News & Views

Citizen Advocacy Center

First Quarter, 2011 A Health Care Public Policy Forum Volume 23 Number 1

SAVE THE DATES: Our next annual meeting will be in Washington, DC, on October 20 and 21, 2011.

Information about the content of our 2011 webinars is now on our website at http://www.cacenter.org/CAC/webinars_upcoming. *Information about dates and speakers will be available shortly.*

CAC is now a membership organization *and we invite your board to join. For information about the benefits that are available to our members, and for a membership enrollment form, please see pages 35 – 36 of this issue.*

Although we encourage you to receive our newsletter by becoming a ***CAC member****, you may still subscribe to our newsletter without becoming a member. Please see page 37 of this issue.*

SCOPE OF PRACTICE

Florida Legislature Considers Implications of Changes in Scope of Practice for Several Professions

The Florida Legislature's Office of Program Policy Analysis and Government Accountability released a Research Memorandum on December 30, 2010, entitled, *Expanding Scope of Practice for Advanced Registered Nurse Practitioners, Physician Assistants, Optometrists, and Dental Hygienists*. Excerpts appear below:

Summary

As requested, OPPAGA examined the implications of expanding particular aspects of the scope of practice for three groups of health care practitioners:

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advanced registered nurse practitioners (ARNPs) and physician assistants (PAs); optometrists; and dental hygienists. Scope of practice laws detail the services that health professionals are authorized to offer and the settings in which they can practice. Our research addressed the following issues.

§ For ARNPs and PAs, differences between Florida's scope of practice laws and those of other states, arguments for and against expanding the scope of practice, and the potential cost savings from greater use of ARNPs and PAs in primary care.

§ For optometrists, differences between Florida's laws and those of other states in authorizing optometrists to prescribe oral medications, arguments for and against revising prescription authority, and the potential cost savings and effect on health care access for Medicaid participants if Florida authorized optometrists to prescribe oral medications.

§ For dental hygienists, differences between Florida's laws and those of other states in authorizing hygienists to provide preventive dental care without dentist authorization, arguments for and against authorizing dental hygienists to practice more independently, and the potential effect on access to preventive dental care for Medicaid participants if dental hygienists practiced more independently.

Advanced Registered Nurse Practitioners and Physician Assistants

Unlike most other states, Florida does not allow ARNPs and PAs to prescribe controlled substances. States vary in authorizing ARNPs and PAs to directly bill insurance companies and managed care organizations; Florida law neither prohibits nor requires insurance companies and managed care companies

~ Continued from Page 1 ~

to allow ARNPs and PAs to bill them directly. Opponents of expanding the scope of practice of ARNPs and PAs cite concerns about patient safety. Proponents assert that these practitioners are qualified to prescribe such medications and expanding scope of practice would increase access to health care. OPPAGA's estimates of potential cost-savings from expanding ARNP and PA scope of practice range from $7 million to $44 million annually for Medicaid, $744,000 to $2.2 million for state employee health insurance, and $339 million across Florida's health care system.

Several factors could affect implementation and the time needed for ARNPs and PAs to assume more responsibility for providing primary care services. These factors include the need for the Department of Health to promulgate rules, the need for the health care industry and providers to change billing practices, and patients' willingness to receive treatment from these practitioners instead of physicians…

Optometrists

While most other states authorize optometrists to prescribe oral medications and controlled substances, Florida does not. Opponents' arguments against giving optometrists this authority primarily relate to patient safety. Proponents' arguments include cost savings due to less frequent referrals to ophthalmologists and increased patient access to eye care. Our analysis found minimal cost savings to the state as a result of expanding optometrists' prescription authority. However, making this change may enhance Medicaid participants' access to eye care. Florida's administrative rule promulgation process would affect the length of time needed to

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implement changes to optometrists' prescription drug authority…

Dental Hygienists

Thirty states allow dental hygienists to initiate patient treatment, such as cleanings, without the specific authorization of a dentist, but Florida does not allow dental hygienists this level of independence. Opponents of allowing dental hygienists more independence cite concerns with patient safety and question whether it would significantly improve access to preventive dental care. Proponents argue that dental hygienists are trained to provide these services, and giving them more independence could improve access for underserved populations, such as Medicaid participants. Underserved populations may receive greater access to preventive dental care if dental hygienists were authorized to practice more independently…

The entire document can be found at: http://www.floridanurse.org/ARNPCorner/ARNPDocs/OPPAGA_ScopeofPracticeMemo.pdf

Virginia Health Reform Initiative Recommends Review of Scope of Practice

The Virginia Health Reform Initiative has as its purpose to "go beyond federal health reform and recommend other innovative healthcare solutions that meet the needs of Virginia's citizens and government." To achieve this purpose,

> The Virginia Health Reform Initiative will ensure that meaningful reform is achieved throughout the Commonwealth. There is a desire to see that the health care delivery system as a whole is positively impacted as a result of the work accomplished through the initiative. From insurance and payment reforms to how care is delivered, the initiative will work with stakeholders to reduce costs and improve quality.
>
> The initiative will seek to build off of what is already successful in Virginia and will remodel or reorganize practices that do not achieve optimal results. It is recognized that this effort must leverage the strengths of competent, effective government with the experience and knowledge of the private sector. Together, great things will be achieved throughout Virginia. We will implement reform in a way that is unique enough to meet Virginia's specific needs, cost effective, and beneficial to all involved.

The Initiative's Advisory Council issued a report and recommendations December 20, 2010. In the section on healthcare delivery capacity, the report says the following about the impact of scope of practice laws and regulations:

> State scope of practice laws vary considerably, and for some health professionals, like nurse practitioners, Virginia's are among the more restrictive. Scope of practice restrictions may limit the ability to fully expand capacity as much as optimal "team" care delivery might allow. Similarly, knowledgeable professionals like pharmacists may be underutilized by existing care delivery patterns, especially for pharmacy-related consults to reduce confusion and increase patient compliance among those taking more than one medication. These consults should be properly compensated and considered part of what well-functioning primary care teams do.
>
> Considerable clinical and practical evidence suggests that some scope of practice restrictions and supervisory plus care delivery norms in Virginia may no longer be necessary to protect the health and safety of the public and may indeed

contribute to inefficient and even ineffective care delivery and thereby raise costs unnecessarily. At the same time, feelings are strong on both sides of this issue, and for some, the evidence base is "new," appropriate supervision questions have not been resolved, and therefore there is not yet consensus on the best way forward.

For some professionals, including nurses, "norms" of practice may be as limiting as scope of practice laws. For example, consider pharmacists. They are accessible in a community setting; their location positions them well to meet the needs of patients with chronic disease. They can counsel patients (help alleviate the stress on primary care to attend to these patients) and as a result help reduce costs and visits to the physician, which may require more travel and increase expenses for both the patient and the payer. Expanding the use of medication therapy management will enable pharmacists to reach their full potential/capacity, improve patient understanding of compliance needs and potentially improve patient outcomes and lower costs from unnecessary doctor visits and hospitalizations. Some of the patients who could benefit include those with diabetes, heart failure, hypertension, dyslipidemia, chronic obstructive pulmonary disease, asthma, rheumatoid arthritis, depression, osteoporosis and osteoarthritis. These patients are often taking multiple drugs and often any one physician even does not know all the drugs they are prescribed, whereas pharmacy data may actually be more complete at the present time. To date, this expanded use of pharmacists' potential is rare.

The entire report can be found at: http://www.hhr.virginia.gov/Initiatives/HealthReform/docs/VHRIFINAL122010.pdf

"Non-Physicians" Gain Due Process Rights

Editorial note: The following article appeared in the online version of the Journal of the American Academy of Physician Assistants (AAPA), January 13, 2011 (see http://www.jaapa.com/the-speed-of-change/printarticle/193944/). It describes a significant reduction in the working environment barriers affecting physician assistants, nurse practitioners and certified registered nurse anesthetists at one California hospital. The author, Steve Hanson, is immediate past president of the AAPA.

The Speed of Change
Stephen H. Hanson, MPA, PA-C

The speed of change in recent years for the PA profession has taken my breath away. I have simply been astounded at how quickly positive change has come in numerous areas that affect PAs' ability to serve their patients and communities. The barriers to effective and efficient physician-PA practice continue to fall at every level.

While change can be glacial in the health care system at times, if you observe as long as I have, significant movement is evident (smile!). I have also learned that determined individuals can make a local difference, armed with the right tools.

A prime example is the local environment in my hometown, Bakersfield. I work for an Adventist Health hospital, with a strong sense of mission and vision, which focuses on community service. I joined the medical staff two years ago and have had the good fortune to work with medical staff people who understand that barriers to good physician-PA practice interfere with the mission of the hospital.

One example is due process on the medical staff. When I arrived at the hospital, "non-physician" clinicians (NPs, PAs, and CRNAs) could find their privileges revoked with the stroke of a pen by the chief of staff. No hearing, no evidence – just out the door at the whim of one person. Our only association with medical staff was credentialing; there were no other privileges, such as committee membership. Along with the hospital experts at the AAPA, using the model hospital privileges and JCAHO standards, we have been able to work with the physician and non-physician leadership of the hospital medical staff to make a dramatic change in the hospital bylaws, which culminated in December.

This change includes full medical staff membership for PAs and others, due process, committee voting membership, and the ability to take our place alongside our physician colleagues in monitoring and improving the care delivered in our facility. PAs support physician-led teams at every level and have a lot of experience and expertise to add in supporting the governance work of medical staff.

So, I now find myself on the Credentialing, Surgery, and Clinical Improvement committees. Rules on co-signature, rounding, procedures, etc, have been dramatically improved to allow them to be more practice based and at the discretion of the supervising physician, while still maintaining patient safety and quality as our highest standards. This all positively affects the work environment for PAs and others at our facility.

The better news is that this change will create a ripple effect in the community. (It already is in the Adventist Health system.) The state-of-the-art PA working environment is already attracting the best and brightest PAs in the community and will encourage other hospitals in our community to remove their barriers to physician-PA practice. Failure to do so will make it difficult for these facilities to recruit and retain increasingly scarce PAs and other health care providers.

