News & Views

Citizen Advocacy Center

First Quarter, 2015 - A Health Care Public Policy Forum - Volume 27 Number 1

Announcements:

On June 23, 2015, we will convene a meeting in Washington, DC to examine the implications of the Supreme Court's "Teeth Whitening" decision for legislatures, regulatory boards, credentialing bodies and professional associations that want to claim immunity from FTC anti-trust oversight. ***The Program Announcement and Meeting Registration Form*** *are at http://www.cacenter.org/files/DentalWhiteningMeetingProgram2015.pdf.*

CAC is a membership organization *and we invite your board to join. More information is at http://www.cacenter.org/cac/membership and on pages 24 and 25 of this newsletter.*

Although we encourage you to receive our newsletter by becoming a ***CAC*** *member,* ***you may still subscribe to our newsletter without becoming a member.*** *More information is at http://www.cacenter.org/view/newsletter and on page 26 of this newsletter.*

ANTI-TRUST

SUPREME COURT RULES IN FAVOR OF FTC IN TEETH WHITENING CASE

On February 25, 2015, the U. S. Supreme Court issued its opinion in North Carolina State Board of Dental Examiners v. Federal Trade Commission, a case that will undoubtedly have great impact on state professional and occupational licensing boards. In a 6 – 3 decision, the Court found in favor of the FTC's position that a licensing board controlled by "active market participants" (a term not defined in the Court's opinion), cannot invoke the state-action antitrust immunity unless the board was subject to "active supervision by the State." The Court cited 4 elements of "active supervision by the State:"

~ TABLE OF CONTENTS ~

ANTI-TRUST

Supreme Court Rules In Favor of FTC In Teeth Whitening Case 1

LICENSURE

Federal Trade Commission Testifies on Competition and Licensure 4

NABP Updates Model Act For Pharmacy Boards 5

CONSUMER INFORMATION

Consumers Have Difficulty Evaluating Doctor Quality 5

New York Governor Proposes Eliminating Physician Profiles 6

Report Says CMS Not Doing Enough To Promote Transparency 7

Consumer Reports Rates California Physician Groups 7

PAIN MANAGEMENT AND END OF LIFE CARE

Medical Boards Adopt Varied Postures On Pain Care 7

Bill Calls For 24-Hour Nursing Presence For Long-Term Care 8

Study Finds Improved Post-Surgery Pain Control 8

New Jersey Panel To Review Pain Management / Drug Diversion 8

NIH Panel Recommends Individualized Pain Care 8

~~Continued on Page 2~~

- The state supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it;
- The state supervisor must have the power to veto or modify particular decisions to ensure that they are in accord with state policy;
- The "mere potential for state supervision is not an adequate substitute for a decision by the State;" and,
- The state supervisor may not itself be an active market participant.

The Supreme Court rejected the contention raised by the dental board and raised by many state licensing boards and their federations that "allowing this FTC order to stand will discourage dedicated citizens from serving on state agencies that regulate their own occupation." The Court said, "If this were so – and for reasons to be noted, it need not be so – there would be some cause for concern." While the Court acknowledged that the Board argued that the potential for money damages would discourage members of regulated occupations from participating in state government, the Court said that since money damages were not an issue in this case it did not need to address this issue specifically. The court did say, "Of course, the States may provide for the defense and indemnification of agency members in the event of litigation.

At least two major issues were not resolved, and States will need to wrestle with both of them.

~~Continued from Page 1~~

SCOPE OF PRACTICE
Massachusetts Considers New Approach to Scope Decisions 9
Washington State Asked to Give Health Secretary Final Say on Scope of Practice 9
National Governors Association Endorses Expanded Pharmacy Scope 10
California Considers Addressing Scope via Obamacare Provision 10
Physician Lawmaker in Montana Proposes Oversight of Alternative Medicine 10

CONTINUING PROFESSIONAL DEVELOPMENT
Controversial Model Law Organization Fighting Maintenance of Licensure and Certification 11
Pharm Tech Certification Board Adds Recertification Requirement 11
ACCME Issues Reports About Continuing Medical Education 12
ABIM Modifies Maintenance of Certification Program 12
New Group Offers Alternative Maintenance of Certification Option 13

DISCIPLINE
State Audit Finds Fault With Long-Term Care Complaint Handling 13
Guide to Developing Disciplinary Guidelines 14
Failure of Reporting Allows Abusive Nurse to Continue Practicing 14

ADMINISTRATION
Boards Met Without Quorum, Casting Cloud Over Actions 14

TELEHEALTH
Medical Boards Differ on Requirements for "Physical Exam" Before Tele-Prescribing 15
Study Says Telehealth Improves Pain Care 15
Medical Board To Develop Standards for Users of Telehealth 16
AMA Supports Interstate Compact to Facilitate Licensure 16

IN DEPTH
2014 Shimberg Lecture Delivered by Charles Ornstein and Tracy Weber, Representing the Shimberg Public Service Award Winner, ProPublica 17

CAC
Membership Information 24

Membership Enrollment Form 25

Newsletter Subscription Form 26

First, what constitutes "Active Market Participants?" In this case, the 6 dentists serving on the licensing board were all in active practice (this is required by the North Carolina statute treating the board). Would they be "active market participants" if they were academics or otherwise not engaged in the practice of dentistry? What if the board included non-dentists (public members, health care delivery institution executives), and the dentist members were *not* in the majority? (For example, in California a number of non-health boards have a *majority* of Public Members).

Second, what constitutes Active Supervision by the State? In the North Carolina case, the board's anti-competitive action that caused the FTC to intervene was writing cease-and-desist letters to non-dentist teeth whiteners, threatening criminal liability if they continued to provide teeth whitening services. Suppose the North Carolina Dental Board had *not* taken this enforcement approach, but rather had gone through the required processes to draft and publish a *regulation* that declared teeth whitening to be the practice of dentistry? It so happens that in North Carolina *all* board regulations must be reviewed by an independent statutory "rules review commission," and no rule can become effective until the *substance* of the regulation (as well as the procedure followed in promulgating the regulation) has been approved. Would that be sufficient "Active Supervision?"

The language the court used here is critical: "The question is whether the state's review mechanisms provide 'realistic assurance' that a non-sovereign actor's anti-competitive conduct promotes state policy, rather than merely the party's individual interests. ***In general, however, the adequacy of the supervision will depend on all the circumstances of a case.***" (Emphasis added).

States will need to think about how they will provide active state supervision. Will an umbrella board with policy oversight authority be sufficient? Will a scheme like that in Nebraska, where the licensing boards are only *advisory* to a more broadly-based health committee be sufficient? Would requiring all policy opinions to go through formal rulemaking be the answer? Providing active state supervision may be the greatest challenge faced by the States as they seek to comply with the ruling in this case.

The Court's decision can be found at http://www.supremecourt.gov/opinions/14pdf/13-534_19m2.pdf.

