News & Views

Citizen Advocacy Center

Third Quarter, 2011 A Health Care Public Policy Forum Volume 23 Number 3

SAVE THE DATES: *Our annual meeting* ***"Achieving Regulatory Excellence – Effective Discipline Programs*** *will be held on* ***Thursday, October 20, 2011****, and* ***Friday, October 21, 2011****, at our offices in Washington, DC. You may download a* ***Program and Registration Form*** *or register online by going to http://www.cacenter.org/cac/meetings.*

Audio recordings and PowerPoint presentations *from past CAC webinars are now available. More information is at http://www.cacenter.org/cac/webinars_past.*

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

CPR Cites Cost-Effectiveness of Non-Physician Care

On March 9, 2011, the Coalition for Patients' Rights issued a press release documenting cost savings from better utilization of non-physician health care professionals. The release read in part:

> **Recent Studies Show That Access to Full Spectrum of Healthcare Professionals Key to Cost-Effective Care**
>
> ***Health services delivered by a variety of health professionals save money, broaden patient options***

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WASHINGTON – Several recent studies have demonstrated that cost effectiveness for healthcare improves when health services are provided by licensed professionals other than MDs or DOs. Evidence also shows that there is no loss in quality or effectiveness of care.

These studies add to a large body of research over several decades about the quality of care and cost effectiveness of healthcare professionals other than doctors of medicine (MDs) or osteopathy (DOs). With a greater emphasis on preventive care and health coverage slated to expand to 32 million people who are currently uninsured, many healthcare professions agree that scope of practice limitations are a barrier to improving the delivery of healthcare in the United States.

"The services provided by healthcare professionals other than MDs or DOs are critical for the patient community because of the promise of less expensive, high quality care," said Lisa Summers, CNM, DrPH, spokesperson for the Coalition for Patients' Rights, whose member professions provide patients with essential health services and options they otherwise would lack, especially in medically underserved areas. "Studies demonstrate the cost effectiveness of care from professionals such as psychologists, naturopathic physicians and registered nurses, among others," continued Summers.

Notable new research on cost effectiveness includes the following:

- A study published in *Health Affairs* titled "No Harm Found When Nurse Anesthetists Work without Supervision by Physicians," concluded that patients receive the same level of care at a lower cost when certified registered nurse anesthetists

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(CRNAs) are permitted to perform without physician supervision. Additionally, the May – June 2010 issue of *Nursing Economics* found that CRNAs acting independently provide anesthesia services at the lowest economic cost.

- A study of Canada Post employees titled "Naturopathic Treatment for the Prevention of Cardiovascular Disease: A Whole System Randomized Pragmatic Trial," found that high-risk individuals prescribed naturopathic treatments (such as diet and exercise) experienced a $1,025.00 cost benefit per participant, gained 28 times more productive work days than those treated with traditional medicine and predicted that one in every 100 participants would have died, had they been treated with conventional care.
- A study comparing care received at retail clinics and delivered by nurse practitioners for three acute conditions – ear infections, pharyngitis (sore throat) and urinary tract infection (UTI) – with that received at other care settings found that overall costs of care were substantially lower at retail clinics, with no adverse effects on quality of care.
- A study published in *Health Affairs* in March 2011 found that multidisciplinary teams headed by nurse practitioners were able to sharply reduce hospitalizations among elderly patients and the physically and mentally disabled. Using this model, monthly medical costs for disabled patients were $3,061.00 in 2008 compared with $5,210.00 for Medicaid fee-for-service patients.
- These studies are further reinforced by key healthcare stakeholders who are taking steps to uphold and promote the valuable services available by a broad spectrum of healthcare professionals.

Among recent developments:

- In January 2011, a California judge declared that CRNAs no longer require physician supervision to provide care. The court's final order found that

CAC *News & Views* is published quarterly by the

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there were no safety risks to patients, citing evidence from two national anesthesia studies confirming the safety and cost-effectiveness of nurse anesthetists.

The Robert Wood Johnson Foundation's (RWJF) Initiative on the Future of Nursing has challenged state policymakers to reform scope of practice regulations, which limit the role of health professionals other than MDs or DOs. The report recommends that the Federal Trade Commission and the Department of Justice review state regulations pertaining to advanced practice registered nurses to identify ones with anti-competitive effects without improving public health and safety. RWJF has also recommended that the Centers for Medicare and Medicaid Services support the development of alternative payment and delivery models to reduce cost and expand the role of nurses.

See the complete press release at: http://www.patientsrightscoalition.org/Media-Resources/News-Releases/Key-to-Cost-Effective-Care.aspx.

California Pulls Controversial Dietician Licensure Bill

Originally scheduled to be heard on May 3, 2001, AB 575 was pulled from consideration. As explained online by *Around the Capitol*, (http://www.aroundthecapitol.com/Bills/AB_575/20112012/). AB 575 would do the following:

Existing law provides that any person representing himself or herself as a registered dietitian or dietetic technician shall meet specified requirements and qualifications.

This bill would repeal these provisions and enact new provisions providing for the licensing and regulation of registered dietitians by the Dietitians Bureau in the Department of Consumer Affairs, which the bill would create. The bill would specify the qualifications required for registered dietitians and their scope of practice. The bill would specify the qualifications and required supervision for dietetic technicians, registered. The bill would create an advisory committee within the bureau, with 5 members appointed by the Director of Consumer Affairs and the Legislature. The bill would authorize the bureau to impose licensing fees, which would be deposited in the Dietitian Licensing Fund, which the bill would create, and would continuously appropriate those revenues to the bureau. The bill would authorize the bureau to enforce these provisions and would enact other related provisions. The bill would provide that a violation of these provisions is a misdemeanor. By creating a new crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Similar bills are being introduced in other states with the backing of the American Dietetic Association. The legislation is opposed by nutritionists who claim it would create a monopoly for dieticians and put nutritionists out of business.

Center for the Health Professions Releases New Workforce Study

April 1, 2011. The Center for the Health Professions at the University of California, San Francisco announced a new case study in its Innovative Workforce Models of Health Care series. Written by Lisel Blash, Susan

Chapman, and Catherine Dower, the case study examines medical assistant teams at University of Utah community clinics.

> CASE STUDY: The University of Utah Community Clinics' success in achieving a remarkable financial turnaround empowered the organization to innovate further in order to improve the patient experience. The organization implemented a team-based model of care that increased the ratio of medical assistants (MAs) per provider to 5:2 and expanded MA roles, further enhancing the organization's clinical and financial outcomes, and improving staff, provider, and patient satisfaction.

More information is available at:

http://www.futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=University_of_Utah%20Community%20Clinics%20-%20Medical%20Assistant%20Teams%20Enhance%20Patient-Centered,%20Physician-Efficient%20Care

Professional Associations Back Interprofessional Education

Two new reports released May 10, 2011, by six national health professions associations and three private foundations recommend new competencies for interprofessional education in the health professions, and action strategies to implement them in institutions across the country. By establishing these competencies, the proponents believe our nation's health care system can be transformed to provide collaborative, high-quality, and cost-effective care to better serve every patient.

The first report, *Core Competencies for Interprofessional Collaborative Practice*, was produced by an expert panel convened in 2009 by the Interprofessional Education Collaborative (IPEC), a unique partnership of six associations – the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the Association of Schools of Public Health. Interprofessional education, as defined by the World Health Organization, involves shared learning among students from two or more health professions. (See http://www.aamc.org/download/186750/data/core_competencies.pdf).

Overall, the panel recommends that future health professionals be able to:

- Assert values and ethics of interprofessional practice by placing the interests, dignity, and respect of patients at the center of health care delivery, and embracing the cultural diversity and differences of health care teams.
- Leverage the unique roles and responsibilities of interprofessional partners to appropriately assess and address the health care needs of patients and populations served.
- Communicate with patients, families, communities, and other health professionals in support of a team approach to preventing disease and disability, maintaining health, and treating disease.
- Perform effectively in various team roles to deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

The second report, *Team-Based Competencies, Building a Shared Foundation for Education and Clinical Practice*, was the result of a conference, sponsored by the Health Resources and Services Administration, the Josiah Macy, Jr. Foundation, the Robert Wood Johnson Foundation, and the ABIM Foundation in partnership with IPEC. The meeting, held in

February 2011, brought together more than 80 leaders from various health professions to preview the core competencies presented by IPEC, and create action strategies that would use them to "transform health professional education and health care delivery in the United States." (See http://www.aamc.org/download/186752/data/team-based_competencies.pdf).

Conference participants developed the following action strategies to implement the IPEC core competencies and move to a system of educating health professionals to work collaboratively:

1) Communicate and disseminate the core competencies to key stakeholders – academic deans, policymakers, and health care leaders – and launch an education campaign that makes the critical link between collaborative health care teams and providing high-quality, safe, and cost-sensitive treatment.
2) Prepare faculty for teaching students how to work effectively as part of a team and encourage all health professions to use the competencies in their fields.
3) Develop metrics for interprofessional education and collaborative care to help advance team-based competencies in teaching and practice.
4) Forge partnerships among the academic community, health care providers, and government agencies to advance interprofessional education.

The Interprofessional Education Collaborative and the foundations believe that establishing these core competencies for health professionals will provide the valuable transformative direction needed to improve the nation's health care system.

Massachusetts Medical Society Testifies Against Scope of Practice Expansions

Editorial Note: On April 12, 2011, The Massachusetts Medical Society (MMS) announced its testimony against eight bills that would expand the scope of practice of health care professionals and a ninth that would license naturopaths. Excerpts from the MMS press release appear below. The full release can be found at: http://www.massmed.org/AM/Template.cfm?Section=News_and_Publications2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=52759.

The Massachusetts Medical Society (MMS) today provided testimony to the legislature's Joint Committee on Public Health in opposition to nine bills, one that would license naturopaths and eight that would expand the scope of services of other professional groups. The Society's opposition is based on its belief that, should these bills be enacted, diminished patient safety for Massachusetts residents could result.

House 2367 – An Act to Create a Board of Registration in Naturopathy

Saying that naturopathy is "a hodge-podge of nutritional advice, home remedies, and discredited treatments," the MMS opposes a bill that would make naturopathic doctors licensed health care providers in the Commonwealth.