Ann Davis of AAPA staff fame is fond of saying "If you are not at the table, you are on the menu." Never doubt that as a committed individual, you can make a positive local change.

American Dental Education Association Issues Education Principles

Editorial Note: The American Dental Education Association (ADEA) created a task force in 2009 to develop a set of principles to guide the educational preparation of oral health professionals in emerging workforce models. The report of the task force is excerpted below. The full text can be found at: http://www.adea.org/publications/library/Documents/GuidingPrinciples.pdf

ADEA TASK FORCE ON THE EDUCATION OF ORAL HEALTH PROFESSIONALS IN EMERGING WORKFORCE MODELS

…The core values and key assumptions that guided the Task Force's work are articulated below, followed by the *ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models.*

Core Values

ADEA believes that with appropriate levels of education and supervision oral health professionals in emerging workforce models can provide quality care, contribute to increasing access to oral health services for all, and help to improve the oral health of the nation.

ADEA acknowledges the reality that most of the emerging workforce models are intended to increase access to oral health care for underserved populations.

ADEA believes that expanding the capacity of the oral health workforce will increase access to oral health care *for all* and, consequently, have a positive impact on access to care for underserved populations.

ADEA believes that its role, in collaboration with its member institutions, is to anticipate and prepare for changes to the curriculum and the academic environment that emerging workforce models will require as states modify their practice acts to increase the capacity of the oral health workforce. The Association's role is not to develop new workforce models, but to ensure the quality of the educational preparation of oral health professionals in these emerging models.

Notwithstanding the creation of emerging workforce models, ADEA believes that the extended use of existing allied dental professionals can contribute to expanding the capacity of the oral health workforce, thereby further increasing access to oral health care *for all*.

Key Assumptions

- Demographic shifts in society have major implications for the future composition of the oral health workforce. Professionals in the workforce of the future should possess values, attitudes, knowledge, and skills that enable them to competently meet changing societal needs.
- A single standard of quality should apply when the same service is provided by different members of the oral health team.
- The creation of new workforce models will require modification to the educational preparation of existing oral health team members to support the successful integration of emerging models.
- The Guiding Principles articulated for emerging workforce models have application to and implications for the education of all oral health professionals.

Guiding Principles

Principle 1: Educational programs for oral health professionals in emerging workforce models should be based on clearly defined goals and desired educational outcomes. These programs should be competency-based, providing learning experiences to ensure that students attain the values, attitudes, knowledge, skills, and experiences needed to provide quality care in a collaborative, interprofessional environment…

Principle 2: Educational programs for oral health professionals in emerging workforce models should have appropriate processes to ensure program quality and assessment of graduates' competency…

Principle 3: Educational programs for oral health professionals in emerging workforce models should ensure that students attain the skills necessary to engage individuals from diverse populations in decisions about their oral health…

Principle 4: Educational programs for oral health professionals in emerging workforce models should be evaluated continuously to determine their success in meeting their defined goals and educational outcomes…

Conclusion:

The American Dental Education Association believes that with appropriate education and preparation, oral health professionals in emerging workforce models can provide quality care and make meaningful contributions

to expanding the capacity of the oral health workforce, thereby increasing access to oral health care *for all*. ADEA encourages institutions, organizations, and policymakers that are designing oral health workforce models, and those who are developing educational programs to prepare these professionals, to incorporate these Guiding Principles into their planning and decision-making.

Implications for Educators of IOM Report on Future of Nursing

Two articles in the New England Journal of Medicine following the issuance of the IOM Report on the Future of Nursing discuss scope of practice regulations and nursing education. The gist of these articles is described in the following December 17 entry in the online newsletter EndoNurse (see http://www.endonurse.com/news/2010/12/nursing-profs-changes-needed-in-nursing-education-and-policy.aspx).

> The increased numbers of advanced practice nurses needed to provide primary care to the 32 million currently uninsured Americans to be covered under healthcare reform will require far-reaching changes including national uniformity in how nurses are allowed to practice, and how they are educated, such as moving the minimum educational requirement for nurses to the bachelor's degree, according to two Penn Nursing professors in the most recent issue of *The New England Journal of Medicine.*
>
> "Between 3 and 12 nurse practitioners can be educated for the price of producing one physician, and this can be accomplished more quickly than traditional medical education," wrote nursing professor Julie Fairman, PhD, RN with former Health and Human Secretary Donna Shalala, PhD, now president of the University of Miami urging states to adopt uniform scope of practice laws. The recently-passed Affordable Care Act is expected to add 32 million Americans who will need primary care to the healthcare rolls.
>
> However, producing enough nurses to bridge the gap will be a "mathematical impossibility" unless the minimum degree for nursing is raised to a bachelor's, writes nursing professor Linda Aiken, PhD, RN, noting that 3.5 times as many nurses from bachelor's programs as from two-year programs go on to achieve master's degrees to enable them to provide primary care, or doctorates to become faculty members to teach the next generation of nurses. Currently, nurse practitioners staffing the start-up retail clinics see patients in 3 million visits in 1,000 clinics nationally, but the profession graduates only 8,000 nurse practitioners annually.
>
> In addition, shortages may be exacerbated as variations in state law may mean that states with tougher regulatory barriers restricting nurse practitioners' authority to write prescriptions or conduct chart reviews may reduce patients' ability to find primary care providers as many nurse practitioners migrate to less restrictive states, writes Fairman. And states can lose the opportunity to save billions of dollars if nurse practitioners and other professionals are not fully utilized, estimated in Massachusetts alone to be $4 to $8 billion over 10 years. Fairman also noted that patients fare as well with nurses as with doctors urging medical groups to drop their resistance to having nurses deliver primary care.
>
> Specifically, the articles urge lawmakers to:

- Establish a standardized and broadened scope of practice for nurse practitioners or risk legislating scarcity in areas with restrictive laws (Fairman)
- Reform payments to include global or bundled team-based payments, and medical home-based payments to "ease professional tensions and fears of substitution while enhancing support for an increased scope of nursing practice" (Fairman)
- Use federal funding "to 'steer' the change in basic nursing education, just as public funding for patient care steers change in health care delivery" (Aiken)

The nursing workforce is on the verge of losing approximately 500,000 nurses to retirement, and half of nursing-school faculty members will reach retirement age within the next 10 years. Nursing schools are "turning away tens of thousands of qualified applicants" because of budget constraints and a worsening faculty shortage. Without bachelor's-prepared nurses, the country's nursing resource will be "crippled" as fewer will go on to receive master's degrees (to work in primary care) or doctorates (to work as faculty members educating the next generation of nurses), Aiken wrote.

Source: *The New England Journal of Medicine*

Legislation Introduced in New Mexico Addressing Scope of Practice

Editorial Note: Senate Bill 161 was introduced in New Mexico in January 2011 by Linda M. Lopez. Section 4, which is reproduced below, addresses scope of practice. Section 5 would establish a similar procedure for reviewing requests to license a new profession.

AN ACT

RELATING TO HEALTH; ENACTING THE PROFESSIONAL LICENSING BOARD REVIEW ACT; PROVIDING FOR A PROCESS TO REVIEW SCOPE OF PRACTICE CHANGES FOR ALL LICENSED HEALTH PROFESSIONALS AND THOSE SEEKING TO BECOME LICENSED HEALTH PROFESSIONALS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. SHORT TITLE. – This act may be cited as the "Professional Licensing Board Review Act".

SECTION 2. PURPOSE. – The purpose of the Professional Licensing Board Review Act is to:

A. provide a procedure for a review of proposed changes in the scope of practice of health professionals licensed by the state in order to ensure that the changes contribute to the improvement of the overall health of the people of New Mexico;

B. provide a process for health professionals who wish to become licensed; and

C. make findings based on the review available to the governor and the legislature…

SECTION 4. LICENSING BOARD ANALYSIS. – A member of a licensing board, a licensee of the licensing board or any other person seeking a change in the scope of practice of a health profession shall notify the respective licensing board of that profession and request review concerning the proposed change. Upon receipt of a request for review of a proposed change, the licensing board shall:

A. collect data, including information from the requester and all other appropriate persons, necessary to review the proposed change;

B. conduct a technical assessment of the proposed change, with the assistance of a technical advisory group established by the licensing board for that specific purpose, if necessary, to determine whether the change is within the health profession's current scope of practice or could be accomplished with expanded education or training;

C. hold a public hearing concerning the proposed change with appropriate notice of its proceedings;

D. invite testimony from persons with special knowledge in the field of the proposed change;

E. assess the proposed change using the following criteria:

(1) whether the proposed change offers potential benefit to the health, safety or welfare of health care consumers; whether the proposed change offers potential harm to the health, safety and welfare of health care consumers; and whether the potential benefits of the proposed change outweigh the potential harm;

(2) the likely economic impact on overall health care delivery of the proposed change; and

(3) the extent to which the proposed change will affect the availability, accessibility, delivery and quality of health care in New Mexico;

F. provide its analysis, conclusions and any recommendations, concerning the proposed change together with all materials gathered for the review, to the legislature and to the governor; and

G. provide to the governor, the New Mexico legislative council, the legislative finance committee and the legislative health and human services committee a full report, including legislative recommendations, on each proposed change in scope of practice brought before the board between September of the previous year and August of the current year. The director of the licensing board shall also provide an oral presentation of the report to the legislative finance committee and the legislative health and human services committee…

Texas Medical Association Takes Hard Line on Scope Changes

Editorial Note; The following "Scope of Practice Legislative Brief" has been posted on the Texas Medical Association Web site. It can be found at: http://www.texmed.org/Template.aspx?id=19666.

Physicians and non-physician practitioners work together as a team to provide high-quality patient care every day. They are trained together; they practice together. Physicians serve as the leader of the team because they have clinical expertise and training to exercise independent medical judgment. Non-physician practitioners work with physicians and should be able to provide

care based on their level of education, training, and skill.

