News & Views

Citizen Advocacy Center

Second Quarter, 2015 – Health Care Public Policy Forum – Volume 27 Number 2

Announcements

Our 2015 annual meeting will be held on November 12 and 13, 2015, in Washington, D.C. *More information is at http://www.cacenter.org/cac/2015AnnualMeeting.*

CAC is a membership organization *and we invite your board to join. Membership information and enrollment forms are at http://www.cacenter.org/cac/membership and on pages 27 and 28 of this newsletter.*

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 and on page 29 of this newsletter.*

SCOPE OF PRACTICE

FTC Comments on Competitive Impact of Collaborative Practice Bill

On April 21, 2015, the staff of the Federal Trade Commission's Office of Policy Planning and Bureaus of Economics and Competition responded to the invitation of Missouri House Member, Jeanne Kirkton to comment on pending legislation (HB633) that would modify collaborative practice arrangements between APRNs and physicians. The staff summarizes its conclusions this way:

> As currently drafted, HB633 may lower costs of these arrangements by facilitating electronic collaboration.

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However, the bill retains a mandatory collaborative practice structure that FTC staff have identified as raising possible competitive issues. Additionally, the potential benefits of electronic collaboration may go unrealized unless the new statutory provisions explicitly supersede, rather than supplement, more onerous regulations that currently require in-person collaboration.

See the complete FTC staff comment at http://tinyurl.com/q9hkc5o.

See also this FTC policy paper dated March 2014 on "Competition and the Regulation of Advanced Practice Nurses" at http://tinyurl.com/pak3jx4.

"DOC FIX" LEGISLATION APPLAUDED BY APRNS AND PAS

The National Council of State Boards of Nursing reported in its April 21, 2015, *Good Morning Members* blog that:

The passage of the Medicare payment reform bill improves health care delivery by identifying PAs and APRNs (nurse practitioners [NP], clinical nurse specialists [CNS], certified registered nurse anesthetists [CRNA] and certified nurse midwives [CNM]) as Medicare applicable practitioners. The reform bill authorizes payment to APRNs to document evaluations for durable medical equipment, includes NP, CNS and CRNA in the first year of the merit-based Incentive Payment System and ensures that NP, CNS and CNM-led patient centered medical homes are eligible to receive incentive payments for the management of patients with chronic disease. For PAs, the chronic medical care provision authorizes them to provide complex chronic care. Additionally, PAs

and APRNs will now be able to document face-to- face encounters for durable medical equipment.

Although PAs and APRNs have been given greater authority to receive reimbursement with the passage of the reform bill, growing the health care workforce to meet a potential increased demand may be difficult. An online education program provider has projected that increased demand for chronic-disease management and a shortage of primary care physicians will create a need for more than 30,000 PAs by 2022.

See more at http://tinyurl.com/na36gda.

Editorial Note: See also IN THE LEGISLATURES in this issue for a discussion of the provisions in this legislation affecting malpractice.

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Citizen Advocacy Center
1400 Sixteenth Street NW
Suite #101
Washington, DC 20036
Phone: (202) 462-1174 Fax: (202) 354-5372
Email: cac@cacenter.org

Editor-in-Chief: Rebecca LeBuhn
Contributing Editor: David Swankin
Newsletter Layout / Subscription Manager: Steven Papier

TEXAS CONSIDERS RANGE OF SCOPE CHANGES

Writing in the *Texas Tribune* on April 21, 2015, Edgar Walters examined bills that would affect the scopes of practice of several professions. Entitled, "Bills on Medical Authority Spark More Doc Fights," his article explained the positions of proponents and opponents of bills that would affect nurse practitioners, optometrists, and dental hygienists.

See the article at http://tinyurl.com/pqu77zw.

CALIFORNIA CONSIDERS EXPANDED SCOPE FOR OPTOMETRISTS

The California State Senate Appropriations Committee approved a bill that would expand the scope of practice of optometrists. According to the California Healthline, a service of the California HealthCare Foundation:

> The bill is designed to help address the dearth of primary care providers in California by allowing some of their duties to be taken up by optometrists who undergo special training for the tasks. Those include:

- Post-cataract surgery laser procedures for glaucoma patients;
- Eyelid lesion removal; and
- Vaccinations for adults.

See http://tinyurl.com/pyftsxf.

MARYLAND LAW PERMITS INDEPENDENT PRACTICE FOR NURSE PRACTITIONERS

In May 2014 Maryland's Governor Larry Hogan signed a law permitting experienced Nurse Practitioners to practice independently of physicians. The state medical society succeeded in addition two amendments to the original bill. One requires inexperienced NPs to have collaborative agreements and another would discipline NPs who do not refer patients to a physician when referral is called for.

For more see http://tinyurl.com/kks6mpl.

CALIFORNIA DOCS PROPOSE "ANESTHESIA ASSISTANT" CATEGORY

California physicians are supporting legislation that would create a new category of caregiver called an 'anesthesia assistant." The rationale for the bill (AB 890) is to address a shortage of physician anesthesiologists in the state. Anesthesia Assistants would work under the supervision of physicians.

See more at http://tinyurl.com/nqk2zxo.

Editorial Note: There may be a shortage of physician anesthesiologists in California, but what about the supply of nurse anesthetists, who, studies have demonstrated, deliver the same level of care as physician anesthesiologists? If a new category called anesthesia assistant is justifiable, the legislation should authorize nurse anesthetists as well as physician anesthesiologists to supervise them. CAC* News & Views *believes the legislation should be rejected if its unstated purpose is to interfere with the practice of nurse anesthetists.

NURSE PRACTITIONER AND PHYSICIAN ASSISTANT CENSUS AVAILABLE

The American Association of Nurse Practitioners has released a new census of Nurse Practitioners in the U.S. By way of background, "The National Nurse Practitioner Practice Site Census has been conducted by the American Association of Nurse Practitioners (AANP) every two to three years since 2002 to provide current and essential data as they relate to nurse practitioner (NP) practice environment. The objectives of the census were to: 1) characterize the NP workforce, 2) review trend data on the NP workforce, and 3) update the AANP National NP Database."

The document is at http://tinyurl.com/nro7xwx.

The National Commission on Certification of Physician Assistants has also released a statistical profile of that profession. "The first annual *Statistical Profile of Certified Physicians*" issued in summer 2014 provided a new foundation of data that has been used

by policy makers, researchers, journalists and others to support important dialogue about the critical role of certified PAs in our changing health care system. We hope this most recent annual report proves just as helpful as we strive to promote the PA profession and inform the thinking of decision makers at the federal, state, health system and practice level."

See http://tinyurl.com/pfkabyv.

CALIFORNIA CONSIDERS VIRTUAL DENTAL HOME LEGISLATION

Legislation introduced in California in February 2015 would expand access to community-based oral healthcare services. The bill would:

> …(E)stablish the Virtual Dental Home program to expand the virtual dental home model of community-based delivery of dental care to the residents of this state who are in greatest need, as prescribed. The bill would authorize the administrator of the program to, among other things, encourage development and expansion of the delivery of dental health services in community clinics and school programs, as prescribed.

