D.C. Board of Medicine

INFORMATION FOR THE MEDICAL COMMUNITY AND THE PUBLIC FROM THE D.C. BOARD OF MEDICINE

Government of the District of Columbia
Adrian M. Fenty, Mayor

DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

September 2010
Volume 13 Number 3

INSIDE THIS ISSUE

YOUR MAILING ADDRESS

Changing your mailing address? Send your name, mailing address, and license number to:

Health Professional Licensing Administration
Department of Health
717 14th Street NW
Suite 600
Washington, DC 20005

RENEWAL — See page 3.

LETTER FROM THE CHAIR

The Board of Medicine met in April and in August to strategically plan for Board development. Some of the areas which the Board will undertake performance improvement measures or new initiative include:

- a review of all disciplinary processes and in particular a review of the process used to monitor physicians practicing under a consent decree.
- a review of the physician work force in DC
- a review of our application process for licensing and renewal
- a review of the technology used by the board
- the development of simulation programs to assess physician skills on re-entry to practice or as part of an assessment.

We look forward to hearing from you regarding your thoughts in these efforts and will keep you up to date as we review the work of the Board.

License renewal will commence on October 1, 2010. All physicians licensed in the District of Columbia will be required to renew their license prior to December 31, 2010. If you believe that your license renewal may be delayed for further review of circumstances which have arisen in the past two years, I recommend that you provide a complete disclosure of the concern and that you begin your renewal as early as possible to avoid delay and disruption of your practice. Look for renewal packages in the mail regarding the license renewal process.

As a reminder as you fill out your license this year, CME requirements for license renewal are as follows:

Physicians with an active license in the District of Columbia shall submit proof of having completed fifty (50) American Medical Association Physician Recognition Award (AMA/PRA) Category I hours of Board of Medicine approved continuing education credit during the two-year period preceding the date the license expires.

Random audits of CME documentation will begin after the renewal period in calendar year 2011.

Finally, the Board of Medicine is often called upon to address issues regarding the physician workforce in the District. The number of physicians and the type of practice they provide has not been adequately assessed until now.

Janis M. Orlowski, MD, MACP
Chair, DC Board of Medicine

Many physicians are licensed in DC but do not actually provide clinical work in the District to our residents. In order to assess the physician workforce and to begin to answer questions on this issue the license renewal process will be used to query physicians licensed in the District as to their time spent in clinical work in the DC and the greater metro area. We appreciate your support in this process.

Look forward to hearing from you with questions or concerns.

Sincerely,

Janis M. Orlowski, MD, MACP
Chair
Board of Medicine

From Where I Sit

by Jacqueline A. Watson, DO, MBA
Executive Director, DC Board of Medicine

Summer is officially over but **TEA** time is still in full swing at the Board of Medicine. We keep on working methodically to build the "best practice" framework that will enable us to become more **Transparent, Efficient and Effective, and Accountable**. August is traditionally a month of recess, however, this year the Board elected to meet in order to continue the strategic planning begun in April, during the annual board retreat, and to set concrete plans and realistic timeframes for achieving operational excellence. This work will continue throughout the new fiscal year.

IT'S TIME TO RENEW!
You should have received your renewal notices in the mail, and as you know, this renewal period will include an additional but critical step—a ***Healthcare Workforce Survey***—for Physicians and Physician Assistants. The survey will only take a few minutes and allow the Board to accurately capture, quantify and analyze our current physician workforce demographics and develop strategies for building the capacity needed in this new era of healthcare reform.

We are ready to process your renewal applications beginning October 1, 2010, and I encourage you to renew early so that there will be ample time to evaluate each application and address any areas of concern.

To renew online you will need Internet Explorer 6.0 or higher. Our system is not compatible with Firefox, Safari, and Google Chrome browsers and I know that this is frustrating for many of you. Please bear with us. Our IT staff is working to ensure that in the future our system will interface with all commonly used browsers and our online system will go through a complete update and face lift in FY 2011.

Since our last publication there are several significant activities that have taken place and/or are ongoing that are worthy of mentioning:

ACTIVITIES

- **New Attorney Advisor**
  We welcomed our new board attorney Eugene (Gene) Irvin, Esq. who comes to us after a seasoned career with the DC Department of Employment Services. (*Meet Gene on page 5.*) I would be remiss if I didn't take this opportunity to thank Ms. Carla Williams, Esq., who served as our Interim Attorney General, and capably guided us for three months until Gene was on board—Thank you Carla!
- **Physician Assessment and Remedial Programs**
  In June, I attended the **Center for Personalized Education for Physicians (CPeP)** seminar in Colorado to learn more about assessment and remediation programs available for doctors. Over the past several months, many states, including DC, have been receiving applications or queries from doctors who have left the active practice of medicine and are seeking to reenter the profession. BoMed has begun to work on a formal reentry policy for physicians returning to clinical practice and will refer to research conducted by the Federation of State Medical Boards (FSMB) for implementation guidance.
- **Colorado Board Visit**
  While in Colorado, I visited with the Executive Director of the Colorado Medical Board. The Colorado Board was again recognized by Public Citizen as one of the top ten best performing boards with respect to disciplining doctors and the ED shared best practice advice on methods to improve the District's monitoring and disciplining capacity.
- **Opioid Abuse Prescribing**
  In July, I presented testimony to panel members of the Joint Meeting of the Anesthetic and Advisory Committee and Drug Safety and Risk Management Advisory Committees to the FDA, on behalf of the Federation of State Medical Boards (FSMB) and the DC Board, in support of the FDA's proposal for a class-wide REMS (Risk Evaluation and Mitigation Strategy) for long acting opioid drugs. My testimony included BoMed support for the use of the handbook ***"Responsible Opioid Prescribing: A Physician's Guide"*** accredited for 7.25 Category 1 hours of Continuing Medical Education (CME) and that can be used to fulfill state medical boards CME requirements for licensure renewal.
- **Electronic Health Records**
  In August, I was asked to serve on the newly created Health Information Exchange (HIE) Steering Committee. The committee was established by the DC Health Care Financing Agency (HCFA) as a result of a cooperative agreement grant titled **"Connecting the Capital Region: The District of Columbia's HIE"**. The purpose of the grant, awarded to the District by the US Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) is to develop a "*District-wide HIE that will allow for the secure, appropriate exchange of patient-centered health information among treating providers of care to facilitate accurate and timely decision making and ultimately improve health care quality and outcomes*". The Committee consists of a diverse group of stakeholders that will meet over the next four months to provide policy and strategy guidance to HHS to facilitate the **"meaningful use"** of electronic health records in the nation's capital. Primary care doctors in the District serving Medicaid patients and interested in adopting electronic health records in their DC practice should contact the **DC Regional Extension Center (REC)**, the local organization that has the funds and is charged to help 100,000 primary care providers become "**meaningful users**". (*See page 6 for an article by David Blumenthal, MD, Director of ONC and page 7 for an article from Board Vice Chair, Wayne Frederick, MD.*)
- **Best Practices in Regulation**
  Later this month, I, along with designated staff members, will be attending the 9th International Association of Medical Regulators Authorities (IAMRA) conference in Philadelphia titled "Best Practices in Medical Regulation" and the Administrators in Medicine (AIM) regional conference in Baltimore.

