

## Breakout Group One

### BME Sunset

Moderator: Ned Calonge, MD

Policy Adviser: Kari Hershey, JD

**Sunset History and Review Specifics:** Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form or regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operations is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether the final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

**BREAKOUT INSTRUCTIONS:**

1. Review the policy options developed by the ad hoc work group on patient safety and provider accountability;
2. Subject each option to a robust discussion and make one of the following recommendations
  - a. Reject the option and the concept;
  - b. Accept the option and the concept;
  - c. Accept the option and the concept with clarification
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
  - d. Add the following policy options not currently contemplated in the report of the ad hoc work group on patient safety and professional accountability
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_

***ADEQUACY OF BOARD OF MEDICAL EXAMINERS: RESOURCES, OPERATIONS, AND GOVERNANCE:***

Board members make considerable professional, economic, and personal sacrifice to serve on the Board. The Board is functioning at full capacity and further resources may be needed to effectively discharge its legal responsibilities. A number of factors are likely to increase the Board's workload in the coming years, including expansion of reporting and related disciplinary policies, and licensure application growth. This in turn may require an increase in licensure fees in spite of possible process efficiencies.

The majority of disciplinary complaints come from patients or family members. Many of these complaints are frivolous or retaliatory, involve misunderstandings of medical standards, or are otherwise without a legal basis. Thus, most complaints are resolved without formal disciplinary action. Nonetheless, there are also gaps in reporting of actionable offenses that do not reach the Board.

***Policy Options for Consideration:***

1. Expand Board (maintaining proportional representation), staff, or other mechanisms to allow for more manageable workload.
  - a. Reject
  - b. Accept
  - c. Accept with clarification
2. Create additional complaint review mechanisms.
  - a. Reject
  - b. Accept
  - c. Accept with clarification

3. Further refine conflict of interest law for members of all Boards.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
4. Evaluate the licensure fees necessary to support the Board in achieving its mission.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**

#### **ADEQUACY OF LAW AND BOARD OF MEDICAL EXAMINERS' AUTHORITY**

##### *DISCIPLINARY PROCESS AND LEGAL GROUNDS*

Although each state's statutory grounds for discipline vary, the Federation of State Medical Boards has developed a model practice act outlining the basic legal grounds for discipline it believes all practice acts should contain. Colorado's Medical Practice Acts contains most, but not all of these grounds. Exceptions will be evaluated for inclusion by sunset staff, legislators, and other interested organizations. Legislative activities in other states, recent or otherwise, will also provoke interest and potential action. Many, if not all of policy options listed below will be under consideration both during the staff review and legislative debate.

##### ***Policy Options for Consideration***

1. Add to the disciplinary options available to include a period of public service.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
2. Adding to the grounds for disciplinary action to include:
  - Prescribing to family members.
    - a. **Reject**
    - b. **Accept**
    - c. **Accept with clarification**
  
  - Conduct which exploits the physician-patient relationship for personal gain.
    - a. **Reject**
    - b. **Accept**
    - c. **Accept with clarification**
  
  - Disruptive behavior, which includes interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient.
    - a. **Reject**
    - b. **Accept**
    - c. **Accept with clarification**

- Providing treatment or consultation recommendations without an adequate medical evaluation/basis.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
- 3. Clarifying that rendering a medical opinion concerning diagnoses, treatments, or medical necessity is within the jurisdiction of the Board of Medical Examiners.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
- 4. Clarifying that the practice of medicine is defined as occurring where the patient is located.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
- 5. Review the appropriateness of prohibitions against corporate practice, including exceptions.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
- 6. Evaluate the adequacy of current levels of professional liability coverage.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
- 7. Consider a “three-strike” rule to provide automatic action for recurring meritorious sanctions taken by the Board:
  - Require competency evaluation and, if necessary, retraining
    - a. **Reject**
    - b. **Accept**
    - c. **Accept with clarification**
  
