

**STATE COMMISSION ON PATIENT SAFETY  
ROUND ONE RECOMMENDATIONS  
APRIL 28, 2005**

**Category C:** Setting Performance Standards and Expectations

Code: ProfLic – Improvement of patient safety through licensing and/or certification of professionals working in the health care field, including the specific inclusion of content related to patient safety in licensing and certification requirements.

***Recommendation C.07 (ProfLic).1***

The Michigan state legislature, administrative regulatory agencies and licensure boards should enhance the safety of patient care by appropriately educating, licensing and disciplining individuals providing health care services.

In particular, the Michigan state legislature, administrative regulatory agencies and licensure boards should:

***Recommendation C.07 (ProfLic).1.1*** require licensure for:

- a) ***C.07 (ProfLic).1.1.1*** technologists who operate ionizing radiation equipment<sup>1</sup> and
- b) ***C.07 (ProfLic).1.1.2*** registered dietitians who provide medical nutritional therapy<sup>2</sup>;

***Recommendation C.07 (ProfLic).1.2*** require all healthcare practitioners to undertake approved and appropriate discipline-specific patient safety education<sup>3</sup> which shall include radiation safety training for physicians overseeing use of ionizing radiation<sup>4</sup> as a condition of licensure/re-licensure; and

***Recommendation C.07 (ProfLic).1.3*** review and revise the structure and functions of licensure boards so that they may more effectively discharge their responsibilities<sup>5</sup> by

- a) ***C.07 (ProfLic).1.3.1*** rescinding or modifying Executive Order 96-2 which removed the ability of healthcare licensure boards to promulgate rules,<sup>6</sup>
- b) ***C.07 (ProfLic).1.3.2*** encouraging special consideration of situations where individual practitioners voluntarily disclose errors which are “errors of the system” rather than “errors of the individual”<sup>7</sup>,

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- c) **C.07 (ProfLic).1.3.3** *permitting use of non-disciplinary approaches such as alternative mediation when appropriate<sup>8</sup>, and*
- d) **C.07(ProfLic).1.3.4** *putting systems in place that more quickly and effectively identify and remove from practice unsafe practitioners until competence to practice or operate is proven.<sup>9</sup>*

**Rationale:**

The recommendations related to professional licensure endeavor to improve patient safety in Michigan in three distinct ways: 1) legally defining and regulating a distinct area of clinical practice and the characteristics of persons who may perform such practice; 2) setting educational and competency standards as a condition of licensure for practitioners within a defined area of clinical practice; and 3) modifying the way licensure boards operate to more fully incorporate “culture of safety” principles into its operations and to protect the public from unsafe practitioners. This general categorization scheme will be used throughout this analysis.

These three areas are legitimate and compelling interests of the State of Michigan because of its exclusive right to license, monitor and control the activities of individuals engaging in healthcare practice as but one mechanism available to the State to protect the health and well-being of its citizens. The overarching rationale for the State Commission on Patient Safety to consider recommendations related to licensure of healthcare professionals is because the State is legally obligated to assume responsibility for this area of commerce. A secondary rationale is that there appears to be gaps in the system that have the potential to jeopardize the safety of patient care in Michigan as will be described more fully in the Evidence Section of this analysis.

Defining and Regulating Distinct Areas of Clinical Practice.

It is the responsibility of the State Legislature to pass laws defining certain areas of clinical practice that require the safeguards that can be accorded through licensure and specification of educational requirements and areas of competence required to grant such licenses. In contrast to “statutory certification” and “registration” of healthcare practitioners, licensing statutes include an explicitly defined scope of practice, and performance of the profession is illegal without first obtaining a license from the state. Apart from those exceptions listed in Section 333.16171 of the Public Health Code, it is a felony to practice a regulated health profession in Michigan without first obtaining a license or registration from

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the Bureau of Health Professions, Department of Community Health. The submitted testimony argued that some practitioners who operate ionizing radiation equipment and provide medical nutritional therapy are insufficiently regulated by the State and as a result, pose a threat to patient safety.

Setting Knowledge Standards for Licensed Practitioners.