However, in every legislative session, one or more groups of non-physician practitioners seek to expand their scope of practice beyond their training and attempt to practice medicine without graduating from medical school. In 2011, advance practices nurses will seek diagnosis and prescribing privileges — essentially the practice of medicine — without physician supervision; physical therapists will seek direct access to patients without a physician's referral; and podiatrists will seek authority to work above the foot. Other groups will likely seek similar expansions, all based on the claim of improving access to care.

Expanding this authority will not enhance access or ensure better care to patients. All patients deserve high-quality care by practitioners who are well trained, operate in an efficient team, and properly supervised by physicians who answer to the regulatory body responsible for medical care in Texas, the Texas Medical Board (TMB).

Medicine's 2011 Agenda

- Prevent any efforts to expand scope of practice beyond that safely permitted by non-physician practitioners' education, training, and skills.
- Defend a single standard of care, the physician's role as leader of the health care team, and the physician's ability to delegate and responsibility to supervise medical care for patients.
- Support licensure efforts by non-physician practitioners when it improves patient care, when the practitioners are appropriately trained, and when there is appropriate linkage to the TMB for regulatory oversight.

Medicine's Message

- There should be a single standard of medical care for all practitioners. Physicians embrace their role as both providers and supervisors of care and understand the responsibility and accountability they bear for properly delegated medical acts.
- Lowering the standard of care does not improve access to health care services for Texans.
- Non-physician practitioners should practice to the highest level of their training and skills but not beyond.
- Maintaining the integrity of the health care team, under the physician's overall direction, is good for patient care.

Journal Editor Calls for Collaboration between Doctors and Nurse Practitioners

In stark contrast with the legislative brief reprinted above, Jeff Simon, MD, the editor-in-chief of the Journal of Family Practice wrote an editorial in December, 2010 entitled It's Time to Collaborate – not Compete – with NPs." It can be found at http://www.jfponline.com/Pages.asp?AID=9173&issue=December_2010&UID

It is time – time to abandon our damagingly divisive, politically Pyrrhic, and ultimately unsustainable struggle with advanced practice nurses (APNs). I urge my fellow family physicians to accept – actually to *embrace* – a full partnership with APNs.

Why do I call for such a fundamental change in policy? First, because it's the reality.

In 16 states, nurse practitioners already practice independently. And I many more states, there is a clear indication

that both the public and politicians favor further erosion of barriers to independent nursing practice. Indeed, such independence is outlined in "The Future of Nursing: Leading Change, Advancing Health," published by the Institute of Medicine (IOM) in October 2010. Among the IOM's conclusions:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.

Second, I believe our arguments against such a shift in policy don't hold up. Despite the endless arguments about outcomes, training, and patient preferences, I honestly believe that most nursing professionals – just like most physicians – practice within the bounds of their experience and training.

Indeed, the arguments family physicians make against APNs sound suspiciously like specialists' arguments against us. (Surely, the gastroenterologists assert, their greater experience and expertise should favor colonoscopy privileges only for physicians within their specialty, not for lowly primary care practitioners.) Rather than repeating the cycle of oppression that we in family medicine battle as the oppressed, let's celebrate differences in practice, explore opportunities for collaboration, and develop diverse models of care.

Third, I call for a fundamental shift in policy because I fear that, from a political perspective, we have much to lose by continuing to do battle on this front. Fighting fractures our support and reduces our effectiveness with our legislative, business and consumer advocates.

Finally, I'm convinced that joining forces with APNs to develop innovative models of team care will lead to the best health outcomes. In a world of accountable health care organizations, health innovation zones, and medical "neighborhoods," we gain far more from collaboration than from competition.

As we ring in the new year, let's stop clinging to the past – and redirect our energies toward envisioning the future of health care.

Academic Leaders Call for Worldwide Reforms in Training Healthcare Professionals

Editorial Note: The following excerpts are reprinted from the online Medical News Today, November 30, 2010.

Recommendation 6 is directly relevant to scope of practice. The full text of the online article can be found at:
http://www.medicalnewstoday.com/articles/209374.php

In a major new report, 20 professional and academic leaders call for major reform in the training of doctors and other healthcare professionals to equip them for the 21st century. This Lancet Commission report is written by Professor Julio Frenk, Dean of Harvard School of Public Health, Boston, MA, USA, and Dr Lincoln Chen, China Medical Board, Cambridge, MA, USA, and their colleagues.

Worldwide, 2420 medical schools, 467 schools or departments of public health, and an indeterminate number of postsecondary nursing educational institutions train about 1 million new

doctors, nurses, midwives, and public health professionals every year. Severe institutional shortages are exacerbated by maldistribution, both between and within countries. High-income countries are struggling to adapt to increasing costs and changing demographics of their populations, while in poorer nations it is obviously much worse. A large proportion of the 7 billion people who inhabit our planet are trapped in health conditions of a century ago.

Changes are needed, say the authors, because of fragmented, outdated, and static curricula that produce ill-equipped graduates. They say: "The problems are systemic: mismatch of competencies to patient and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health-system performance."

They add: "Laudable efforts to address these deficiencies have mostly floundered, partly because of the so-called tribalism of the professions – i.e., the tendency of the various professions to act in isolation from or even in competition with each other."

The authors suggest a number of reforms, both instructional and institutional. Instructional reforms (1 to 6 below) should encompass the entire range from admission to graduation, to generate a diverse student body with a competency-based curriculum that, through the creative use of information technology (IT), prepares students for the realities of teamwork, to develop flexible career paths that are based on the spirit and duty of a new professionalism. Institutional reforms (7 – 10 below) should align national efforts through joint planning especially in the education and health sectors, engage all stakeholders in the reform process, extend academic learning sites into communities, develop global collaborative networks for mutual strengthening, and lead in promotion of the culture of critical inquiry and public reasoning.

1. Adoption of competency-based curricula that are responsive to rapidly changing needs rather than being dominated by static coursework…
2. Promotion of interprofessional and transprofessional education that breaks down professional silos (i.e., the barriers between various healthcare professions and specialties) while enhancing collaborative and non-hierarchical relationships in effective teams.
3. Exploitation of the power of information technology (IT) for learning through development of evidence, capacity for data collection and analysis, simulation and testing, distance learning, collaborative connectivity, and management of the increase in knowledge.
4. Adaptation locally but harnessing of resources globally…
5. Strengthening of educational resources…
6. *Promote a new professionalism that uses competencies as the objective criterion for the classification of health professionals, transforming present conventional silos. A set of common attitudes, values, and behaviours should be developed as the foundation for preparation of a new generation of professionals to complement their learning of specialties of expertise with their roles as accountable change agents,*

competent managers of resources, and promoters of evidence-based policies. (Emphasis added.)

7. Establishment of joint planning mechanisms in every country
8. Expansion from academic centres to academic systems, extending the traditional discovery-care-education continuum in schools and hospitals into primary care settings and communities.
9. Linking together through networks, alliances, and consortia between educational institutions worldwide and across to allied actors, such as governments, civil society organisations, business, and media…
10. Nurturing of a culture of critical inquiry as a central function of universities and other institutions of higher learning…

The authors conclude: "Ultimately, reform must begin with a change in the mindset that acknowledges challenges and seeks to solve them. No different than a century ago, educational reform is a long and difficult process that demands leadership and requires changing perspectives, work styles, and good relationships between all stakeholders. We therefore call on the most important constituencies to embrace the imperative for reform through dialogue, open exchange, discussion, and debate about these recommendations…"

California Doctors Sue Over Optometry Rule

The California Medical Association and the California Academy of Eye Physicians filed suit on January 11, 2011 objecting to a Board of Optometry rule that would allow recent graduates to treat glaucoma without additional graduate training. Previously, optometrists wanting this authority had to treat fifty glaucoma patients over two years under the supervision of a board-certified ophthalmologist.

The two physician groups contend that the rulemaking was faulty because a consultant to the optometry board was himself not certified to treat glaucoma. Their suit points to a case involving the Veterans' Administration facility in Palo Alto where several patients suffered harm, including blindness, after treatment by optometrists.

New Report Explores Collaborative Practice Models in Dentistry

The Center for the Health Professions at the University of California, San Francisco released a report on January 1, 2011 entitled, Collaborative Practice in American Dentistry: Practice and Potential. The report's authors are Catherine Dower, Vanessa Lindler, and Elizabeth Mertz. The Center's announcement describes the report this way:

> As the US seeks to improve the effectiveness and accessibility of the oral health care delivery system – in order to reduce stark disparities in oral health utilization and outcomes that exist in this country – new and innovative models of practice will be necessary. One model includes collaborative practice arrangements between clinicians. These models have long been used in medical and other health care fields, such as between physicians and nurse practitioners delivering primary care. Collaborative practice models can also be found, though less frequently to date, in oral health care settings. This report describes collaborative practice models in medicine and dentistry; presents a typology for the various structural, legal and financial components that are founding such models; and explores the potential for such models to be used more extensively in dental care. As legislatures look to collaborative practice as a way to connect providers within a system of care, issues such as the level of

formality of the relationship between providers and each provider's degree of autonomy deserve careful attention. Collaborative practice models, if carefully structured and implemented, have significant potential for improving access to oral health care, improving care quality and promoting better health outcomes.

The report can be accessed at http://www.futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Collaborative_Practice%20in%20American%20Dentistry:%20Practice%20and%20Potential.