It listed two reasons why the state should deny licensure: (1) that licensure is interpreted by the public as an endorsement of the field, and (2) a self-regulating profession determines its own standards of practice…

Urging the Committee to reject the bill "as other thoughtful legislators have done

for the past 15 years," MMS said "there simply cannot be one standard of care for one group purporting to be doctors engaged in diagnosis and treatment of human beings and a different standard for legitimate physicians, nurse practitioners, and physician assistants. There must be a single standard, and in health care it must be based on rational decision-making informed by science and clinical research."

House 1476 and Senate 1145 – Acts Relative to the Registration of Podiatrists

These are identical bills that would extend the scope of practice of podiatry beyond the diagnosis and treatment of the foot to include the ankle and the leg below the knee. The MMS said "this is an unfortunate example of non-physicians seeking to practice medicine without having to undergo the educational and training requirements demanded of all medical doctors or orthopedic surgeons."

"Podiatrists are not medical school graduates nor are they licensed by the Board of Registration in Medicine," the Society said. "They have a completely different educational process, postgraduate training and licensing system from medical doctors."…

House 2348, House 2357, and House 3163, Acts relative to optometric patient care

These bills would expand the practice of optometrists by allowing them to prescribe oral therapeutic medications. MMS opposes these bills because there is sufficient access to ophthalmologists to treat any eye disease and that optometrists are seeking to expand their business at the expense of their patients.

Stating that "Doctors of optometry are not medical doctors" and that "optometry is a different profession from the treatment of disease," MMS said it strongly believes the legislature has a responsibility to protect the public from allied health professionals who "seek to unnecessarily expand their scope of practice without a corresponding increase in education and training requirements." It asked the Committee on Public Health to "seriously consider the potential harm to individual patients, the lowering of quality standards for essential vision care and the limited ability of the optometry board or the courts to protect patients harmed by being subjected to the lower standards of care of optometrists."

House 2369 – An Act Relative to Enhancing the Practice of Nurse Midwives

The Medical Society opposes this bill because it repeals the existing legal structure for nurse midwifery as practiced in Massachusetts for decades and "severs the connection between nurse midwives and obstetrician gynecologists and eliminates a requirement to work with a hospital-based team."… "If the decision were to be made for the best interest of children," the Society concluded in its testimony, "the decision would be clearly not to support legislation designed to eliminate or minimize physician participation in obstetrics."

House 1520, An Act Encouraging Nurse Practitioners and Physician Assistants of Primary Care and House 1477, An Act to Streamline Health Care Services by Allowing Nurse Practitioners to Verify Medical Papers and Records

The bills seek to eliminate the word "physician" from current state statutes and instead use the term "provider," raising the issue of the statutory role of physicians in patient care. While it would eliminate the word 'physician'

from statutes, the bill offers a nebulous definition of primary care provider to the public health laws of the Commonwealth. The bills also would strike out the current law requiring that the name of a supervising physician be listed on prescriptions of physician assistants, and that "when a provision of the law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, when related to physical or mental health, that requirement may be fulfilled by a nurse practitioner."

"This section replacing all requirements for a physician signature is indefensible," the Medical Society said, "unwarranted and a threat to the public." The Society also noted that the bills call for the term "provider" to be placed through the insurance laws as replacements for "physicians."

Saying that "no legislation before you today undermines the quality of our health care system and patients' rights more than H 1520," MMS asked the legislature to consider the potential value and harm in this legislation. "As it stands now," MMS said, "nurse practitioners and physician assistants have a valuable and growing role in health care. Insurers, hospitals, and other entities hire them, pay them well, and fully utilize their talents. What possible reason is there to pass this legislation other than the desire of some "providers" to increase their bargaining power with a wide variety of insurers and public payers?"

The complete testimony of the Medical Society is available at http://www.massmed.org/testimony.

Acupuncturists Claim Exclusive Authority to Use Dry Needling

The following position statement was issued by the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM):

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

Rationale

A recent trend in the expansion in the scopes of practice of western trained health professionals to include "dry needling" has resulted in redefining acupuncture and re-framing acupuncture techniques in western biomedical language. Advancement and integration of medical technique across professions is a recognized progression. However, the aspirations of one profession should not be used to redefine another established profession.

In addition proponents of "dry needling" by non-acupuncture professionals are attempting to expand trigger point dry needling to any systemic treatment using acupuncture needles and whole body treatment that includes dry needling by using western anatomical nomenclature to describe these techniques. It is the position of the CCAOM that these treatment techniques are the *de facto* practice of acupuncture, not just the adoption of a technique of treatment.

Terminology

The invasive procedure of dry needling has been used synonymously with the following terms:

- Trigger Point Dry Needling
- Manual Trigger Point Therapy, when using dry needling
- Intramuscular Dry Needling
- Intramuscular Manual Therapy, when using dry needling
- Intramuscular Stimulation, when using dry needling

History

…Today over 50 accredited professional colleges teach a diversity of styles of health care utilizing acupuncture, Chinese herbology, manual techniques such as tuina (Chinese therapeutic massage), nutrition, and exercise/breathing therapy. Individuals who attain this degree undergo a rigorous training program at a minimum standard of three academic years that contains 450 hours in biomedical science (biology, anatomy, physiology, western pathology, and pharmacology), 90 hours in patient counseling and practice management, and 1365 hours in acupuncture. Of the 1365 hours in acupuncture, 660 hours must be clinical hours.

Acupuncture is a system of medicine that utilizes needles to achieve therapeutic effect. The language used to describe and understand this effect is not limited and is articulated in both traditional and modern scientific terms. The National Institutes of Health has recognized the efficacy of acupuncture in its consensus statement of 1997 and continued funding of research. It is clear that other professions such as physical therapy and others also recognize the efficacy of acupuncture and its various representations such as dry needling due to the fact that they are attempting to use acupuncture and rename it as a physical therapy technique…

Documented practice of "dry needling" by acupuncturists

The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for acupuncture, completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of dry needling techniques, i.e. the treatment of trigger points or motor points with acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients that presented with pain. Of the patients that present for acupuncture treatment, it is estimated that 56% present with trigger point pain. The others present for non-pain conditions such as non-trigger point pain, digestives disorders, infertility and many other conditions. The other 18% of acupuncturists used acupuncture needling techniques in non-trigger point locations. These findings document that acupuncturists are well trained to use and have consistent historical usage of trigger and motor point "dry needling" treatment. Dry needling represents a substantial daily practice among American acupuncturists…

In 2009, a physical therapist submitted a complaint to the Maryland Board of Acupuncture concerning the use of the term dry needling in chart notes by an acupuncturist. The Maryland Board of Acupuncture correctly dismissed the complaint because the procedure was done by a licensed acupuncturist trained in the use of dry needling, *i.e.*, acupuncture.

In filing the complaint, the physical therapist was not asserting that the acupuncturist caused any harm or potential of harm to the patient. Rather, the physical therapist asserted that the acupuncturist used proprietary language that was unique to physical therapy, when in fact the acupuncturist was using language that was common across professions. The Little Hoover Commission, in its 2004 report to the California legislature concluded, "Interactions with other health care providers, including collaboration and referrals, as well as with many members of the public, benefit from the use of common, Western-based diagnostic terminology"

Summary Position of the CCAOM on Dry Needling

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

It is the position of the CCAOM that any intervention utilizing dry needling beyond trigger point dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique. (Emphasis provided).

The full statement can be found at: http://www.acupuncturetoday.com/mpacms/at/article.php?id=32377.

UK Redefines Scope of Practice for Physiotherapists

The Chartered Society of Physiotherapy issued the following open letter based on a Council decision in December, 2010. Note that it establishes an open-ended authority for physiotherapists "…to consider that any reasonable practice could be included within the scope of the profession. This means that where there is benefit to the patient, a body of evidence to support the practice and the individual is competent to carry out the treatment procedure or method, then the CSP will support the activity as being within scope of practice."

Dear Members,

We wish to draw your attention to the recent Council endorsement of a new CSP approach to the interpretation of the definition of the scope of physiotherapy practice. The profession's scope of practice is defined by the royal charter, granted to the Society in 1922, which sets out the four pillars of physiotherapy practice as: massage, exercise and movement, electrotherapy and kindred methods of treatment.

This definition remains unchanged. However, the fourth pillar has been explored thoroughly by the professional practice committee, which recommends a new approach to the interpretation of 'kindred methods of treatment.'

We specifically ask that you consider the implications for your personal professional practice. It is hoped that the new emphasis will support members by facilitating new and innovative practice to be explored safely by chartered physiotherapists.

Council agreed that the scope of practice of physiotherapy should now be defined as. "Any activity undertaken by an individual physiotherapist that may be situated within the four pillars of physiotherapy and that the individual is educated, trained and competent to perform. Such activities should be linked to existing or emerging occupational and/or practice frameworks acknowledged by the profession."

So what does this mean for you?

The first three pillars are straight-forward to interpret. The fourth pillar should now support an individual to consider that any reasonable practice could be included within the scope of the profession. This means that where there is benefit to the patient, a body of evidence to support the practice and the individual is competent to carry out the treatment procedure or method, then the CSP will support the activity as being within scope of practice.

This will allow the CSP to support individual physiotherapists who wish to develop their practice and apply their skills in new roles, while retaining the philosophical basis of physiotherapy that is defined within the royal charter, the curriculum framework and the World Confederation for Physical Therapy definition of physiotherapy.

The PPC will be the final arbiter on scope of practice issues if a formal challenge is received about the nature of physiotherapy. Provided there is substantive evidence of an individual's competence to undertake the role/activity in question and the activity can be shown to be linked in some way to the four pillars of practice, the individual would be covered by their professional liability insurance as working within the scope of the profession.

We would encourage all members to read the new briefing paper, which sets out the detail of this change, and where a clear decision-making pathway is available to assist members, the CSP and the Health Professions Council in determining whether a given or proposed activity is within the scope of practice of the profession and/or the individual.

Ontario Gives Optometrists Prescriptive Authority

The Ontario Association of Optometrists issued the following press release when the Province authorized prescriptive authority:

New Regulations Give Ontarians Better Access to Eye Care

Wednesday April 6, 2011, Toronto, ON

The Ontario Government approved a regulation today that allows Ontario's optometrists to start prescribing medications for their patients. Optometrists will now be able to prescribe treatments for conditions ranging from routine bacterial eye infections to more serious diseases including glaucoma. The change will alleviate wait times in emergency rooms and walk-in clinics for patients with eye-related problems.