Editorial Note: The Citizen Advo0cacy Center (CAC) joined in an amicus brief filed by 5 national nurse organizations supporting the FTC in this case. The 5 nurse organizations were The American Association of Nurse Anesthetists, American Nurses Association,

Board of Directors

Honorary Chair Emeritus (deceased)
Benjamin Shimberg

Chair
Rebecca LeBuhn

President and CEO
David Swankin

Secretary/Treasurer
Ruth Horowitz

Vice President
Mark Speicher

Directors
Carol Cronin
Julie Fellmeth
Gary Filerman
Arthur Levin
Cheryl Matheis
Barbara Safriet
Mark Yessian

CAC *News & Views* is published quarterly by

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

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

© 2015, **Citizen Advocacy Center**

American Association of Nurse Practitioners, American College of Nurse Midwives, and the National Association of Clinical Nurse Specialists. CAC has long advocated that health professional licensing boards avoid developing rules, regulations, policy documents, or enforcement strategies that are anti-competitive. We have long opposed business restrictions that have little to do with protecting public health or safety.

LICENSURE

FEDERAL TRADE COMMISSION TESTIFIES ON COMPETITION AND LICENSURE

In testimony on July 16, 2014, entitled "Competition and the Potential Costs and Benefits of Professional Licensure," Andrew Gavil, Director of the Office of Policy Planning at the Federal Trade Commission explained to the House Committee on Small Business the FTC's approach to evaluating the potential competitive effects of licensure regulation. He said, in part:

> Occupational regulation can be especially problematic when regulatory authority is delegated to a nominally "independent" board comprising members of the very occupation it regulates. When the proverbial fox is put in charge of the henhouse, board members' financial incentives may lead the board to make regulatory choices that favor incumbents at the expense of competition and the public. This conflict of interest may lead to the adoption and application of licensure restrictions that discourage new entrants, deter potential competition from professionals in related occupations, and suppress innovative forms of service delivery that could challenge the status quo. Such entry and innovation can have substantial consumer benefits…
>
> In recent years, for example, we have focused on diverse issues including advertising restrictions, automobile distribution, nursing scope of practice restrictions, accreditation standards, taxicabs and related forms of passenger vehicle transportation, casket sales, and real estate brokerage. Typically, we urge policy makers to integrate competition concerns into their decision-making process – specifically, that they consider whether 1) any particular licensure regulations are likely to have a significant and adverse effect on competition; 2) the particular restrictions are targeted to address actual risks of harm to consumers; and 3) the restrictions are narrowly tailored to minimize any burden on competition, or whether less restrictive alternatives may be available…

The text of the prepared testimony can be found at http://www.ftc.gov/system/files/documents/public_statements/568171/140716professionallicensurehouse.pdf.

Congress John Sarbanes (D-MD) introduced the Primary Care Physician Reentry Act in September 2014 to help address the shortage of primary care providers. The Federation of State Medical Boards and a handful of physician specialty associations support the legislation.

NABP Updates Model Act for Pharmacy Boards

The October 8, 2014, National Association of Boards of Pharmacy e-News announced an updated model pharmacy practice act:

> Updated NABP *Model Act* Now Available to Assist Boards of Pharmacy in Developing Laws and Rules to Protect the Public Health
>
> The recently amended NABP *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* is now available to assist the state boards of pharmacy in developing state laws or board rules in their efforts to protect the public health. The *Model Act* was revised to add clarifying information on resident and nonresident pharmacy licensure standards and pharmacy inspections, and to recommend that boards should be provided with a report of any inspection of their licensees. Further, in recognition of the fact that many pharmacy benefit managers (PBMs) design the clinical programs for their associated mail-order and/or network pharmacies, direction and design of clinical pharmacies was added to the list of activities that may constitute the practice of pharmacy by PBMs. Language was also revised to address five percent rules to avoid conflict with Drug Enforcement Administration controlled substance regulations…

The *Model Act* is at http://www.nabp.net/members/model-pharmacy-act-rules, and a full summary of the changes can be found in the September 2014 issue of the *NABP Newsletter* on pages 171 and 176 of http://www.nabp.net/system/rich/rich_files/rich_files/000/000/556/original/september2014nabpnewsletter.pdf.

Consumer Information

Consumers Have Difficulty Evaluating Doctor Quality

A survey by the Associated Press – NORC Center for Public Affairs Research conducted in the spring of 2014 found that less than a quarter of respondents are confident they can find information to compare the quality of doctors. More than half trust recommendations from family and friends and slightly fewer than half trust referrals by other doctors. More than 90% believe they receive quality care.

On some measures, respondents' opinions were based on erroneous assumptions. Many assumed, for example, that more costly care is better care. Many considered good listening skills to be an indicator of doctor quality; fewer identified accurate diagnosis and knowledge as indicators of quality.

See the survey report at http://www.apnorc.org/projects/Pages/finding-quality-doctors-how-americans-evaluate-provider-quality-in-the-united-states.aspx.

NEW YORK GOVERNOR PROPOSES ELIMINATING PHYSICIAN PROFILES

Governor Andrew Cuomo's proposed budget would eliminate $1.2 million in funding to support publicly available physician profile information, which has been available since 2000. Sixteen advocacy organizations wrote to the governor on February 19, 2015, asking him to restore the funding and strengthen rather than weaken disclosure of healthcare quality information. The letter states, in part:

> While the New York State executive Budget Briefing Book describes this as a proposal to "discontinue a physician profile website," the legislative language would actually require the complete dismantling of an entire medical safety reporting and public disclosure program. This important program, established pursuant to the Patient Health Information and Quality Review Act of 2000, has been in place for a decade and a half.
>
> The New York Physician Profile reporting and disclosure program is a positive "transparency" measure that allows consumers to access, at one website, key information on the credentials and safety records of doctors practicing in New York. We urge instead that you protect and strengthen this consumer protection program.

In an editorial published on February 23, 2015, the New York Daily News took the same position, urging the governor to preserve the program:

> Fifteen years ago – in response to a Daily News exposé on "The 15 Most Sued Doctors in New York" – the state Health Department began publishing physician profiles to give consumers basic protection against incompetence and quackery. Please see http://www.nydailynews.com/archives/news/docs-fight-hide-lawsuits-lobbyists-pressuring-albany-malpractice-cases-secret-article-1.860253.
>
> That breakthrough system, available at NYDoctorProfile.com, was visited 35,000 times in December alone – a clear case of the public making good use of its right to know.
>
> In spite of that heavy demand, Gov. Cuomo's budget includes a proposal to kill the program. Please see http://www.nydailynews.com/news/politics/cuomo-plan-nix-doctor-info-website-criticized-article-1.2099974.
>
> After blowback from consumer groups, the governor's aides said he would continue the portion of the system that discloses malpractice histories.
>
> Cuomo should reverse course completely – and continue full support for this important tool for navigating a complex health-care system…

See the letter at http://media.syracuse.com/health_impact/other/Read%20letter.pdf, http://www.syracuse.com/health/index.ssf/2015/02/consumer_groups_urge_cuomo_to_keep_website_that_lets_patients_check_up_on_doctor.html, and the Daily News editorial at http://www.nydailynews.com/opinion/editorial-new-york-bad-doctors-hide-article-1.2123515.