CAC Comments on Colorado Midwife Scope of Practice

Sunset hearings in Colorado for direct-entry midwives gave The Citizen Advocacy Center (CAC) an opportunity to comment on recommendations for changes in the scope of practice. As readers will see in our written submission, we coordinated our comments with a state-based consumer group:

CAC writes to support the recommendations made in the 2010 "Sunset Review: Regulation of Direct-Entry Midwives" (Oct. 15, 2010), prepared by the Colorado Department of Regulatory Agencies (DORA). In that Sunset report, DORA recommends:

> **Continue the regulation of direct-entry midwives for five years, until 2016.**
>
> The laws that govern direct-entry midwives ensure competent and qualified practitioners. Complications that may arise during pregnancy, delivery, and childbirth are numerous, and include lifelong injury and death. Therefore, it is in the interest of the public to regulate direct-entry midwives.
>
> **Allow direct-entry midwives to obtain and administer vitamin K and specific medications.**
>
> The following vitamin and medications are life-saving, prophylactic treatments for women and babies:
>
> - Vitamin K;
> - Rho(D) immune globulin; and
> - Antihemorrhagic drugs.
>
> Direct-entry midwives are trained and test on the use of vitamin K, Rho(D) immune globulin, and antihemorrhagic drugs. Allowing direct-entry midwives to administer them is consistent with the public interest.
>
> **Repeal the prohibition against being simultaneously licensed as a nurse and registered as a direct-entry midwife, except for certified nurse-midwives.**
>
> A licensed nurse, who obtains the necessary skills and qualifications to be registered as a direct-entry midwife and maintains his or her license in good standing, should be allowed to work as a direct-entry midwife without giving up his or her nursing license in order to do so.

CAC is a unique support center for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory and other health policy boards, or selected by private sector institutions and agencies to serve on boards or advisory panels, public members are typically in the minority and are usually without the resources and technical support available to the counterparts from professional and business communities. CAC is a not-for-profit 501(c)(3) organization created to serve the public interest by providing research, training, technical support, and networking opportunities to help public members make their contributions informed, effective, and significant. More detailed information about CAC is available on our website at http://www.cacenter.org.

Scope of practice reform is a major priority for CAC. This year, CAC launched a scope of practice initiative whose mission is "to provide independent, third party, economically disinterested input into processes and criteria for removing unjustified scope of practice restrictions." Our primary goal is to encourage consumers and consumer advocacy organizations to become knowledgeable about the impact of scope of practice decisions on the population's access to affordable quality healthcare and then to make their opinions known when scope of practice changes are being considered by legislatures and when implementing regulations are being written by regulators.

In addition to removing unjustifiable scope of practice restrictions that prevent professions from practicing to the full extent of their training and skills, CAC aspires to help bring some rationality to scope of practice decision-making in state legislatures so that the outcome is not determined solely by turf battles among the professions. We believe the sunset review process Colorado follows is a good one because the starting point is a well-researched, public-oriented report with recommendations by DORA.

A list of the publications CAC has developed addressing scope of practice issues can be found on our Website at http://www.cacenter.org/cac/SOP.

Regarding Direct Entry Midwives, DORA has made a compelling case to justify its recommendations. None of the recommendations propose ground-breaking scope of practice expansions. Rather, adoption of the recommendations would bring Colorado into conformity with a majority of other states that regulate direct-entry midwives. Once these recommendations are adopted, Colorado would no longer be an outsider. There are no safety issues that argue against any of the proposed scope expansions, as documented in the DORA sunset report.

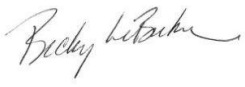
The training and certification requirements help assure that direct-entry midwives will continue to provide safe and quality health services to the women in Colorado who choose to utilize them.

We strongly support the DORA recommendation that would remove the restriction prohibiting licensed nurses from being licensed as both a nurse and a direct-entry midwife, provided they meet the same licensing requirements as non-nurses. There is no justification for continuing this restriction.

We are aware that a coalition of Colorado consumers join us in supporting the DORA recommendations and will also urge the legislature to allow suturing by direct-entry midwives, something that DORA recommended in its 2000 Sunset Report on this profession. We have been in touch with that coalition, Delivering Natural Care for Families, listened to and evaluated their rationale for allowing suturing, and are pleased to support their recommendation, which they will justify in some detail in their own statement.

Thank you for considering our comments.

Sincerely,



Rebecca LeBuhn
Board Chair

David Swankin
President and CEO

PAIN MANAGEMENT AND END OF LIFE CARE

CAC Signs on to Letter to the IOM Committee on Pain Care

CAC was pleased to be a signatory to the following letter sent by the American Pain Foundation along with comments and recommendations to the Institute of Medicine's Committee on Advancing Pain Care, Research, and Education.

To: The Members and Staff of the IOM Committee on Advancing Pain Care, Research, and Education
From: The Undersigned Organizations
Date: January 25th, 2011
Subject: Recommendations for the Committee's Consideration

Dear Members and Staff of the IOM Committee on Advancing Pain Care, Research, and Education:
The undersigned organizations wish to express our appreciation for the work you are performing to fulfill the daunting charge of the IOM Committee on Advancing Pain Care, Research, and Education. We understand your challenge to be great and important for the improvement of pain care in America. Many of us, and other organizations of the Pain Care Forum, worked for years in promoting the passage of the Military Pain Bill, the Veteran's Pain Bill and the pain provisions in the Affordable Health Care Act. We wish to do all we can to help in promoting the best policy and practice in pain care and management. To further that purpose, we prepared the attached document for your consideration as you deliberate the issues in your purview. The content is arranged by topic as articulated in your committee's charge.

We would welcome your review of this document and standby to assist in any way we can.

Sincerely,

American Academy of Pain Management
American Chronic Pain Association
American Pain Foundation
American Society for Pain Management Nursing
Cephalon
Citizen Advocacy Center
Endo
International Association for Pain and Chemical Dependency
King Pharmaceuticals
Medtronic
Oncology Nursing Society
Pain and Policy Study Group
Pain Treatment Topics
Purdue Pharma

More information can be found at: http://www.painfoundation.org.

Researchers Study Medical Board Members' Views on Pain Medication Prescribing

Researchers from the University of Wisconsin surveyed medical board members to determine their views about the legality of long-term prescribing of pain medications. Their research was published in the ***Journal of Pain and Symptom Management***. Vol. 40, issue 4, October 2010, pp. 599 – 612. An abstract of the article is available online:

State Medical Board Members' Attitudes about the Legality of Chronic Prescribing to Patients with Noncancer Pain: The Influence of Knowledge and Beliefs about Pain Management, Addiction, and Opioid Prescribing Aaron M. Gilson MS, MSSW, PhD, Pain & Policy Studies Group, Carbone Comprehensive Cancer Center, School of Medicine and Public Health, University of Wisconsin – Madison, Madison, Wisconsin, US.

Abstract

Context

In the United States, physicians' practice is regulated at the state level, with medical board members distinguishing legitimate medical practice from unprofessional conduct. For this process to be effective, regulators should have knowledge and beliefs that conform to current standards of practice and medical understanding. Past research has

demonstrated that some board members continue to view the prolonged prescribing of opioid analgesics to treat noncancer pain as being unlawful or unacceptable medical practice, especially when the patient with pain has a history of substance abuse.

Objectives

This study was designed to determine whether relevant clinical or policy issues can adequately explain regulators' attitudes about the legality of opioid prescribing for patients with noncancer pain.

Methods

A total of 277 questionnaires were obtained from a national sample of medical board members. Using binomial logistic regression procedures, the predictive significance of 12 factors related to four variable domains was explored: 1) beliefs about opioid addiction and diversion, 2) beliefs and knowledge about federal and state policy, 3) clinical beliefs about opioid prescribing, and 4) demographic characteristics.

Results

Separate logistic regression models were computed to determine the extent that knowledge and beliefs contribute to attitudes about the legality of chronic opioid therapy for noncancer pain and for noncancer pain with a history of substance abuse. Three variables demonstrated statistical significance in both regression models: 1) characterizing addiction in terms of physiological phenomena, 2) believing regulatory policy is useful to improve pain relief, and 3) incorrectly believing that federal law limits the amount of Schedule II medication that can be prescribed at one time. When considering the legality of prescribing opioids for patients with noncancer pain, the following additional factors had a notable influence: viewing addiction as common when treating pain with opioids ($P = 0.030$), considering it very important for a board to have a regulatory policy about pain treatment ($P = 0.038$), doubting the legitimacy of more than one opioid prescription for a single patient ($P < 0.0001$), and being younger ($P = 0.038$). Alternatively, for patients with noncancer pain and a history of abuse, only one other factor was significant: reporting the adequacy of their training in pain management as “poor” ($P = 0.012$).

Conclusion

Study results showed that the parsimonious regression models used in this study reasonably explained such attitudes. Suggestions were offered for achieving more comprehensive insight about the factors that can shape regulators' attitudes about prescribing legality.

The abstract can be found at:
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T8R-50M3CF2-2&_user=10&_coverDate=10%2F31%2F2010&_rdoc=14&_fmt=high&_orig=browse&_origin=browse&_zone=rslt_list_item&_srch=doc-info(%23toc%235093%232010%239995999995%232472748%23FLA%23display%23Volume)&_cdi=5093&_sort=d&_docanchor=&_ct=20&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=477e8cb9ea194c6c88224d4d113aeda2&searchtype=a

IN DEPTH

Ben Shimberg Memorial Lecture, by Art Levin, Recipient of 2010 Ben Shimberg Public Service Award

Editorial Note: The following talk was delivered by Art Levin at CAC's 2010 Annual Meeting in Washington, D.C.

A few weeks ago, while reviewing materials for this meeting, I noticed for the first time that I was billed as giving a "lecture"; something I frankly have no intention of doing. My "no lecture" stance flows from personal experience; one being that my own education consisted primarily of Socratic method rather than the lecture hall; and second and more to the point, that I, like everyone else in this room, have been lectured to nonstop over the last several weeks. This onslaught, yea tsunami, of continuous political admonishment reached a level of pain usually associated with needing a root canal. So I, for one, do not want to re-awaken those frayed nerve endings.

Now I have not read the fine print of the award text – but I hope that this wonderful Ben Shimberg honor doesn't come with a legally binding requirement to lecture – or risk a demand to surrender the award. And so, Dave, whatever the legal status, I am not giving the Shimberg award back. End of story.