As you can see, the Board, staff and I continue to work diligently and deliberately to make the DC Board a best practice board in the country.

Our next issue will be published in January—the first of our new fiscal year FY 2011 (October 1, 2010-September 30, 2011).

Until then, Be Well, Be Safe and Enjoy all the Holidays in between!

2010 LICENSURE RENEWAL

This is the year to Renew!

Your license will expire on 12/31/2010. You may renew your license online beginning October 1, 2010-December 31, 2010. **To renew online you must use Internet Explorer 6.0 or higher and pay by MASTERCARD or VISA. Our system is not compatible with Firefox, Google Chrome or Safari.**

This renewal period will include an additional but critical step — *a Healthcare Workforce Survey* — for Physicians and Physician Assistants. The survey will allow the HPLA to accurately capture, quantify, and analyze our current physician workforce demographics and practice information and develop strategies for building the capacity needed to meet the workforce needs of the future. **The data will be used for workforce statistical analyses and reporting purposes ONLY.**

To renew online, go to the HPLA website https://app.hpla.doh.dc.gov/mylicense/ and complete the steps as listed below.

1. **Workforce survey** (MDs/DOs and PAs) only. Voluntary survey
2. **Home Address:** Update and confirm your home address.
3. **Business Address:** Update and confirm your business address.
4. **Physician Profile:** Provide detailed information regarding your medical practice. MDs/DOs only.
5. **Renewal Questions:** Complete the renewal and screening questions.* Print a summary for your records.
6. **Fees and Payment:** Make payment (MC/VISA) and print the receipt for your records.

MDs/DOs must also update physician profiles and controlled substance registrations. Physician Assistants must also renew registrations.

Continuing Education (CE) is not required for those who are first time renewal applicants who were licensed by exam or were enrolled in an approved training program during any part of the two-year period prior to renewal. While we encourage the exempted licensees above to take CE courses, continuing education is not required of exempted licensees for this period.

MDs / DOs:	Must complete 50 hours of CME
PHYSICIAN ASSISTANTS:	Must complete 100 hours of CME or hold a current valid NCCPA certificate
ANESTHESIOLOGIST ASSISTANTS:	Must hold a current valid NCCAA certification
NATUROPATHIC PHYSICIANS:	Must complete 50 hours of CE
SURGICAL ASSISTANTS:	Must complete 50 hours of CE
CHIROPRACTORS:	Must complete 24 hours of CE

PLEASE NOTE ONLY CEs OBTAINED IN THE TWO (2) YEARS IMMEDIATELY PRECEDING THE APPLICATION DATE WILL BE ACCEPTED. **CE Audits will be conducted immediately following the renewal period. You may be contacted to submit proof of your documented CEs.**

PLEASE NOTE:

- If you answer YES to any of the renewal screening questions you MUST provide complete documentation.*
- If you would like to request a PAPER RENEWAL APPLICATION, please call 1-877-672-2174.
- If you would like to have your license placed in PAID INACTIVE status, please call 1-877-672-2174 for an application.

Frequently Asked Questions (FAQs): http://hpla.doh.dc.gov/bomed/faq

After 24 hours, you may verify your renewal at **http://app.hpla.doh.dc.gov/weblookup/**.

DC STATE HEALTH PLANNING AGENCY SEEKS PHYSICIAN VOLUNTEER

The State Health Planning and Development Agency (SHPDA) is seeking a physician to sit on their State Health Coordinating Council (SHCC). The SHPDA, an agency within the District's Department of Health, is responsible for planning, policy development, as well as data collection and analysis of the health care delivery system in DC. The SHPDA, with the advice and recommendation of the State Health Coordinating Council (SHCC), is also responsible for developing a Health Systems Plan adopted in accordance with rules issued to guide health policy in DC. The SHCC plays a major role in the review of certificate of need applications and in the Plan development process. The members appointed to the SHCC include: 1. Four consumers of health services who are not affiliated with any health care provider or facility; 2. Three public members; 3. Two representatives of incorporated associations of a health care facility in DC; 4. One physician representative of an incorporated association of professional physicians in the District; 5. One nurse representative of an incorporated association of professional nurses in the District; 6. One representative of an incorporated association of the health care insurance industry in the District; and 7. The Director of the Department of Mental Health, or his or her designee. The Council meets once a month, usually on the second Thursday of the month at 6:00 pm. The meetings are open to the general public. According to the law, members of the SHCC should receive no compensation, but may be reimbursed for actual expenses incurred in the performance of official duties. Those who are interested in serving on SHCC are requested to complete an application form (OBC Form 8), available at www.obc.dc.gov.

COUNSEL'S COLUMN

by Eugene E. Irvin, Esq.
Senior Assistant Attorney General & Board Legal Advisor

The Board has implemented some new directives that could have impact on your practice. This article will provide insight into those topics and impart guidance that will aid you in aligning your actions such as to be in compliance with the Board's policies.

LETTERS OF CONCERNS

The Board reviews each complaint against a physician for violations of the District of Columbia Health Occupations Revision Act of 1985, as amended. Of course, not all allegations rise to the level of a statutory violation. But this determination may not end the Board's consideration of the matter. The Board may feel that significant deviations from an acceptable course of conduct are evident in the doctor's approach to providing medical services. In those instances the Board may issue a Letter of Concern to the doctor.

The Board has reformatted their Letters of Concern to more keenly emphasize the area(s) in need of attention, and to encourage the doctor to address his or her vision of the circumstance at issue in writing. A key component of the doctor's response is a detailed plan for correcting the problem in such a fashion that recurrence is unlikely. The plan should indicate a definitive, constructive paradigm for correcting the defect and a specific timeline for implementation of each and every component part. The response to the Board is generally expected within 15 days from receipt of the letter.