REPORT SAYS CMS NOT DOING ENOUGH TO PROMOTE TRANSPARENCY

In November 2014 The Government Accountability Office (GAO) released a report criticizing the consumer information tools offered by the Centers for Medicare and Medicaid Services for not providing sufficient information for consumers to make informed decisions based on quality and cost. The report says, in part:

> The Centers for Medicare & Medicaid Services (CMS) operates five transparency tools – Nursing Home Compare, Dialysis Facility Compare, Home Health Compare, Hospital Compare and Physician Compare – that are limited in their provision of relevant and understandable cost and quality information for consumers. In particular, GAO found that the tools lack relevant information on cost and provide limited information on key differences in quality of care, which hinders consumers' ability to make meaningful distinctions among providers based on their performance. Because none of the tools contain information on patients' out-of-pocket costs, they do not allow consumers to combine cost and quality information to assess the value of health care services or anticipate the cost of such services in advance. Additionally, GAO found substantial limitations in how the CMS tools present information, such as, in general, not using clear language and symbols, not summarizing and organizing information to highlight patterns, and not enabling consumers to customize how information is presented.

The report can be found at http://www.gao.gov/products/GAO-15-11.

CONSUMER REPORTS RATES CALIFORNIA PHYSICIAN GROUPS

Based on surveys of California 52,000 patients, Consumer Reports released ratings of physician groups in January 2015. *Los Angeles Times* reporter Chad Terhune wrote that "medical groups were rated on communication with patients, timely care and service, coordination of care and the helpfulness of office staff. Data on individual doctors isn't published yet."

Read more at http://www.latimes.com/business/la-fi-doctor-ratings-california-20150107-story.html?utm_campaign=KHN%3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15503736&_hsenc=p2ANqtz-9nQuS_jHTPM-djch_SJYXyDddF91JFQ7Hhr_y6zNKQhz2iZnXPoIzJj2KeB1f-LiTnhynk_qyoXLOzkX4cd0i5KhK7kMve5alTP3P58l0zR63kzUQ&_hsmi=15503736.

PAIN MANAGEMENT AND END OF LIFE CARE

MEDICAL BOARDS ADOPT VARIED POSTURES ON PAIN CARE

The North Carolina Medical Board adopted a new position on pain management at its May 2014 meeting. It provides detailed guidelines and warms about "recent evidence that risk associated with opiates has surged, while evidence for benefits has remained controversial and insufficient."

The Iowa Board of Medicine adopted a less prescriptive approach when it reissued its 2009 policy statement saying that licensees will not be scrutinized by the board so long as they take a "reasonable and responsible" approach to pain care, including appropriate patient

assessments, documentation, monitoring and consultation with the Iowa Prescription Monitoring Database.

Source: *Journal of Medical Regulation*, vol. 100, #2, 2014, pp. 33-34.

BILL CALLS FOR 24-HOUR NURSING PRESENCE FOR LONG-TERM CARE

Legislation introduced by Jan Schakowsky (D-Il) in July 2014 would require all nursing homes reimbursed by Medicare and Medicaid to have an RN on duty 24 hours per day, 7 days a week. The current requirement calls for an RN only 8 hours a day. The legislation has been referred to the Health Subcommittee of the House Committee on Energy and Commerce, Ways and Means.

Follow action on the legislation at https://www.congress.gov/bill/113th-congress/house-bill/5373/all-actions.

STUDY FINDS IMPROVED POST-SURGERY PAIN CONTROL

The percentage of patients experiencing moderate to severe pain two weeks after surgery declined from 63% in 2003 to 39% in 2014. The drop has been attributed to caregivers' better understanding of how pain medications work.

For more, see http://www.fiercehealthcare.com/story/gains-reported-war-against-post-surgical-pain/2014-10-14?utm_medium=nl&utm_source=internal.

NEW JERSEY PANEL TO REVIEW PAIN MANAGEMENT / DRUG DIVERSION

In October 2014 the New Jersey Department of Consumer Affairs announced the creation of a Pain Management Council:

> The Pain Management Council is tasked with reviewing the current professional standards and regulations that apply to all healthcare professionals who prescribe or dispense prescription drugs, including physicians, advance practice nurses, pharmacists, and others. Over the next several months, the advisory group will help the Division of Consumer Affairs develop a set of best practice recommendations for New Jersey's healthcare professionals. The goal is to provide voluntary guidelines that will enable healthcare professionals to provide pain management, while maintaining effective controls to prevent the diversion and abuse of prescription drugs.

For details, visit http://www.workerscompensation.com/compnewsnetwork/news/20013-nj-convenes-pain-management-council-to-develop-best-practices-for-managing-pain-while-maintaining-controls-against-rx-drug-diversion-and-abuse.html.

See also the Federation of State Medical Board's updated book on curbing opioid abuse at http://newswise.com/articles/fsmb-foundation-releases-updated-book-aimed-at-curbing-opioid-abuse.

NIH PANEL RECOMMENDS INDIVIDUALIZED PAIN CARE

An independent panel convened by the National Institutes of Health concluded that individualized, patient-centered care is needed to treat and monitor the estimated 100 million Americans living with chronic pain. To achieve this aim, the panel recommends more

research and development around the evidence-based, multidisciplinary approaches needed to balance patient perspectives, desired outcomes, and safety.

See the panel report at http://www.nih.gov/news/health/jan2015/odp-12.htm.

SCOPE OF PRACTICE

MASSACHUSETTS CONSIDERS NEW APPROACH TO SCOPE DECISIONS

Legislation proposed in Massachusetts would re-set the process for making scope of practice decisions, according to an article in *Nashoba Publishing*:

> The bill (H4561) aims to reform the current committee process for reviewing bills by tasking the Health Policy Commission, an independent body that analyzes the health care market, with reviewing legislative proposals and providing guidance to the Legislature. The proposed process is similar to how the Center for Health Information and Analysis reviews and makes recommendations on legislation concerning mandated health insurance benefits.

The bill apparently died in committee.

Read more at http://www.nashobapublishing.com/ci_27234675/committee-hears-scope-practice-bill#ixzz3TSnSbMbW.