I propose to spend the rest of my time talking about several concerns that in one way or another bubble up from my personal experience over three plus decades of work as an advocate, as an itinerant public member of varied oversight and policy bodies and as a generalist policy wonk, without portfolio. I believe there is a general lack of appreciation of the relevance of continued competency and scope of practice, to the larger discussions about health care transformation. Taken out of context, these two concerns seem somewhat rarified – and perhaps of interest to only a few. Continued competency appears to some to be the rightful purview of the health professions themselves and scope of practice likewise, but the latter has the added complication of interference from state policy makers and professional guild lobbyists added for good measure. I would propose that the success or failure of our journey to transform/reform how health care is delivered, or better put, how health care is experienced by patients and their families, is to no small degree dependent on recognizing the critical need to resolve continued lack of progress in these two areas of concern.

Last year marked the 10th anniversary of the Institute of Medicine's report on medical mistakes, *To Err is Human*. The report had unusually strong words for its audience. In addressing the alarming human and economic costs associated with an error-ridden delivery system, the report warned, **"The status quo is not acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort."**

This was a powerful admonition, a lecture if you will, on the immorality of allowing preventable medical harm to continue.

Many of us in the advocacy community noted the 10th anniversary of the errors report by pointing out that, despite the considerable public attention and the arguably impressive effort being invested by providers to make care safer, we do not know whether a hospitalized patient is any less likely to be injured than she or he was ten years ago.

This year marks the 10th anniversary of the other shoe dropped by the IOM Committee on the Quality of Health Care in America – *Crossing the Quality Chasm, A New HealthCare System for the 21st Century*. Arguably the most important report to ever come out of the IOM, it put forward a bold vision for a complete system re-design noting that, **"The American health care delivery**

system is in need of fundamental change. Many patients, doctors, nurses and health care leaders are concerned that the care delivered is not, essentially, the care we should receive…Health care has safety and quality problems because it relies on outmoded systems of work. Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher-quality care, we need to have redesigned systems of care…"

(I had the privilege of serving as the "public" member of that committee and will describe that experience later.)

These two reports offered up a number of recommendations, some of which were more eagerly embraced by the health care provider and professional community than others to put it kindly. And some recommendations simply fell off the radar screen in short order – in my opinion because they were seen as potentially alienating the health care professional communities.

For example, the Committee's first report, *To Err is Human*, made a strong recommendation related to a topic I suspect is near and dear to the hearts and minds of many of those in this room – the need for routine assessment of continuing competence.

Recommendation 7.2 Performance standards and expectations for health professionals should focus greater attention on patient safety.

Health professional licensing bodies should

(1) Implement periodic reexaminations and relicensing of doctors, nurses and other key providers, based on both competence and knowledge of safety practices; and

(2) Work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.

This recommendation quickly disappeared from the radar screen and only a few individuals or organizations, Citizens Advocacy Center among them, subsequently appeared very interested in launching a search and rescue mission.

Crossing the Quality Chasm also contained a recommendation that resonates with the focus of this meeting. Recommendation 12 suggests the need for **"restructuring clinical education to be consistent with the principles of the 21**st **century health system."** The report noted that a major challenge exists in transitioning the health care system of the 21st century envisioned in the Chasm report – one that is safe, effective, patient-centered, timely, efficient and equitable. That challenge is the preparation of the workforce to acquire new skills and adapt to new ways of relating to patients and to each other. Specifically, the Chasm report cites the need to:

(1) Redesign the way health care professionals are trained to emphasize the aims of evidence based practice and multi-disciplinary approaches.

(2) Modify the ways in which professionals are regulated to facilitate the changes in care delivery. "Scope of practice acts and other workforce regulations need to allow for innovation in the use of all kinds of clinicians to meet patient's needs in the most effective and efficient ways possible."

These recommendations undergird a strong case for why assuring and assessing the continued competency of health care professionals and removing the artificial barriers to teamwork inherent in scope of practice laws deserve more breadth and depth of attention than it ordinarily gets in the policy arena. Let me embellish a bit. The processes by which we educate, train, license and provide oversight for the health

professions is simply put, stuck in the 19th century or to be more than generous, in the early part of the 20th. It harkens to a time when doctors had little in their black bag but reassurance and a few nostrums (if you were lucky they were opiate based) of doubtful efficacy; when nurses attended to the personal needs of patients and comforted them; pharmacists were hard at work mortaring and pestling noxious ointments that stained clothing permanently and a whole lot of today's specialized health professions did not even exist. What exists today is clearly unequal to the task in an 21st century health care environment featuring ever increasing professional specialization; the constant diffusion of new, complex technologies whose benefits may be great but whose toxicity is as well; a body of evidence of varying robustness and varying and contradictory conclusions that seems to grow exponentially by the minute; and the complexity of caring for an aging population that is kept mostly vertical by what the great biologist, physician and educator Lewis Thomas long ago described as "half way technology" that may add to life span but not the quality of life.

This disconnect between what professionals may end up actually doing in their everyday clinical practice and the relevance of their earlier education and training, seems to me to be obvious, yet health professionals appear to be held hostage by their own hidebound traditions and financial turf fears, and so are mostly appear oblivious to the compelling need for a complete workforce education and training reboot.

The Chasm Report points out that the current systems designed to deal with competency which include the mainstays of licensure, credentialing and privileging, do not generally employ real time testing to assure that skills are current for what that individual professional actually does in their practice and have not deteriorated. The industry comparator is the rigorous and never-ending demonstration of current and relevant competencies that airline flight crews must demonstrate to fly commercial airliners.

In describing the growing use of and interest in the value of multidisciplinary teams, the Chasm report pointed out that such effective teams must be created and maintained. "Yet members of teams are typically trained in separate disciplines and educational programs, leaving them unprepared to enter practice in complex collaborative settings." Once again the comparator is the airline industry, with its emphasis on crew resource management. At meeting after meeting, multidisciplinary team approaches to safety and quality so that patient experience is improved are described as contributing to the success of the improvement enterprise. But little if any progress has been made in reforming professional education and training to better support the aim – at least that I am aware of.

Some might wonder why I have spent so much time citing two IOM reports that are 10 and 11 years old. I do so because I believe they serve to highlight how critically important the issues of health professional competency and scope of practice are to the goal of care transformation and system reform.

The goals of reform have recently been re-articulated into a kind of insider shorthand – known as "the Triple Aims." First conceived by Don Berwick and his colleagues at the Institute for Health Care Improvement, they are rapidly being taking up by others – and of course with Berwick now at CMS we can assume they will help guide that agency's future work as well.

(The triple aims are

(1) to improve the health of the population;

(2) to enhance the patient experience of care (including quality, access and reliability); and

(3) to reduce, or at least control, the per capita cost of care.)

Assuring the competency of health care professionals to do what it is they do in their encounters with patients – and allowing a more professionally diverse reconfiguration of the professional workforce that will respect skill and knowledge over credentials, seems to this observer concordant with the triple aims. Reducing preventable harm and maximizing the quality of outcomes certainly can contribute to the health of the population, make for a better the patient experience and can reduce costs.

Let me switch subjects now and talk a bit about my own experiences as a "public member" over the years and what I view as the failure to provide the kind of support for public members needed to optimize their effectiveness.

To my mind, public membership is first about transparency, especially in the context of state boards that license and provides oversight of the health professions. Having "outsiders" to at least bear witness, if not actively shape, to what essentially is an "insider" process is important for a number of reasons. I think many of us believe that public members can change the group dynamic simply by their presence in ways that can enhance public safety. Their presence can help hold state oversight agencies accountable for the quality of the work that they do. And most important, public members can bring what is more often than not the missing perspective of the subject of all health care interventions, that of patients, to the table.

Over the years, advocates and advocacy organizations such as CAC have been effective in lobbying for greater public participation in the health professional oversight process. States may vary as to the robustness of the mandate, whether it concerns aggregate numbers, percentages, definitions of public member eligibility and levels of governance, but few have not made some concession of public participation. Yet, I would respectfully suggest that we are far from having realized the intended and unique potential contributions of public members. That is in large part because of the practical reality that they are mostly abandoned after their appointment. What do I mean by abandoned? Well they receive little or no training and mentoring. They are expected to effortlessly glide into their seat at the table and magically understand the rules of the game. They are never evaluated as to the quality of their participation. They are often at a disadvantage as to their subject matter experience and education and if they lose their way because of that reality, are at great risk of being co-opted by the insider process.

So I wonder what would be a realistic expectation of the potential contributions of public members, given how little we appear willing to invest in their support. While I have not suspended my long running belief in the potential benefits of having outsiders at the insider's table – I worry that we run the risk being falsely assured that our interests are being adequately protected when they are not.

Earlier I described myself as an itinerant public member. Among my forays into the world of "public membership" was my service as the consumer representative on what was a brand new FDA Advisory Committee (Drug Safety and Risk Management or DSaRM) in 2003 for a four-year term and as an "invited" expert on safety and risk management at meetings both before and after my term of service on DSaRM.

FDA statute and regulation require that there be a consumer representative member serving on each drug and device advisory committee and present at every meeting. While all advisory committee members have their travel and lodging paid for – and all receive the same modest per diem – that is the where the support stops. The agency has no program to nurture consumer reps, or for that matter new scientific and clinician members as they begin their service. Now for many of the latter, an FDA advisory committee meeting is familiar territory. But FDA policy is to limit consumer representatives to one full term on a

committee, although some do come around again to serve on another committee. This means the overwhelming majority of public members are new to their role and most have never even observed a meeting before. With the average committee meeting only once or twice a year, there is not much on the job learning opportunity either.

So picture this: You are the new public member on an FDA advisory committee and you walk into a hotel ballroom in Bethesda, or Rockville, or Gaithersburg to find an audience which can number in the hundreds, the sponsor's claque of elegantly groomed women and men, TV cameras, reporters, and a group of experts who know each other professionally, even if it's their first experience on the committee. You likely know no one and no one knows you.

I frankly am surprised that some public member newbies just don't turn around and leave – it can be that overwhelming. Now approximately three weeks before the meeting you received a FedEx package containing a CD of 300 – 400 pages of background material, but no coaching in how to approach this overwhelming task. I was lucky; I had colleagues who clued me in as to what I needed to pay attention to in the briefing materials and what I could let slide. Then the meeting begins, the chair asks everyone around the table to identify themselves, and you settle in to listen to hours of complex presentations with lots of complex tables and graphs and references to Kaplan-Meier survival curves. Well, it's no wonder that the majority of consumer reps remain silent unless specifically asked to comment and rarely, if ever, offer a dissenting opinion.