It particularly important that a physician in receipt of a Letter of Concern give due regard to the letter and provide a thoughtful, comprehensive response that accurately details an intended course of action. A copy of the letter and response will be maintained in the physician's file and will evaluated by the Board as a reference source if similar complaints are received in the future.

TEMPORARY LICENSURE RULES

As a general principle every physician practicing a health care occupation in the District of Columbia must be licensed to do so by a governing board. This rule applies with equal vigor whether the practitioner does so on a permanent or temporary basis. It also has application to individuals participating in residency programs within the District. Each practitioner is personally obligated to ensure that their discharge of services is fully authorized by the governing board in advance of the commencement of their health care activities.

Three varieties of temporary licensure are available to practitioners. They are temporary license, temporary permit and medical training license. Each is different and specific to limited to its own circumstances.

A temporary license is a one year permit that is renewable in one year increments for a maximum period of two years, or at the discretion of the Board, for a greater period. It is academic training program specific, but does not require enrollment in a traditional of formal fellowship program. It is available to a practitioner licensed to practice outside the United States seeking authorization to practice in the District for longer than two weeks. The applying practitioner must not be licensed to practice in any state or territory in the United States. Enrollees in accredited and non-accredited fellowship programs and enrollees in non-accredited residency programs should apply for temporary licenses. Likewise, health care professionals invited to teach a health care curriculum should seek a permit of this type. A temporary licensure does not qualify the recipient for full licensure.

A temporary permit is an authorization to practice in the District for 2 weeks or less. Approval for this authorization is only possible where there is an affiliation with a D.C. licensed physician. The D.C. physician is required be on the site of the practice for the duration of the activity. The applicant must be licensed and in good standing in another state or territory of the U.S. A permit letter will be issued to the qualifying applicant which should be prominently displaced at all times at the practice site or readily available upon request, if display is not practicable.

A medical training license is an authorization required of any individual enrolled in a residency or fellowship program in the District. Generally this has application for individuals enrolled in an ACGME or AOA residency program, a U.S. residency program approved by the appropriate accrediting body, or a fellowship program. It may also apply to enrollees in a post-graduate training program in another U.S. state where the enrollee is on rotation to a program in the District. In any event, the enrollee does not yet qualify for full licensure in the District. Postgraduate physicians in training must apply to the Postgraduate Physician Trainee program every year that they are in the residency or fellowship program. The participant can expect to be exempted from full licensure for up to 5 years past graduation from medical school. However, an exemption beyond five years may be possible upon a showing to the Board of special circumstances.

(continued on page 5)

BOARD WELCOMES NEW LEGAL ADVISOR EUGENE IRVIN, ESQ.

Eugene E. Irvin, Esq.

The Board of Medicine welcomes the new Senior Assistant Attorney General for HPLA, Eugene E. Irvin, Esq. As our Board's attorney advisor, Mr. Irvin will provide legal counsel on health professional licensing and oversight matters.

With over 20 years of service in the United States Navy, Mr. Irvin served as Deputy Director Appellate Government Division; Staff Judge Advocate, Commander Navy Region MidAtlantic (Formerly Commander Naval Base Norfolk); Deputy Assistant Judge Advocate General, Civil Affairs; Assistant Force Judge Advocate, Commander Naval Surface Forces, US Atlantic Fleet; and Staff Judge Advocate, USS Nimitz (CVN 68).

In addition, Mr. Irvin has ten years of legal service to the DC government, most recently as General Counsel to the Department of Employment Services. In this position, he was the primary legal advisor to the director and program managers on matters relating to personnel law, training and recruitment regulations, workers' compensation law, wage-hour law, alien certification, OHSA standards and unemployment compensation law. He also served as the agency's ethics counselor and FOIA officer.

Mr. Irvin holds an LLM degree in Labor Law from The George Washington Law Center, a JD/MBA from the University of Kansas, and a BA in political science from Brown University. He has been awarded three Meritorious Service Medals, five Navy Commendation Medals and a Navy Unit Commendation. He holds admissions to practice with the DC Bar, Kansas Bar, Federal District Court in Kansas, Court of Appeals for the Armed Forces, Navy-Marine Court of Criminal Appeals, and the United States Supreme Court.

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PATIENT ABANDONMENT

Practitioners must be careful not to cease providing services to a patient without sufficient regard for the patient's continued well being. Physician should bear in mind that this is a key standard of care issue. The DC Board of Medicine regulations on patient abandonment states:

> A licensed physician shall not abandon a patient whose care a licensed physician has undertaken without giving notice to the patient far enough in advance of the discontinuation to allow the patient time to secure appropriate substitute care. District of Columbia Municipal Regulations Title 17, § 4612.6.

Physicians are obligated to ensure that viable arrangements have been put in place with due consideration for the time necessary for the patient to seamlessly transfer to the care of another physician. The patient's well must be kept paramount at all times.

Familiarity and compliance with the requirements in these areas should aid responsible practitioners in avoiding incidents that could become the subject of Board review.

DC BOARD OF MEDICINE MISSION STATEMENT

"To **protect** and enhance the health, safety, and well-being of District of Columbia residents by **promoting** evidence-based best practices in health regulation, high standards of quality care and implementing policies that **prevent** adverse events."

PROMOTING USE OF HEALTH IT: WHY BE A MEANINGFUL USER?

by DAVID BLUMENTHAL, MD, MPP, National Coordinator for Health Information Technology, Department of Health and Human Services

DR. DAVID HUNT OF THE ONC SPEAKS TO THE BOARD OF MEDICINE

Above: David R. Hunt, MD, FACS, Chief Medical Officer for the Office of the National Coordinator for Health Information Technology (ONC).

Dr. Hunt addressed the Board on the US HHS Health Information Technology (HIT) initiative to promote the meaningful use of adopting electronic medical records.

Below is an article provided by Dr. Hunt on behalf of his boss, who is the National Coordinator for Health Information Technology.

DAVID BLUMENTHAL, MD, MPP serves as the National Coordinator for Health Information Technology under President Barack Obama. In this role he is charged with building an interoperable, private and secure nationwide health information system and supporting the widespread, meaningful use of health IT. Previously, he was a practicing internist at Massachusetts General Hospital and the Samuel O. Thier Professor of Medicine and Professor of Health Policy at Harvard Medical School.