Read the legislation at http://tinyurl.com/pp3adfm.

PHARMACISTS SEE THEIR ROLE INCREASE

An April 19, 2015, article in *Business Wire* entitled, "Pharmacists' Roles on the Healthcare Team are Expanding, Study Shows" includes:

> Over the past decade, there has been a dramatic increase in the percentage of pharmacists who are performing healthcare-related services. Sixty percentage of pharmacists provided medication therapy management and 53 percent performed immunizations in 2014, compared to only 13 and 15 percent, respectively in 2004. The percentage of time that full-time pharmacists spent on services associated with medication dispensing decreased from 55 percent in 2009 to 49 percent in 2014.

Read more about the study, commissioned by the Pharmacy Workforce Center at http://tinyurl.com/odktj8x.

California pharmacists are now authorized to prescribe Naloxone without a prescription. The National Association of State Boards of Pharmacy (NABP) reported in its April 22 2015 issue of *e-News* that:

> Pharmacists in California may now provide naloxone, the medication that can help to reverse the effects of an opioid overdose, without a prescription after the California State Board of Pharmacy approved new emergency regulations (PDF). To be eligible to dispense the drug under the new regulations, pharmacists must complete one hour of continuing education (CE) on the use of the drug, notes a press release (PDF) from the Board. When dispensing the drug, pharmacists must screen for any hypersensitivity, and must provide the recipient with training in opioid overdose prevention, recognition, response, and on the administration of the drug. The pharmacist must also provide the recipient a naloxone fact sheet (PDF), which has been approved by the Board.

In October 2014, NABP released a statement supporting an active role for pharmacists in increasing access to naloxone. NABP is also active in educating consumers about prescription drug abuse and prevention through the AWARXE® Prescription Drug Safety Program, and information and educational resources on these topics are available on the program's website.

Involving pharmacists in care management both improves quality and reduces cost: http://tinyurl.com/oxvb9nc.

IOM Looks at Impact of Interdisciplinary Education on Practice

A report from the Institute of Medicine entitled, "Measuring the Impact of Interprofessional Education (IPE) on Collaborative Practice and Patient Outcomes" calls for research into the appropriate data and metrics to evaluate the impact of interprofessional education on actual clinical outcomes.

Over the past half-century, there have been ebbs and flows of interest in linking what is now called interprofessional education (IPE) with interprofessional collaboration and team-based care. Whereas considerable research has focused on student learning, only recently have researchers begun to look beyond the classroom and beyond learning outcomes for the impact of IPE on such issues as patient safety, patient and provider satisfaction, quality of care, health promotion, population health, and the cost of care. In 2013, the Institute of Medicine's (IOM) Global Forum on Innovation in Health Professional Education held two workshops on IPE. At these workshops, a number of questions were raised, the most important of which was "What data and metrics are needed to evaluate the impact of IPE on individual, population, and system outcomes?" To answer this question, the Forum's 47 individual sponsors requested that an IOM consensus committee be convened to examine the existing evidence on this complex issue and consider the potential design of future studies that could expand this evidence base.

See more at http://tinyurl.com/q6z7cnl.

CONTINUING PROFESSIONAL DEVELOPMENT

The Case for Competency-Based Medical Education

Editorial Note: While the article referenced in this item addresses graduate medical education, the observations about the importance of clinical observation as part of educational preparation would seem to apply equally to continuing professional development activities.

In the journal *Academic Medicine*, Eric S. Holmboe, M.D. makes the case that direct observation of clinical performance should play a more prominent role in medical education. The article's Abstract reads as follows:

> Competency-based medical education (CBME) places a premium on both educational and clinical outcomes. The Milestones component of the Next

> Accreditation System represents a fundamental change in medical education in the United States and is part of the drive to realize the full promise of CBME. The Milestones framework provides a descriptive blueprint in each specialty to guide curriculum development and assessment practices.
>
> From the beginning of the Outcomes project in 1999, the Accreditation Council for Graduate Medical Education and the larger medical education community recognized the importance of improving their approach to assessment. Work-based assessments, which rely heavily on the observations and judgments of clinical faculty, are central to a competency-based approach. The direct observation of learners and the provision of robust feedback have always been recognized as critical components of medical education, but CBME systems further elevate their importance. Without effective and frequent direct observation, coaching, and feedback, the full potential of CBME and the Milestones cannot be achieved. Furthermore, simply using the Milestones as end-of-rotation evaluations to "check the box" to meet requirements undermines the intent of an outcomes-based accreditation system.
>
> In this Commentary, the author explores these challenges, addressing the concerns raised by Williams and colleagues in their Commentary. Meeting the assessment challenges of the Milestones will require a renewed commitment from institutions to meet the profession's "special obligations" to patients and learners. All stakeholders in graduate medical education must commit to a professional system of self-regulation to prepare highly competent physicians to fulfill this social contract.

For more, see: http://tinyurl.com/qg62uwy.

ADMINISTRATION

NORTH CAROLINA AUDIT RECOMMENDS MORE BOARD OVERSIGHT

A report by the Program Evaluation Division of the North Carolina General Assembly issued in December 2014 recommends more oversight for the state's regulatory agencies, but stopped short of recommending centralization. The report's summary says:

> Occupational licensing agencies (OLAs) are state agencies that regulate the licensure of persons within a particular profession or occupation but that receive no state general revenue and are not subject to legislatively mandated spending restrictions. PED found that transferring regulatory authority or administrative responsibilities from OLAs to a central state agency may not result in improved performance and would likely entail significant implementation costs. PED also determined that there is insufficient state-level oversight to ensure OLAs are efficiently and effectively protecting the public. The General Assembly should establish an Occupational Licensing Commission to assist the General Assembly and OLAs in improving effectiveness and resolving disputes; ensure that the OLAs required to comply with reporting requirements are clearly defined and listed; ensure the complaint process used by OLAs includes specified capabilities and

attributes; and assign a legislative committee to evaluate the continuing need for licensing authority for 12 identified OLAs.

See the report at http://tinyurl.com/oj4jnxo.

AUDIT FINDS IMPROVED ARIZONA MEDICAL BOARD

A follow-up audit of the Arizona Medical Board has found that the board has taken steps to improve its licensing and registration policies and procedures. The auditors do nevertheless recommend that the board conduct a risk-based review of licenses issued during a period of time in 2014.

Read the full audit report here: http://tinyurl.com/otoo8co.

IN THE COURTS

TEXAS MEDICAL BOARD SUED OVER TELEHEALTH POLICY

Editorial Note: Since this article was written, a federal judge told the Texas Medical Board it could not enforce its rule prohibiting doctors from diagnosing patients over the phone because the rule is probably anti-competitive.

Texas-based Teledoc filed suit on April 29, 2015 against the Texas Medical Board to enjoin a board rule that would restrict Texan's access to telehealth services. Teledoc provides services via the telephone and interactive video to patients with non-emergency conditions. The board rule would physicians to have an in-person visit with patients prior to treating them.