"This is great news for our patients and everyone in Ontario," notes Dr. John Mastronardi of Windsor, President of the Ontario Association of Optometrists (OAO). "Most of our members have been educated and trained to prescribe medications for years. We are pleased that the Ontario government has made changes that will broaden access to medically necessary services across the province."

While Ontario is one of the last provinces to enact this regulation, the new regulation has the widest scope in Canada and brings about the most benefits to patients. For patient Jason Secord of Acton, he applauds the decision. "A few years ago, I almost lost the vision in my right eye because of a condition called iritis. I went to my optometrist and he knew what was wrong but he couldn't prescribe the drops that I needed. Now if I ever have a problem again, I can go to my optometrist right away without putting my eye health at risk by waiting to see three different doctors for treatment."

Today's decision by the Ontario government means better healthcare and shorter wait times for patients while reducing costs for taxpayers.

The Executive Director of the Canadian National Institute for the Blind (CNIB) Ontario, Paul Ting, also applauded the news. "This will make great strides in the treatment of all eye care," says Ting. "Seventy five percent of vision loss is preventable or treatable. Preventing blindness is an urgent challenge with an aging population, and this will drastically improve access to clinical care."

Optometrists are eye doctors who are university educated and clinically trained to diagnose and treat disorders of the eye and visual system. Optometrists complete a four year professional doctorate degree program and are regulated by the College of Optometrists of Ontario.

For more information: Jim Warren 416-505-4773 jimwarren@riseley.ca.

Ontario Nurses Expand Scope

The government of Ontario has removed restrictions on the scope of practice of nurse practitioners. New regulations will allow nurse practitioners to admit and discharge patients from hospitals, to prescribe some types of medications, order diagnostic tests, and other new services.

PUBLIC MEMBER

Public Member of Missouri Board is Malpractice Defense Attorney

According to an article in the December 14, 2011, *St. Louis Post Dispatch* (http://www.stltoday.com/lifestyles/health-med-fit/fitness/article_f64e5713-5f13-509e-9364-eb59402a09b3.html), the sole public member of the Missouri Board of Registration for the Healing Arts is an attorney who specializes in defending doctors in malpractice cases. Appointed by Governor Jay Nixon in July 2009, Kevin O'Malley serves of the board's Licensure Committee, according to the board's Web site.

O'Malley lists representative cases in his online biography. Under the category "Medical Negligence Defense" in his online biography, O'Malley says:

> Defended physicians and physician groups of almost every medical specialty and hospitals in the state courts of Missouri. Cases tried to jury verdict in the areas of anesthesiology, obstetrics, gynecology, otolaryngology, orthopedic surgery, cardiovascular surgery, radiology, pulmonology, pathology, and others.
>
> The biography also boasts: "He is continuously selected for inclusion by the editors of "The Best Lawyers in America" for his work in three categories: medical negligence defense, white collar criminal defense, and personal injury litigation."
>
> The board's Web site has a link titled "Public Member Report." The most recent entry on this page is in 2008, prior to O'Malley's appointment. Apparently, he has not issued any reports since becoming the public member.

Editorial Note: O'Malley's career and credentials clearly disqualify him for the public member position. Section 33334.120.2 of the enabling statute says this about the public member:

> The public member shall be at the time of his or her appointment a citizen of the United States; a resident of this state for a period of one year and a registered voter; a person who is not and never was a member of any profession licensed or regulated pursuant to this chapter or the spouse of such person; and a person **who does not have and never has had a material, financial interest in either the providing of the professional services regulated by this chapter, or an activity or organization directly related to any profession licensed or regulated pursuant to this chapter.** All members, including public members, shall be chosen from lists submitted by the director of the division of professional registration. The duties of the public member shall not include the determination of the technical requirements to be met for licensure or whether any person meets such technical requirements or of the technical competence or technical judgment of a licensee or a candidate for licensure. (Emphasis added).

QUALITY OF CARE

Quality Measurement Still Immature

Kenneth Kizer, founder of the National Quality Forum, which develops methodologies for health care providers to measure the quality of care, believes the tools for measuring quality are far from fully developed. In a telephone interview on April 29, 2011, with Cheryl Clark, reporter for *HealthLeadersMedia*, Kizer commented on the state of quality measurement.

The timing of the interview coincided with the release of the Obama Administration's final rules for Value-Based Purchasing, which draw heavily of quality measurements developed or endorsed by NQF. In her May 5, 2011 report based on the interview, Clark quotes Kizer:

> Now everyone is talking about measuring quality… But that wasn't how it was 11 or 12 years ago when I started NQF. No one really wanted to engage in measurement. Now, it's in a different place, but it clearly is not being used as much as it should be. There are many areas of medicine where there simply are no measures – or there are, but they aren't as good as they should be… This is a very young and immature science, and that statement's probably more significantly true for outcome measures than for process measures.
>
> We have to remember that the healthcare that hospitals and doctors provide is only a small piece of what makes people healthy, perhaps only 10%... There are a lot of other things that we should be looking at.

These other variables have to do with family, food, diet, environment, education, lifestyle, etc., where measurement tools are just beginning to be developed.

Like many other health care experts, Kizer told Clark that the way to deal with the 90% of healthcare quality that is not direct medical care is through health care teams that provide personalized education and follow-up related to such things as compliance with medication regimens, diet, and lifestyle.

Kizer says he's happy that hospital care is finally being measured in a meaningful way, though he realizes that many providers think the science isn't quite there yet. Still, he believes the most important revelations about quality of care are still to come.

He says quality measurement will become more sophisticated as it is used in the field. "Because once it is used in the real world, you find out all the little nuances; the real world situations that may not have been thought about when it was being designed."

Editorial Note: As quality measurement plays a more prominent role in healthcare delivery and reimbursement, professional licensing boards and licensing board associations would do well to think about the implications for their work, currently and in the future. For example, what can regulatory boards do to promote team practice? What are the implications of the growing emphasis on preventive medicine and modifications in lifestyle for health professional education, testing and continuing professional development?

Cheryl Clark's article can be found at: http://www.healthleadersmedia.com/print/QUA-265810/NQF-Founder-Quality-Measure-Science-Still-Immature

CONTINUING PROFESSIONAL DEVELOPMENT

ABMS Surveys Consumers about Value of Certification and Re-Certification

The American Board of Medical Specialties (ABMS) commissioned a consumer survey, which was conducted in December 2010 by Opinion Research Corporation. One thousand consumers were asked about their knowledge of doctors' qualifications and the importance of Board Certification and Maintenance of Certification as factors in selecting a physician.

Consumers were asked how important it is that their physician(s) participate in a maintenance of competence (MOC) program (defined as: "a process by which doctors who are Board Certified continue to participate in a continuous process of lifelong learning and self-assessment in their specialties"). The responses were:

- 95% say it is "important," with 66% saying it is "very important."
- 84% would do one of the following if they learned their physician does not participate in the MOC program:
    - 59% would ask their doctor why he or she chose not to participate
    - 56% would try to learn more about the MOC program
    - 45% would look for a new doctor
    - 41% would stop referring the doctor to family and friends

When it was explained that physicians who were certified before 1990 are not required to participate in the MOC program, 78% of the respondents (83% of women and 72% of men) said they would be bothered if their doctor opted out of the MOC program.

Respondents were asked to evaluate the importance of six aspects of the MOC program. Ninety percent said they are all "important." The following percentages of respondents said a factor is "very important:"

- testing at regular intervals to assess a doctor's medical knowledge (60%)
- providing quality of care information to patients/the public (54%)
- periodically assessing the doctor's clinical performance and quality of care to see how he or she compares with others who offer the same types of services (51%)
- participating in self-assessment activities to determine how the doctor is doing (51%)
- conducting surveys among doctors, nurses and other health care professionals who work with the doctor (48%)
- surveys of patients to assess the doctor's communication skills (47%).

The top six factors in choosing a doctor ("somewhat important" or "very important") are:

- bedside manner or communication skills (95%)
- board certification (91%)
- recommendation of a friend or family member (83%)
- location of the office (80%)
- hospital affiliation (76%)
- the school of hospital where the doctor trained (62%).

For more information, visit www.abms.org**.**

PAIN MANAGEMENT AND END OF LIFE CARE

Washington State Adopts New Pain Management Rules

Effective January 2, 2012, physicians and physician assistants in Washington State will follow new rules for management of non-cancer pain. [WAC 246-919-850 through 246-919-863 (physicians) and WAC 246-918-800 through WAC 246-918-813 (physician assistants)]

The statement of intent for the new rules reads in part:

> These rules govern the use of opioids in the treatment of patients for chronic non-cancer pain.
>
> The Washington State Medical Quality Assurance Commission (commission) recognizes that principles of quality medical practice dictate that the people of the state of Washington have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this rule, the inappropriate treatment of pain includes non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments.
>
> The diagnosis and treatment of pain is integral to the practice of medicine. The commission encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this rule has been developed to clarify the commission's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.
>
> Inappropriate pain treatment may result from a physician's lack of knowledge about pain management. Fears of investigation or sanction by federal, state, and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. **As such, the commission will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis…** (Emphasis added.)
>
> (T)he commission expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.
>
> Physicians should not fear disciplinary action from the commission for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice…
>
> **The commission will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including**

physical, psychological, social, and work-related factors.

These rules are designed to assist practitioners in providing appropriate medical care for patients. They are not inflexible rules or rigid practice requirements and are not intended, nor should they be used, to establish a legal standard of care outside the context of the medical quality assurance committee's jurisdiction…

…A conscientious practitioner may responsibly adopt a course of action different from that set forth in the rules when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology subsequent to publication of these rules. However, a practitioner who employs an approach substantially different from these rules is advised to document in the patient record information sufficient to justify the approach taken… The sole purpose of these rules is to assist practitioners in following a reasonable course of action based on current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care.