As I write, physicians throughout the United States are deciding whether to become meaningful users of electronic health records by 2011 when Medicare and Medicaid start making extra payments to meaningful users. For some the decision may be pretty simple. Almost 200,000 doctors already have adopted EHRs and are using them at a basic or sophisticated level. For these physicians, the journey to meaningful use, and its financial and clinical rewards, may be comparatively short. Many other doctors, however, remain undecided.

I don't want to minimize the obstacles. When I started using an EHR, I found it challenging. I often longed for a dose of my old prescription pad (confession – I cheated once in a while). I chafed at reconciling medication lists, updating problem lists, scanning through seemingly endless consultant notes. (In the past, many wouldn't have been available – lost somewhere in the paper world.) It was much easier to use the triplicate x-ray requisition I had used for 30 years than the radiology order entry software required by my EHR. My visits were longer and more complicated. Every time I turned on the computer, it seemed, I had to learn something new.

But I am glad I did it, as are 90 percent of all physicians who adopt an EHR, according to a scientific survey published in the New England Journal of Medicine. My EHR made me a better doctor. I really knew what was going on with my patients. I could answer their questions better and more accurately. I made better decisions. I felt more in control.

Physicians don't go into medicine because it's easy. They go through grueling training – spending endless days and nights at the bedside or in the OR. They face tough personal and clinical decisions throughout their professional lives. They constantly have to grow and learn to keep up with the science and practice of medicine. That's what makes them the professionals they are. That's what earns their patients' and colleagues' respect and admiration. That's what gets them up in the morning knowing there's nothing else they would rather be doing.

The EHR is just another of the transitions that physicians are constantly called upon to make in the interest of their patients, their professional competence, and their professional self-esteem. Its advent is inevitable – no more avoidable than the arrival of the stethoscope in the early 1800s or anti-sepsis in the mid 1800s (both of which some physicians furiously resisted) or the ICU in the mid-1900s. Positive change is often disruptive, but it is irresistible nevertheless. In 10 years, paper records will be the exception. Lagging physicians will be seen as quaint throwbacks, no longer at the top of their game, nostalgic reminders of a bygone age when offices brimmed with manila folders and piles of forms, or when nurses and doctors searched endlessly on hospital rounds for that one essential patient chart that always seemed missing from the nursing station. (How many millions of hours have clinicians spent wandering hospital floors looking for those elusive missing paper records?).

Still, some physicians may be tempted to put off the inevitable, trying to postpone the disruption and expense. Why not wait five or six years? Maybe it will get easier? Less expensive?

For several reasons. First, the sooner physicians start using an EHR, the sooner they and their patients will realize its benefits – the ability to share patient data with colleagues and patients, the ability to retrieve old data effortlessly, the ability to access patient records remotely, so they answer patient questions intelligently from home, or even from a medical meeting.

Second, **right now, the federal government is making a once in a lifetime, never to be repeated, offer: it will help physicians pay for the transition with up to $44,000 in extra fees from Medicare, or $63,750 from Medicaid. Physicians can take the leap now with financial and technical help from the government.*** Or they can do it on their own (or facing a financial penalty) in five years.

Third, anyone who is building a practice, and wanting to recruit young, talented physicians needs to confront the reality that the next generation will expect and demand that their own medical home have a modern information system. I know this from personal experience. With two children in medical school, and a daughter in law who is an intern, I know young physicians will never settle for paper records. Wait, and the cream of the recruiting crop will pass you by.

To me the choice is clear. Physicians' professional, clinical and financial interests all point in the same direction. Become part of the future. Become a meaningful user of an electronic health record.

*** FOR FUNDING INFORMATION, CONTACT DC REGIONAL CENTER (REC):**
Donna Ramos-Johnson Email: dramosjohnson@dcpca.org
Phone: (202) 638-0252 Website: www.dcpca.org

ELECTRONIC HEALTH RECORDS

by Wayne A.I. Frederick, MD, FACS
Vice Chair of the DC Board of Medicine

Electronic medical records are presently being utilized and installed throughout healthcare facilities in the United States. They have been around in some form or fashion for the better part of the last three decades. Medical records in general have been an integral part of medicine dating back to the early Egyptian physicians who recorded health events in various heliographies. Medical records are used to record patients' medical histories, family medical histories, current medical events, medications, procedures, diagnostic imaging and the results of those, and patients' directives with respect to end of life desires. One very important function associated with the keeping of medical records is the communication of information from one provider to the next. Today's handwritten medical records are often difficult to read because of poor penmanship and the inconsistent use of terminology from one healthcare provider to another. The inconsistency of record keeping and lack of portability of non-electronic medical records has resulted in poorer quality care, increased costs, and less access to care.

The adoption of the electronic health record has been accelerated by the Health Information Technology for Economic and Clinical Health Act (HITECH Act) that was signed into law in 2009 by President Obama under the American Recovery and Reinvestment Act of 2009. The Centers for Medicareand Medicaid Services (CMS) were given authorization to implement incentive programs toreimburse healthcare providers and hospitals that "meaningfully use" certifiedelectronic health record (EHR) technology. Implementation of qualified, certified EHRs formeaningful use may reduce errors, increase availability of records and data, provide remindersand alerts, provide clinical decision support, and increase e-Prescribing and automatic refillsystems.The Medicare incentive program offers payments to healthcare providers (e.g., a doctor of medicine orosteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, adoctor of optometry, or a chiropractor, who is legally authorized to practice under state law),eligible hospitals, and critical access hospitals that are meaningful users of certified HERtechnology. Certain specialty hospitals, such as rehabilitation, psychiatric, long-term care,children's, and cancer hospitals, are ineligible to partake in the Medicare incentive program.

An EHR also represents a huge potential for cost savings and decreasing workplace inefficiencies. However, just as there are advantages and disadvantages with the paper medical record, there are also advantages and disadvantages associated with the EHR. In addition, since an EHR is a fairly newconcept, there will also be barriers and obstacles in the implementation of the EHR. There have been phenomenal scientific and technological breakthroughs, yet patient documentation remains largely the same. Even though the technology is available for an EHR there are several barriers and obstacles that must be overcome before it can be successful. Technology has continued to move forward at a rapid pace, but many organizational and human issues have slowed the pace of implementation of automated systems for an electronic documentation record.

The EHR has several distinct advantages over paper health records. One definite advantage is the fact that there are increasing storage capabilities for longer periods of time. Also, the EHR is accessible from remote sites to many people at the same time and retrieval of the information is almost immediate. The record is continuously updated and is available concurrently for use everywhere. Information is immediately accessible at any unit workstation whenever it is needed.