Teledoc accuses the board of violating the Sherman Antitrust Act and unfairly restricting competition, to the detriment of consumers. The suit also alleges that the board ignored comments from the public – 203 of 206 comments opposed the rule.

See more at http://tinyurl.com/o4hg9sf, http://tinyurl.com/nh9yjqz, and http://tinyurl.com/pcdp69n.

MAINE CONSUMERS CAN NO LONGER IMPORT MEDS

A United States district court judge ruled in February 2015 that Maine's 2013 law allowing consumers to import prescription drugs by mail from certain countries violates federal law. The Maine Pharmacy Association and the Retail Association of Maine, which were both plaintiffs in the suit, applauded the decision. The state has not decided whether to appeal the ruling.

For more, see: http://tinyurl.com/lh35p4b.

DISCIPLINE

MISSOURI FAILS TO DISCIPLINE WRONG-SIDE BRAIN SURGERY

Samantha Liss reported in the *St. Louis Post Dispatch* on December 13, 2014, about a case in which a neurosurgeon escaped discipline by the Missouri Board of Registration for the Healing Arts for operating on the wrong side of a patient's brain. The surgeon settled a malpractice lawsuit for an undisclosed amount, but the licensing board chose not to take

action. Malpractice attorney Marty Perron (not apparently involved in this lawsuit) told Liss: "I don't think it's common for doctors to be sanctioned in Missouri at all."

See more at http://tinyurl.com/pf8ulwe.

CALIFORNIA TV STATION REPORTS ON DENTAL BOARD DISCIPLINE

KCRA News in Sacramento, California, reviewed three years of citations issued by the state dental board. Fifty dentists were cited during the period. The televised story gave examples of the types of violations and informed the public that citations are the equivalent of "fix-it tickets." The story also explains that the board acts from complaints and does not conduct routine inspections.

For more, see: http://tinyurl.com/n868hyf.

TELEHEALTH

SURVEY DOCUMENTS TIME SPENT OBTAINING MULTIPLE STATE LICENSURE

Fierce Health IT reported in February 2015 on a survey of doctors documenting the length of time they spend applying for licenses in multiple states in order to provide telehealth services. More than half of the respondents said it can take more than 12 hours per license. The survey also found that the least amount of time states take to process licensure applications is one to three months.

See the article at http://tinyurl.com/pvrbpl5.

Editorial Note: In March 2015 Wyoming became the first state to sign on to a compact developed by the Federation of State Medical Boards designed to facilitate licensure portability. See: http://tinyurl.com/oece953.

In May 2015 the seventh state signed on, officially triggering an interstate compact: http://tinyurl.com/nq6dbnl. And in May 2015, the U.S. House of Representatives Energy and Commerce Committee advanced legislation that includes a section endorsing interstate compacts http://tinyurl.com/pe7k672.

FSMB TACKLES THE PHYSICAL EXAM FOR TELE-PRESCRIBING

In its *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, the Federation of State Medical Boards recommends medical boards follow this guideline:

> Prescribing. If using telemedicine technologies, where prescribing may be contemplated, providers must implement measures – left to the discretion of the physician – to uphold patient safety in the absence of traditional physical examination. Measures should guarantee that the identity of the patient and provider is clearly established. To assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to those considered safe by the state medical board.

Currently, states vary widely in their requirements for a physical exam as a benchmark of a proper physician-patient relationship. Some require an in-person exam; others permit an exam by electronic or telemedicine technologies.

For more see http://tinyurl.com/p6n54xz and http://tinyurl.com/on2vljp.

IOWA ADOPTS TELEMEDICINE REGULATIONS

The Board of Medicine adopted regulations effective in June 2015 governing the practice of telemedicine. The regulations define when it is necessary to perform a physical examination and other aspects of a "proper" physician-patient relationship, and it also addresses the safety and security of equipment: http://tinyurl.com/qdhyt8j.

For a review of other state and federal legislation affecting Telehealth, see http://tinyurl.com/onuqpa7 and http://tinyurl.com/p9vj8to.

See also IN THE COURTS to read about a lawsuit accusing the Texas Medical Board of Anti-Trust activity by restricting access to Telehealth.

PATIENT INFORMATION

MEDICAL BOARD CALLED OUT FOR INCOMPLETE PRACTITIONER PROFILES

In an article posted April 17, 2015, on the *Cincinnati Enquirer* website, Amber Hunt wrote about the difficulty consumers have finding disciplinary information on the Ohio medical board's website. She sites two recent cases to make her point. One involves a Dr. Kurt Froehlich, whose license has been in trouble for years because of allegations of sexual misconduct and was permanently revoked in February 2015. This information did not appear on the board's website when Hunt wrote her article. More importantly, Froehlich continues to practice (with a chaperone present) pending the outcome of his appeal of the board's ruling.

Dr. James Bressi, a Cleveland physician, was sentenced to 59 days in jail and five years' probation also for a sexual misconduct conviction, but this information is not posted because he has appealed the conviction.

See Hunt's article at http://tinyurl.com/o694bj8.

ONTARIO REGULATOR APPROVES GREATER TRANSPARENCY

The College of Physicians and Surgeons of Ontario voted in June 2015 to disclose more extensive information on its website about disciplinary actions and verbal warnings. Called "oral cautions," these verbal warnings have previously been kept secret. Examples of problems that call for an oral caution include improper communication with patients, lack of timely referrals and prescribing errors. The College will also inform the public when a physician is faces criminal charges, has been ordered to take remedial education, or has been disciplined in another jurisdiction.

For more see: http://tinyurl.com/qzvwfy3.

INFOGRAPHIC HELPS CONSUMER IDENTIFY BOGUS ONLINE PHARMACIES

The February 25, 2015, *e-News* from the National Association of Boards of Pharmacy announced a new resource from the Partnership for Safe Medicines to help consumers identify fake online pharmacies:

> With many illegal drug sellers operating websites that claim to be legitimate, the Partnership for Safe Medicines has released a new resource to help consumers identify the characteristics of a fake online pharmacy. The infographic highlights five common tactics used by rogue online drug sellers that may make a website appear safe and legal, and explains how they may actually represent safety concerns. For example, many illegal websites that claim to be Canadian are actually selling counterfeit drugs manufactured in dirty, unsafe conditions. Other suspicious characteristics explained in the infographic include websites that link to an "international drug list," claim to be certified, claim to employ licensed pharmacists, or offer to allow users to "chat live" with a doctor.
>
> NABP has reviewed more than 10,900 websites selling prescription drugs to patients in the United States and found that nearly 97% are operating out of compliance with pharmacy laws and practice standards established to protect the public health. To help consumers in the US find the safest sources for purchasing medications online, NABP developed the Verified Internet Pharmacy Practice Sites® (VIPPS®) program. NABP encourages consumers to look for the VIPPS Seal and to check NABP's list of accredited sites on the AWARXE® Prescription Drug Safety Program website. In addition, consumers may soon watch for pharmacy sites using the newly launched .pharmacy Top-Level Domain; sites in the domain (with a website address ending in .pharmacy) will be reviewed by NABP and approved only if they are legitimate online pharmacies or pharmacy resources adhering to applicable pharmacy laws and best practices.