The Bureau of Health Professions within the Department of Community Health regulates all health professionals in Michigan who are licensed, registered or certified<sup>10</sup>. The Bureau of Health Professions's authority is limited to granting licenses or registrations for these professions and taking disciplinary actions against the licenses or registrations. This authority does not include fee disputes or personal conflicts between patients and their health care providers. According to the Bureau's website, its mission "is to protect the health, safety and welfare of the citizens of Michigan through implementation and enforcement of laws involving the licensing and regulation of health professionals".<sup>11</sup> To achieve this mission, its mandate involves:<sup>12</sup>

- regulating over 340,000 health professionals in Michigan who are licensed, registered, or certified under Articles 7, 15 and 17 of the Michigan Public Health Code and 42 Code of Federal Regulation (CFR) Part 483, and
- licensing/registering 32 health care occupations<sup>13</sup>, including pharmacies and manufacturer/wholesale distributors.

Although the requirements vary by occupation, generally speaking, for initial licensure the applicant must graduate from an "approved" educational program and pass one or more examinations among other things. In the case of nursing as it relates to licensed registered nurses, the core curriculum for an approved educational program is defined in the statute (MCL R 338.10201, Rule 201). Currently, courses in patient safety, per se, are not required as part of the core curriculum.<sup>14</sup>

Similarly, coursework in patient safety is not a required continuing education topic for nurses seeking license renewal. In fact, only one topic, pain management, is required of all healthcare practitioners with continuing education requirements seeking license renewal (except for dental hygienists).<sup>15</sup> In Michigan, pain management education is required by statute MCL 333.16204.<sup>16</sup> Individuals must complete an appropriate number of hours or courses in pain and symptom management as determined by their respective board.<sup>17</sup> Specifically, the rule for nurses is as follows:

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An applicant for license renewal shall complete at least 1 continuing education contact hour in pain and pain symptom management in each renewal period. Continuing education contact hours in pain and pain symptom management may include, but are not limited to, courses in behavior management, psychology of pain, pharmacology, behavior modification, stress management, clinical applications, and drug interactions. This sub rule will take effect with the April 1, 2005 renewal cycle. (R 338.10601)<sup>18</sup>

Because of some changes to the rulemaking authority of licensing boards, it's not clear what mechanism would be required to include patient safety education as a condition of licensure. Per 333.16205(2) of the Public Health Code: *A board may promulgate rules to establish a system of assessing the continued competence of licensees as a condition of periodic license renewal.* However, due to Executive Order 96-2, licensing boards are now in an important but advisory role, and only draft rules and specific requirements to be considered. They do not have the legal ability to technically engage in rulemaking, as only the state department has the authority to develop the final rules, and to do so through legislative or administrative binding actions.

Modifying Licensing Board Operations.

The Bureau of Health Professions regulates licensed, registered and certified healthcare practitioners through a series of Licensing Boards. The activities of the Licensing Boards are governed by administrative rules specific to each healthcare occupational group.<sup>19</sup> Regulatory discipline is usually a function of a licensing board or task force which is composed of both professional and public members appointed by the Governor. Also key to achieving its mission of protecting the health, safety and welfare of Michigan citizens, the Bureau and its licensing boards are mandated to:<sup>20</sup>

- receive and investigate allegations against licensed, registered and certified professionals, and
- support the Controlled Substances Advisory Commission, the Health Professional Recovery Program, and the Advisory Committee on Pain and Symptom Management.