Needless to say, this does not describe my behavior as a consumer rep. In fact I came to refer to myself as "Dr No" because on numerous occasions I was the lone dissenting voice when a panel voted to leave a drug on the market despite serious safety concerns. But I would be dishonest if I did not admit that even for me, it was often daunting to be in such a hothouse atmosphere and to be willing to go on record as opposing the majority opinion.

In all my years of experience with the FDA advisory committee process, there were exactly two in-person "orientation" sessions held for new committee members. No effort was made to offer public members specialized briefings to prepare them for their service and the day was mostly spent explaining FDA law and regulation, how to fill out reimbursement forms, conflict of interest rules and the like. I was asked to be one of several presenters to explain the role of consumer representative. My panel was always scheduled towards the end of the day, when most in the room, secure in the knowledge they now understood how to get reimbursed, had already fled.

Now some might wonder if this lack of meaningful support for the service of public representatives is unique to the FDA advisory committee process. Well according to Dave and Becky – it is not. They know from their conversations with dozens of public members of state health professional licensing and oversight boards that a "sink or swim" mentality is the norm. Sadly, while touting the importance of public representation, those responsible appear oblivious to how this not so benign neglect sabotages the potential contributions of public members to the mission and operations of oversight bodies.

This shortcoming in support takes on added significance in light of the current emphasis on "patient engagement" in elements of health care reform legislation. Most of the reference to "patient-engagement" or the increasingly popular expansion to "patient, family and caregiver engagement" is related to the clinical experience of patients in their encounter with providers. However, there are other contexts in which such engagement is thought to be important to the success of the research enterprise. One such example arises from the government's planned $1.1 billion investment in comparative effectiveness research (CER). While far from unanimous,

there is substantial agreement among many leading researchers and it is the policy, if not yet practice, of the relevant agencies that every phase of CER should include participation by patients, families and caregivers. We are talking here about involvement at every step of the way – from start (decisions about research design) to finish (strategies for dissemination of results). But even in this instance, we still have no process in place to identify those individual patients, family members or caregivers who might best represent the public perspective about how to construct and operate the CER enterprise. And as far as I know there is as yet nothing in place to suggest how, after such individuals are identified and placed, they will be supported in their need to understand the scientific and methodological issues under discussion as well as the more practical need of being able to financially afford to participate.

Over the years, CAC has tried periodically tried to interest foundations and agencies in this critical need for public member support and training. While there is almost universal agreement as to the need – unfortunately there is the same unanimity in the lack of responsiveness. This failure to provide support for public members I would suggest raises some interesting questions as to the value of public representation as we know it. For example should there be a moratorium on efforts to expand public participation until and unless there is an accompanying realistic commitment of meaningful support.

And it would be myopic not to enlarge our view to include all of the oversight and advisory activities that have been opened up to public participation over the years – no matter the sector.

As we have created more opportunities for public membership on health professional boards and other health-related venues, another critical concern is raised. There are certainly hundred of such positions in health-related oversight and advisory bodies across the 50 states. Filling these positions with qualified candidates is a daunting task. Who are the potential public members? Where are they? How do we find them? How do we interest them? How do we vet them?

Again, my FDA experience is instructive. I was involved for over two plus decades in FDA's ad-hoc process for screening and nominating consumer representatives to serve on advisory committees. What eventually became known as the Consumer Nominating Group had original representation from national consumer organizations that worked on FDA-related issues. So Public Citizen, Consumers Union, Consumer Federation of America, National Consumers League, and National Women's Health Network were among the dozen or organizations involved. Over 20 years ago the FDA had a robust consumer affairs division and they contracted with a non-profit advocacy group to run the operations of the CNG. Meetings and discussions of candidates were always held face to face in DC and offered the opportunity for a rich selection process. In addition, a lot of effort was expended in orienting and bringing new members of the Group up to speed.

Over time, the process vaporized mainly because of the not so gradual withdrawal of resources by the FDA.

In 2010, increasingly concerned about the reality that the CNG had operated outside of the Federal Advisory Committee Act for decades (for example, its deliberations were not on the public record) and that its membership was chosen arbitrarily, the FDA decided to end the decades old process altogether. Now the process is totally transparent; consumer rep vacancies are published in the Federal Register and nominations are solicited. A list of nominees is subsequently published in the Federal Register and organizations are asked to vote.

I know that for Dave Swankin and CAC, the FDA consumer representative recruitment and selection process may have been viewed as a

process gold standard – admittedly it had little if any competition. But over the years I have expressed to Dave and others my concern whether this at one time elaborate and costly process was ever worth it? After an initial period of self-congratulatory complacency, I began to wonder about the "performance" of the consumer representatives that had emerged from our process. More often than not, the FDA took our advice on candidates (the agency had the final say) and that made us feel like we had been successful in finding good people who truly would act in the public interest. But was this metric (the percent of nominee candidates we proffered that FDA accepted) the right metric with which to judge the value of the process? Probably not.

The CNG process, until its recent demise, included telephone interview with each prospective candidate conducted by a randomly assigned CNG member. The interview attempted to uncover more about the relevant experience, skills and commitment of the individual, their degree of interest in the specific committee, the ability to and comfort level for working with scientists and professionals and to be "at ease" in the difficult environment I described earlier.

The interview was obviously a well-intentioned effort to go beyond the resume and nominating letter. While we had a script of questions covering various domains and were asked to score the candidate, interviewers were free to ask additional questions. As I became more concerned about the value of our process, I developed some probing questions that I thought helpful to the task. These included asking: (1) have you ever attended an FDA advisory committee meeting – before or after your candidacy; (2) before or after becoming a candidate did you ever go to the FDA website and research the charter and past work of the committee; and (3) if there were controversial agenda items past or future, what did you identify as critical concerns from a public interest or public health perspective. Sadly the answers of most candidates did not inspire confidence. I also decided it made good sense to ask the Executive Secretaries of the various advisory committees whether or not the consumer representative we had advanced had regularly participated in their advisory committee's deliberations. More often than not I learned that they had not.

So if I had to grade the process I think it would deserve a "C" at best. It was able fairly successful at screening out those who were not appropriate as public representatives, those who lacked the commitment and time to devote to the task or who had real or perceived conflicts of interest that were not originally screened out by the federal process. But what failed to do was identify public members that would best do what we hoped: robustly represent the public interest.

Again, this is only one persons experience and in the context of the FDA process selecting public members for an advisory rather than oversight function. But it was, despite its flaws, most likely the best intentioned and for a while at least, best-resourced effort to attract high quality public member candidates and to vet them through a formal selection process.

You might ask – what does this national, federal agency process have to do with public members and state licensing boards? They are really very similar as far as process is concerned. At the state level it is usually the Governor's office (rather than an agency) that makes board appointments. Someone within the executive branch has the responsibility for soliciting candidates who are interested in filling public member vacancies. And finally there has to be a process for culling the list and making the actual appointments.

The lesson from my FDA experience is that how we design and resource the recruitment, selection and support of public members on health professional licensing boards – or any other venue for that matter – is what in large measure will determine the value of public

membership in maintaining transparency and holding boards accountable. And we must get all the pieces of the puzzle right – having well qualified, but orphaned candidates will not get us there.

Thank you again to Mark, Dave, Becky and the CAC Board for this much-appreciated honor.

DISCIPLINE

California Medical Boards Attempt Reforms – Again

Christina Jewett Health and Welfare Reporter for California Watch, a project of the Center for Investigative Reporting, filed the following report in her February 9, 2011 blog (see http://californiawatch.org/dailyreport/medical-boards-crack-down-sex-offenders-addicts-8587).

> Medical boards to crack down on sex offenders, addicts
>
> Boards that license nurses, doctors and chiropractors in California are working to pass separate slates of get-tough regulations less than a year after a similar proposal died in the Legislature.
>
> Russ Heimerich, a spokesman for the Department of Consumer Affairs, said a number of medical professional licensing boards are drafting the regulations in hopes of accomplishing what the failed bill would have done in one fell swoop.
>
> "There were provisions like not allowing sex offenders to practice," he said of the bill, SB 1111. "Some boards have that, some don't. The idea was to give that to them all at once. Now the idea is to do that through regulations."
>
> In addition to automatically revoking licenses from nurses who are convicted of a sex offense (see http://www.rn.ca.gov/pdfs/regulations/notoal11211.pdf), the proposed regulations would prohibit chiropractors from entering into "gag clauses" in court – orders banning them from discussing their cases, even with regulatory officials (see http://www.chiro.ca.gov/res/docs/pdf/business/Omnibus_45Day_Notice.pdf). And the board that licenses doctors would gain additional authority [PDF] over doctors who abuse drugs or alcohol, or shirk requirements to work under another physician's watchful eye.
>
> Last year's bill, proposed by state Sen. Gloria Negrete McLeod, D – Chino (see http://www.mbc.ca.gov/laws/regs_guidelines_isr.pdf), was meant to close a variety of loopholes exposed by ProPublica and the Los Angeles Times (see http://www.propublica.org/series/nurses). Those articles focused on failures by the state nursing board to crack down as nurses harmed patients repeatedly (see http://www.propublica.org/article/board-knew-of-nurses-criminal-records-but-took-years-to-act).
>
> But the legislation met stiff opposition from a number of health worker associations and died in a Senate committee (see http://www.propublica.org/article/schwarzenegger-loses-bid-to-fix-oversight-of-health-care-professions). One of the most controversial provisions was a change in state law that would allow the director of the Department of Consumer Affairs to instantly strip workers of their licenses.
>
> Heimerich said the agency cannot and will not pursue that change in regulations.
>
> New provisions aimed at nurses (see http://www.rn.ca.gov/pdfs/regulations/notoal11211.pdf) include allowing the board to accuse them of "unprofessional conduct" if they refuse to cooperate with an investigation. Also, nurses would be required in some cases to submit to a

physical or mental fitness test when applying for a license.