See also http://tinyurl.com/nm9zcsy.

LICENSURE

PRESIDENT'S BUDGET CALLS FOR ELIMINATION OF UNNECESSARY LICENSING

President Obama's budget proposal contains a section entitled, "Reducing Unnecessary Occupational Licensing Requirements." The Budget text reads:

> The Budget seeks to reduce occupational licensing barriers that keep people from doing the jobs they have the skills to do by putting in place unnecessary training and high fees. The Budget proposes a $15 million increase for grants to States and partnerships of States for the purpose of identifying, exploring, and addressing areas where occupational licensing requirements create an unnecessary barrier to labor market entry or labor mobility and where interstate portability of licenses can support economic growth and improve economic opportunity, particularly for dislocated workers, transitioning service members, veterans, and military spouses.

GEORGIA LICENSES DOCS DESPITE DISCIPLINE ELSEWHERE

Staff writer Danny Robbins published two articles on December 14, 2014, in the *Atlanta Journal-Constitution* about doctors approved for licensure by the Georgia Composite Medical Board despite discipline in other jurisdictions. One article, entitled "Board OKs Doctor Despite Sanctions in NY," tells the story of Dr. Yvon Nazaire who was disciplined in New York for negligent treatment of five emergency room patients, including discharging a patient complaining of chest pain who died twenty-four hours later. He was given an unrestricted license in Georgia, even though he had not completed his probationary period in NY, and became medical director at Pulaski State Prison in Hawkinsville, GA. A spokesperson for the Georgia board said it was unusual to license someone with an outstanding disciplinary order from another jurisdiction.

A second article, entitled "Prison Docs Have Troubled Pasts," profiles several doctors, some with lengthy disciplinary histories in Georgia and other jurisdictions, who are not only permitted to practice in Georgia prisons, some are under a board instruction to limit their practice to "institutional" or "structured" settings, such as prisons, VA hospitals and free clinics. Robbins quotes Sarah Geraghty of the Atlanta-based Southern Center for Human Rights calling such board orders "disgraceful" because they suggest that there is a "certain class of people for whom these (disciplined doctors) can provide services."

The articles are available for a fee at http://tinyurl.com/p5k43m2 and http://tinyurl.com/prof9a3.

FSMB TALLIES CRIMINAL BACKGROUND CHECK LAWS

The Federation of State Medical Boards has released a board-by-board overview of criminal background check requirements. FSMB reports that:

- 45 state medical boards conduct criminal background checks as a condition of initial licensure;
- 39 state medical boards require fingerprints as a condition of initial licensure; and
- 43 state medical boards have access to the Federal Bureau of Investigation database.

The overview is at http://tinyurl.com/oafoxw8.

IN THE LEGISLATURES

U.S. HOUSE OF REPRESENTATIVES PUTS LIMITS ON MALPRACTICE SUITS

Legislation passed by the U.S. House of Representatives in March 2015 for the purpose of creating a new way to reimburse physicians for services provided to Medicare and Medicaid beneficiaries contains a provision related to malpractice lawsuits. The provision says that the federal quality of care standards that apply to Medicare, Medicaid and the Affordable Care Act cannot be used in malpractice suits. These standards will, nevertheless, be used to evaluate physician care and calculate reimbursement based on their performance.

Editorial Note: Queried about this provision in legislation intended to end uncertainty over Medicare's physician reimbursement formulas, Art Levin, CAC Board Member and Director of the New York-based Center for Medical Consumers, said "It's bad for science-based medicine, bad for consumers, and probably bad for doctors."

He continued, "From a patient's point of view, it is perfectly reasonable for evidence-based practice guidelines, based on good science, to be one part of the calculation when a court is assessing physician performance and patient harm. It makes sense to bring science into the equation."

"I'm surprised that organized medicine would worry about using practice guidelines as one variable in evaluating whether malpractice occurred. Physicians could conceivably be held harmless if following evidence-based guidelines were admissible as exculpatory evidence."

"If I were in organized medicine's shoes, I'd be more concerned about using adherence to practice guidelines as a basis for calculating physician reimbursement. Legislating against using quality of care standards in malpractice cases is just the latest reflection of organized medicine's paranoia about liability."

Levin recalled less than a handful of pilot programs some years ago in which physicians were allowed to introduce evidence-based standards of care as exculpatory evidence in malpractice suits, but plaintiffs could not use the standards as evidence of a physician's malpractice.

OKLAHOMA CONSIDERS AMENDMENTS TO MEDICAL PRACTICE ACT

Characterized by one of its sponsors as a bill that will end a "chamber of horrors," legislation passed by the Oklahoma House on February 18, 2015, amends the medical practice act in several significant ways. It increases the size of the board to eleven, with two public members. It adopts a system whereby the board is divided into two panels to handle complaints, one charged with investigation and the other with holding formal hearings. Each panel has a public member. The bill also revises the board's procedures for investigations, hearings and negotiated settlements.

The bill can be found at http://tinyurl.com/net9uau.

U.S. CONGRESS CONSIDERS BILL TO PUT RNS IN NURSING HOMES 24/7

The Consumer Voice, an advocacy organization for long-term care facility residents is urging support for a Congressional proposal that would require Registered Nurses to be on duty around the clock in nursing homes. In an *Action Alert* emailed to subscribers, Consumer Voice asked readers to write their Congressional Representatives in support of the legislation:

February 19, 2015

Support Round-the-Clock RN Coverage in Nursing Homes:
Ask your Congressperson to Co-sponsor H.R. 952

Great news! Congresswoman Jan Schakowsky has re-introduced legislation in the new Congress – H.R. 952, the *Put a Registered Nurse in the Nursing Home Act* – to require nursing homes to have a registered nurse (RN) on duty 24 hours a day/7 days a week.

Under current federal law, nursing homes are only required to have a RN on duty 8 hours a day/7 days a week regardless of facility size or the complexity of residents' care needs. Round-the-clock RN coverage is critical to ensuring quality care within these settings, which is why passing H.R. 952 is so important. Now that this legislation has been reintroduced in the U.S. House of Representatives, we need you to ask your U.S. Representative to co-sponsor this vital legislation!

Getting as many cosponsors as possible will help H.R. 952 get off to a strong start in the 114th Congress. The more sponsors there are – particularly when they are both Republicans and Democrats – the more likely other House members will be to support the bill as it moves forward.