At this point, it's not clear what range of disciplinary procedures are available to the licensing boards. One testimony raised a concern about the licensing board's inability to use non-disciplinary procedures to deal with practitioners involved in certain types of errors.<sup>21</sup> According to officials within the Bureau, licensure boards are not permitted by statute to use non-disciplinary approaches

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to dealing with professionals. In reality, however, the boards and the department do make good faith attempts to work with an “offender”, and frequently will accommodate the practitioner’s discretion through a specific internal process so that the reporting of an infraction does not necessarily lead to a black mark or a disciplinary record. Resolution of these types of incidents is usually done on an individual, case-by-case basis. This process is not reflected in any official rule and is referred to as “alternative mediation” which is often institutionalized in other states.<sup>22</sup>

The official rules that govern licensing boards are clear with respect to the Board’s obligation to make public the names of healthcare practitioners who have been disciplined. Pursuant to the Michigan Public Health Code, P.A. 368 of 1978, as amended, the board is required to publish the names of disciplined individuals. To comply with this requirement, the Bureau of Health Professions publishes a Disciplinary Action Report (DAR). The DAR lists the disciplinary actions taken against health professionals who are licensed and regulated by the various health boards within the Bureau of Health Professions. The report also includes updated information regarding licensees who have appealed the Board’s action to a higher court. The report includes the names of the health professional, their professional license number, the type of disciplinary action taken, the effective date of the action and the general nature of the complaint.<sup>23</sup>

Clearly, the State of Michigan has a legal obligation to protect and safeguard the health of its citizens through licensure mechanisms as noted above. A sound rationale exists for supporting recommendations related to licensing of healthcare practitioners. The recommended programs and evidence of effectiveness related to healthcare practitioner licensing mechanisms are reviewed in the following section.

**Evidence and/or information on comparable initiatives being carried out in other states:**

Defining and Regulating Distinct Areas of Clinical Practice.

In 2004, the State of Michigan passed laws that licensed the practice of audiologists, social workers, and respiratory therapists.<sup>24</sup> Although there are 141 bills pending in the U.S. Congress that relate to patient safety, there is no pending federal legislation that addresses the use of licensure of healthcare practitioners as mechanisms for improving patient safety.<sup>25</sup> A document prepared by the Michigan Health & Hospital Association, indicates that there at

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least five bills introduced in the Michigan House and Senate during this session that address some aspect of credentialing or licensure.<sup>26</sup> Specifically, the bills address standardizing credentialing processes and clinical practice as it relates to speech-language pathologists, surgical technologists, and performance of interpretation of nerve conduction studies and needle electromyography. Additionally, there is a bill pending in the Senate that addresses the training and education requirements of for x-ray technicians.<sup>27</sup> Lastly, there are no known pending administrative rules within the Department of Community Health related to licensure of healthcare professionals.<sup>28</sup>

Testimony submitted to the State Commission on Patient Safety recommended that two groups of healthcare practitioners – registered dietitians who provide medical nutritional therapy and radiation technologists who work with ionizing radiation – need to be licensed as a means to improve the safety of patient care in Michigan. Specifically, **Recommendation C.07 (ProfLic).1.1** requests that the Michigan state legislature, administrative regulatory agencies and licensure boards should require licensure for technologists who operate ionizing radiation equipment **Recommendation C.07 (ProfLic).1.1.1**<sup>29</sup> and registered dietitians who provide medical nutritional therapy **Recommendation C.07 (ProfLic).1.1.2**.<sup>30</sup> Each will be discussed separately.

With respect to **Recommendation C.07 (ProfLic).1.1.2** dealing with the practice of dietitians and nutritionists, 46 states have enacted legislation regulating the practice of dietetics through licensure, statutory certification, or registration. State licensure and state certification are entirely separate and distinct from registration or certification by the Commission on Dietetic Registration. Dietetics practitioners are licensed by states to ensure that only qualified, trained professionals provide nutrition services or advice to individuals requiring or seeking nutrition care or information. Only state-licensed dietetics professionals can provide nutrition counseling. Non-licensed practitioners may be subject to prosecution for practicing without a license. States with certification laws limit the use of particular titles (e.g., dietitian or nutritionist) to persons meeting predetermined requirements. However, persons not certified can still practice.<sup>31</sup>

The dietitians argue that in Michigan, anyone can use the title of “dietitian” or “nutritionist” because registered dietitians are not licensed.<sup>32</sup> Additionally, the safety of the residents of Michigan is at risk due to unqualified persons giving nutrition misinformation. Several examples of harm to patients resulting from misinformation were provided in the submitted testimony. The dietitians believe that the public is bombarded with many mixed messages regarding nutrition and