WASHINGTON STATE ASKED TO GIVE HEALTH SECRETARY FINAL SAY ON SCOPE OF PRACTICE

House Bill 1339 would allow the Secretary of Health "intercede and stay any decision of a disciplining authority that expands scope of practice." This 2015 bill states, in part:

Scope of practice for all health care professions is determined by the legislature.
The scope of practice may be clarified, but not expanded, by a disciplining authority.
Disciplining authorities do, on occasion, impermissibly expand the scope of practice for a profession under the guise of clarification…
The bill specifies factors the Secretary of Health shall consider in determining whether a licensing board has improperly expanded a scope. These include required education and training, legislative intent, and whether the expansion encroaches upon the scope of another profession.

Editorial Note: Even if one concurs with the intent of this legislation, it is hard to accept the notion that a board's action should be overruled if a scope expansion "encroaches upon the scope of another profession." CAC News & Views believes there is no problem with overlapping scopes of practice so long as the professions involved have the training and skills to safely perform the healthcare services or procedures at issue.

Read the bill at: http://app.leg.wa.gov/billinfo/summary.aspx?bill=1339&year=2015.

National Governors Association Endorses Expanded Pharmacy Scope

The National Association of Boards of Pharmacy reported in its January newsletter that the National Governors Association recommends changes in state laws to permit pharmacists to participate in integrated healthcare teams:

> However, many state laws and regulations prevent pharmacists from being able to practice "to the full scope of their professional training," the NGA reports. The association suggests that states "seeking to integrate pharmacists more fully into the health care delivery system can examine state laws and regulations governing the profession." NGA identified three areas that can be considered:
>
> > Laws and regulations that guide collaborative practice agreements;
> >
> > Recognition of pharmacists as health care providers to ensure compensation; and,
> >
> > Pharmacists' access to health information technology systems.

The paper highlights Minnesota as one example of a state with regulations that support pharmacist-delivered services for chronically ill patients. In 2005, the state started covering medication therapy management for patients in Medicaid and state employee health programs. An evaluation of the initiative showed that participating pharmacists identified and resolved 587 drug therapy problems in the first year of the program.

Read the NGA's paper at http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1501TheExpandingRoleOfPharmacists.pdf.

See also this related story about the scope of practice of pharmacists in Saskatchewan: http://www.swbooster.com/Living/2014-10-31/article-3923530/Amendments-introduced-to-expand-pharmacists-scope-of-practice/1.

California Considers Addressing Scope via Obamacare Provision

Assembly Bill 41 before the California legislature would incorporate the "non-discrimination" section of the Affordable Care Act into state law. The bill would prohibit health insurers from preventing any health care professional from delivering services within their scope of practice. Supporters of the legislation, Ed Chau and David Beneveneto explained their position in an article in the December 16, 2014, *Sacramento Bee* entitled, "State Should Let More Providers Treat Patients."

Read more at http://www.sacbee.com/opinion/op-ed/soapbox/article4530285.html#storylink=cpy.

Physician Lawmaker in Montana Proposes Oversight of Alternative Medicine

On February 15, 2015, Troy Carter, staff writer for the *Bozeman Daily Chronicle*, wrote that State Representative Albert Olszewski, an orthopedic surgeon and member of the state medical association, has sponsored legislation that would create a "technical review committee" that would advise the Legislature on alternative health care practices by

midwives, acupuncturists, chiropractors and naturopathic physicians. The Montana Medical Association asserts that the existing licensing boards have expanded alternative medicine practice beyond what the legislature intended. Opponents of the legislation claim it would restrict consumer choice.

For more see http://www.bozemandailychronicle.com/news/mtleg/midwives-oppose-bill-that-could-restrict-alternative-health-care/article_d38b57ed-ef90-5860-90c0-bf3fea1f4a82.html.

CONTINUING PROFESSIONAL DEVELOPMENT

CONTROVERSIAL MODEL LAW ORGANIZATION FIGHTING MAINTENANCE OF LICENSURE AND CERTIFICATION

The American Legislative Exchange Council (ALEC), a controversial ultraconservative entity that promotes model legislation is disseminating the deceptively named "Patient Access Expansion Act" to the states. According to ALEC's summary of the act:

> This act prohibits the state from requiring any form of the Federation of State Medical Boards' proprietary Maintenance of Licensure program, including any Maintenance of Licensure program tied to Maintenance of Certification, as a condition of medical licensure, and additionally prohibits the state from requiring Specialty Medical Board Certification and Maintenance of Certification in order to practice medicine within the state. This act also prohibits state medical boards, and any agencies or facilities accepting state funding, from discriminating against physicians who do not maintain specialty medical board re-certification. This act in no way is intended to discourage lifelong learning or continuing medical education, and does not change the current status of physician licensure.

Read the legislation at http://www.alec.org/model-legislation/patient-access-expansion-act/.

PHARM TECH CERTIFICATION BOARD ADDS RECERTIFICATION REQUIREMENT

On April 21, 2014, the Pharmacy Technician Certification Board (PTCB) announced that pharmacy technicians will be required to take at least one hour of consumer safety continuing education to qualify for recertification:

> **Pharmacy Technician Certification Board Adds New Patient Safety Continuing Education Requirement for Recertification**
>
> WASHINGTON, April 21, 2014 /PRNewswire-USNewswire/ – The Pharmacy Technician Certification Board (PTCB) has announced that Certified Pharmacy Technicians (CPhTs) eligible to recertify are now required to complete one hour of continuing education (CE) in patient safety, in addition to the already required hour of law CE, as part of 20 hours of CE needed for recertification. The new requirement is one of the planned Certification Program changes PTCB announced early last year to advance CPhT qualifications…
>
> Eighty-nine percent of respondents to a profession-wide online survey conducted by PTCB in March 2012 supported adding a medication safety (equivalent to patient safety) CE requirement for recertification… Other planned Certification Program

changes include American Society of Health-System Pharmacists (ASHP)-accredited education requirements for certification by 2020, and additional changes in acceptable CE programs for recertification, including requiring all 20 CE hours to be pharmacy technician-specific ('T'-designated) in 2015. Allowable CE hours from college courses will be reduced from 15 to 10 by 2016, and allowable in-service CE hours will be phased out by 2018.

PTCB's program changes elevate PTCB's certification standards and thereby support and advance improved patient care and safety throughout pharmacy practice. The changes are the result of a PTCB initiative, which began with a 2011 summit on future directions for pharmacy technicians. Summit findings, combined with results from two profession-wide surveys, called for decisive changes in certification standards.

See PTCB's press release at http://www.virtualpressoffice.com/publicsiteContentFileAccess?fileContentId=1583719&fromOtherPageToDisableHistory=Y&menuName=News&sId=&sInfo.

ACCME Issues Reports about Continuing Medical Education

The Accreditation Council for Continuing Medical Education (ACCME®) is pleased to announce the publication of two reports addressing important issues in CME.