Massachusetts Pharmacists Given Limited Prescriptive Authority

Editorial Note: On March 11, 2011, the American Pharmacists Association reported that the Drug Enforcement Agency has issued prescriber numbers to some Massachusetts pharmacists. The release said, in part:

Pharmacists working in institutions under signed Collaborative Drug Therapy Management (CDTM) agreements in Massachusetts can now prescribe controlled substances once they have registered with DEA…

Pharmacists register with DEA as midlevel practitioners, meaning they must have a supervising physician to practice. Nurse practitioners and physician assistants also fall into the midlevel practitioner category, (a spokesperson) said. The DEA registration number is limited to pharmacists practicing in an institution.

DEA has granted registrations to pharmacists in six other states. (a spokesperson) said these are California, Montana, New Mexico, North Carolina, North Dakota, and Washington…

One practical result of the DEA decision is that pharmacists who work in pain clinics within an institution in Massachusetts can now write prescriptions for controlled substances.

"Pharmacists could meet with the patient and adjust the pain regimen," Johnson said. "The pharmacist would be able to write the prescription and the patient would be able to have it filled in a timely manner. Under the current system, patients may meet with pharmacists for medication therapy management and the pharmacists may make recommendations to the physician but there may be a significant lapse in time before the suggestion is acted upon."…

According to a Massachusetts College of Pharmacy and Health Sciences press release issued the day after CDTM was signed into law, the law permits pharmacists in Massachusetts to do the following:

- Refills for up to a 30-day supply
- Administer all immunizations to adults (18 years or older)
- In an institutional setting, participate in the selection of therapies for patients

(See http://www.mcphs.edu/news_and_events/press_releases/2009/2009.01.16.gov_patrick_signs_drug_therapy_bill.html).

…Including Massachusetts, 46 states have CDTM. Of the remaining four states without CDTM, New York has a bill under consideration this session, and Maine may take action this year. Oklahoma considered the concept in 2010 and will revisit it in the future. Alabama doesn't have a bill in this session yet, Rebecca P. Snead, BPharm, Executive Vice President and CEO, National Alliance of State Pharmacy Associations, told pharmacist.com.

CDTM is not the only situation in the United States in which pharmacists can prescribe. In Florida, pharmacists can prescribe certain medicinal drugs, (a spokesperson) said. In the U.S. Department of Veterans Affairs (VA) health system, pharmacists with specific advanced training can prescribe. "The success of the VA pharmacists was the impetus for CDTM laws in the various states," he said…

The full release can be found at: http://www.pharmacist.com/AM/Template.cfm?Section=Home2&CONTENTID=25693&TEMPLATE=/CM/HTMLDisplay.cfm

Nurses Identify Underutilized End of Life Care Skills

The following article appeared in the May 2011 issue of the Agency for Healthcare Research and Quality monthly newsletter (http://www.ahrq.gov/research/may11/0511RA5.htm***):***

Nurse survey identifies important but underused end-of-life care skills

Improving end-of-life care has become a major goal of the health care community. Compared with other health care providers, nurses often have the most contact with patients and their families at the end of life. Thus, it is important for nurses to be skilled in end-of-life care. In a survey, nurses identified 19 extremely important end-of-life care skills as being underutilized.

Researchers from the University of Washington and the Medical University of South Carolina questioned 717 nurses in 4 States to determine the specific end-of-life skills that practicing nurses consider important, but that are currently underutilized. Their survey was adapted from the Quality of End-of-life Care Questionnaire, which was designed for patients, families, and nurses to measure physician skill at end-of-life care. The 45-item survey included 5 areas: communications skills, technical skills, affective skills, patient-centered values, and patient-centered care systems. The highest number of skills identified as extremely important and underutilized came from the areas of communications skills and patient-centered care systems. To be extremely important, an item had to be endorsed by 60 percent or more of the respondents; to be considered underutilized, no more than 25 percent of respondents could say that the skill was "already practiced."

Nurses' professional characteristics (such as practice setting, years of professional experience, and amount of continuing education) were significantly associated with importance ratings on eight under-utilized skills, including "being comfortable with people who are dying," "not blaming or being judgmental about lifestyles," and "telling patients how their illness may affect their life." For example, nurses with the most professional experience were significantly more likely to report "being comfortable with dying patients" as an underutilized skill.

The researchers suggest that the skills identified as underutilized could serve as a template to develop targeted curricula. These skills focus on communications, symptom management, and patient-centered care systems. Once the curricula are developed, they could then be taught to practicing nurses within the context of the setting and the patient population they serve. This study was supported in part by the Agency for Healthcare Research and Quality (HS 11425).

See "Nurses' identification of important yet under-utilized end-of-life care skills for patients with life-limiting or terminal illnesses," by Lynn F. Reinke, Ph.D., Sarah E. Shannon, Ph.D., R.N., Ruth Engelberg, Ph.D., and others in the *Journal of Palliative Medicine* 13(6), pp. 753-759, 2010.

Pain Care Coalition Issues Statement on Control of Abuse

The Pain Care Coalition, composed of the American Academy of Pain Medicine, the American Headache Society, American Pain Society and the American Society of Anesthesiologists issued the following statement on abuse and diversion of controlled substances:

> The Pain Care Coalition applauds efforts by Federal policy makers to address the misuse of prescription painkillers, particularly opioids regulated under the Controlled Substances Act. Abuse and diversion of these powerful drugs are serious public health problems with potentially tragic consequences for individuals, their families and their communities. The problem has escalated rapidly in recent years, particularly among young people, and has now reached epidemic proportions in some parts of the country. Aggressive action is required, and required now. Cooperation between and among stakeholders in the public and private sectors, and at the Federal, state and local level, will be essential to turn the tide. The health care professionals represented in the Pain Care Coalition are committed to playing a leadership role in the search for and implementation of responsible solutions.
>
> At the same time, the fight against abuse and diversion must preserve access by clinicians and patients to these drugs for those who need them. Opioids are just one therapeutic option for individuals afflicted with acute or chronic pain. They are not appropriate for all patients or all pain disorders, and thus require careful and experienced clinical judgment on a patient-by-patient basis. But for millions of Americans, they are an appropriate option, when appropriately used under clinical supervision, to restore function and quality of life. Indeed, for many, they are the only currently effective therapeutic option. Thus, it is vitally important that the fight against opioid abuse be balanced with the continuing fight for effective pain management.
>
> Pain is a huge public health problem in the United States. The Centers for Disease Control estimates that 76 million people are afflicted every year--more Americans than are affected by diabetes, heart disease and cancer combined. Given the prevalence of pain, and the terrible suffering of patients when pain is not effectively treated, it is simply not responsible public policy to take effective therapies "off the table."
>
> The causes of prescription drug misuse are complex, and finding solutions will demand multidimensional approaches. The Pain Care Coalition believes that the following elements must be included in a comprehensive response if that response

is to have a reasonable prospect for success:

- A concerted campaign of public education emphasizing both responsible pain management and the dangers of abusing painkillers for non-medical purposes;
- Improved understanding and enhanced prescribing practices for prescribers, dispensers, and other caregivers;
- An effective national system of prescription monitoring for controlled substances;
- Increased biomedical research for alternative non-opioid therapies and behavioral research on substance abuse and addiction;
- Payment and coverage polices that facilitate access, without biasing clinical decision-making towards particular therapeutic options based solely on cost rather than long term benefit;
- New approaches to safe drug disposal; and
- Aggressive enforcement of existing laws…

For more information, visit: http://www.ampainsoc.org/advocacy/statements.htm**.**

CONSUMER INFORMATION

Washington State Enacts Transparency Law

In April, 2011, Washington's Governor Christine Gregoire signed legislation (SHB 1493) which requires state licensing boards to:

1) Allow a complainant in a disciplinary proceeding under the uniform disciplinary act to supplement or amend the contents of his or her complaint or report;
2) Promptly respond to inquiries regarding the status of the complaint or report;
3) Provide a complainant or license holder with the file relating to the complaint; and
4) Inform the complainant on the final disposition of the complaint.

Suzanne Henry, policy analyst for Consumer Union's Safe Patient Project (www.safepatientproject.org), which advocated for the legislation, said this about its passage:

> Unfortunately medical boards in most states don't do a good job when it comes to responding to complaints and keeping patients informed about their investigations. This new law gives patients a better opportunity to have their complaints taken seriously and could serve as a model for other states looking to hold doctors accountable when they fail to maintain high standards for patient care.

New Study Available About Information Release by Licensing Boards

The Southern Public Administration Education Foundation, Inc. Journal of Health and Human Services Administration (Vol. 33 No. 4) contains a report by Denise E. Strong entitled, Access To Enforcement and Disciplinary Data: Information Practices of State Health Professional Regulatory Boards of Dentistry, Medicine and Nursing. The article's abstract explains:

> This article describes a study of public access to enforcement and disciplinary information provided by the websites of health professional regulatory boards. The study explored the current state of

transparency by specifically examining the availability of disciplinary data on the websites of state boards of medicine, nursing and dentistry. Web sites were reviewed regarding availability of enforcement and disciplinary data on the aforementioned state boards in each of the 50 states and the District of Columbia. The study found that there is more information about individual practitioners available from the boards than ever before. On the other hand, there has not been a comparable increase in information about the administrative practices and the work of the boards. Increased availability of this information would allow public administration and policy researchers to develop performance indicators of state boards and assist in improving policy decisions and allocation of resources.

For more information, visit:
http://www.spaef.com/article.php?id=1245

Nursing Homes Respond to Public Report Cards

Research sponsored by the Agency for Healthcare Research and Quality (AHRQ) shows that the Nursing Home Compare Web Site maintained by the Centers for Medicare and Medicaid Services (CMS) has led to a shift in nursing home expenditures from "hotel" expenses (plant operations, housekeeping, laundry, etc.) to clinical related- improvements.

(AHRQ Publication No. 11-R00l)

LICENSURE

Kentucky Licenses Diabetes Counselors

The American Association of Diabetes Educators commended the state of Kentucky on March 16, 2011 for becoming the first state to license diabetes educators:

Kentucky Governor Steve Beshear signed a bill today that requires a license to practice diabetes education, a move that the American Association of Diabetes Educators (AADE) says will enhance consumer protection and increase professional recognition.

"Ultimately, we think that this law will make it easier for people with diabetes to get the information they need to effectively manage their disease," said Martha Rinker, AADE's Chief Advocacy Officer. "Diabetes education has been proven to mitigate the severe complications that are associated with diabetes."

AADE is advocating for licensure in all 50 states, Rinker said. The Association believes that state licenses deliver and communicate a standard of care, and ensure that people have an appropriate comfort level and respect for the discipline.