Why round-the-clock RN coverage is critical:

- Only a RN can assess a resident's condition. The absence of RN staffing for up to 16 hours each day means that there is no one present capable of assessing and responding when residents' medical conditions suddenly change or deteriorate.
- Residents are entering nursing homes from hospitals "quicker and sicker." Their care requires a high level of skill and knowledge. Registered nurses are the only nursing personnel with the education, training, and licensure to provide timely clinical assessment, appropriate medical intervention, and evaluation of nursing home residents. Other nursing home personnel such as LPNs and certified nursing assistants are not trained to provide such assessments or interventions.
- Research shows that higher RN levels improve resident care. Higher RN levels result in lower antipsychotic use, fewer pressure ulcers, less restraint use and cognitive decline, fewer urinary tract infections and catheterizations, less weight loss, less decrease in function and fewer unnecessary hospitalizations of nursing home residents.

MISSOURI CONSIDERS MULTIPLE BILLS AFFECTING NURSES

In her Executive Director's Report in the May, June, July 2015 issue of the *Missouri State Board of Nursing Newsletter*, Lori Scheidt reported on several bills pending in the state legislature. One would authorize several boards, including nursing, pharmacy, dentistry, psychology, and healing arts, to contract for collection and analysis of healthcare workforce data. "Supporters of the bill," writes Scheidt, "say that currently Missouri does not have reliable data about practice characteristics of health professionals practicing in the state. Without reliable information, the state is seriously misallocating resources and making decisions that may actually be detrimental to Missouri's health care workforce."

Other pending bills affect the practice of Advanced Practice Registered Nurses, pain management, prescription drug monitoring, and death certificates.

For more, see pages 1 and 2 of http://tinyurl.com/qhdujw8. In this same publication, see also pages 6 – 9 of the National Council of State Boards of Nursing 2015 Regulatory Environment: Executive Summary, reprinted from the *Journal of Nursing Regulation*, vol. 5, Issue 4, January 2015.

LOUISIANA LEGISLATURE CONSIDERS BILL TO WEAKEN MEDICAL BOARD

The advocacy group Public Citizen has come out in opposition to legislation under consideration in Louisiana that would weaken its medical board:

> May 5, 2015
>
> Contact: Karilyn Gower (202) 588-7779
> Angela Bradbery (202) 588-7741
>
> WASHINGTON, D.C. – The Louisiana Legislature should reject HB 573, a dangerous bill that would protect incompetent and unprofessional physicians while seriously compromising patient safety in Louisiana, Public Citizen said in a letter today.
>
> The bill, expected to be considered soon by the Louisiana House of Representatives' Health and Welfare Committee, includes several provisions that would substantially undermine the Louisiana State Board of Medical Examiners' (LSBME) ability to investigate allegations of incompetence or unprofessional conduct. Also, it would impede the board's ability to discipline physicians found guilty of misconduct.
>
> In its most recent ranking of state medical board performance, Public Citizen deemed Louisiana's board one of the best in the country. The LSBME placed second for its rate of serious disciplinary actions per 1,000 physicians. That ranking was done in 2012, the last year for which data were available. The LSBME has been among the top 10 state medical boards for such actions since Public Citizen released its 2009 rankings.
>
> "Perhaps those pushing this legislation, including the Louisiana State Medical Society, believe the LSBME is performing too well when it comes to investigating and disciplining physicians and protecting patients," said Dr. Michael Carome, director of Public Citizen's Health Research Group. "But there is no question that if this bill passes, the rate of disciplinary actions against Louisiana physicians soon will decrease, and patient safety will be jeopardized."
>
> Key provisions of the proposed legislation that would cause the most harm to patients and public health in Louisiana include:

- Requiring the board to accept only non-anonymous complaints made in writing. This would deter the many individuals who have witnessed physician misconduct and are afraid to use their names when reporting it.
- Requiring that a minimum of four board members agree with taking disciplinary action against a physician – instead of the simple majority of a quorum (i.e., two of three convened members) currently required.
- Limiting the scope of the definition of "unprofessional conduct" by creating a specific list of behaviors that could be considered unprofessional. Under this definition, the LSBME would lack the flexibility to discipline physicians for other behaviors that could reasonably be judged to constitute unprofessional conduct.
- Removing the ability of the LSBME to make consent orders, agreements and other dispositions public. Therefore, the board would be able to tell the public that a physician was disciplined, but not why.
- Requiring the destruction of all LSBME records and information related to a complaint and initial investigation that is dismissed. This would make it impossible to track a pattern of incompetence or unprofessional conduct by a physician.
- Eliminating the limit on how long enforcement of final disciplinary actions can be suspended by courts – which could unnecessarily delay such actions against physicians.
- Prohibiting the LSBME from acting on complaints if the care related to the complaint was more than three years before the complaint was filed – even if the incompetence may have resulted in serious injury or death of a patient.
- Imposing unnecessary arbitrary procedural deadlines at multiple steps in the LSBME's investigation process. These deadlines likely would restrict the ability of the board to fully and properly investigate the complaints. They also would provide opportunities for physicians found guilty of misconduct to delay disciplinary action based solely on non-substantive procedural grounds.
- Prohibiting the LSBME from spending money on any activity or function sponsored by the Federation of State Medical Boards (FSMB). Severing ties between the LSBME and the FSMB would deprive the board of important resources used by all other state medical boards, weaken the board and ultimately harm patients throughout Louisiana.

"This bill represents a blatant attempt to tilt the board process for investigating and disciplining physicians from one that protects patients and public health to one that protects dangerous physicians," Carome said. "The Louisiana Legislature needs to reject HB 573."

QUALITY OF CARE

AHRQ REPORT SEES IMPROVEMENT IN QUALITY OF HOSPITAL CARE

The overall quality of health care and patient safety are improving, particularly for hospital care and for measures that are publicly reported by the Centers for Medicare & Medicaid Services, according to AHRQ's newly released 2014 National Healthcare Quality and Disparities Report. Hospital care was safer in 2013 than in 2010, with 17 percent fewer harms to patients and an estimated 1.3 million fewer hospital-acquired conditions, 50,000 fewer deaths, and $12 billion in cost savings over three years (2011, 2012, 2013). However, quality is still far from optimal, with millions of patients harmed by the care they receive, and only 70 percent of recommended care being delivered across a broad array of quality measures. A few disparities among racial groups for services such as childhood vaccinations have been reduced to zero; however, much additional work remains to address a broad range of other disparities affecting quality of care. This year's report has been consolidated and now tracks performance measures that align with HHS' National Quality Strategy. Chartbooks on specific topics such as patient safety and care coordination will be issued in coming months to provide more detailed information and easy-to-understand slides that can be downloaded for presentations.

The report is available here: http://tinyurl.com/m2a8fha.