Kelly Green, regulatory advocate for the California Nurses Association, said the union has asked the board to ensure nurses are not unduly penalized or that qualified applicants are not turned away because of limited disabilities.

The Department of Consumer Affairs provided California Watch with regulatory comment letters sent to the board.

Nurses who sent messages railed against a proposal that the board be notified when a nurse is arrested. The nurses said the board should only get notification of convictions, noting that a nurse arrested for protesting or picketing should not be targeted with a board investigation.

Details aside, Green said the regulations fail to address the largest problem facing the board's mandate to protect the public from unfit nurses: understaffing.

"If you really want to tackle reforming the way the board enacts discipline and investigates cases, you really need to give them the resources to do it," Green said. "The bottom line is that the board cannot tackle the backlog of complaints.

Doctor Sues Medical Board over Civil Rights

Dr. Kevin Buckwalter sued the Nevada State Board of Medical Examiners in November 2010 alleging that the board violated his civil rights by failing to detail charges against him and scheduling a hearing at which he could defend himself. The suit also charges that members of the board succumbed to political pressure to discipline doctors in the context of a much-publicized hepatitis C crisis in southern Nevada in 2008.

The Board countered that it had scheduled a hearing in 2009 to review its decision to suspend Dr. Buckwalter's subscription authority, but that the hearing was vacated at Buckwalter's request and negotiations were conducted to resolve the case.

The board began receiving complaints in 2006 related to Buckwalter's prescribing methods. Investigations and peer reviews concluded that his prescribing history was below the appropriate standard of care and summarily suspended his prescribing authority.

Nurse Implicated in Death Had Been Fired By another Hospital

Missouri law requires hospitals to notify regulators when a heath care practitioner is fired or otherwise disciplined. It is unknown whether Hawthorn Children's Psychiatric Hospital notified the Missouri State Board of Nursing when it fired Iris Blanks for repeatedly failing to meet the standard of care during 2006 – 2008.

Subsequently, Blanks was implicated in a patient death at DePaul Health Center when she failed to attempt to revive a teen-aged patient whom other health care workers had sedated and held face down in a beanbag chair. The other nurse and an aide also failed to resuscitate the patient. Discipline by the nursing board is pending.

Missouri Medical Board is Subject of Newspaper Expose

St Louis Post-Dispatch reporter, Jeremy Kohler, wrote an article published on December 12, 2010 with the headline, "Regulators Coddle Doctors Who Err: The Healing Arts Board's Most-common Punishment is to Issue a 'Letter of Concern" to Doctors: The Letters Carry No Repercussions and are Unavailable to the Public." The article summarizes several actual cases of the board's tardy action or inaction.

Kohler interviewed Board of Registration for the Healing Arts executive Tina Steinman, who as frank about the board's frustration with a secretive, drawn out process that requires showing a pattern of misconduct in

order to bring a case against a licensee. Even then, the board attempts to agree on sanctions in secret negotiations with the accused licensee. Licensees continue to practice while their cases work their way through the system.

Kohler also interviewed the board's first public member, Jean Mathews, whose term on the board began in 1993. She said the board she served on would have treated evidence of substandard practice "much more severely" than the current board is doing. She told Kohler that toward the end of her term, the physicians appointed to the board were more protective of other physicians and resisted admonishing them for fear that the board would be sued.

Editorial Note: Articles such as this one sometimes get the attention of state legislators who then sponsor bills to correct the problems exposed by the investigative reporters. Given its medical boards' antiquated statutes and processes, Missouri is clearly ripe for just that kind of fallout from Jeremy Kohler's excellent reporting.

Authorities Failed to Act on Complaints against Abortion Doctor

An abortion clinic in West Philadelphia was the subject of widespread new coverage in January 2011, when the doctor in charge, Kermit Gosnell was indicted for the murder of a patient and seven infants. The grand jury report faults the state health department for failing to inspect the clinic for a seventeen-year period. The conditions in the clinic were discovered by accident, when inspectors went in to investigate allegations that Gosnell was illegally dispensing pain medications.

The grand jury report was especially hard on the medical board, which had received complaints about the clinic, including one lodged by a former employee who reported unsanitary conditions, the practice of medicine by unlicensed caregivers, and other illegal activities. According to the grand jury, the board responded to this complaint by sending one investigator to interview Gosnell off-site. The state legislature is considering several actions to beef up inspections and enforcement in the future.

The grand jury report can be found at: http://www.docstoc.com/docs/69618219/Grand-Jury-Report----Philly-Abortionist-Kermit-B-Gosnell-Multiple-Counts-of-Murder-(January-2011).

IMPAIRED PRACTITIONERS

Impairment Program Subcontractor Used Wrong Standard

California's licensing boards retained a Virginia company, Maximus Inc, to run its confidential diversion programs. Maximus subcontracted it bodily fluid testing to First Lab in Pennsylvania, which in turn subcontracted to Clinical Reference Lab in Kansas. For at least ten months, Clinical Reference Lab was using the wrong standard to assess its drug testing results. As a consequence, nurses, pharmacists and other medical professionals who tested positive for drug or alcohol use were allowed to continue to practice in California.

A total of 146 individuals had "unconfirmed positives," according to Maximus, which re-tested each person at its own expense. An audit of Maximus conducted in June, 2010 by the California Department of Consumer Affairs found that the company's reporting to licensing boards is not always timely and that its record-keeping is insufficient to confirm that health care practitioners are complying with the requirements of the program.

PUBLIC MEMBERS

FSMB Foundation Unveils Public Member Initiative

The Federation of State Medical Boards (FSMB) is developing a Public Member Initiative, which will provide support for public members of state medical and osteopathic boards. A primary mover behind this initiative is Stephen Heretick, J.D., Vice-

President of the FSMB Foundation and the first public member to serve as President of the Virginia Board of Medicine. A public member resource Web page is being developed on the FSMB Web site. Eventually, it will contain written modules and a video for public members.

CAC is working with FSMB on this initiative, preparing resources for appointing authorities and Governors that expound upon the role of public members and explain characteristics to look for when selecting individuals to nominate for public member positions.

Check periodically at http://fsmb.org/foundation-pmi.html as the public member Web page evolves.

Editorial Note: Mr. Heretick wrote an article for FSMB's Journal of Medical Regulation, Vol. 96, No. 1, 2010 in which he makes a case for enhanced public membership on regulatory boards.

QUALITY OF CARE

Who is Monitoring Aging Health Care Practitioners?

An excellent article in The New York Times on January 24, 2011 explored the problem of aging physicians whose cognitive and motor skills may be declining. Reporter Laurie Tarkan interviewed several experts who pointed out a number of potential problems that can develop as a physician ages.

Some of the experts worry about dementia, depression, or substance abuse. Others call for periodic evaluation of physicians. Others believe continuing education or continuing professional development associated with renewing specialty certification can be helpful, although there are questions about whether continuing education is meaningful, and it was pointed out that the older physicians who are of concern are "grandfathered" by specialty certification boards and therefore exempt from current maintenance of certification requirements.

Tarkan writes that a few hospitals have begun to monitor their aging physicians.

Editorial Note: Although it does point out that physicians can lose their licenses if they cause harm, the article does not mention a proactive role for licensing boards, such as requiring demonstrations of current competence on the part of all licensees, including those who are exempt from maintenance of certification requirements by virtue of their age.

The article can be found at: http://www.nytimes.com/2011/01/25/health/25doctors.html?scp=1&sq=as%20doctors%20age,%20worries%20about%20their%20ability%20grow&st=cse

Researchers Find U.S. Healthcare System Produces Lower Survival Rates

Writing in the November, 2010 issue of Health Affairs, researchers Peter Muennig and Sherry Glied compare 15-year survival rates in the U.S. with those in other advanced countries. They find the U.S. healthcare system does not compare favorably. According to the article's abstract:

> Many advocates of US health reform point to the nation's relatively low life-expectancy rankings as evidence that the health care system is performing poorly. Others say that poor US health outcomes are largely due not to health care but to high rates of smoking, obesity, traffic fatalities, and homicides. We used cross-national data on the fifteen-year survival of men and women over three decades to examine the validity of these arguments. We found that the risk profiles of Americans generally improved relative to those for citizens of many other nations, but Americans' relative fifteen-year survival has nevertheless been declining. For example, by 2005, fifteen-year survival rates for forty-five-year-old US white women were lower than in twelve comparison countries with populations of

at least seven million and per capita gross domestic product (GDP) of at least 60 percent of US per capita GDP in 1975.

The findings undercut critics who might argue that the US health care system is not in need of major changes.

The complete article is available at: ***http://content.healthaffairs.org/content/29/11/2105.full?sid=0248575c-af27-42d6-b638-7fb7a29730d1***

LICENSURE

Nurses Develop Model for Regulating Advanced Practice

The National Council of State Boards of Nursing (NCSBN), working with other organizations in the nursing community, has developed a *Consensus Model for APRN Regulation.* Its goal is to promote uniform state laws governing four advanced practice specialties: certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists, and certified nurse practitioners.

NCSBN has developed numerous resources to help boards of nursing and legislators adopt requirements outlined in the *Consensus Model for APRN Regulation*. NCSBN says that by adopting the model requirements states can ensure uniformity in licensure, accreditation, certification, and education and facilitate the regulation of safe and competent advanced practice registered nurses (APRNs).

The model and accompanying materials can be found at: https://www.ncsbn.org/aprn.htm.

Nurses Who Default on Student Loans Lose Licenses

Tennessee has been cracking down on licensed professional who ignore their obligation to repay student loans. According to the Tennessean.com (Get Citation), 42 nurses lost their licenses in October 2010 and at least one social worker in December 2010. Licensees who enter into a repayment plan with their educational institutions can regain their licenses to practice.