Rinker added that Diabetes Educators Licensure is intended for the health care professional who has a defined role as a diabetes educator, not for those who may perform some diabetes-related functions as part of or in the course of other routine occupational duties.

All health care providers need sufficient diabetes knowledge to provide safe, competent care to persons with or at risk for diabetes. Licensure of the Diabetes Educator will provide minimum standards for patient safety and for recognition of the professional. And, this will address the current workforce shortage of qualified professionals who can deliver diabetes education, Rinker said.

While diabetes education is a covered benefit through Medicare and many private insurers, many people with diabetes are unfamiliar with how to

manage the disease and how to seek education.

Diabetes educators are highly skilled professionals integral to the multidisciplinary diabetes care team. They counsel patients on how to incorporate healthy eating and physical activity into their life. They also help patients understand how their medications work, teach them how to monitor their blood glucose to avoid the risk of complications, and give them the ability to problem solve and adjust emotionally to diabetes.

The role of the diabetes educator can be assumed by professionals from a variety of health disciplines, including, but not limited to: Registered nurses, registered dietitians, pharmacists, physicians, mental health professionals, podiatrists, optometrists, and exercise physiologists. Some services, such as nutrition counseling, medication counseling and psychological support services, however, may be provided in collaboration with a licensed dietitian, registered pharmacist, a licensed psychologist or social worker, or a psychiatric and mental health clinical nurse specialist or nurse practitioner.

Mastery of the knowledge and skills to be a diabetes educator is obtained through professional practice experience, continuing education, individual study, and mentorship. Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM).

Health Club Association Opposes Licensure

Editorial Note: It is typically the profession itself that seeks the enactment of licensure statutes, but this is not always the case. The International Health, Racquet and Sportsclub Association (IHRSA) opposes licensure for personal trainers, but supports certification. Bills have been re-introduced in Georgia and Texas to establish personal trainer licensing. A bill before the Massachusetts legislature would require certification by an organization accredited by the National Commission for Certifying Agencies or graduation from a recognized, accredited school. The following column appeared in the February 2010 industry journal, Club Business International, when similar legislation was under consideration. http://download.ihrsa.org/cbi/10feb.

Everyone has heard stories of people who, after only a few hours on the Internet and a credit card payment, become "certified personal trainers." Knowing that these types of trainers could erode the credibility of the growing industry – and, more importantly, lead to dangerous conditions for unassuming consumers – IHRSA and industry leaders began discussions in 2002 about how to best promote safety for consumers at health clubs.

Those discussions determined that the best option for the industry and the consumers it serves was the adoption of independent, nationally recognized accreditations for certifying organizations. So, beginning on January 1, 2006, the IHRSA Board of Directors recommended that "member clubs hire personal trainers holding at least one current certification from a certifying organization/agency that has begun third-party accreditation of its certification procedures and protocols from an independent, experienced, and nationally recognized accrediting body."

Given the 30-year history of the National Organization for Competency Assurance (NOCA) as an organization dedicated to establishing quality standards for certifying agencies, IHRSA identified the National Commission for Certifying Agencies (NCCA), the NOCA's accreditation body, as

being an acceptable accrediting organization of certifying agencies.

With regard to personal training-based educational programs, IHRSA acknowledges accrediting bodies that are recognized by the Council for Higher Education Accreditation and/or the United States Department of Education for the purposes of providing independent, third-party accreditation.

Despite the widespread acceptance of this recommendation within the industry, personal training has increasingly attracted the attention of legislators in recent years. "The bills we've seen ignore the major steps that the personal training industry has taken to use accreditation as a responsible means of self-regulation to ensure consumer safety," explains Amy Bantham, IHRSA's deputy vice president of government relations.

Just weeks after the IHRSA recommendation, legislators in Georgia introduced a Senate bill that sought to require trainers to obtain a license. Though the bill failed to move out of committee, it's worth noting that there was only one certifying agency that met the educational requirements of the bill. It was not accredited by the NCCA or the Distance Education and Training Council (DETC).

California, a state that's widely considered to be a bellwether in state legislation, took up the issue when Senators introduced a bill in early 2009. Although the educational requirements in the legislation were in line with industry practices, recognizing NCCA-accredited programs, IHRSA was concerned that the fines for non-compliance were overly burdensome for trainers. IHRSA worked with legislators and fitness professionals in the state, and the bill failed to move out of committee.

One of the most troublesome bills, to date, has been the New Jersey Fitness Professionals Certification Act. Originally introduced as a licensure bill in October 2008, it required curriculum for trainers and group exercise instructors that was currently only available at one organization, which did not have NCCA or DETC accreditation. IHRSA and the New Jersey Coalition of Fitness Professionals lobbied the bill's sponsor, who amended the bill with the inclusion of provisions to grant trainers with NCCA-accredited certifications a temporary pathway to state certification. Despite the changes, however, the bill was detrimental to New Jersey trainers and instructors. IHRSA organized a grassroots campaign that generated over 8,000 e-mails to legislators in opposition to the bill. At press time, the fate of the bill was still unknown.

As the number of personal trainers and the use of their services grow, IHRSA will continue to protect the interests of qualified personal trainers and work with legislators to ensure that any proposed requirements are consistent with industry practices and the Board of Directors' recommendations.

ACCESS TO CARE

Oregon Considers Cultural Competence Legislation

On April 25, 2011, the Oregon Senate passed legislation (SB 97) that would require the boards that license healthcare professionals to develop standards for training in cultural competence. The goal is to encourage (but not mandate) cultural competence in continuing education requirements for health care practitioners in the state.

According to an online article in OPB News (http://news.opb.org/article/oregon-senate-considers-bill-improve-health-care-system/), the Oregon Health Authority has been brainstorming ways to improve cultural competency in the health care system. This could mean having translators for medical appointments, tweaking how nurses explain disease to patients from non-Western cultures, or understanding the health needs of transgendered people.

Editorial Note: As of May 20, 2011, the bill was stalled in the House. In a party line vote, Republicans insisted on more information about the cost of implementation, while the Democrats argued the budgetary impact would be minimal.

The legislation can be found at: http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0097.intro.pdf**.**

DISCIPLINE

Public Citizen Petitions HHS Over Hospital Reporting

Editorial Note: Public Citizen's Health Research Group wrote to HHS Secretary Sebelius on March 14, 2011 transmitting a report showing that fewer than 50% of adverse actions by hospitals against physicians subsequently result in disciplinary action by a licensing board. Excerpts from the letter appear below. The report can be found at: http://www.citizen.org/hrg1937**.**

> March 15, 2011
>
> Dear Secretary Sebelius:
>
> Attached is a Public Citizen report being published today, which found that 5,887 physicians who have one or more clinical privilege reports in the National Practitioner Data Bank (NPDB) – the majority of physicians with such clinical privilege reports – have never had any state medical board action. State medical board licensure action against a physician, if warranted, provides a greater assurance than a hospital privilege action alone that the 105 million patients whose medical care is partly funded by HHS (47 million Medicare, 58 million Medicaid enrollees) would be better protected from questionable physicians. For example, our study discovered that because 220 physicians were considered an "Immediate Threat to Health or Safety" of patients, hospitals ordered an emergency suspension of admitting privileges for 167 (or 75 percent) of these 220 physicians. Despite having been found by hospital peer review to be an immediate threat to the health or safety of patients, none of these physicians had a state licensure board action.
>
> The purpose of this letter is to urge you to re-initiate previous, but currently non-existent Office of Inspector General (OIG) investigations concerning the dangerously lax disciplinary actions by so many state medical boards…
>
> In addition to the 220 physicians noted above, other reasons for the actions against these 5,887 physicians included:
>
> - 1,149 physicians disciplined because of incompetence, negligence or malpractice;
> - 605 physicians disciplined because of substandard care.
>
> Other categories of serious deviations of physician behavior/performance that resulted in clinical privilege revocation or restrictions included sexual misconduct, unable to practice safely, fraud including insurance fraud, fraud obtaining a license, and fraud against health care programs and narcotics violations.
>
> 3,218 physicians in our study lost their clinical privileges permanently, and an additional
>
> 389 physicians lost privileges for more than one year.
>
> Our report also presents specific examples of physicians who have been disciplined by hospitals but who have not a state medical board action. Many of these physicians have multiple medical malpractice payouts…

During the 1980s and 1990s your Office of Inspector General acknowledged the importance of effective medical board oversight; during this time period they conducted

16 evaluations of state health professional licensing boards including nine specifically addressing inadequate medical boards' performance. One of the medical board studies, entitled "Federal Initiatives to Improve State Medical Boards' Performance" (OEI-01-93-00020) noted:

State medical boards provide a vital front line of protection for millions of people who receive medical care including those in the Medicare and Medicaid Programs… the boards have not been at the forefront of quality assurance efforts…

Because of highly questionable legal constraints imposed by OIG lawyers, the last OIG investigation of state medical boards was in 1993.

Notwithstanding continuing harm to Medicare and Medicaid patients from inadequately disciplined physicians, the OIG has taken the position, based on "guidance" from the Office of Council to the Inspector General (OCIG), that OIG has no authority to review the performance of state medical boards…

Although state medical board disclosure policies and other medical board oversight issues could affect millions of Medicare and Medicaid patients, the Office of Council to the Inspector General rejected the staff request for consideration of a medical board study based on the "lack of OIG authority." This decision reflected the above-mentioned long- standing questionable legal conditions imposed by OCIG on OIG studies…

If OIG discretionary sanction authority depends, to a certain extent, on referrals from state licensing boards, OIG's ability to assure the optimal number of medical board referrals by investigating board performance appears to be compromised by the questionable legal barriers established by OIG's own legal staff that prevent OIG studies of medical boards' performance.

Finally, recent stories in the media have continued to highlight concerns about medical boards' effectiveness in disciplining doctors:

1) Illinois Medical Board Fails to Act on Sex Offenders - http://www.chicagotribune.com/health/ct-met-doctor-sex-charges20100729,0,5520049.story.

2) Medical Boards Discipline Doctors with Performance and Conduct Problems by Having Them Treat Indigent Patients and Prisoners - http://www.reportingonhealth.org/blogs/doctors-behaving-badly-maine-welcomes-psychiatrist-fraud-conviction-and-drug-abuse-concerns.

   http://www.reportingonhealth.org/blogs/doctors-behaving-badly-mississippi-makes-public-pony-peek-doctor-histories.

