robust conversation among those of you in this room – and to see if we can finally achieve some movement on this question, perhaps even develop a consensus on what a health care professional board should know and when it should know it – about the status of a health-care professional impaired by reason of drugs and/or alcohol addiction, abuse or misuse.

For the purpose of today's discussion, I am not talking abou0074 transparency in its broadest sense – open and complete public reporting. I am talking about transparency as it relates to the conditions under which state authorities responsible for assuring the public safety through monitoring the competency and character of those privileged and licensed to practice in their chosen health care profession labor. And when appropriate, disciplining them. Are they, the responsible agencies, currently being asked to do their due diligence with one hand tied behind their back?

One seemingly intractable belief expressed by many of the participants in past CAC meetings is that to break the wall of secrecy protecting doctors is a bad idea. Please forgive me if I use the example of doctors only because they, of all the health professions, appear to receive the most protection from disclosure. Some go as far as to assert that transparency could well have the unintended consequence of creating a greater risk of harm for patients – because of its chilling effect on the "willingness" of impaired professionals to seek treatment.

That guarantee of no one else knowing, of complete opaqueness of the fact, is in large measure, many argue, what brings some doctors through the rehab door in the first place. The implication that a lack of transparency is a good thing for patients' well-being stands in stark contrast to the discussion that is taking place all around us about the importance of transparency and openness in efforts to transform health care in the United States and improve the quality and safety of that care in meaningful ways. Once again, I want to emphasize that I am only talking narrowly about transparency as it relates to professional impairment due to substance abuse, misuse and treatment through formal rehabilitation programs and the role of state licensing and discipline boards in protecting the public welfare.

Personally I believe that there is very definitely a place for a public debate over how much patients should know and when they should know it as regards a health care professional's potential behavioral problems involving abuse, misuse, and addiction to drugs and alcohol. And that, I think everyone in the room would agree, such behaviors pose significant and unacceptable potential risks to patients.

So the question before us today is how much a Board should know and when it should know it – about the fact that a health care professional has a problem, is entering

treatment, whether such treatment is on a truly voluntary basis or on what I would categorize as an "externally motivated" voluntary basis. I will explain more about this distinction later.

Let me start with some basic assumptions that I hope we can all agree on.

A) The fifty States, each through its system of professional licensing and oversight, are acting as "surrogates" for the interests of patients and the public.

B) States license and at the same time "privilege" health care professionals based on their completion of a specified education, evidence of competency (at least immediately post-education) and maintenance of what the state defines as necessary competency and character to become and to remain a licensed professional.

C) States accord physicians, physician assistants, nurse practitioners and other practitioners with special privileges, such as prescribing, that are not permitted others, either professionals or the laity.

D) The general public and individual patients and their families, I believe, assume that a state license to practice a health profession has meaning and is assurance of competency and, as a result, protects their safety. This is an example of what I referred to earlier as a board's "surrogate" role – every patient seeking care cannot on their own ascertain whether a caregiver has meet the standards of their profession, has satisfied the state that they are competent to continue to in their practice and represents no evident risk to the public safety.

E) Because of this surrogate role, the state has an ethical, and perhaps even legal obligation to perform its careful due diligence in licensing and re-licensing health care professionals.

F) The ability to exercise due diligence as concerns determining the character and competence of a licensed health care professional, is predicated on having access to the relevant facts about that professional.

To help us discuss this issue, let me also put forward categories or scenarios of how a professional might arrive at the rehab door.

<u>Level One</u>

The professional is brought up on charges and the Board orders treatment as a sanction or as a condition of staying a sanction. This is, of course, completely transparent to the Board, depending on the state's law, regulations and practice, and even can be transparent to the public.