  - Require probation
    - a. **Reject**
    - b. **Accept**
    - c. **Accept with clarification**

#### *REHABILITATION, RETRAINING, AND COMPLIANCE PROCESSES*

Although Board actions tend to emphasize remediation over punishment (licensure revocations, voluntary surrenders, stipulations or admonitions are rare — less than 1/10<sup>th</sup> of all complaints), referrals for remediation (competency evaluation and training, along with treatment for health conditions) have problematic aspects that frustrate those processes. These include questionable legal status while remediation is ongoing, confidentiality concerns (including Board

reporting and lawsuit discovery processes), and adequate resources to handle a growing demand.

The Ad Hoc Committee shares the BME's systemic bias toward early intervention and rehabilitation, rather than a crime-and-punishment disciplinary model. Colorado is fortunate to have nationally recognized organizations to address physician health and competency issues available locally. Intake for physicians, either by agency or self-referral, will continue to increase.

Legal and financial barriers (lack of sustainable funding and related resources, loopholes in confidentiality, and process concerns) impede physician entry into remedial processes — diverting many otherwise recoverable cases to a terminal disciplinary process. Eliminating barriers to physician entry into a restorative process requires legislative reforms regarding licensure status, improved peer review mechanisms and their legal status, and increased allocations of licensure fees and other resources.

### ***Policy Options for Consideration***

1. Consider competency assessment mechanisms.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
2. Provide confidentiality protections for participation in competency or health assessment and monitoring programs.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
3. Provide due process protections for participants in competency or health assessment and monitoring programs.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
4. Eliminate health conditions from the definition of “unprofessional conduct” and instead make failing to appropriately deal with a health condition that jeopardizes patient safety grounds for discipline (not the health condition itself).
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
5. Provide for reentry licensure.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**

***INITIAL AND ONGOING COMPETENCY OF LICENSEES:***

Ensuring competency is a vital responsibility of the Medical Board. How to provide for periodic review of a physician’s clinical skills is a recurring debate among medical licensure boards as well as the Federation of State Medical Boards. The logistics, complexity and cost of imposing regular competency testing, even assuming efficacy and reliability, have thus far rendered Board governed processes problematic.

Many states have opted for mandatory residency and ongoing CME as a condition of licensure. Some Board’s also presume some measure of compliance by virtue of a physician being board-certified or board eligible. Further, Boards rely on peer review, which is discussed separately below.

***Policy Options for Consideration***

1. Consider completion of a residency as a condition of licensure.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
2. Consider attestation by applicants that they have completed a certain amount of annual CME.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
3. Consider Board certification to maintain a license and define appropriate boards for recognition (ABMS and ABOME) or alternate mechanism for assuring competency
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
4. Consider a “three-strike” rule to provide automatic competency evaluation and retraining for recurring meritorious sanctions:
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**

### ***REQUIRED REPORTING***

Informal disciplinary actions and observed but unchallenged instances of ‘unprofessional conduct’, ‘near misses’ and disruptive behaviors go under reported to the Board. CMS recognizes that patient safety involves a balance between privileges, reporting requirements, and disclosure. The law provides a “privilege” against discovery and public release of certain peer review information, while at the same time providing that essential information must be reported to the BME. The BME is in turn charged with the regulatory responsibility to protect the safety and welfare of the public who encounter medical care, and therefore relies in substantial part upon information provided to it by institutions conducting peer review.

Colorado law presently requires hospital governing boards that take action against a physician as a result of peer review to report such action to the BME. The Board, however, has expressed concern that it is not receiving adequate reports.

### ***Policy Options for Consideration***

1. Consider peer review entity reports of interventions (as opposed to only adverse actions) to the BME for monitoring.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**
  
2. Enhance the BME’s ability to inquire into how the peer review process is functioning at those institutions that do not now make regular reports.
  - a. **Reject**
  - b. **Accept**
  - c. **Accept with clarification**