The EHR can also provide medical alerts and reminders. EHR systems have somebuilt-in intelligence capabilities, such as recognizing abnormal lab results, or potential life-threatening drug interactions. Research findings supporting diagnostic tests and the EHR can link the clinician to protocols; care plans, critical paths, literature databases, pharmaceutical information and other databases of healthcare knowledge. Computer systems should not take the place of physicians' critical judgments however, a well-designed EHR supports accountable autonomy, collecting and disseminating information to assist the medical professional in decision making. The avoidance of near misses and the shorter time to intervention in critical situations will result in significant cost savings that are obvious but difficult to measure.

As a management tool, the EHR can provide information to improve risk management and assessment outcomes. Today, reimbursement is based on outcomes therefore healthcare organizations must seek innovative ways to improve quality of care and outcomes while managing costs. An EHR can decrease charting time and charting errors, therefore increasing the productivity of healthcare workers and decreasing medical errors due to illegible notes. Reduction of medical errors is the concern of the public at large, state legislators, healthcare providers, and many other health professionals. There have been numerous stories about fatal mistakes occurring because of illegible notes written by physicians. EHRs address a problem that has plagued medical staff very possibly since the first doctor put pencil to paper.

In conclusion, there is no denying the potential savings that electronic health records would provide. These savings will be realized with improved operational efficiency and decreased errors with increased safety. This savings benefit has to be balanced with the significant start up costs and continued maintenance. The potential investments in improvements in future years along with the attempts to merge the records will potentially be costly.

"There is no denying the potential savings that EHR would provide. These savings will be realized with improved operational efficiency and decreased errors with increased safety. This savings benefit has to be balanced with the significant start up costs and continued maintenance. The potential investments in improvements in future years along with the attempts to merge the records will potentially be costly."

RIGHT Rx AND PERINATAL COLLABORATION: NEW INITIATIVES FROM DC HEALTH CARE FINANCE

by Paul T. Smith, MPA, Associate Director, Health Care Accountability Administration and
Jamie C. Wilkins, PharmD, Pharmacist, Health Care Accountability Administration

On June 30, 2010, Jamie C. Wilkins, Pharmacist, and Paul T. Smith, Associate Director with the Health Care Accountability Administration, of the District of Columbia Department of Health Care Finance, presented two exciting new initiatives to the Board of Medicine, the "Right Rx" and "Perinatal Collaborative" initiatives.

Jamie C. Wilkins and Paul T. Smith

RIGHT Rx INITIATIVE

The Right Rx Initiative is a joint venture of the District of Columbia Medicaid Pharmacy and Therapeutics (P&T) Committee and Drug Utilization Review (DUR) Board. Right Rx provides decision and administrative support to clinicians to facilitate:

1. Ease of Prescribing and,
2. Appropriate use of medications by Medicaid beneficiaries.

This initiative will provide electronic access to a listing of preferred medications that do not require a prior authorization, information to assist prescribing, and evidence-based information on drug classes. It will serve to promote cost-effective pharmaceutical care for current and future beneficiaries. This will assist prescribers in quickly accessing the preferred drug list, prior authorization forms, evidence based guidelines, and dosing/class conversion assistance to ensure that the most cost-effective pharmaceutical care is being provided.

PERINATAL COLLABORATIVE

The Perinatal Collaborative is a partnership with District Medicaid Managed Care Organizations (MCOs), healthcare experts, and stakeholders; the goals of this collaboration are to reduce the rates of:

- preterm births and infants born with low birth weight
- miscarriages
- babies who are HIV positive, and
- infants who die in the first year of life.

The Collaborative was formed because of the high infant mortality rate in the District, the ability to effect positive change and provide for consistency in quality improvement initiatives, as well as the need to bring resources together around a common goal.

In the past year, the Collaborative has improved and standardized the MCO assessment and authorization processes for perinatal care, implemented psychosocial and case-management tools, developed formal measurement specifications with baseline data, and designed a standard case-management resource website.

For more information about the Collaborative or to become involved, please email Paul Smith at **paul.smith@dc.gov.**

BoMED NEWSFLASH

OPEN SESSION TIME CHANGE: Open Session for Board of Medicine meetings will now take place from 10:30 am to 12:00 noon on the last Wednesday of every month. If you would like to register to attend or present information during Open Session, please contact Health Licensing Specialist Lisa A. Robinson at lisaa.robinson@dc.gov.

E-NEWS: The BoMed Newsletter will be available as an e-newsletter. To register to receive e-news updates from BoMed, please go to www.hpla.doh.dc.gov/bomed and click the link.

BoMED COLLABORATES WITH EMERGENCY PREPAREDNESS AGENCY

Emily Litt, RN

Emily Litt, RN, Chief of Staff of the DC Department of Health Emergency Preparedness and Response Administration (HEPRA), met with Board members to brief them on the District's state of readiness, and to forge stronger bonds between the Board and HEPRA. Ms. Litt informed Board members about HEPRA's ongoing coordination with federal partners. In addition, she urged physicians to log-on and register at DC Responds—HEPRA's online registry for medical and non-medical volunteers (**www.dcresponds.dchealth.com**). DC Responds integrates local, regional, and statewide volunteer programs and is part of a national initiative to mobilize volunteers. BoMed Chair Janis Orlowski noted a number of physicians who volunteer, but who are not on the DC Responds list. Ms. Litt said that some physicians may be hesitant to register at DC Responds because they know they would likely not be available to help outside of their hospital.

PUBLIC CITIZEN'S SIDNEY WOLFE, MD SPEAKS WITH BOARD

Sidney Wolfe, MD

Sidney Wolfe, MD, spoke with Board members about the purpose of the Public Citizen organization, and about PC's ranking of Medical Boards. PC ranks boards according to the number of disciplinary actions taken against licensees. Board members asked Dr. Wolfe what, in his opinion, are the characteristics of a highly functioning board. He stated that excellent leadership, adequate staffing, and high public reporting numbers are the leading indicators of an effective board. The Board asked about malpractice suits and Dr. Wolfe stated that all malpractice suits should be looked at, and acted on. Especially if there are multiple actions. Dr. Wolfe suggested the Board pay closer attention to hospital disciplinary actions; he stated that he feels hospitals do a poor job of peer review and discipline, and feels boards should take their own action. Dr. Wolfe is a general internist who became a consumer advocate.