3) Missouri's Regulation of Doctors is Among the Nation's Most Lax - http://www.stltoday.com/lifestyles/health-med-fit/fitness/article_5cc342ba-dd6c-5428-b25e-99f8faeca638.html.

4) Connecticut Often Takes No Action against Doctors Disciplined in Nearby States - http://newhavenindependent.org/index.php/health/entry/connecticut_lax_on_doc_discipline/id_31659.

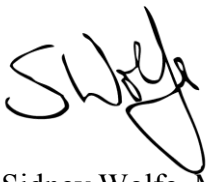
5) Wisconsin Medical Board Sued To Require Action -

http://www.wisconsin-lawyers-blog.com/malpractice-leads-to-unusual-writ-of-mandamus/. Tennessee Medical Board Fails to Adequately Sanction Physician Who Left Surgery for 80 Minutes to Visit Daughter's School - http://www.newschannel5.com/story/12871850/why-patients-may-not-get-whole-truth-about-doctors.

6) Sole Public Member of Medical Board is Attorney for Physicians - http://www.stltoday.com/lifestyles/health-med-fit/fitness/article_f64e5713-5f13-509e-9364-eb59402a09b3.html.

Madame Secretary, because of OIG's significant historical oversight role involving state medical boards performance, and because of medical boards importance to Medicare and Medicaid patients' protection from questionable doctors, Public Citizen calls upon HHS to re-initiate OIG investigations of medical boards.

Sincerely,



Sidney Wolfe, M.D.
Director, Health Research Group

Texas Considers Bill To Protect Whistle-blowing Nurses

Readers will recall that two Texas nurses were accused of misconduct associated with reporting a complaint to the state medical board. Legislation working its way through the Texas legislature would provide protection against retaliation for filing a complaint. The bill has passed the state senate and is under consideration in the House Public Health Committee.

The bill was described in the February 28, 2011 *Austin APNs* (http://austinapns.enpnetwork.com/page/2671-cnap-leg-update-5-2011).

SB 192 by Senator Jane Nelson (R – Lewisville, SD #12) is scheduled for a hearing in the Senate Health & Human Services Committee on Tuesday, March 1st. This bill is supported by all nursing organizations and is part of TNA's legislative initiative to improve protections for nurses who advocate for patients. The bill addresses lessons learned from the case of the two Winkler County nurses who were terminated and criminally indicted for reporting a physician to the Texas Medical Board.

What would SB 192 do? (See http://www.votervoice.net/link/clickthrough/ext/148058.aspx):

- Protects nurses from criminal prosecution for reporting unsafe care;
- Increases fines against persons who retaliate against nurses who engage in protected patient advocacy activities; and
- Protects nurses who advise other nurses about their patient advocacy rights and protections.

A similar bill was filed by Rep. Donna Howard (D–Austin, HD #48) in the House. H.B. 575 was referred to the House Public Health Committee…

Assisted Living Facility Abuses Go Unpunished

Miami Herald reporter Fred Grimm reported on May 5, 2011, that an investigation by the newspaper discovered multiple abuses at assisted living facilities in the state that have gone unpunished by state licensing authorities. They found illegal use of

restraints, filthy conditions, neglect, and physical abuse of patients.

They also found reports to state regulators and law enforcement authorities documenting problems, including negligence resulting in deaths. They also found instances in which doctors listed innocuous causes on death certificates, even when there were obvious signs of traumatic injuries.

The article can be found at: http://www.miamiherald.com/2011/05/04/2201449/alf-horrors-have-gone-unpunished.html.

New Jersey Considers Disciplining Doctors for Illegal Dumping

The New Jersey House of Representatives unanimously passed legislation that would call for a three-year license suspension in addition to a fine for doctors who illegally dump medical waste. Stricter penalties would also apply to medical waste facilities, generators and transporters up to fines of $200,000 and up to 20 years in prison for the most flagrant offenses.

The bill is presently being considered by the Senate Commerce Committee. The text of the bill can be found at: http://e-lobbyist.com/gaits/text/31431.

Radiologist Battles Iowa Hospital

A University of Iowa professor, Malik Juweid has filed a civil suit against officials of the University of Iowa Hospitals and Clinics alleging a cover up of inappropriate medical care and obstruction of an investigation by the state's medical board. The hospital denies the allegations and accuses Juweid of violating federal patient privacy protections.

The dispute, which dates to 2010, was written up in a *Huffington Post* article on February 18, 2011, (http://www.huffingtonpost.com/2011/02/18/malik-juweid-university-o_n_825220.html?view=print):

University of Iowa professor Malik Juweid faces losing his tenure after sending at least 27 e-mails this year subjecting colleagues to "personal vilification and verbal abuse," in language that the university called "prejudiced, insulting, inflammatory" and "vitriolic" in tone, reports the Daily Iowan. (See http://www.medicine.uiowa.edu/Radiology/faculty-staff/faculty/juweid-malik.html).

The controversy began in December, when Juweid filed a complaint with the Iowa Civil Rights Commission accusing radiology department head Laurie Fajardo of calling him an "academic terrorist," and referring to a Pakistani member of staff as "Osama bin Laden." Juweid said he felt discriminated against by Fajardo and other members of the department, but a university review found that although Fajardo likely made derogatory comments, they did not constitute discrimination, reports the Associated Press. (See http://www.chicagotribune.com/news/chi-ap-ia-iowaprofessor-inv,0,3131051.story).

Juweid, a radiology professor, was put on paid leave on recommendation from the university's threat assessment team before the school began investigating the case on January 12th. Since that time, Juweid has been forbidden from seeing patients, continuing research and entering campus without a police escort.

Now, the university is saying that Juweid's allegations against fellow faculty members -- he has called them anti-Arab and anti-Muslim -- mark an attack on his colleagues.

In an e-mail to Juweid obtained by the AP, Iowa Associate Provost Tom Rice wrote that the professor had "disparaged and attacked the character and integrity

of colleagues at the university and other institutions." (See http://www.chicagotribune.com/news/chi-ap-ia-iowaprofessor-inv,0,3131051.story).

"Even if there are valid reasons to disagree with the actions or statements of the various people you identified in these remarks, your abusive tone is unprofessional, unnecessary, and embarrassing to yourself and the university," Rice wrote.

For his part, Juweid stands by what he's written. He told the AP that the e-mails "always represented how I felt, and they reflected my interpretation of what's happening around me, and how I was treated differently from others who had different backgrounds."

Do you think Juweid was justified in his e-mailed remarks, or should he be punished for his actions? Let us know how what you think in the comments section.

IN DEPTH

Federal Trade Commission Opines on Professional Licensing Issues

Editorial Note: In recent years, the staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition have been asked to comment on legislation and proposed rules related to health professional licensing in several states. This In-Depth Feature contains excerpts from two such comments.

In addition, in June 2010 the FTC initiated an action against the North Carolina Board of Dental Examiners for anti-competitive conduct. Excerpts from the FTC's complaint also appear below.

This is how the FTC explains its interest in these matters:

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Competition is at the core of America's economy, and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, more choices, and greater innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement, research, and advocacy.

FTC Staff Comment to the Florida House of Representatives on House Bill 4103 and the Regulation of Advanced Registered Nurse Practitioners (ARNPs) – March 22, 2011

… You have asked FTC staff to analyze the "likely competitive impact" of HB 4103, which seeks to replace some of the current constraints on ARNPs' scope of practice with the less-restrictive supervision requirements that existed in Florida before the 2006 legislation took effect.

Based on current evidence, HB 4103 appears to represent a pro-competitive improvement in the law, one that is likely to benefit Florida health care consumers. As Florida's Department of Health notes in its own analysis of HB 4103, reducing current supervision requirements "would allow more access to healthcare." We therefore urge the legislature to consider carefully the impact of the 2006 requirements and to avoid maintaining provisions that would limit ARNP provision of health care services more strictly than patient protection requires. For analogous reasons, we urge the legislature to avoid maintaining undue limits on PA provision of health care services. Unnecessary restrictions on the

> ability of physicians to supervise ARNPs – or physician assistants ("PAs") – are likely to reduce the availability, and raise the prices, of the health care services that ARNPs and PAs are able to offer Florida health care consumers. In particular, the current restrictions may impose undue burdens on underserved populations, including rural or inner-city patients or the elderly… Moreover, the legislative history does not appear to include evidence of particular patient harms that the 2006 legislation was meant to cure. Absent evidence that the heightened restrictions were, and still are, necessary to protect the public, it appears that HB 4103 would benefit Florida consumers by facilitating the provision of lower cost and more accessible health care services…
>
> HB 4103 would remove certain supervision requirements that were adopted in 2006, while retaining the general supervision requirements that predate the 2006 revisions to Florida law. In particular, HB 4103 would eliminate restrictions on how physicians may supervise ARNPs. The Bill would rescind the requirements that (a) a primary care physician may not supervise more than four offices besides his or her primary practice location, (b) a specialist physician – except one who provides dermatologic or skin care services – may not supervise more than two offices besides his or her primary practice location, and (c) a physician providing dermatologic or skin care services may not supervise more than one office besides his or her primary practice location. The Bill also would remove certain reporting and notice requirements imposed in 2006. Likely Effects on Florida Health Care Consumers

… FTC staff concurs with Florida's Department of Health's assessment that HB 4103 "would allow more access to healthcare."By reducing barriers to innovation in health care delivery, the Bill will permit health care providers greater flexibility to offer basic health care through ARNP-staffed clinics. The IOM recently recognized the important role that ARNPs can play in improving access to health care. The IOM also noted, among other things, that "[r]estrictions on scope of practice… have undermined the nursing profession's ability to provide and improve both general and advanced care."Increasing the number of ARNP-staffed clinics may also increase competition to provide basic health-care services. For example, ARNP-staffed clinics generally offer weekend and evening hours, providing flexibility for patients. Further, the existence of such clinics may incent other types of clinics to offer extended hours as well. To the extent that HB 4103 increases the deployment of ARNPs in a variety of health care delivery settings, and thereby increases the range of choices available to consumers, the proposed legislation is likely to benefit Florida health care consumers.