The first report reviews the literature about the effectiveness of continuing medical education. The second report addresses the question about whether there is a relationship between commercial support and bias in CME activities. The reports are *Effectiveness of Continuing Medical Education: Updated Synthesis of Systematic Reviews* and *Is There a Relationship between Commercial Support and Bias in Continuing Medical Education Activities? An Updated Literature Review.*

The first report found that CME is most effective if it is based on practice-based needs assessment, and is ongoing, interactive, and focused on outcomes that are considered important by physicians. The second literature review was inconclusive and recommends the development of rigorous scientific studies to address questions about the relationship between commercial support and bias in accredited CME.

For details see http://www.accme.org/news-publications/news/accreditation-council-cme-publishes-two-reports-addressing-important-issues.

ABIM Modifies Maintenance of Certification Program

On February 3, 2015, the American Board of Internal Medicine (ABIM) announced that it will postpone for two years portions of its Maintenance of Competence (MOC) requirements that relate to practice assessment, patient voice and patient safety. ABIM apologized to its credential holders for introducing these requirements before they were ready.

See the ABIM announcement at http://www.abim.org/news/abim-announces-immediate-changes-to-moc-program.aspx.

NEW GROUP OFFERS ALTERNATIVE MAINTENANCE OF CERTIFICATION OPTION

The newly created National Board of Physicians and Surgeons (NBPAS) is offering a path to maintenance of certification (MOC) in internal medicine specialties as an alternative to the requirements of the American Board of Medical Specialties (ABMS).

See more at http://nbpas.org/ and http://www.medpagetoday.com/PublicHealthPolicy/MedicalEducation/49553?xid=nl_mpt_DHE_2015-01-16&utm_content=&utm_medium=email&utm_campaign=DailyHeadlines&utm_source=ST&eun=g504008d0r&userid=504008&email=rebeccalebuhn%40cacenter.org&mu_id=5629123&utm_term=Daily.

The National Association of Boards of Pharmacy e-News reported in February 2015 that the Accreditation Council for Pharmacy Education (ACPE) has released two guidance documents related to continuing education and continuing professional development. For details, see: Definition of Continuing Education for the Profession of Pharmacy at http://nabp.net.bmetrack.com/c/l?u=4E36BC7&e=68AE69&c=8AB9&t=0&l=1161D654&email=ykfSJIUqLGX%2FpmSHZOtaW%2FANyf4zh32MmMYADqvCF08%3D and Guidance on Continuing Professional Development (CPD) for the Profession of Pharmacy at http://nabp.net.bmetrack.com/c/l?u=4E36BC8&e=68AE69&c=8AB9&t=0&l=1161D654&email=ykfSJIUqLGX%2FpmSHZOtaW%2FANyf4zh32MmMYADqvCF08%3D.

DISCIPLINE

STATE AUDIT FINDS FAULT WITH LONG-TERM CARE COMPLAINT HANDLING

An audit in the state of California found that the Department of Public Health is seriously deficient in the handling of complaints related to long-term healthcare facilities.

> As of April 2014, Public Health had more than 10,000 open complaints and ERIs (entity-reported incidents) related to long-term health care facilities and nearly 1,000 open complaints against individuals. Many of these open complaints and ERIs had relatively high priorities – indicating a safety risk to the residents – and had remained open for nearly a year on average. For example, the Santa Rosa–Redwood Coast district office prioritized 102 open complaints and ERIs related to facilities as immediate jeopardy – indicating a situation that poses a threat to an individual's life or health. These complaints and ERIs had remained open for an average duration of almost a year. Similarly, a significant number of complaints against individuals have remained open for long periods. By not ensuring that all complaints and ERIs are processed promptly, Public Health is placing at risk the well-being of residents of long-term health care facilities.

Read the report at http://www.centralvalleybusinesstimes.com/links/2014-111.pdf.

Editorial Note: Several years ago, CAC pointed out deficiencies in communication between facility regulators, Long-Term Care Ombudsmen and health professional licensing boards about complaints involving licensed professionals working in long-term care facilities. The California audit is noteworthy for several reasons, including the finding of 1,000 complaints against individuals, many of which have been open for "long periods." It is safe to assume that some of the individuals hold licenses from California's health profession regulatory boards. It is concerning to think that licensing boards are not receiving information they should know about the conduct of licensees in long-term care settings.

GUIDE TO DEVELOPING DISCIPLINARY GUIDELINES

The Fall 2014 issue of the Federation of State Boards of Physical Therapy's *Federation Forum* contains an article based on a presentation by Donna Moody, Manager Regulatory Affairs for the North Carolina Board of Nursing, entitled "How to Develop Regulatory Guidelines."

> Consistency in sanctioning is a question often raised by board members, licensees and their attorneys and as an issue on appeal. It is always important to include consistency and fairness in any disciplinary process… This article describes a framework for developing disciplinary guidelines for your disciplinary process in order to have consistency and fairness in the decision-making process. You will find resource documents at the end of the article to assist in developing your board's disciplinary guidelines.

Read the entire article at http://portal.criticalimpact.com/newsletter/newslettercontentshow1.cfm?contentid=21629&id=2614.

FAILURE OF REPORTING ALLOWS ABUSIVE NURSE TO CONTINUE PRACTICING

Washington Post reporter Peter Hermann wrote on December 20, 2014, about miscues in reporting that allowed a nurse accused multiple times of inappropriate behavior with patients to continue to practice in the District of Columbia and Maryland. When the D.C. Board of Nursing disciplined the nurse in September 2014, his identity became public and law enforcement and the Maryland nursing board took action.

Read the story at http://www.washingtonpost.com/local/crime/nurse-continued-to-work-in-dc-maryland-despite-allegations-of-sexual-abuse/2014/12/20/4711b660-73d2-11e4-a589-1b102c2f81d0_story.html.

ADMINISTRATION

BOARDS MET WITHOUT QUORUM, CASTING CLOUD OVER ACTIONS

Boston Globe reporter Todd Wallack reported on November 29, 2014, that the state boards of pharmacy, physician assistants, dentistry, and perfusionists met repeatedly without a quorum and cast 465 votes during those meeting between January 2008 and May 2013. Votes related to disciplinary action, investigations and licensure applications have been called into question.

See the article at http://www.bostonglobe.com/metro/2014/11/29/health-licensing-boards-voted-repeatedly-without-quorums/nB9ogqpPP9wna8sAyg3XCN/story.html?s_campaign=8315.

TELEHEALTH

MEDICAL BOARDS DIFFER ON REQUIREMENTS FOR "PHYSICAL EXAM" BEFORE TELE-PRESCRIBING

In an article in the online *National Law Review*, René Y. Quashie, Senior Counsel in the Health Care and Life Sciences practice, in the Washington, DC office of the law firm Epstein, Becker and Green, takes a position in favor of the permissive approach taken in the Federation of State Medical Board's Model Policy on telemedicine. Currently, some states require an in-person physical exam prior to prescribing via telemedicine; other state laws are less explicit, opening them to the interpretation that the "physical" exam could be electronic; another group of states explicitly permit exams via telemedicine.