DR. BARRY LEWIS APPOINTED TO THE BOARD'S ANESTHESIOLOGIST ASSISTANT ADVISORY COMMITTEE

Barry Lewis MD, MBA

In June, Mayor Fenty appointed Barry Lewis MD, MBA, to serve as an Anesthesiologist member of the Board of Medicine's Anesthesiologist Assistant Advisory Committee.

Dr. Lewis arrived in the DC/Baltimore area in 1994, to train in anesthesiology at the Johns Hopkins Hospital. In 1998, he moved to Washington DC to begin his private practice at Sibley Memorial Hospital and followed with an academic position as a faculty member for the Anesthesia and Critical Medicine Department at Johns Hopkins Hospital. His focus at Hopkins was regional anesthesia, OR coordinator, and resident education.

Seven years ago, Dr. Lewis joined the staff at Washington Hospital Center. His roles have included resident and anesthetist training, participation in the acute pain service, and assisting in the development of the regional anesthesia service. His service responsibilities have spanned the hospital organization including the operating room, radiology suites, the emergency rooms, and the electrophysiology lab.

Dr. Lewis's career has been focused on delivering quality care for each individual patient. In addition, he has had an ongoing interest in the impact of organizational structure and financial allocations on the delivery of patient care. This drive fueled a desire to acquire an MBA with the focus on health care management.

Dr. Lewis, his wife, and 3 children are proud members of the Washington DC community. As a committed member, he is excited to utilize his academic and clinical experiences to serve as a member of the Anesthesiologist Assistant Advisory Board.

BoMed Executive Director Dr. Jacqueline Watson visited headquarters of the National Board of Osteopathic Medical Examiners (NBOME) to observe the administration of the COMLEX USA exam (USMLE counterpart for assessing the competency of osteopathic medical students and physicians). Below is an article submitted by the president of NBOME on the status of the Osteopathic profession and their contribution to the physician workforce throughout the country.

OSTEOPATHIC PHYSICIAN WORKFORCE

Contributed by John R. Gimpel, DO, MEd, President and Chief Executive Officer of the National Board of Osteopathic Medical Examiners

While we are regularly confronted with dire predictions about impending physician shortages—particularly in the areas of primary care—the world of osteopathic medicine is proving to be a bright spot in an otherwise gloomy forecast. Osteopathic medical schools represent the fastest-growing element of US medical education. Over the last decade, DO medical schools have grown from 19 colleges with just over 10,300 students to 26 colleges with more than 18,000 students. Currently, one in five US medical students is attending an osteopathic medical school.

According to the American Association of Colleges of Osteopathic Medicine (AACOM), applications to US colleges of osteopathic medicine have risen for the fourth straight year, increasing from 12,875 in 2009 to more than 13,380 this year. And the other good news is, approximately 60% of osteopathic physicians choose to practice in the areas of family medicine, internal medicine, obstetrics and gynecology, and pediatrics. (Reference: AOA letter to the Editor of *The Wall Street Journal*, http://wwwdo-online.org/index.cfm?PageID=mcWSJ April2010&Prev=Y)

As a result, licensing boards, graduate medical education directors and others in a position to review physician credentials are likely to more often encounter applications from osteopathic physicians who have taken the COMLEX-USA series of examinations. The National Board of Osteopathic Medical Examiners (NBOME) created the COMLEX-USA series, and is its sole administrator. Like the District of Columbia Board of Medicine, the heart of our mission is to protect the public, and we do this primarily through COMLEX-USA, the means by which we assess the competency of osteopathic medical students and physicians.

COMLEX-USA provides the pathway to initial licensure for osteopathic physicians and is accepted in all 50 states and many international jurisdictions. The Federation of State Medical Boards of the United States has undertaken a comprehensive review of COMLEX-USA and the USMLE, and concluded that both are valid and reliable for their respective intended purposes, stating: "the evidence supporting the validity of score-based inferences for COMLEX-USA" was "exemplary."

As a profession, osteopathic medicine honors its shared social contract with the public and its critical role in self-regulation by assuring osteopathic physicians are licensed based on the COMLEX-USA series, which assesses the skills and philosophy unique to the osteopathic medical profession and is designed based on the practice patterns of osteopathic physicians. As a result of its design, COMLEX-USA is the most appropriate assessment tool to measure the competencies of an osteopathic medical student or physician. In fact, in 2007 the Commission on Osteopathic College Accreditation, the accrediting agency for osteopathic medical schools, made passing the COMLEX-USA examination (Levels 1 and 2-CE and PE) a requirement of graduation from a college of osteopathic medicine.

The COMLEX-USA series assesses the osteopathic medical knowledge and clinical skills considered essential for osteopathic generalist physicians to practice unsupervised medicine. It is constructed in the context of medical problem-solving, which involves clinical presentations and physician tasks.

The COMLEX-USA series is an examination sequence with three Levels, and the blueprint for the examination has two dimensions that are present in all the Levels taken. The Clinical Presentation ("Dimension I") of the COMLEX-USA examination identifies high-frequency and/or high-impact health issues that osteopathic generalist physicians encounter in practice. The Physician Task ("Dimension II") specifies the major steps osteopathic physicians generally undertake to solve medical problems.

COMLEX Level 1

A computer-based, cognitive evaluation that emphasizes medical science concepts and principles necessary for understanding health and disease.

Level 1 integrates the medical sciences of anatomy, behavioral science, biochemistry, microbiology, osteopathic principles, pathology, pharmacology, physiology and other areas necessary to solving clinical problems and promoting and maintaining health.

COMLEX Level 2 - Cognitive Evaluation

A computer-based, cognitive evaluation that emphasizes the medical concepts and principles necessary for making appropriate medical diagnoses through patient history and physical examination findings.

Level 2-CE integrates the clinical disciplines of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, osteopathic, principles, pediatrics, psychiatry, surgery, and other areas necessary to solve clinical problems and promote and maintain health.