ARNPs have, for example, played an important role in the recent proliferation of limited service clinics ("LSCs") in many states. LSCs typically are staffed by ARNPs – with consultation and supervision commonly provided at a distance, via telemedicine – and offer consumers a convenient way to obtain basic medical care at competitive prices.

Restrictions on oversight and supervision of ARNPs may limit both the number and types of LSCs available to Florida consumers.

Consumer Protection Concerns and Scope of Practice and Supervision

Patient safety or consumer protection concerns can justify licensure requirements and scope of practice restrictions.FTC staff recognize that particular health care procedures may require specialized training or heightened supervision if they are to be safely administered. The staff note, however, that

the legislative history of the 2006 law does not appear to include any demonstrated patient harms associated with the supervision requirements that had been in force before its enactment or any evidence that the safety of care provided by ARNPs varies according to such requirements. Moreover, the record does not appear to contain evidence supporting uniquely heightened supervision requirements in the general areas of dermatologic and skin care. In addition, there does not appear to be a safety rationale distinguishing the exemption of various practices from the special supervision requirements imposed under the 2006 law. The legislative history suggests, rather, that ARNPs in general are safe providers of health care services within their scope of practice. More broadly, the available empirical evidence indicates that APRN-delivered care "across settings, is at least equivalent to that of physician-delivered care as regards safety and quality."Studies also indicate that increased ARNP care may be associated with improved outcomes for particular disease indications or patient populations. Studies of limited service clinics – which offer certain basic primary care services and tend to be staffed by ARNPs without direct, on-site physician supervision – indicate that the clinics provide high quality health care.

In addition, studies of ARNP subspecialties, such as certified registered nurse anesthetists, suggest safe delivery of care… Absent evidence that the special restrictions imposed in 2006 are required to address demonstrable patient harms, FTC staff urges that HB 4103 be enacted to remove those restrictions. If particular medical procedures demonstrably require heightened supervision requirements, then staff recommends that the legislature tailor supervision requirements to address those particular services.

Editorial Note: A coalition of stakeholders in Florida is attempting to eliminate supervision requirements that apply to ARNPs.

FTC Staff Comment to the Alabama Board of Medical Examiners on Proposed Regulation of Pain Management Services – November 3, 2010

…The Proposed Rule restricts the "interventional treatment of pain" to "qualified, licensed medical doctors and doctors of osteopathy," who "may not delegate to non-physician personnel the authority to utilize such procedures to diagnosis [sic], manage or treat chronic pain patients. The rule appears to prohibit certified registered nurse anesthetists (CRNAs) from performing, under the supervision of a physician, pain management procedures that the Board of Nursing considers within the scope of CRNA practice. Absent evidence that the proposed restrictions are necessary to protect the public, there appears to be no reason to sacrifice the benefits of CRNA pain management services as currently available under Alabama law.

Unnecessary restrictions on the ability of physicians to provide pain management services in collaboration with CRNAs are likely to reduce the availability, and raise the prices, of pain management services in Alabama. In particular, the Proposed Rule may burden cancer patients and others with chronic pain, rural Alabamans and others whose access to health care, or ability to pay for it, is limited, and hospice patients.

We therefore urge the Board to consider carefully the impact of the Proposed Rule and to avoid adopting provisions that would limit the role of CRNAs in pain management more strictly than patient protection requires. The Proposed Rule provides no evidence that the current practice has harmed patients. Further, studies that have examined CRNA provision

of anesthesia services have not found safety or quality defects in CRNA practice…

Available evidence indicates that CRNAs operating within the scope of their licensure provide pain management services safely. Published data tend to indicate that the baseline risk of anesthesia is extremely low across all providers, and provider settings, with several studies indicating that recent decades have seen "a remarkably abrupt decrease in anesthetic related death rates, morbidity, and risk of perioperative deaths." In publishing its final rule regarding the provision of hospital anesthesia services under the Medicare and Medicaid programs, the U.S. Department of Health and Human Services (HHS) concluded that, "the anesthesia-related death rate is extremely low, and that the administration of anesthesia in the United States is safe relative to surgical risk." Moreover, HHS found no "need for Federal intervention in State professional practice laws governing CRNA practice… [and] no reason to require a Federal rule in these conditions of participation mandating that physicians supervise the practice of [state-licensed CRNAs]"

Likely Effects on Alabama Health Care Consumers

The Proposed Rule's restrictions on the ability of physicians to direct and supervise CRNA provision of interventional pain treatments to chronic pain patients practice may increase prices for pain management services and decrease access to such services. By limiting the number of health care professionals licensed to provide pain management services, the Proposed Rule would reduce price competition. Further, prices may rise to the extent that physician services are substituted for lower-cost CRNA services. Finally, the Proposed Rule may thwart innovation in health care delivery by limiting the ability of health care providers to develop, test, and implement the most efficient teams of pain management professionals.

Moreover, the burdens imposed by the Proposed Rule may be felt especially by some of the most vulnerable citizens of Alabama. For example, CRNA practices disproportionately serve smaller, rural hospitals. In addition, hospice providers and patients may face both increased prices and reduced access to care if only physicians can provide palliative care for chronic pain.

It is possible that the Proposed Rule may, on balance, reduce patient safety. As noted, economic or geographic access problems may place some Alabamans at risk of inadequate care. Also, if CRNA pain management specialists are sometimes replaced not by board certified anesthesiologists, but by physicians and osteopaths who do not specialize in pain management, the average quality of interventional pain management in Alabama, or certain parts of Alabama, could be reduced…

If particular interventional pain treatment services demonstrably require more specialized training and experience than CRNAs working under physician supervision posses, then the Board should tailor the rule to address those particular services. To the extent that there is no evidence that CRNA practice harms patients, staff recommend that the Board reject the Proposed Rule outright.

FTC Complaint against the North Carolina Board of Dental Examiners for Improperly Excluding Non-Dentists – June 17, 2010

… Dentists in North Carolina, acting through the instrument of the North Carolina Board of Dental Examiners ("Dental Board"), are colluding to exclude non-dentists from competing with dentists in the provision of teeth whitening services. The actions of the Dental Board prevent and deter non-dentists from providing or expanding teeth whitening services, increase prices and reduce consumer choice without any legitimate justification or defense, including the "state action" defense. The actions of the Dental Board unreasonably restrain competition and

violate Section 5 of the Federal Trade Commission Act.

RESPONDENT

…The Dental Board consists of six licensed dentists, one licensed hygienist, and one "consumer member," who is neither a dentist nor a hygienist. Each dentist member is elected to this position by the licensed dentists of North Carolina, and serves a three-year term. Collectively, the six dentist members can and do control the operation of the Dental Board. Each dentist member is financially interested in decisions reached by the Dental Board because, while serving on the Dental Board, each dentist member continues to engage in the for-profit business of providing dental services.

...The conduct of the Dental Board constitutes concerted action by its members and the dentists of North Carolina.

…The Dental Board is the sole licensing authority for dentists in North Carolina. It is unlawful for an individual to practice dentistry in North Carolina without holding a current license to practice issued by the Dental Board. The Dental Board is also tasked with policing instances of unauthorized practice of dentistry ("UPD") as defined by and pursuant to the North Carolina dental statute…

Teeth whitening services are offered by dentists and non-dentists.

… Many dentists offer patients both in-office teeth whitening services and take-home teeth whitening kits. The most common in-office procedure consists of covering the gums with a protective material, applying to the teeth a hydrogen peroxide solution in the 20 – 35% range, and then exposing the teeth to a light source. Take home kits include a custom-made whitening tray, and a whitening gel that is generally a 15 – 20% carbamide peroxide solution. The consumer self-applies the gel in essentially the same manner as when using an over-the counter ("OTC") teeth whitening product purchased at, for example, a pharmacy…

Typically, a non-dentist provider operates in the following way. The provider hands a strip or tray containing peroxide to the customer, who applies it to his or her own teeth. The customer's teeth are then exposed to a light-emitting diode ("LED") light source for 15 to 30 minutes. The amount of hydrogen peroxide applied to the teeth at non-dentist outlets generally falls into the 10 – 15% range. This is a greater concentration than OTC products (usually 10% or less), but less than the concentration employed in dentist-applied products (approximately 20 – 35%). The non-dentist provider generally does not touch the customer's mouth.

…Teeth whitening services performed by non-dentists are much less expensive than those performed by dentists. A non-dentist typically charges $100.00 to $200.00 per session, whereas dentists typically charge $300.00 to $700.00, with some procedures costing as much as $1,000.00…

The North Carolina dental statute does not expressly address whether, or under what circumstances, a non-dentist may engage in teeth whitening.

…The Dental Board has decided that the provision of teeth whitening services by non-dentists constitutes UPD. As detailed herein, the Dental Board has acted in various ways to eliminate the provision of teeth whitening services by non-dentists.

…The Dental Board interprets the North Carolina dental statute as permitting non-dentists to engage in the retail sale of teeth whitening products for use at home. However, the Dental Board has determined that any service provided along with a teeth whitening product, including advice, guidance, providing a customer with a personal tray, whitening solution, mouth piece and/or LED light, or providing a location to

use the whitening product, constitutes the practice of dentistry…

The Dental Board has engaged in extra-judicial activities aimed at preventing non-dentists from providing teeth whitening services in North Carolina. These activities are not authorized by statute and circumvent any review or oversight by the State.

…On 42 occasions, the Dental Board transmitted letters to non-dentist teeth whitening providers, communicating to the recipients that they were illegally practicing dentistry without a license and ordering the recipients to cease and desist from providing teeth whitening services.

…On at least six occasions, agents of the Dental Board also threatened and discouraged non-dentists who were considering opening teeth whitening businesses by communicating to them that teeth whitening services could be provided only under the direct supervision of a dentist.

…Furthermore, the Dental Board issued at least 11 letters to third parties, including mall owners and property management companies, with interests in approximately 27 malls, stating that teeth whitening services offered at mall kiosks are illegal. The purpose of these letters was to block the expansion of teeth whitening kiosks in shopping malls.