<u>Level Two</u>

This is when something in the licensee's professional or personal life creates pressure to seek treatment. It is in anticipation of discipline or punishment of some sort. Examples of triggers would include involvement with a peer or employee assistance program, a DUI or DWI event, peer pressure at work (get treatment or your out of here), encounter with the criminal justice system, a threat of a report to state board. This is semi-

transparency; someone besides the professional knows there is a problem and likely will know if the professional enters and finishes treatment.

Level Three

Has potential to be completely off the grid. The individual enters treatment on his or her own, perhaps with pressure from family or friends, but its locus in not professionally based. The individual self-selects a treatment provider, the success of treatment is not formally evaluated, and it is unknown what any follow-up care consists of.

It is my opinion that licensing boards need complete, timely information on licensee compliance with monitoring programs, regardless of which of the three entry levels brings them into treatment and monitoring. Let the debate begin!

Editorial Note: Always a timely subject, the identification and management of chemically dependent licensees was brought front and center by the publication in the Journal of the American Medical Association in April 2013 of recommendation by two distinguished Johns Hopkins University physicians and safety experts that hospitals routinely and randomly test physicians for drug and alcohol use. The authors further recommend that physicians be tested for chemical impairment immediately following an unexpected patient death or other sentinel event.

CAC *News & Views* concurs and would add another recommendation that regulatory boards and hospitals enter into an agreement or MOU ensuring that hospitals notify regulators when random testing uncovers evidence of substance abuse placing patients at risk.

For more about the recommendations made by Julius Cuong Pham, emergency medicine physician and Peter J. Pronovost, M.D., Ph.D., director of the Johns Hopkins Armstrong Institute for Patient Safety and Quality, see: http://www.news-medical.net/news/20130508/Hospitals-need-to-test-physicians-for-drug-and-alcohol-use-to-improve-patient-safety.aspx.

See also:

http://www.fiercehealthcare.com/story/patient-safety-hospitals-physician-substance-abuse-drug-testing-policies/2013-05-09?utm_medium=nl&utm_source=internal and http://www.amednews.com/article/20130311/business/130319984/5/.

LETTERS

Dear CAC *News & Views*:

I'm writing to express my concerns about legislation recently enacted in Oregon that provides for mediation of disputes over medical errors. (See http://www.leg.state.or.us/13reg/measures/sb0400.dir/sb0483.en.html. While mediated settlements may well be good for the individual physicians and injured patients involved in specific cases, the new legislation greatly increases secrecy concerning medical errors and therefore increases the likelihood that the relatively few incompetent physicians with histories of malpractice will continue to harm other patients.

Several provisions are problematic:

Section 2 allows facilities, practitioners, and patients to file a notice of an adverse health care incident and open negotiations. The problem is that even if a demand for or offer of payment is made during the negotiations, this would not constitute a written demand for payment under the statute, and therefore it would not be reportable to the National Practitioner Data Bank (NPDB). Reporting all malpractice payments to the NPDB is extremely important for patient safety since licensing boards and hospital credentialing authorities use these reports to identify physicians with patterns of malpractice payments who may not meet standards for competency or otherwise not qualify for licensing or hospital medical staff membership. If mediated malpractice payments in Oregon are kept secret from the NPDB, licensing boards and hospital credentialing authorities will be unable to identify problem practitioners and do their job to protect the public. Oregon patients will be placed at greatest risk, but physicians who get in trouble in one state often move to another state, so the new Oregon law puts all Americans at greater risk of being treated by a physician with a questionable malpractice record.

Section 2, Sub-sections 3 and 4 read: "(3) A patient may file a notice of adverse health care incident with the commission in the form and manner provided by the commission by rule. When the commission receives a notice of adverse health care incident from a patient under this subsection, the commission shall notify all health care facilities and health care providers named in the notice within seven days after receiving the notice. However, **(4) A notice of adverse health care incident filed under this section is not: (a) A written claim or demand for payment.** [my emphasis]

Section 6 reiterates that there has been no reportable written demand for a payment. It reads: "SECTION 6. Payment and resolution. (1) A payment made to a patient under Section 3 of this 2013 Act or as a result of a mediation under section 5 of this 2013 Act is not a payment resulting from a written claim or demand for payment."