COMLEX Level 2 - Performance Evaluation

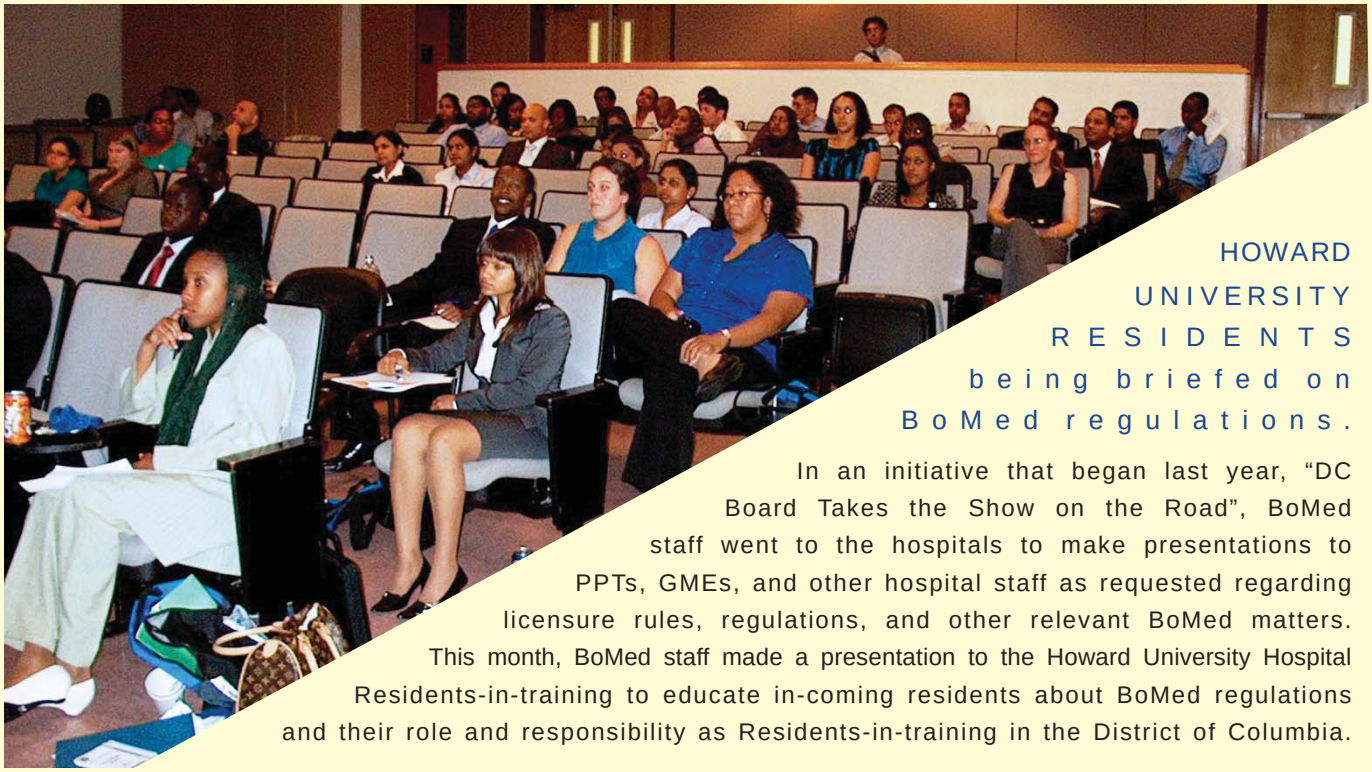
A standardized patient-based clinical skills examination that assesses fundamental clinical skills, including physician-patient communication, interpersonal skills and professionalism; medical history-taking and physical examination skills; osteopathic principles and osteopathic manipulative treatment; and written communication skills, including synthesis of clinical findings, integrated differential diagnosis, and formulation of a diagnostic and treatment plan.

COMLEX Level 3

A computer-based, cognitive evaluation that emphasizes the medical concepts and principles required to make appropriate patient

(continued on page 11)

BoMED TAKES ITS SHOW ON THE ROAD AT HOWARD UNIVERSITY HOSPITAL



HOWARD UNIVERSITY RESIDENTS being briefed on BoMed regulations.

In an initiative that began last year, "DC Board Takes the Show on the Road", BoMed staff went to the hospitals to make presentations to PPTs, GMEs, and other hospital staff as requested regarding licensure rules, regulations, and other relevant BoMed matters. This month, BoMed staff made a presentation to the Howard University Hospital Residents-in-training to educate in-coming residents about BoMed regulations and their role and responsibility as Residents-in-training in the District of Columbia.

Would you like to have Board of Medicine staff come to your hospital, agency or organization to present information on BoMed requirements and regulatory updates?

If so, please contact Board Health Licensing Specialist Ms. Aisha Williams:

Mailing Address
DC Board of Medicine
717 14th Street, NW, Suite 600
Washington, DC 20005

Email aisha.williams@dc.gov
Phone (202) 724-8750
Fax (202) 724-8677

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management decisions. Level 3 integrates the clinical disciplines of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, osteopathic principles, pediatrics, psychiatry, surgery, and other areas necessary to solve clinical problems and promote and maintain health.

While all examination Levels have the same two-dimensional content structure, the depth and emphasis of each Level parallels the educational experiences of the candidate. This progressive nature of the COMLEX-USA examinations ensures the consistency and continuity of the measurement objectives of the osteopathic medical licensing examinations. Osteopathic principles and practices, by design, are integrated throughout all areas of the examination, as this best reflects the manner in which osteopathic principles and practices permeate osteopathic medicine.

Rigorous and industry-standard methodology is used in NBOME's processes for standard setting.

Members of state medical licensing boards participate in NBOME committees, examination development, and standard setting. (Please visit the NBOME website, www.nbome.org, for a more detailed description of each of the COMLEX-USA Levels and standard setting procedures, and please do contact NBOME if you would like further information or would like to get involved.)

The NBOME is proud of the role it plays in helping to ensure the public safety by providing the means to assess competencies for osteopathic medicine and related health care professions through the COMLEX-USA series of examinations. In the 75 years since its establishment, the NBOME has gained considerable recognition for excellence in the national and the international arena of physician testing and evaluation. Looking ahead, we continue to enhance the COMLEX-USA series to meet the needs of the profession, and create new assessment tools in order to fulfill our vision of becoming the testing organization for the entire osteopathic profession.

FILING A COMPLAINT WITH THE BOARD

To file a complaint against a licensed DC physician or other licensee under the authority of the Board, simply write a letter that describes your complaint. The letter must be signed, and you should attach copies of any pertinent documents that you may have. The letter must also include your address, so we may contact you as necessary and notify you of any findings.

Please note: You can print a complaint form from our website at www.hpla.doh.dc.gov/bomed

You should mail the complaint to:

DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

You can also fax the complaint to the Board at (202) 724-8677.

If your complaint alleges unlicensed activity, you should address your complaint to:

Supervisory Investigator
717 14th Street, NW
Suite 1000
Washington, DC 20005

You can also fax your complaint about unlicensed activity to (202) 724-8677.