The FSMB's Model Policy says this about prescribing:

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

Mr. Quashie embraces this approach, writing,

> Some states have adopted the FSMB's Model Policy in whole or in part. It is my hope that many more states will adopt the Model Policy as it represents a very positive step in the right direction toward harmonizing the disparate, inconsistent, and often confusing patchwork of state laws governing online prescribing.

Read the article at http://www.natlawreview.com/article/prescribing-and-telemedicine-physical-exam.

STUDY SAYS TELEHEALTH IMPROVES PAIN CARE

A study reported in the July 16 issue of the *Journal of the American Medical Association* found that automatic symptom monitoring by nurses could improve pain relief by about one pain point, which is clinically significant. Specifically, the authors concluded that: "Telecare collaborative management increased the proportion of primary care patients with improved chronic musculoskeletal pain. This was accomplished by optimizing non-opioid analgesic medications using a stepped care algorithm and monitoring."

Read the article at http://jama.jamanetwork.com/article.aspx?articleid=1887761#ArticleInformation.

MEDICAL BOARD TO DEVELOP STANDARDS FOR USERS OF TELEHEALTH

The Iowa Board of Medicine voted to initiate a rule-making process to establish standards of practice for physicians who use telemedicine in their medical practices:

> On October 3, 2014, the Board approved a notice of intended action to establish a rule that defines telemedicine, a valid physician-patient relationship, informed consent, and technology requirements for physicians who use electronic communications, information technology or other means of interaction between a physician in one location and a patient in another. The rule requires out-of-state physicians to have a valid Iowa medical license if they diagnose and treat patients located in Iowa.
>
> The rule's preamble notes that telemedicine is "a useful tool that, if applied appropriately, can provide important benefits to patients."
>
> The rule was born out of the Board's ongoing discussions about telemedicine and in reaction to health care providers who sought advice and guidance on telemedicine practices. Board staff conducted an extensive review of other states' laws and rules and national reports on telemedicine policies and practice standards, and a Board subcommittee met with representatives of Iowa physician and hospital organizations, medical educators, and other regulatory officials to identify precepts for a rule.
>
> The rule is the first time the Board has broadly addressed the application of telemedicine. In 1996, the Board issued a policy statement that embraced a nationally recognized standard that the practice of medicine is where the patient is located, not where the physician is located.

For more, see http://www.medicalboard.iowa.gov/Board%20News/2014/Press%20release%20-%20Board%20votes%20to%20establish%20standards%20for%20physicians%20who%20use%20telemedicine%20-%20October%2010%202014%20(2).pdf.

AMA SUPPORTS INTERSTATE COMPACT TO FACILITATE LICENSURE

At its 2014 Interim Meeting the AMA endorsed efforts to make it easier for doctors to obtain licenses in multiple states:

> A special compact designed to facilitate a speedier medical licensure process with fewer administrative burdens for physicians seeking licensure in multiple states received the support of the nation's physicians with a new policy adopted Monday at the 2014 AMA Interim Meeting. The model legislation was developed by the Federation of State Medical Boards (FSMB) to make it easier for physicians to obtain licenses in multiple states while providing access to safe, quality care. Under the new policy, the AMA will work with interested medical associations, the FSMB and other stakeholders to ensure expeditious adoption of the compact and the creation of an Interstate Medical Licensure Commission. "At least 10 state medical boards have adopted the compact, which streamlines the licensing process for physicians seeking licenses in multiple states and increases patient access to telemedicine services," AMA President Elect Steven J. Stack, MD, said in a news release. "We encourage more states to sign on to the compact so that we can ensure standards of care are maintained, whether treatment is provided in-person or via telemedicine."

The compact, which was released in July, is based on several key principles, including:

> The practice of medicine is defined as taking place where the patient receives care, requiring the physician to be licensed in that state and under the jurisdiction of that state's medical board. This tenant aligns with the principles for telemedicine that were developed by the AMA Council on Medical Service and adopted at the 2014 AMA Annual Meeting. See http://www.ama-assn.org/ama/pub/ama-wire/ama-wire/post/physicians-telemedicine-bolster-care-delivery.
>
> Regulatory authority will remain with the participating state medical boards, rather than being delegated to an entity that would administer the compact.
>
> Participation in the compact is voluntary for both physicians and state boards of medicine.

Please see http://www.ama-assn.org/sub/meeting/index.html, http://www.ama-assn.org/ama/pub/ama-wire/ama-wire/post/ama-backs-interstate-compact-streamline-medical-licensure and http://www.ama-assn.org/ama/pub/ama-wire/ama-wire/post/medical-licensure-streamlined-under-new-interstate-compact.

IN DEPTH

2014 SHIMBERG LECTURE DELIVERED BY CHARLES ORNSTEIN AND TRACY WEBER, REPRESENTING THE SHIMBERG PUBLIC SERVICE AWARD WINNER, PROPUBLICA

At its 2014 Annual Meeting in Baltimore, Maryland, the Citizen Advocacy Center presented the Ben Shimberg Public Service Award to ProPublica "for informing and protecting the public through in-depth research and incisive reporting about shortcomings in our healthcare system and oversight institutions." Charles Ornstein and Tracy Weber accepted the award on behalf of ProPublica, and delivered the following Ben Shimberg Memorial Lecture:

CHARLES ORNSTEIN

In many ways the Citizen Advocacy Center and ProPublica have a lot in common because we both focus on accountability, effectiveness, and transparency. ProPublica was founded to promote accountability journalism. We were founded also to bring about transparency in what we do as journalists and also in government operations. One thing that makes ProPublica unique is that we not only talk about transparency, we live it in what we do. So, we are deeply honored to be here to share our story with you tonight.

We are journalists, so let us start with stories. Here is one about a nurse named Orphea Wilson. She got her nursing license initially in Connecticut. As many healthcare professionals do, Orphea moved to another state, Florida. While there, she cared for a 21-month old boy who stopped breathing. Instead of calling 911, Orphea tried CPR on her own and then drove the boy's limp body three miles to his parents' home by which time he was dead. She lost her nursing license in Florida in 2004. Remember, she endorsed into Florida from Connecticut.

So, she returned to Connecticut to work there as a nurse. In 2005, she was caring for a three-year old boy who suffered from chronic respiratory failure and muscular dystrophy. He stopped breathing, as well. While the boy's father raced to his side and began performing CPR, Orphea stood by. It was too late and the boy died in the hospital the next day. Orphea lost her nursing license in Connecticut and went to prison.