…The Dental Board's exclusion of the provision of teeth whitening services by non-dentists does not qualify for a state action defense nor is it reasonably related to any efficiencies or other benefits sufficient to justify its harmful effect on competition…

The exclusionary course of conduct of the Dental Board… may be expected to continue in the absence of effective relief. As a consequence of the challenged actions and course of conduct of the Dental Board, the availability of non-dentist teeth whitening services in North Carolina has been and will be significantly diminished…

The challenged actions and course of conduct of the Dental Board have had and will have the effect of restraining competition unreasonably and injuring consumers in the following ways, among others:

- preventing and deterring non-dentists from providing teeth whitening services in North Carolina;
- depriving consumers of the benefits of price competition; and,
- reducing consumer choice in North Carolina for the provision of teeth whitening services…

The combination, conspiracy, acts and practices described above, constitute anticompetitive and unfair methods of competition in or affecting commerce in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. Such combination, conspiracy, acts and practices, or the effects thereof, are continuing and will continue or recur in the absence of appropriate relief.

Editorial Note: See http://administrativelaw.ncbar.org/ ***for a commentary on this complaint and briefs filed by the FTC and the board by Jeff Gray, a North Carolina trial attorney practicing with the firm Bailey and Dixon, LLP. Note his comment that "In the opinion of this author, the biggest threat to the State occupational and professional licensing boards and commissions in North Carolina, or in any state nationally that has similar statutorily created regulatory scheme, is that this suit threatens the immunity previously enjoyed by these boards and commissions."***

The dental board counter-sued on February 1, 2011, alleging that the FTC had exceeded its authority. This suit was dismissed on May 3, 2011, on a jurisdictional technicality.

In addition to its comments on scope of practice restrictions by individual licensing

boards, the FTC staff has also commented several times on proposed state-based restrictions on retail clinics. Illustrative is the letter sent to the Kentucky Cabinet for Health and Family Services (CHFS) dated January 28, 2010. An FTC press release described the letter this way:

> FTC Staff Comment to the Kentucky cabinet for Health and Family Services on Proposed Regulations for Licensing Retail Clinics Raise Competitive Concerns – January 28, 2010
>
> *What follows is the press release announcing the FTC staff's letter to the Kentucky officials.*
>
> The Federal Trade Commission's staff has sent a letter to the Kentucky Cabinet for Health and Family Services (CHFS) stating that certain new regulations proposed for the licensing of "limited service clinics" (LSCs) in the state raise competitive concerns and are likely to increase the cost of health services for Kentucky consumers, particularly the uninsured. LSCs – which are sometimes called "retail clinics" or "store-based clinics" – are one way to deliver a limited range of basic health care services in a clinic setting.
>
> The proposed rule would regulate the operation of LSCs in Kentucky. While many provisions of the proposed rule mirror basic consumer protection standards in other states and do not raise competitive concerns, according to the FTC staff comments, several provisions impose distinct costs and restrictions on LSCs, but not on other limited-care operations such as urgent care centers.
>
> According to the comments, those provisions would limit the scope of professional services that licensed health care professionals could provide at Kentucky LSCs, would impose physical or operational restrictions on LSCs but not comparable limited-care settings, and would impose on LSCs licensing fees greater than those imposed on all other categories of health care facilities. Each provision could limit market entry by LSCs, reducing competition from LSCs on the price, convenience, and availability of basic health care services in the state, the staff concludes. Health and safety consumer protection benefits can offset the costs of potentially anticompetitive regulations, but there is no evidence that the discriminatory provisions in the proposed rule are likely to provide such benefits.
>
> The staffs of the Office Policy Planning, Bureau of Competition, and Bureau of Economics submitted the comments, which can be found on the FTC's Web site and as a link to this press release, on January 28, 2010, in response to a call for public comments from the CHFS's Office of Inspector General.
>
> The FTC vote approving the staff letter was 4-0. (FTC File No. V100007; the staff contact is Daniel J. Gilman, Office of Policy Planning, 202-326-3136. See related press release dated October 2, 2007, at http://www.ftc.gov/opa/2007/10/massdph.shtm.)

More information about these FTC actions can be found on the Commission's Website: http://www.ftc.gov/**.**

LETTERS

Dear Colleague,

I thought you would be interested in recently completed work that addresses what patients and family members should do if they have a concern about quality in Maine and Pennsylvania.

The following six Tip Sheets are available both online and as pdfs on the Informed

Patient Institute (IPI) website (www.informedpatientinstitute.org) on the right hand side of the home page:

What to Do If You Have a Concern about Quality in a Maine or Pennsylvania Hospital

What to Do If You Have a Concern about Quality in a Maine or Pennsylvania Nursing Home

What to Do If You Have a Concern about the Quality of Care from a Maine or Pennsylvania Doctor

The Maine Tip Sheets were prepared for the Maine Health Management Coalition and are also available on their website Get Better Maine: http://www.getbettermaine.org/ (look under "Find Health Resources", then "Poor Care"). Funding was provided by the Maine Health Access Foundation.

The Pennsylvania Tip Sheets were prepared for the Consumer Health Coalition in Pittsburgh and are also available on their website:

http://consumerhealthcoalition.org/programs/health-care-quality/. Funding was provided by the Jewish Healthcare Foundation.

These Tip Sheets replicate work that was originally conducted in California and New York. Other states are planned in the future.

IPI is a non-profit organization dedicated to providing credible online information about health care quality and patient safety for consumers. In addition to Tip Sheets on Quality Concerns, IPI also provides information on health care report cards.

Please feel free to link to this information or pass it on to others that might be interested.

Thank you.

Carol Cronin
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SAVE THE DATES: *Our annual meeting* ***"Achieving Regulatory Excellence – Effective Discipline Programs*** *will be held on* ***Thursday, October 20, 2011****, and* ***Friday, October 21, 2011****, at our offices in Washington, DC. You may download a* ***Program and Registration Form*** *or register online by going to http://www.cacenter.org/cac/meetings.*

Audio recordings and PowerPoint presentations *from past CAC webinars are now available. More information is at http://www.cacenter.org/cac/webinars_past.*

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.*

MEMBERSHIP INFORMATION

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

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

We provide the following services to boards that become members:

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

We have set the annual membership fees as follows:

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

MEMBERSHIP ENROLLMENT FORM

TO BECOME A CAC MEMBER ORGANIZATION, PLEASE COMPLETE THIS FORM AND SEND IT TO:

CAC

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

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

Payment Options:

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

Purchase Order Number:

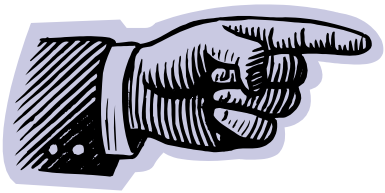
or

4) Provide the following information to pay by credit card:

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

Signature Date

Our Federal Identification Number is 52-1856543.



WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of **CAC**. Membership includes a subscription to our newsletter for **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.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2011 and back-issues for $240.00.**

Name of Agency:	
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Payment Options:

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

Purchase Order Number:

or

4) Provide the following information to pay by credit card:

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

Signature Date

Our Federal Identification Number is 52-1856543.

CAC CONSULTANT SERVICES

We know licensure boards and the environments in which they function. We know the many operational activities they carry out to protect the public. We know the resource and other constraints they confront. We know the skepticism they often face from licensees and the general public. We know the disruptions and added distrust that emerge when media reports reveal how board shortcomings failed to protect the public.

And we know that we can help boards to improve their performance and to shore up public confidence. We know the intricacies of professional regulation and we know how to carry out rapid feedback evaluations that can be of practical use to decision-makers.

What Do We Offer?

We provide quick turnaround reviews, identify best practices worthy of emulation, develop practical solutions geared to real-world environments, and present crisp, action-oriented reports and/or briefings. Among the questions we can help boards address are these:

- How can alternative-to-discipline programs for impaired practitioners be made more accountable for performance?
- How can board websites be made more informative and helpful to the public?
- How can efficiencies be incorporated into licensure and discipline processes?
- How can training programs for board members be enhanced?
- How can boards tie in more effectively with the movement to reduce medical errors?

How Do We Work?

We emphasize close collaboration with you, the client. We start by working with you to narrow down our scope of services to the discrete issues and approaches warranting attention. Once we agree on the review's focus and methods, we assemble a small team that conducts interviews, reviews and develops data, and presents findings and recommendations. Throughout the process, we consult with you and offer feedback on an as-needed basis. Our aim is to provide you with information, ideas, and recommendations that you can readily adapt.

Who Are We?

CAC is a nonprofit organization focused on the improved accountability and performance of health professional oversight boards. Since its establishment in 1987, it has produced scores of reports aimed at enhancing the public protection mission of the boards; conducted annual meetings intended to sharpen the skills and insight of public members on the boards; convened policy-focused conferences on key issues of concern to boards (most recently on competency assessment);

served as a resource for board members, executives, and staff seeking guidance on policy and operational matters; and, not least of all, fostered greater attention to proactive error-prevention and quality improvement initiatives through its Practitioner Remediation and Enhancement Partnership (PREP). For more information on PREP see www.4patientsafety.net.

CAC's Consultant Services Division, established in 2008, draws on this background to provide services specifically for heath care licensure boards. The three principals are David Swankin, Rebecca LeBuhn, and Mark Yessian. For more than a quarter of a century, each has had considerable exposure to boards, from the ground up. Swankin, co-founder, president, and CEO of CAC has been on the forefront of licensure and discipline issues as a speaker, trainer, writer, and advisor. LeBuhn, co-founder and CAC chair, has been an integral part of all CAC operations and has served as a public member on boards herself. Yessian, CAC board member and recently retired from the Office of Inspector General of the U.S. Department of Health and Human Services, has led numerous high profile studies of boards.

Our consultant services, however, draw on far more than the three individuals noted above. One of our unique advantages is that we can draw on a vast network of individuals with whom we have associated with over the years and who can be deployed on individual studies. A first step once we have delineated the scope of services with a client is to assemble a study team well suited for that particular engagement. This approach enables us to tailor the expertise needed for each project.

Why Retain CAC Consulting Services?

Boards can turn to many consultant organizations to help them with management and operational issues. Three factors help to distinguish us:

1. Our expertise in the substance of professional regulation;
2. Our capacity to conduct rapid feedback, high-quality assessments;
3. Our track record and reputation for ensuring that licensure boards are publicly accountable.

When you contract with us to examine some aspect of your board's operation, you can have confidence that you will gain timely, useful, and credible insights that can enhance your public protection mission.

For inquiries, contact David Swankin at DavidSwankin@cacenter.org.