FDA ISSUES GUIDANCE FOR COMPOUNDING PHARMACIES

In the wake of the meningitis outbreak from a compounding pharmacy in New England, the FDA has issued pharmacy compounding guidance documents. As reported in the National Association of Boards of Pharmacy online e-News:

> FDA Releases Five Draft Documents Related to Compounding and Repackaging Requirements
>
> Food and Drug Administration (FDA) has issued five draft documents related to drug compounding and repackaging requirements under the Drug Quality and Security Act (DQSA). The draft documents are applicable to pharmacies, federal facilities, outsourcing facilities, and physicians and are as follows.
>
> - Draft Guidance for Industry: For Entities Considering Whether to Register As Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act (PDF) provides guidance to entities considering whether to register as an outsourcing facility. The document provides information about the regulatory impact of registering with FDA as an outsourcing facility.
> - Draft Guidance for Industry: Repackaging of Certain Human Drug Products by Pharmacies and Outsourcing Facilities (PDF) describes the conditions under which FDA does not intend to take action for certain violations of the law when state-licensed pharmacies, federal facilities, or outsourcing facilities repackage certain drug products.

- Draft Guidance for Industry: Mixing, Diluting, or Repackaging Biological Products Outside the Scope of an Approved Biologics License Application (PDF) describes the conditions under which the FDA does not intend to take action for violations of certain sections of the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act (FD&C Act) when state-licensed pharmacies, federal facilities or outsourcing facilities mix, dilute or repackage specific biological products without an approved Biologics License Application (BLA), or when such facilities or physicians prepare prescription sets of allergenic extracts (used to treat allergies) without an approved BLA.
- Draft Guidance for Industry: Adverse Event Reporting for Outsourcing Facilities Under Section 503B of the Federal Food, Drug, and Cosmetic Act (PDF) explains adverse event reporting for outsourcing facilities as required by the DQSA.
- Draft Memorandum of Understanding Addressing Certain Distributions of Compounded Human Drug Products (PDF) describes the responsibilities of a state that chooses to sign the memorandum of understanding in investigating and responding to complaints related to compounded human drug products distributed outside the state, and in addressing the interstate distribution of "inordinate amounts" of compounded human drug products under section 503A of the FD&C Act.

The draft guidance documents will be available for public comment for 90 days, and the comment period for the draft memorandum will be open for 120 days. Additional information on the release of these documents is available in a press release on the FDA website.

ALL PROFESSIONS MUST NOW REPORT TO THE NPDB

In February 2015, the National Practitioner Data Bank reminded licensing boards that "State health profession regulatory boards and agencies are now required to submit an attestation for all health professions they regulate. Prior to January 26, 2015, only professions who were not part of a compliance effort were required to attest. The attestation is linked to the board's registration renewal every two years."

For details, see http://tinyurl.com/pg5ynrg.

TEN-YEAR STUDY INFORMS PHARMACY QUALITY CONTROL

A ten-year study sponsored by insurance underwriter CNA and Healthcare Providers Service Organization (HPSO) found that the most prevalent causes of patient injury from dispensing errors involved the wrong medication or the wrong dosage. The sponsoring organizations hope that awareness of the most common allegations in malpractice suits will help pharmacies institute policies and practices to proactively avoid these problems.

For more see http://tinyurl.com/pfbhcej.

COLLABORATION AND CERTIFICATION ASSOCIATED WITH FEWER INFECTIONS

A study published in Critical Care Nurse documents lower infection rates in intensive care units when APRNs and physicians collaborate and when the units have a higher percentage of certified nurses.

For details, see http://tinyurl.com/kwre3gu.

PAIN MANAGEMENT AND END-OF-LIFE CARE

U.S. SENATORS INTRODUCE BILL TO REDUCE PRESCRIPTION DRUG ABUSE

Senators Ayotte (R-NH) and Donnelly (D-IN) re-introduced a bill on April 29, 2015, that would help curb prescription drug abuse and heroin use. Entitled the "Heroin and Prescription Opioid Abuse Prevention, Education and Enforcement Act of 2015," the legislation would "better enable healthcare providers and public health officials to prevent prescription drug abuse; support law enforcement efforts to get heroin off the streets; allow more first responders access to life-saving naloxone, and raise awareness among health care providers, patients, and the public regarding prescription opioid abuse and heroin."

For more see http://tinyurl.com/q3fjno3.

NIH HOLDS CONFERENCE ON END-OF-LIFE CARE

On Friday, March 20, 2015, the Institute of Medicine (IOM) convened health leaders, policy makers, and other stakeholders to discuss how the recommendations from the IOM report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* could be implemented and what barriers exist that might prevent them from becoming a reality. The conference featured panels on national policy issues, including:

- Opportunities and challenges for health care systems, providers, insurers, hospice and palliative care organizations, patient groups, and quality standards organizations
- The integration of financing for medical and social services near the end of life
- Improvements to public and private payment systems to facilitate high-quality care.

CALIFORNIA COMMUNITY GROUPS BRAINSTORM OPIOID PRESCRIBING

The California Health Care Foundation reported in March 2015 that:

> Clinics and health plans serving low-income populations face a tremendous challenge – how to provide compassionate care for patients dependent on high-dose opioids, in the face of a growing epidemic of narcotic addiction and overdose deaths.

The California Healthcare Foundation's California Improvement Network (CIN), a community of organizations engaged in improving health care delivery, convened leaders from health plans, community clinics, and government agencies to come up with a menu of approaches appropriate for California clinics and Medi-Cal health plans.

The group talked about the current challenges facing providers caring for patients on high-dose opioids and promising models for treatment. They converged on a set of recommended approaches:

- Create broad community coalitions
- Build a culture of safe prescribing by establishing consistent clinical and operational practices
- Offer providers training programs and resources
- Create multidisciplinary teams to work with patients on high-dose opioids or those with complex conditions
- Spread medication-assisted addiction treatment options
- Deploy utilization and reporting tools to support safer prescribing
- Explore payment reform to support integrated care
- Develop and report outcome measures

Read more at http://tinyurl.com/o3zgdlz.

INTERAGENCY GROUP SAYS PAIN IS PUBLIC HEALTH CRISIS

Kristina Fiore of MedPage Today reported on April 7, 2015, that an interagency advisory group has drafted a National Pain Strategy under a mandate in the Affordable Care Act. The strategy calls for research to understand pain and how to treat it more effectively.

For more, see http://tinyurl.com/pxu99bt.

IN DEPTH

WHAT HARVARD LAW STUDENTS SHOULD KNOW ABOUT THE RECENT SUPREME COURT NC DENTAL CASE: ARGUABLY, THE MOST IMPORTANT NEW PRECEDENT FOR PUBLIC INTEREST, ADMINISTRATIVE, ANTITRUST, AND STATE GOVERNMENT LAW SINCE 1943.

Editorial Note: The following opinion piece is reprinted with permission from the April 3, 2015, print edition of the Harvard Law Record, which is available online at http://hlrecord.org/. The author, Robert C. Fellmeth, earned his AB at Stanford University (1967) and JD at Harvard University (1970). He is a former state and federal antitrust prosecutor (1973-1982), coauthor of California White Collar Crime (w/Papageorge, Tower Publishing, 4th edition 2013), et al., and former State Bar Discipline Monitor for California, Director of the Center for Public Interest Law, Price Professor of Public Interest Law, University of San Diego School of Law.