What happened with Orphea Wilson could have been stopped. The State of Connecticut relied on nurses, including Ms. Wilson, to tell the truth on their renewal applications about the status of their licenses in other states. The State of Florida didn't see fit to tell Connecticut because it viewed it as another state's responsibility to know whether a nurse had been disciplined. Two states took different positions on this and two children died. To us, this symbolizes the importance of the work we are doing and also the importance of the work that CAC and licensing boards are doing. This is not a hypothetical or theoretical issue. The lives at stake are very real and the decisions that health professional licensing boards make on a day-to-day basis and in their policy decisions have the potential to impact the lives of children.

We did not initially intend to investigate the California Board of Registered Nursing. For a number of years Tracy and I had been covering a troubled hospital in South Los Angeles called King Drew Medical Center. This hospital served a poor community in South Central Los Angeles that was transitioning from being predominantly African-American to being predominantly Hispanic. We found that this hospital was harming the very people it was intended to help. In fact, some of the actions were deliberate. We wrote stories in 2003, 2004, 2005, 2006 and 2007 about actions taken at the hospital that harmed patients. We named individual caregivers who were responsible and who were terminated as a result.

One nurse turned down a patient's monitor because they were tired of hearing it alarm. The patient died, but the nurse pre-charted to indicate they had checked on the patient even at a time when the patient was dead. Another nurse gave an anti-cancer medication to a patient with meningitis and also was found to have turned down the alarm on a monitor. Another nurse ignored a patient while she was undergoing dialysis and the dialysis catheter came lose and was spurting blood across the room. Another nurse was fired because she falsified the CPR certification cards for employees at the hospital.

These are nurses whose discipline was upheld by independent arbiters. As Tracy and I wrote about these and other stories, including ones about organ transplant centers, we kept looking at the California nursing board's Web site to see whatever happened to these nurses. It was a great surprise to us that nothing happened to these nurses – at least right away. The questions that we had when we wrote these stories were these, "Is this a function of King Drew, or is this a function of nursing oversight in California? Is it that the hospital wasn't reporting discipline to the nursing board, or is there a bigger issue at play with the nursing board?"

We decided to build a database of every nurse who had been disciplined in California over the course of seven years. There were more than 2,000 in all. We hand-entered each of these disciplinary actions into our own database. One of the things we learned is that in California, the nursing board signs off on every discipline. So, board members presumably read these cases and signed off on them.

One thing became very clear as we went through the database: in California it took an average of 1,254 days from the point of a complaint to the issuance of discipline of a nurse. By way of

comparison, it Texas, it took 173 days and in Arizona, it took 197. So California was taking five or six times longer to impose discipline and during that time, nurses were able to work in multiple hospitals.

We found nurses like Owen J. Murphy, who twisted the jaw of one patient until he screamed and picked up a frail elderly man by the shoulders and slammed him against the mattress. He was fired from his job and reported to the nursing board, but was able to get another job at another hospital. At this other hospital, he beat up patients and was convicted for it. He then got a job at another hospital where he was fired for pulling out patients' hair. When Tracy caught up with him, he was working at a fourth hospital. He had taken anger management courses, but he told Tracy, "The nursing board is there to protect the public from me." This is a very telling quote from an individual like Murphy talking about the professional licensing board's responsibility. Indeed, if your state is anything like California and your board is anything like California's nursing board, the preamble to your law reads something like this: "Protection of the public shall be the highest priority for the Board of Registered Nursing in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

Think about your boards. Is the protection of the public paramount in what you do? Or, is the interest of the profession, including its interest in protecting its scope of practice, paramount in the decisions being made? When we went to meetings of the Board of Registered Nursing in California, what struck us was that we were the only ones there, other than union representatives representing the interests of the profession. The public wasn't there. What also struck us was that nobody on the board – not the staff members, nor the licensee members, nor the public members – asked questions about why it was that it took so long to discipline nurses. Why was it that they were looking at cases where the offense had taken place ten years earlier? Why was it that they were looking at a case where a nurse was able to get in trouble at five hospitals before the nursing board took action? These questions weren't asked at any of the meetings we attended.

We also looked at California's program for drug-addicted professionals. It is a lofty mission to help these people overcome their addictions rather than ending their careers. One of the things that we found was that, again, the protection of the public was secondary to the protection of the profession's interests. As may be the case in your states, California's program is confidential. In exchange for the board not pursuing discipline, the nurse agrees to the conditions set forth in a contract with the diversion program. Essentially, nurses voluntarily agreed not to work. But, the board's Web site showed that their licenses were active. When nurses were terminated from the diversion program, they were sometimes labeled a public safety threat. The problem was, the board didn't tell the public. It took an average of 15 months for the board to file accusations against these nurses. In the meantime, they were able to find work.

Tracy talked to another nurse named Tiffany Farney who had been enrolled in the diversion program after stealing and using painkillers. She was labeled a public safety risk in December 2005. The board didn't file its accusation against the nurse until January 2009. During the intervening time, she logged at least two arrests on drug-related charges. She told Tracy, "They terminate you. They say you are a danger to public society. Then it takes three years

for them to do anything. The nursing board should be all over me like a hawk. An addict, you've got to watch them like a baby." This is a person in the program. The board put its faith in the addicts and allowed them to control the rules of the program.

I talked to another nurse in the program named Annette Aquilias. She was in the diversion program because she sold drugs. Officially, she couldn't work without the board's permission, but she knew nothing would stop her. She told me, "I thought, this is good. I need to work. I need to pay my bills." She got an unauthorized job as a temporary nurse at a hospital and pleaded guilty to stealing Demerol on her first (and also her last) day. The hospital reported her to the board, but she remained in the diversion program. Months later, she got another job without permission. At this hospital, she appeared high and was accused of leaving a critically ill patient unattended. Two days later, she was kicked out of the diversion program. But, guess what, she got another job and stole drugs before the board filed the accusation against her. All told, it took three years to bring this case to fruition.

Another thing we found was that temporary staffing agencies were empowering these healthcare professionals. The level of protection they provided to the public was definitely inferior. We found that temp agencies shuffled nurses from one hospital to another, even as complaints mounted. We found one staffing agency that sent a nurse to hospitals despite more than a dozen warnings that she was ignoring her patients and sleeping on the job. Before she was hired, that nurse had been convicted of twelve crimes, including prostitution, carrying a concealed weapon, and possessing cocaine.

Nurses who got in trouble at one agency had no trouble landing a job at another. We found one Oklahoma nurse who cycled through at least four Southern California agencies in a year while being accused of pilfering drugs at each. Before her final stop, she was arrested in her home state for posing as a doctor's office employee and calling in prescriptions.

Nothing was being done to look at these temp agencies because the nursing board didn't view it as their job to regulate temp agencies. We came across a deposition in which a CEO of one of the temp agencies was asked about how they find and interview nurses.

Question:	"Do you speak to the prospective nurse before hiring them?"
Answer:	"Not necessarily."
Question:	"More often than not or less often than not?"
Answer:	"Less often."
Question:	"Infrequently?"
Answer:	"Hard to say. I certainly didn't speak to every nurse."
Question:	"How about meeting a particular nurse?"
Answer:	"Never."