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food and they are often confused and frustrated.<sup>33</sup> They argue further that the public deserves to know which individuals in Michigan are qualified by education, experience and examination to provide nutrition care.<sup>34</sup> A number of issues<sup>35</sup> related to licensure of dietitians are addressed on the ADA's website. A bill to license dietitians (S920/HB5408) was considered but not passed by the Michigan legislature in the last session and to date, has not been re-introduced.<sup>36</sup>

The scope of practice for dietitians includes provision of Medical Nutrition Therapy (MNT). MNT is a Medicare-approved benefit that includes nutritional diagnostic, therapeutic and counseling services provided by a registered dietitian. As of January 1, 2002 the Center for Medicare and Medicaid Services (CMS) permits registered dietitians or nutrition professionals to directly bill their Medicare local carrier for MNT provided to beneficiaries with renal disease or diabetes (gestational, type 1 and type 2). MNT services are defined in statute as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional pursuant to a referral by a physician..."<sup>37</sup> Additionally, MNT is covered by national employers and health plans.

There appears to be reasonable scientific evidence offered in the testimony to support the dietitian's assertion that properly and safely provided MNT improves health.<sup>38</sup> Additionally, the American Dietetic Association (ADA) argues that MNT, when provided by licensed dietitians, has been shown to effectively treat and manage disease conditions, reduce or eliminate the need for prescription drug use, help reduce complications in patients with disease, and improve patients' overall health and quality of life.<sup>39</sup> On its website, the ADA summarized substantial literature that addresses the cost-effectiveness of MNT.<sup>40</sup> In particular, it mentioned a review of the literature conducted by the Agency for Healthcare Quality and Research (AHRQ). The ADA indicated that despite limited research on clinical effectiveness, AHRQ concluded that research showed that dietitian practice as it relates to parenteral and enteral feeding in surgical and other types of patients produced cost-effective results.<sup>41</sup> Specifically, a study of enterally fed patients revealed a benefit of \$4.20 for every \$1 invested in nutrition support team management.<sup>42</sup> The ADA also produces and promotes use of evidence-based dietetics practice through use of clinical practice guidelines, protocols, and other guides for practice. The guides are based on published scientific evidence and best practices as determined from quality improvement and outcomes measurement activities.<sup>43</sup>

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With respect to **Recommendation C.07 (ProfLic).1.1.1**<sup>44</sup> which deals with licensure for technologists who operate ionizing radiation equipment, the testimony submitter, the Michigan Chapter of the American College of Radiology, stated “we are very concerned with the use of ionizing radiation and believe that those operating the equipment should be licensed technologists and that the physicians overseeing the use of ionizing radiation must have documented training in radiation safety”<sup>45</sup> The American College of Radiology is the national organization for radiologists and it promulgates practice guidelines and technical standards to improve the safety and quality of radiologic practice.<sup>46</sup>

Senate Bill No. 231 was introduced during the current legislative session and it contains provisions that would require radiation technologists working with ionizing radiation to be licensed.<sup>47</sup> Specifically, the bill would, in part, revise Sec. 13505 of the Public Health Code to disallow “registered -only” persons to use ionizing radiation. The proposed revision states that a person shall not manufacture, produce, transport, transfer, dispose of, acquire, own, possess, or use a radioactive material or other source of ionizing radiation unless the person is licensed or exempted under this part or is licensed or exempted by the department in accordance with rules promulgated by the department under this part. Currently, the only radiation technicians who are licensed in Michigan are those who perform mammography and meet specific state and federal rule requirements.<sup>48</sup>

The state has a compelling interest in regulating the use of ionizing radiation due to the fact that improper use of the equipment has the potential to greatly harm patients. The regulatory requirements are found in the Public Health Code under part 135, and they primarily speak to the actual machines or equipment that are used.<sup>49</sup> It should be noted that radiologic technologists do not have a licensing board in Michigan.