Is that title the product of ubiquitous attorney hyperbole? Or accurate? I believe the decision maybe the seminal example of the "King Wears No Clothes" lesson. Indeed, it

has spawned no recognition within the popular press, and is apparently not comprehended by any editorial board from the Wall Street Journal to USA Today.

The U.S. Supreme Court case of North Carolina Dental Board v. FTC last month is, for antitrust and state regulatory law, the equivalent of Brown v. Board of Education for education and civil rights. To explain, in 1943 the same Court decided the seminal case of Parker v. Brown. It held that federal antitrust law applies, as a matter of supremacy, to matters affecting interstate commerce (pretty much everything). But an exemption was made for what is termed "state action." That is, a state regulatory agency could arrange what would otherwise be an antitrust offense. Such a protective status requires two conditions: it must be a restraint that was affirmatively articulated by the sovereign state – and it must be subject to "adequate state supervision." That second prong is critical. The state may not delegate sovereign power to restrain trade without that independent review. Another subsequent case (Midcal) by the Court made clear that this "supervision" may not be a general or pro forma review. It must be specific and real, and examine the anticompetitive implications of each public decision before implementation.

Since this 1943 decision, much has happened to the political reality of our "democracy."

We have seen the rise of special interest influence as never before, especially for legislatures and other elective positions. Political process reformers, including Public Citizen and Common Cause, have been calling attention to this corruptive threat to democracy for decades. We have seen our political process become dominated by "horizontal associations" of trades and professions and businesses: insurance companies, real estate brokers, doctors, you name it – associations of persons normally prohibited from conspiring to restrain trade are allowed, via the Noerr-Pennington doctrine under the First Amendment, to form groups. But for that constitutionally-based exemption, they would be walking per se antitrust felonies. They now dominate our political landscape both federally and at the state level. But here is the rub: What has happened in the executive branches of our 50 states has been far worse. There, over these last 72 years, legislators and other officials have ignored the second prong of the Parker test for "state action" status and immunity.

A large percentage of what these state agencies do restrains trade. From the decision to set up barriers to entry (controlling supply) to rules dictating how one practices, to the excision of practitioners from the trade, you have per se unlawful group boycotts and price fixing offenses as a matter of everyday practice. If they do not have that "state action" exemption, they are (a) committing federal felonies and (b) subject to civil suit for treble damages.

So what has happened? Virtually every trade and profession and area of commerce has been captured directly and ostentatiously by the industries regulated. Most boards and commissions throughout the nation are composed in controlling fashion by current practitioners in the area of commerce allegedly regulated on our behalf as the People. There is little or no actual review by any state official with a broader perspective.

This problem has nothing to do with liberal vs. conservative. The issue of whether the state should regulate an area of commerce is always up for debate. But if there is a market flaw that warrants intervention in a regulatory mechanism, it is not properly delegated to the very private profit-stake tribal interests involved. That conflict of interest is exacerbated in

a branch where actions are not substantially covered by the media, and are subject to virtually limitless ex parte (concealed) contacts with the lobbyists already disproportionately influencing the legislative branch. What some principled conservatives have figured out – most of these agencies are not the gestation of consumer groups – they are created, supported and controlled by the entities regulated. In studying California's agencies for 35 years, I can assure you that their most ardent progenitors and defenders are the industries regulated.

We do not contend that those board members engaged in these functions are mustache-twirling cads tying a maiden to the tracks. Most think they are serving the public interest, and are unpaid. But they are part of an occupational grouping, which is the modern tribal body prevalent and powerful in the 21st century. They have a perspective borne of their grouping. Take state bars, for example, all controlled by practicing attorneys. That is we. How many disciplinary systems go after excessive attorney billing? How many look at large law firms? How many police egregious dishonesty and deceit in court filings? How many ever require a showing of real competence in an area of actual practice (personal injury, criminal defense, bankruptcy, admiralty, etc.) respectively relied upon by consumers? Ever tested at all? For a lifetime? And then how many require malpractice coverage, or even cover unpaid malpractice judgments through funds collected from fees or otherwise from a profession that controls its own regulation? They do not think of it. It is not part of the tribal culture to do so.

But the party is over. This decision has put a bright light on the embarrassment of state agency governance. Nor is that governance trivial in its coverage. Most regulation is not federal but state, everyone from doctors and nurses to lawyers and any kinds of contractors and insurers, real estate agents, architects, engineers, accountants, auto dealers, geologists and so on, reaching over one hundred trades and professions. Federal regulation is relatively trivial in comparison. The Court said "independent state supervision" back then, and now it says, "And we meant it, you flagrant violators." You cannot have any state regulatory body controlled by "active market participants" in the trade or profession (or area of commerce) regulated, including state bars. Explicit, clear, repeated. That delegation removes any sovereign protection. You are all naked. So antitrust counsel, go to town. Board members are all liable. The state treasury is liable.

The 6-3 decision has a strange dissent. Justice Alito argued that it will create a "morass." And that has some truth to it, but only because the Court has been flouted to such a degree. But you do not get "adverse possession" rights to create a cartel government because you have been at it for a long time. The dissent also makes the usual weak argument that these lines are really tough, and what about someone who has a relative or someone who is excessively sympathetic? It even cites one of my works to make the cute point that the respondent FTC was itself accused of being in the hands of industry (citing our Nader Report on the FTC in 1968). In other words, everyone can be corrupt. Ok, fair enough. But then it draws the non sequitur conclusion that because there is somewhat of a slippery slope (such slopes are hardly rare in any area of law or commerce), we should draw no line at all. It would seem reasonable that a fair "bright line" to draw is to say no to broad delegation of state power to a group currently participating in the very economic trade at issue. How is that a slippery slope?

Scalia, in oral argument, notes that he only wants "neurosurgeons" to decide who is competent to perform brain surgery. Partly true: We certainly want competent expertise to determine competence. But again, we have the non sequitur that this legitimate need means they should be the state's governors. It is both possible and realistic to combine needed expertise without delegating state power to restrain trade to the very group benefitting from those restraints. Why did the dissenters not learn this in 9th grade civics class? They rely a great deal on arguments about respecting state sovereignty, but apart from blatant hypocrisy in cases such as the Concepcion case, how do you not draw a line when the Catch-22 issue is whether it is an exercise of a legitimate state creature? The issue of "improper delegation" of constitutional authority is not just a liberal concept. It is germane to conservative theory as well. And delegation to a private group with a conflict of interest hardly corresponds to the most basic notions of democratic self-government.

The few responses thus far are from agencies already making up untenable theories, for example, "it only applies if the trade selects those making the decisions." (Wrong. The Court did not so limit its decision at all). Or, "it does not apply to us because our board decisions are reviewed by general legislative inquiry, or the presence of deputy AGs, or some general review of its operations." But that will not work either, not unless it is specific review of every potentially anticompetitive decision by an entity with full power to approve or disapprove or alter and which does so in a bona fide fashion, considering those effects on behalf of the state, not a self-interested cartel.

The Court has finally struck a blow for democracy. And it will be actualized because of one phrase: Treble damage liability. Thank you, Justice Kennedy. Now we all have to clothe many naked and quite ugly kings.