Health professional licensing boards have a responsibility, we think, to pursue these sorts of things and determine whether they contribute to problematic healthcare professionals in your states, whether in nursing or other professions.

We also looked at healthcare professionals with criminal records and found that in California there is a rule that nurses licensed after 1990 must be fingerprinted, but nurses licensed before then don't need to be. What we found was that hundreds of nurses licensed before 1990 were getting arrested, but the board didn't know anything about it. Only after our story ran did the board require that all nurses be fingerprinted. I think the board was quite surprised by the immense number of arrest reports they received.

The ultimate conclusion is that the board operated with a philosophy of trust the health professional. Our philosophy as journalists is trusting is fine, but you have to verify. Trusting and verifying are essential parts of our job and I would argue they are essential to every job. The lessons we learned covering the California nursing board have broad applications to our future reporting, which Tracy will tell you about.

TRACY WEBER

After we investigated the nursing board, we decided to look at relationships between drug companies and physicians. We have a database on our Web site called "Dollars for Docs." It shows payments by drug companies to healthcare professionals for speaking and consulting. You can look up a doctor and see whether he or she received money from a drug company and for what and how much. We ran the top-paid doctors through the disciplinary boards and found that a lot of the doctors who received money for speaking and consulting were also disciplined doctors.

The Dollars for Docs project made us curious about who monitors the prescribing patterns of doctors and nurses. This was not a popular inquiry. The medical profession doesn't believe one should question what doctors and nurses prescribe or what procedures they perform. Nevertheless, we met with Medicare and persuaded them to give us data about prescriptions written for patients in Medicare's Part D program.

After enormous amounts of research about which drugs are dangerous for patients over 65, we added data to our Web site called "Prescriber Checkup." You can look up a doctor's name and see what drugs he or she prescribes and in what frequency. You can determine whether they prescribe drugs that are dangerous for patients over 65 and can compare their prescription pattern to others in the same specialty.

Of the top twenty prescribers of addictive painkillers, more than half had been disciplined or arrested and convicted. Yet, they were still prescribing in Medicare. Many had been arrested but not disciplined by their medical boards. This was a red flag that something is wrong. Neither Medicare nor licensing boards were looking at this data. When we asked medical boards about this, they told us several different things: "This is not our job." "We don't see complaints about this." "We don't have anyone qualified to do this." "We don't have access to the data."

The case of Chicago psychiatrist Dr. Michael Reinstein illustrates what the data reveals. One of our ProPublica colleagues teamed with the Chicago Tribune in 2009 and wrote about this doctor. The doctor worked with a chain of homes treating people with schizophrenia where he was prescribing tens of thousands of doses of Clozapine, a toxic and risky drug. We could see in the data that he was prescribing more than twice as much of this drug as his colleagues.

There were numerous complaints about Dr. Reinstein, but the medical board took no action against him until three years after our story.

Another doctor popped up in our data for prescribing 8,000 doses of Seroquel to patients over 65. Most of his patients were dementia patients in assisted living facilities. There is a black box warning on the medication saying it is really risky for dementia patients. These are incredibly vulnerable bed-ridden patients who don't have a voice and they were being drugged. This doctor had been kicked out of Medicaid in Florida for incompetence. Still there was no discipline on his medical board record in Florida.

Another doctor in Texas, Dr. Lewis, was the medical director for a string of nursing homes. We found multiple judgments against him, including one for $1.6 million involving the death of a patient. This case was not on his medical board record. Maybe licensing boards should run their doctors through ProPublica's Prescriber Checkup.

We have another database called "Treatment Tracker," which contains data on patients in Medicare Part B. You can look up how many procedures doctors are performing. You can see when a doctor is doing only the most expensive procedures or is claiming to do an impossibly large number of procedures.

The point is we now have lots of data. It is public data. Regulators should be looking at it. We interviewed patients and staffers and doctors. We found massive fraud in the Medicare program. This also should be looked at. Regulatory boards are a safety net. People go to your Web sites and when they find nothing, they feel good about the practitioner.

We found hundreds of doctors in Treatment Tracker who were billing only for the most expensive procedures. We have another database of referrals. Several of the most referred to doctors are being investigated or are already in jail for fraud.

Talk within your boards about how you are going to can use all this data that is now available. What are your responsibilities? The Sunshine Act will reveal even more documentation. Boards often look at the low hanging fruit such as DUIs and other states' discipline. Cases involving quality and competence are harder, but perhaps more worth pursuing.

Charlie and I have been thinking about some of the questions boards we think boards could ask themselves, given our experience talking with boards across the country:

Does your board post disciplinary data online? That enables everyone to look at accusations and disciplinary records. Nine medical boards and eight nursing boards still don't do this.

Does your board check with other states to see whether or not nurses in your state are being disciplined elsewhere? We found that not all states in the compact have the same disciplinary standards.

Do you ask questions, especially if you are a public member? As a public member, you see things that members of the profession may not see. You have to feel free to speak up and ask why it took so much time to pursue a case, or what allowed an offender to move to three hospitals before our board did anything about it.

What is your policy if someone is not complying with the terms of a diversion program? How quickly can your board react? Some states automatically revoke the licenses of professionals who fail. When we started looking at the California nursing board, we were told it was the

best in the country and that its diversion program was the best. This turned out to be untrue. We found things that weren't apparent from the outside.

Do you have a rigorous system for prioritizing cases? If a case comes in where patients are being put at risk, does that get immediate attention? It seems really basic to treat these cases first, but it doesn't happen everywhere. How do you flag those cases? How do you make sure they are assigned to a top investigator?

A judge once called me to take a look at a Los Angeles Juvenile Court system because he couldn't get people to pay attention to how bad the problems were. Sometimes systems need outside scrutiny. Sometimes you need someone to write about what is happening in order to get appropriations or focus attention to fix a problem. Sometimes problems are cultural. It isn't easy to shake things up.

Thank you.

MEMBERSHIP INFORMATION

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

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

We provide the following services to boards that become members:

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

The annual membership fees are as follows:

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

MEMBERSHIP ENROLLMENT FORM

To become a CAC Member Organization for 2015, please complete this form and mail or fax it to:

CAC

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

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

Payment Options:

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:

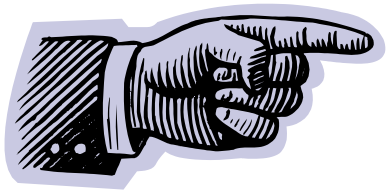
or

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 <u>all</u> of your board members and <u>all</u> of your staff, as well as many other benefits. But if you decide <u>not</u> to join CAC, we encourage you to subscribe to CAC News & Views by completing this form and mailing or faxing it to us.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2015 and back-issues for $240.00.**

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

Payment Options:

1) Mail us a check payable to **CAC** for the $240.00;
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.