The American Society of Radiologic Technologists (ASRT) is professional and credentialing organization for radiologic technology and it tests and certifies technologists and administers continuing education and ethics requirements for their annual registration. ASRT states that it endeavors to ensure patient safety through proper education of radiologic technologists. To that end, ASRT has launched an aggressive campaign to protect patients from overexposure to radiation during radiologic procedures and help reduce the cost of administering health care. The Society is pursuing basic educational and certification standards for health care workers who administer radiologic procedures in every state in the union.<sup>50</sup>

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Based on information posted on ASRT's website, it appears that there is legislation pending in 17 states pertaining to radiation technologists on a variety of topics some of which involve licensure.<sup>51</sup> In 1981, ASRT worked to pass the federal Consumer-Patient Radiation Health and Safety Act to safeguard the public's access to quality radiologic care. This Act contains a Congressional mandate that all state governments establish licensure requirements for radiologic technologists, radiation therapists, nuclear medicine technologists, dental hygienists and dental assistants who administer radiation. Even so, 22 years later, 13 states, including Michigan, and the District of Columbia still do not have comprehensive licensure laws.<sup>52</sup> The remaining 37 states have enacted laws that vary dramatically.<sup>53</sup>

The ASRT states that there are thousands of unlicensed and uncertified individuals administering radiation to the public and it is collecting evidence of harm that has been caused by such individuals. This data will be used to educate the public about the dangers created by improperly trained and uncertified personnel, support the introduction of federal and state legislation to protect the public and encourage health care accrediting agencies to require certification of radiologic personnel. The ASRT's goal is that every person who administers radiologic procedures must be required to demonstrate competence by reason of education, experience and examination.<sup>54</sup>

As for scientific evidence that licensure of radiation technologists improves the effectiveness and safety of patient care, the testimony submitter provided none and there is little provided on the ASRT's website. Although it seems obvious that licensure and ensuring minimal education standards would reduce harm, no evidence was provided to support that assumption.

Of the proceedings from other state-level patient safety commissions, only one addressed the issue of need for additional licensure of healthcare practitioners. The Florida Commission on Excellence in Health Care was asked by its legislature to make recommendations regarding the need to license surgical technologists and pharmacy technicians. It supported licensure for the former but not the latter.<sup>55</sup>

Setting Knowledge Standards for Licensed Practitioners

The second area related to use of licensure as a means to improve patient safety addresses the need to ensure that healthcare practitioners licensed by the state possess the knowledge and skills to correctly perform their duties. To that end,

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**Recommendation C.07 (ProfLic).1.2** require(s) all healthcare practitioners to undertake approved and appropriate discipline-specific patient safety education<sup>56</sup> which shall include radiation safety training for physicians overseeing use of ionizing radiation<sup>57</sup> as a condition of licensure/re-licensure. Testimony submitted raised a concern that knowledge of patient safety was not widely disseminated among practitioners and offered several strategies for remedying the situation.<sup>58</sup>

The general issue of practitioner lack of competency is widely acknowledged as a serious threat to patient safety. (Please note that the recommendation under consideration addresses only competency related to the principles of patient safety and not competency in general.) As noted in the report published by the Pew Health Professions Commission, “[the] ostensible goal of professional regulation- [is] to establish standards that protect consumers from incompetent practitioners...”<sup>59</sup> The report continues and states, “Ensuring the competence of health care professionals throughout their careers is a persistent challenge to both public and private sectors. Few would disagree with the assessment that it is possible for a practitioner’s competence to diminish years after initial licensure and that continuing education credits do not guarantee competence.”<sup>60</sup> The report also notes that most licensure boards do not require “periodic demonstrations of competence” for continued licensure and furthermore, most legislatures have not allowed or required licensure boards assess continuing competence. Regarding competence of practitioners, the Commission recommended that: 1) Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement and 2) states should require that their regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs through their careers.<sup>61</sup>