Please be advised that the Board of Medicine does not have jurisdiction over fee disputes, except for billing for services that were not provided. If you have a fee dispute with a health professional, you can seek redress through the civil courts.

BOARD MEETING SCHEDULE

UPCOMING MEETINGS:

SEPTEMBER 29

OCTOBER 27

NOVEMBER 17*

DECEMBER 15*

The Board of Medicine (full board) meets on the last Wednesday of every month.

Open Session 10:30 am - 12 noon.

**early meeting date due to holidays.*

BoMed STATS

Total Active Licenses as of August 31, 2010

MEDICINE AND SURGERY	9,691
OSTEOPATHY AND SURGERY	173
PHYSICIAN ASSISTANTS	535
ACUPUNCTURISTS	168
ANESTHESIOLOGIST ASSISTANTS	21
NATUROPATHIC PHYSICIANS	22
SURGICAL ASSISTANTS	56
POLYSOMNOGRAPHERS	0
TOTAL	10,666
POSTGRADUATE PHYSICIANS IN TRAINING (PPT ENROLLMENT)	1,098

HAVE A COMMENT FOR US?
SEND AN EMAIL TO DCDOCSSPEAK@DC.GOV
OUR NEW WEB ADDRESS: WWW.HPLA.DOH.DC.GOV/BoMed

BOARD ORDERS

June 1, 2010 - August 31, 2010

Revoked

Qurtom, Helmy (M.D.) (5/10/10) The physician's license was revoked based on his surrender of license while under investigation. The investigation began based on actions in other jurisdictions, where he also surrendered while under investigation for unprofessional conduct. [Pediatrics]

Summarily Suspended

Akhigbe, Ehigiator (M.D.) (3/22/10) The physician's license was summarily suspended based on a felony conviction for Medicaid fraud. [Pediatrics]

Probation

Brown, Jr., William (M.D.) (5/26/10) The physician was permitted to reinstate his license and placed on probation for a minimum of three years, limited to prescribing no scheduled substances except Schedule V controlled substances, prohibited from treating patients suffering from addiction, and shall be monitored through unannounced audits of his records. This was based on his prescribing of drugs when not authorized and submitting false statements to collect fees for services not rendered.

Hope, Shelly-Ann (M.D.) (5/26/10) The physician was reprimanded and placed on probation retroactive to her North Carolina probation. Also prohibited from prescribing medication for any parson without first personally performing a physical examination. This was based on the North Carolina action.

Fined

Fitzgerald, Michael (M.D.) (3/11/10) The physician was fined by consent order and ordered to two CME courses, for failure to meet the standard of care. [Emergency Medicine]

Fined (continued)

Kerr, Paul B. (M.D.) (5/10/10) The physician was fined by Consent Order and also reprimanded for failing to disclose two disciplinary actions to the Board, and for treating an individual with controlled substance without forming a physician-patient relationship. [Neurology/Surgery]

Reprimanded

Aranmolate, Babatunde (Not licensed) (5/10/10) The physician was reprimanded for filing two false Postgraduate Physician Trainee Enrollment forms, omitting that he had been disciplined in Great Britain and dismissed from a training program, also in Great Britain. The physician is also barred from applying for residency, fellowship, or licensure in the District until the revoked medical license in Great Britain is restored. [Unlicensed]

Probation Terminated

Vaughn, William S. (M.D.) (3/12/10) – retroactive to 12/31/08. The physician satisfied the terms of his prior order dated January 22, 2008. [Emergency Medicine]

Williams, Cleveland (M.D.) (2/26/10) The physician satisfied the terms of his prior order dated January 30, 2008. [Preventive Medicine/Public Health]

Brown, Emmanuel (M.D.) (7/28/10) The physician satisfied the terms of his prior order dated 5/5/09. [Internal Medicine]

Obeng, Simeon (M.D.) (7/28/10) The physician satisfied the terms of his prior order dated 5/5/09. [Internal Medicine]

DOCTORS WANTED: The Board continues to work to have all BoMed advisory committees fully operational and all physician and member vacancies filled. Advisory committee members advise the full board on new guidelines and regulations to consider implementing with respect to the other health professions under the board's authority. Advisory committees meet in person on average twice per year. If you are interested in volunteering, please see vacancies listed below and contact the Mayor's Office of Boards and Commissions (OBC). (DC residents only.)

ACUPUNCTURISTS :	• 1 Physician with acupuncture experience
NATUROPATHIC PHYSICIANS:	• 1 Physician with naturopathic medicine experience
PHYSICIAN ASSISTANTS:	• 1 Physician with experience working with Physician Assistants
POLYSOMNOGRAPHERS:	• 2 Physicians certified by national accrediting body as sleep specialists
SURGICAL ASSISTANTS:	• 1 Surgeon with experience working with Surgical Assistants
	• 3 Licensed Surgical Assistants

To apply to serve, go online at www.obc.dc.gov and download an application, or call OBC at (202) 727-1372.

D.C. BOARD OF MEDICINE
717 14th Street, NW
Suite 600
Washington, DC 20005

Government of the District of Columbia
Adrian M. Fenty, Mayor

DC BOARD OF MEDICINE

Address
Health Professional
Licensing Administration
Department of Health
717 14th Street NW
Suite 600
Washington, DC 20005

Phone numbers
(202) 724-4900
(877) 672-2174
Office Hours: 8:15 am to 4:45 pm,
Monday - Friday (except District holidays).

Fax number
(202) 724-5145

Email address
hpla@dc.gov

Web page
www.hpla.doh.dc.gov/BoMed

Health Professional
Licensing Administration

Janis M. Orlowski, MD, MACP
Physician Member and Chairperson

Wayne A.I. Frederick, MD, FACS,
Physician Member

Shivani Kamdar, DO, Physician Member

John J. Lynch, MD, Physician Member

Lawrence A. Manning, MD, Physician Member

Miriam A. Markowitz, MSc, Consumer Member

Melissa Musiker, MPP, RD, LD, Consumer Member

Marc Rankin, MD, Physician Member

Ronald Simmons, PhD, Consumer Member

Robert B. Vowels, MD, MPH, representing
Pierre N. D. Vigilance, MD, MPH,
Statutory Member

Cheryl R. Williams, MD, Physician Member

Director, Department of Health
Pierre N.D. Vigilance, MD, MPH

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Newsletter Editor/Layout
Nancy Kofie

To use HPLA's website to check and verify a license, go to: www.hpla.doh.dc.gov/BoMed