Theoretically, HHS could negate Oregon's definition by issuing a federal definition of a "written demand for payment" in keeping with existing federal regulations requiring reports to the NPDB of written demands for payment. But unless or until they do this, Sections 3 and 6 put patients at risk because physicians will be able to keep their malpractice histories secret.

Another provision, Section 10, creates additional major problems for patient safety. It amounts to a "get out of jail free" card for those committing malpractice. Although Sub-section 1 is written in a way that sounds like it promotes making information public, it actually keeps secret the names of the practitioners or facilities that have malpractice histories. Sub-section 2 provides for even more secrecy. It does not allow reports of even the most serious actions to be given to licensing or credentialing authorities for possible action. And Sub-section 4 prohibits licensing boards, health care credentialing authorities, etc., from even asking if a physician has filed a mediation request concerning an error or use the filing of such a request as the basis for any action, presumably even initiating an investigation as to whether an error occurred.

"SECTION 10. Use of information by Oregon Patient Safety Commission. (1) The Oregon Patient Safety Commission may disseminate information relating to a notice of adverse health care incident filed under section 2 of this 2013 Act to the public and to health care providers and health care facilities not involved in the adverse health care

incident as necessary to meet the goals described in section 9 of this 2013 Act. **Information disclosed under this subsection may not identify a health care facility, health care provider or patient involved in the adverse health care incident."** [my emphasis]

....

(2) **The commission may not disclose any information provided pursuant to a discussion under section 3 of this 2013 Act to a regulatory agency or licensing board.** [my emphasis]

....

(4) **A regulatory agency, licensing board, health care facility, health insurer or credentialing entity may not ask the commission, a health care facility, a health care provider or other person whether a facility or provider has filed a notice of adverse health care incident or use the fact that a notice of adverse health care incident was filed as the basis of disciplinary, regulatory, licensure or credentialing action.** [my emphasis]

So although this law promotes disclosure to injured patients and families, it does so at the expense of keeping licensing and credentialing authorities in the dark so they can't take any licensure action to prevent future malpractice. It also undermines reporting to the NPDB so that if the practitioner decides to move to a different facility or state, the new facility or licensing board won't be notified of the practitioner's malpractice history, which is precisely the kind of thing the NPDB was enacted to prevent.

Robert E. Oshel, Ph.D.
Retired Associate Director for Research and Disputes, National Practitioner Data Bank
Health Resources and Services Administration
U.S. Department of Health and Human Services

Disclaimer: The views expressed above are my own and are not intended to represent the views of my former employer, the U.S. Department of Health and Human Services.

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 is at http://www.cacenter.org/.

MEMBERSHIP INFORMATION

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

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards**.** Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value **to the boards themselves** as they are to the public members**.** Therefore, the **CAC** board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
3) A $20.00 discount for CAC webinars.
4) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
5) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
6) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fees as follows:

Individual Regulatory Board	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organization	$375.00
Association of regulatory agencies or organizations	$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

MEMBERSHIP ENROLLMENT FORM

TO BECOME A CAC MEMBER ORGANIZATION FOR 2013, PLEASE COMPLETE THIS FORM AND MAIL OR FAX IT TO:

CAC

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1) Mail us a check payable to **CAC** for the appropriate amount;
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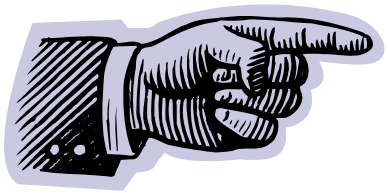

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of **CAC.** Membership includes a subscription to our newsletter for **all** of your board members and **all** of your staff, as well as many other benefits**.** But if you decide **not** to join **CAC**, we encourage you to subscribe to **CAC *News & Views*** by completing this form and mailing or faxing it to us.

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