Editorial Note: See the Court's opinion here: http://tinyurl.com/mh292oa.

See also this Congressional testimony by an FTC Official: http://tinyurl.com/p6ttjw5.

Among the many articles and columns spawned by the Supreme Court decision, Michael Hiltzik wrote in the Los Angeles Times that the ruling means "the vast majority of …boards in all 50 states are untenable and illegal…" See: http://tinyurl.com/qxan9cy.

LETTERS

DEAR CAC NEWS & VIEWS,

Recent activities of Alabama's state professional licensing board for veterinarians, the Alabama State Board of Veterinary Medical Examiners (ASBVME) highlight the dangers of "active market participants" controlling state professional licensing boards. Over the past few years, ASBVME members have been actively engaged in an effort to close Alabama's non-profit, low-cost spay/neuter clinics. Some of this work has been as part of their official board duties, and some as part of a splinter group called the Alabama Veterinary Practice Owners Association (ALVPOA).

It's astounding to have the state licensing board assert that clinics, which the board itself inspected and licensed, are unsafe, but health concerns are merely a cover for the real issue: what some vets see as "unfair competition."

On the political front, the ASBVME has resisted attempts by Alabama legislators and even fellow veterinarians to protect the low-cost clinics. When the state's largest veterinary professional group, the Alabama Veterinary Medical Association (ALVMA) supported legislative action, a faction led by ASBVME board members Dr. Robert Pitman and Dr. Ronald Welch left the group and formed the Alabama Veterinary Practice Owners Association. In 2013, then-ASBVME President Robert Pitman actually sued the ALVMA for "taking actions" (meaning supporting the low-cost clinics) that were "not in the interest of members."

The AVPOA doesn't keep its agenda a secret: it wants the clinics shut down because members see them as a threat to clinic profits. In the 2013 legislative session, they called on their membership to oppose spay/neuter clinic legislation in stark profit-driven language:

Every veterinarian in the state of Alabama who values what this profession is, who wants to see it continue to be a proud profession with high standards, and who wishes to pass on a legacy of a quality private practice to a child, or a colleague, needs to contact their senator TODAY and ask them to support Senator Paul Bussman in stopping HB188.

It is imperative that you do this this morning! All evidence indicates that SB 25 will get stuck in committee. We must kill HB188 in the senate today to stop this attack on our profession.

The ASBVME itself isn't much better. In 2014, the board forced a humane society group to shut down a planned low-cost vaccination clinic because a local veterinarian complained of "unfair competition."

The ASBVME's September 2014 newsletter then featured an editorial penned by Dr. Pitman titled "Alabama Veterinarians Are Under Attack" and this warning to doctors (PDF):

"The ASBVME has received numerous calls and complaints from Veterinarians conducting Rabies Clinics and Microchip Clinics off premise of a duly licensed veterinary premise. We must remind you the Rabies Clinics must be conducted only by the appointed Rabies Officer in each county. Clinics can only administer one (1) year Rabies Vaccines (no 3-year vaccines)."

Many Alabama veterinarians are angered and humiliated by these antics, but are afraid to speak out. With good reason: the board brought charges against Dr. William Weber (a spay/neuter clinic doctor), and his trial was such an ordeal that another low-cost clinic doctor quit her job in fear of similar charges. The ASBVME next filed charges against another spay/neuter clinic vet, Dr. Margaret Ferrell - who, in a delicious bit of irony, was nominated by Alabama Governor Robert Bentley to replace Dr. Pitman on the ASBVME board.

Alabama media outlets have reported on the political maneuvering in the state legislature, but have (with the exception of state blogs and DVM360, a national online veterinary news

source) largely ignored the greater problem of the ASBVME itself. The board has used its regulatory power to protect the profits of veterinarians instead of acting in the public interest. I'm thrilled to see the CAC taking an interest in this issue and can only hope that our state officials will do the same.

Larisa Thomason
593 Sharpes Hollow Rd.
New Market, AL

Greetings,

Attached is the current edition of "SPAN"ing New York State, published by the Statewide Peer Assistance for Nurses (SPAN) program of the New York State Nurses Association. Please feel free to share this newsletter with your colleagues. If you know of someone who would like to receive future editions of the newsletter, notify us at SPAN@NYSNA.org.

Thank you,

Angela

Angela A. Grabowski, CAP-OM
Assistant to the Director
40 British American Boulevard, Suite 2A
Latham, NY 12110
Ph: 518-782-9400, ext. 350
Fax: 518-786-3007
angela.grabowski@nysna.org

Find a link to the SPAN newsletter at http://tinyurl.com/orkvx29.

SPAN's mission is to be the resource for New York State nurses affected by substance use disorders, while fostering public safety through outreach and education.

From: Greg Pulaski [mailto:noreply@qemailserver.com]
Sent: Friday, March 27, 2015 3:45 PM
To: davidswankin@cacenter.org
Subject: CBC Consensus Body Voting

Please note the following message from NSDC Chair, Nathan Goldman.

Thank you for participating in the NCSBN Standards Development Committee's Consensus Body. As a member of the Consensus Body, we are asking you to vote on the attached proposed standard, Criminal Background Checks for Licensure for Nurses. By voting, you are not committing your board or organization to adopt this Standard. Rather, you are expressing your opinion on the efficacy of such a standard for the licensure of nurses. If approved by a majority of the members of the Consensus Body, this would become an American National Standard and boards of nursing would be encouraged to adopt it, if they chose to. An American National Standard is an expression of best practices, in this case, regarding the regulation of nurses. Its adoption is entirely voluntary and, as indicated by the standard, would require state legislative action.

A copy of the standard and a link to access the ballot is at http://tinyurl.com/np7ukw8.

As you can see from the ballot, you are asked to either vote in the affirmative, in the negative without comment, in the negative with comment, or abstain. An abstention will be counted as an affirmative vote. Pursuant to ANSI requirements, all negative votes must be resolved. See ANSI AER, section 2.7.

Thanks,

Greg Pulaski
Director of Performance Measurement and Standard Setting
National Council of State Boards of Nursing (NCSBN)
111 E. Wacker Drive
Suite 2900
Chicago, IL 60601
312-525-3681(D)
312-279-1032 (F)
gpulaski@ncsbn.org
www.ncsbn.org

Our Mission – NCSBN, Leading in Nursing Regulation

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 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.

The annual membership fees are 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 the remainder of 2015 and 2016, please complete this form and mail or fax it to:

CAC

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

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

PAYMENT OPTIONS

There are three ways to pay for your membership:

1) Mail us a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
3) Provide the following information to pay by credit card:

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

Signature Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of CAC. Membership includes a subscription to our newsletter for <u>all</u> of your board members and <u>all</u> of your staff, as well as many other benefits. But if you decide <u>not</u> 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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Downloaded from our website: **Calendar year 2016 and back-issues for $240.00.**

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Our Federal Identification Number is 52-1856543.