Similarly, in its report, *To Err is Human: Building a Safer Healthcare System*, the IOM raised a number of concerns regarding the relationship between current practitioner licensure practices and competence related to patient safety.<sup>62</sup> Specifically, it noted that, “Although there are many kinds of standards in health care, especially those promulgated by licensing agencies and accrediting organizations, few standards focus explicitly on issues of patient safety”.<sup>63</sup> Specifically, the IOM recommended that performance standards and expectations for health professionals should focus greater attention on patient safety and to that end, health professional licensing bodies should implement periodic reexaminations and re-licensing of doctors, nurses, and other key

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providers, based on both competence and knowledge of safety practices (Recommendation 7.2).<sup>64</sup>

Agreeing with the findings of the Pew Commission, the IOM noted that “for most health professionals, current methods of licensing and credentialing assess knowledge, but do not assess performance skills after initial state licensure.”<sup>65</sup> Responsibility for tracking continued competence is dispersed and tends to be through certification which, for many occupations, is optional and is undertaken by private enterprises. The IOM also found that there is tremendous variation in the way boards operate within a given state and across all states.<sup>66</sup>

The Missouri Commission on Patient Safety echoed the findings of the Pew Commission and IOM and recommended that “The Missouri Center for Patient Safety’s education coalition should promote patient safety competency of healthcare professionals through continuing education activities.”<sup>67</sup> Similar to the situation in Michigan, the Missouri Commission found that “patient safety is not a mandatory element for Missouri professions whose license renewals depend upon continuing education”.<sup>68</sup> The Commission reasoned that, Missouri “does not mandate that licensed healthcare professionals complete any patient safety courses as part of their continuing education requirements for license renewal [and] they are not allowed by law to do so.”<sup>69</sup> The Commission noted that Florida and other and other states have mandated patient safety education as part of their continuing education requirements and the effectiveness of doing so has been established.<sup>70</sup> The Commission recommended “that the education coalition promote patient safety competency of healthcare professionals through continuing education activities”.<sup>71</sup>

Similarly, the Florida Commission on Excellence in Health Care recommended that “legislation should be proposed requiring a course in medical errors and patient safety, including root cause analysis, error reduction, error prevention and patient safety practices as a requirement for initial and re-licensing of appropriate health care professionals. The course will be included I the existing number of required hours”<sup>72</sup>.

Clearly, there is support from major evaluations of practitioner continued competence conducted by leading national organizations and state patient safety commissions for requiring healthcare practitioners to maintain competence particularly as it relates to knowledge of patient safety fundamental concepts. There was, however, very little empirical evidence offered to support the various recommendations.

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Modifying Licensing Board Operations

The third and final recommendation related to licensure of professionals would require that the structures and functions of the licensure boards in Michigan be reviewed and revised in ways that enable boards to better discharge their responsibilities (**Recommendation C.07 (ProfLic).1.3**). The specific recommendations fall into two main groups. One group deals with disciplining practitioners who are involved in system errors and is asking that the “culture of safety” apply to licensing boards (**Recommendation C.07 (ProfLic).1.3.2 encourages special consideration of situations where individual practitioners voluntarily disclose errors which are “errors of the system” rather than “errors of the individual”<sup>73</sup> and Recommendation C.07 (ProfLic).1.3.3 permits use of non-disciplinary approaches such as alternative mediation when appropriate<sup>74</sup>**). The second group deals with the need for licensure boards to be able to act in flexible ways and to quickly identify unsafe practitioners and remove them from the clinical arena (**Recommendation C.07 (ProfLic).1.3.4 put systems in place that more quickly and effectively identify and remove from practice unsafe practitioners until competence to practice or operate is proven**).<sup>75</sup> One recommendation, (**Recommendation C.07 (ProfLic).1.3.1 rescinding or modifying Executive Order 96-2 which removed the ability of healthcare licensure boards to promulgate rules**)<sup>76</sup> applies to both groups of recommendations.