Health Care Reform Contains Incentives to States to Conduct Background Checks

An article posted on Indystar.com by Heather Gillers on August 5, 2010, points out that Indiana is one of a few states that still do not conduct criminal background checks on healthcare workers, specifically nurses employed in long term care facilities. The state's Attorney General told Gillers that background checks would be the single most important measure that would improve the safety of nursing home residents.

The federal healthcare reform legislation offers to pay 75% of the cost of establishing a system for conducting background checks, but Indiana failed to apply for that financial aid. The board of nursing checks nurses' licenses against a statewide list of sex offenders, but other illegal acts are not included. The board has to rely on nurses to tell the truth on their applications and renewal documentation.

A follow-up article posted on TheIndyChannel.com on August 19, 2010 reported that the Attorney General's office is trying to enlist regulators, legislators and the governor's office in an effort to construct a criminal background check system for the state.

Nursing Academies Associated with Falsified Transcripts

Authorities investigating events involving the Academy for Practical Nursing and Health Occupations in West Palm Beach, FL and the International Institute of the Palm Beaches in Riviera Beach, FL are trying to find out who is responsible for a scam involving falsified transcripts sent to other states to obtain a license with the goal of getting a reciprocal license to practice in Florida. According to Palm Beach Post staff writers, Eliot Kleinberg and Daphne Duret, the West Virginia nursing

board received applications from 34 supposed graduates from the Academy in West Palm Beach, but nineteen of these applicants either never finished or never attended the academy.

The two academic institutions claim no involvement. The director of one alleges that a man claiming to be a recruiter for the other academy is responsible for the fraud.

PATIENT SAFETY

Patient Safety Organization Announces Certification Program

Then National Patient Safety Foundation has announced that beginning in January 2012, it will launch a certification program tailored specifically to the needs of patient safety professionals. The program will offer certification for healthcare professionals according to criteria determined through clinical research and industry best practices.

Certification for Professionals in Patient Safety (CPPS) will enable healthcare professionals to assess activities that affect patient safety according to the best available information, and implement strategies to reduce medical errors.

Inspector General Finds Alarming Incidence of Adverse Events in Hospitals

Research published in November 2010 by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) estimates the national incidence of adverse events for hospitalized Medicare beneficiaries, assesses the preventability of such events and estimates associated costs to Medicare.

The researchers reviewed the records of 780 Medicare beneficiaries discharged during October 2008. They determined 1) whether there was an adverse event; 2) whether the event was on the National Quality Forum list of Serious Reportable Events or the Medicare list of hospital-acquired conditions (HAC); 3) what the level of harm was to the patient, and 4) whether the event was preventable.

The researchers found that:

- An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays.
- An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm.
- Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable.
- Hospital care associated with adverse and temporary harm events cost Medicare an estimated $324 million in October, 1008.

The OIG made the following recommendations:

- The Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) should broaden patient safety efforts to include all types of adverse events.
- AHRQ and CMS should enhance efforts to identify adverse events.
- CMS should provide further incentives for hospitals to reduce the incidence of adverse events through its payment and oversight functions.

Editorial Note: Also in November, 2010, the New England Journal of Medicine published research led by Christopher Landrigan, Assistant Professor at Harvard Medical School that found little progress in reducing hospital-based medical errors since the first IOM report on the subject a decade earlier. Based on incidents in ten North Carolina hospitals between 2002 and 2007, the study found that the most common errors were

complications from procedures or drugs and hospital-based infections. They found that about 18 percent of patients were harmed by medical care and that 63.1 percent of those injuries were preventable.

The full report can be found at: http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

CONTINUING COMPETENCE

Psychology Board Association Proposes Continuing Professional Development Guidelines

In October 2010, the Association of State and Provincial Psychology Boards (ASPPB) posted for comment a Draft Proposal in the form of a Report of the ASPPB Task Force on Maintenance of Competence and Licensure (MOCAL).

The authors explain that the report:

> is intended to provide the empirical and professional bases for SPPB's recommended Guidelines for Continuing Professional Development, and a first draft of the actual Guidelines, to jurisdictions regarding the need for mandated continuing professional development (CPD). We see what is contained in these recommendations as being a first draft of a work that remains in progress. Our goal is to distribute this document to as many interested stakeholders as possible and to ask for feedback, reactions and other ideas on any and all aspects of the recommendations. We anticipate the need to adapt, change, edit add and/or delete elements of the recommendations in order to make the Guidelines as useable, relevant, and effective for jurisdictions as possible.

The report provides the task force's rationale for addressing continuing professional development rather than continuing education, discusses the importance of evidence-based practice, analyzes the literature on self-assessment, and provides a useful discussion of ways to evaluate outcomes of CPD activities as they affect clinical practice.

Editorial Note: CAC News & Views recommends that readers review the ASPPB report, particularly the sections on self-evaluation and outcomes, which contain important research and analysis which will be helpful to any profession developing guidelines or requirements for CPD.

The document can be found at: http://www.asppb.net/i4a/pages/index.cfm?pageID=3572.

ETHICS

Maryland Considers Ban on Gifts to Healthcare Workers

After a Towson, MD cardiologist was accused of performing unnecessary stent surgeries at the behest of stent-maker Abbott Laboratories, legislators in the state proposed conflict of interest laws. Several possibilities are under consideration, according to an article in the Baltimore Sun on January 26, 2011.

One option is a ban on gifts from drug and device makers. Another is accreditation of cardiac catheterization labs where stent procedures are done. Another would facilitate communication among regulatory agencies. Finally, legislation was proposed that would strengthen hospital based peer review.

The doctor who set all this in motion, Dr. Mark Midei, was first exposed by the Baltimore Sun and subsequently investigated by a U.S. Senate committee. "Since then," according to the article in the Sun, the medical board charged Midei with violating the practice act. The state's Health Services Cost Review Commission has been studying data from the department of health to determine whether other doctors are performing unnecessary procedures.

Editorial Note: CAC News & Views believes that board should be routinely monitoring licensees to uncover patterns of performing unnecessary procedures. The news organization ProPublica has developed a database showing payments from seven large pharmaceutical companies to health care providers in 2009 and 2010. This is a resource regulatory boards should regularly consult.

INFORMATION

CAC Signs On to Comments on *Physician Compare*

In November 2010, the Centers for Medicare and Medicaid Services (CMS) requested comments on how its program called *Physician Compare* should be implemented. The Consumer-Purchaser Disclosure Project at the Pacific Business Group on Health drafted a comment letter to which CAC agree to sign-on. The central themes in the comment letter are:

- Put consumers' first – CMS should populate the website with performance information that is meaningful to consumers and design the website a way that is easy for consumers to understand and navigate.
- Report information at the level of the individual physician – The law supports reporting on individual physician performance and the science behind it has been continually improving. More importantly, consumers need and want it.
- Set standards that don't allow variations in performance to be unduly – Consumers and purchasers need information that distinguishes performance. Over-adjusting performance data for risk and/or applying unreasonable standards for statistical confidence can hide important variations in care, and CMS should prevent this from happening.
- Don't let methodological perfection be the enemy of the public good – Consumers are making decisions physicians virtually blind. They are far better served by making current performance information available rather than waiting in the dark for more precision.
- Foster the growth of all-payer databases for both Physician Compare and private sector reporting initiatives.

LETTERS

Dear **CAC *News & Views***:

The Coalition for Patients' Rights has developed a "Toolkit" of materials for consumers that serves as an informative resource for patients looking for the most appropriate healthcare provider for their individual needs. These materials will also equip consumers to help protect and promote access to a broad spectrum of healthcare professionals.

The Toolkit consists of five documents designed to help members of the public and potential patients understand what healthcare professionals, who are not MDs/DOs, do. It also supports patients as they communicate with these professionals, their health insurance companies, and state legislators and policymakers. Within the Toolkit, you will find:

- Meet your healthcare professional backgrounder
- Tips for finding healthcare providers
- Questions for new healthcare providers
- Template letter to your insurance company
- Template letter to state legislators

These documents are available on the Coalition's website through the following link: http://www.patientsrightscoalition.org/Patient-Resources.aspx

We are trying to disseminate this information to patients and all consumers of healthcare.

Sincerely,

Maureen Shekleton
Professional Relations Specialist
American Association of Nurse Anesthetists

Dear **CAC** ***News & Views****:*

The Dental Board of California has dropped a plan to weaken the warnings about amalgam required in the Watson Law fact sheet. The stark warnings in that fact sheet – which must go to every dental patient – will remain:

> Dental Amalgam: Mercury in its elemental form is on the State of California's Proposition 65 list of chemicals known to the state to cause reproductive toxicity. Mercury may harm the developing brain of a child or fetus.

At its November 2010 meeting, the Dental Board announced that it would review the fact sheet and created a subcommittee of two pro-mercury dentists to propose changes. While the Board was content to let the California Dental Association call the shots, Consumers for Dental Choice was ready to make the mercury-free dentistry movement heard.

We began to organize the kind of coalition we had that led to the demise of the predecessor dental board (which, in violation of the Watson Law, had refused to produce any fact sheet at all). Consumer activist Anita Vazquez Tibau testified before the Board at its November 5 meeting, calling for a stronger – not a weaker – fact sheet, one that acknowledged the 2009 FDA rule's warning that amalgam endangers the neurological systems of children and unborn babies. We followed up with strongly-worded letters. While the Board's executive officer refused to answer, he got the message.

Last Friday, the Dental Board retreated, announcing it will not weaken the California fact sheet.

Charlie Brown
National Counsel
Consumers for Dental Choice

CAC is now a Membership Organization

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

If your board or agency is ready to become a member of **CAC**, please complete the following **CAC Membership Enrollment Form**. Mail the completed form to us, or fax it to (202) 354-5372.

MEMBERSHIP ENROLLMENT FORM

CAC

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Washington, D.C. 20036
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PAYMENT OPTIONS:

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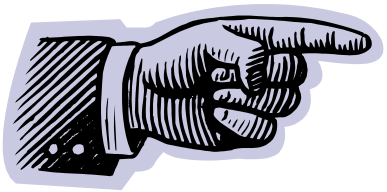

WE WANT YOU EITHER WAY!

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 and returning this form by mail or fax.

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