Regarding the first set of recommendations that deal with “systems-thinking” and the “culture of safety” within licensing boards, the literature and evidence viewed to date is surprisingly silent. This subject is related to the broad areas of peer protection, error reporting and overhauling the “name, blame and shame” culture of which licensing boards and other state regulatory agencies are a part. These topics are covered by other recommendations to be presented to the review committee at a later date. Clearly, licensing boards need to be able to distinguish “flawed” individuals from “flawed” systems. In the case of individual practitioners caught up in “flawed” systems, the testimony argues that boards need to have the regulatory authority to be able to support<sup>77</sup>, rather than punish, practitioners who come forward and voluntarily report errors.<sup>78</sup>

The patient safety literature reviewed focuses on the inability of licensure boards to completely and quickly remove from practice practitioners who threaten the health and safety of the public due to incompetence or other limiting characteristics. For example, the Pew Commission found that there was very little coordination among boards or states to protect the public from unsafe healthcare practitioners.<sup>79</sup> It stated that the “lack of coordination and integration

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among systems has resulted in inefficiencies and inadequate protection of the public". Moreover, "[p]oor coordination also allows incompetent practitioners to move from health plan to health plan and from state to state".<sup>80</sup> To remedy this situation, the Commission recommended that "states should provide the resources necessary to adequately staff and equip all health professions boards to meet their responsibilities expeditiously, efficiently and effectively".<sup>81</sup>

The Missouri Commission reviewed the procedures used by healthcare boards, facilities and practitioners and found a number of deficiencies that required correction in order to appropriately deal with unsafe practitioners. In particular, the Commission recommended that "the General Assembly, where appropriate, allow licensing agencies to improve investigations of unsafe healthcare professionals, and take disciplinary action when it is evident that the provider was reckless, incompetent, impaired, negligent or abusive".<sup>82</sup>

Similarly, the IOM recommended that performance standards and expectations for health professionals should focus greater attention on patient safety and to that end, health professional licensing bodies should work with certifying and credentialing organizations to develop more effective methods to identify unsafe providers and take action.<sup>83</sup>

In some sense, these two groups of recommendations appear to be at odds with each other. One group asks licensing boards for flexibility in dealing with practitioners involved in system errors and the other group asks licensing boards for more efficiency in dealing with practitioners involved in personal errors. These competing sets of recommendations do create challenges for licensure boards, especially in situations where the board lacks the regulatory authority to modify the way it operates. Despite very little empirical research findings related to effectiveness, based on evaluations conducted by major national and state organizations, both sets of recommendations are worthy of consideration by the review committee.

**Pros and Barriers by Recommendation:**

Defining and Regulating Distinct Areas of Clinical Practice

**Pros:**

- Licensure of unlicensed practitioners provides a means by which activities can be monitored and regulated.

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- Licensure status provides a way for consumers to know the minimal education credentials possessed by the practitioners.

**Barriers:**

- Licensure has the potential to create barriers to entry, to restrict some aspects of free speech and create a monopoly on certain types of commerce.
- Licensure increases the regulatory activity of the state and creates more “red tape.”
- There are costs involved with licensure of unlicensed practitioners.

Setting Knowledge Standards for Licensed Practitioners

**Pros:**

- Greater likelihood of ensuring some level of competence as it relates to fundamental knowledge of patient safety concepts.

**Barriers:**

- There are costs involved with developing, implementing and monitoring compliance with new areas of continuing education.
- Healthcare professionals have limits to the amount of time spent in continuing education and spending time on this topic may mean that other important topics receive less attention.
- The depth of knowledge may be inadequate and if cognitive approaches are the only approaches used, technical skills may be lacking.

Modifying Licensing Board Operations

**Pros:**

- Improving the operations and legal capacity of boards may increase the board’s ability to operate more efficiently and effectively.
- Improve the safety of patient care by removal of unsafe practitioners from clinical settings.

**Barriers:**

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- Increased enforcement of systems to identify and remove unsafe practitioners could be viewed as antithetical to systems thinking as it relates to errors of systems and not individuals.
- Such programs could discourage practitioners from coming forward when errors are identified.
- Cost involved in modifying operational procedures.

**Additional Comment/Concerns:**

**Recommendation C.07 (ProfLic).1.2** as proposed would require all healthcare practitioners to undertake approved and appropriate discipline-specific patient safety education. The Pew Commission and others have mentioned the need to do something much broader than provide education regarding patient safety. In particular, they recommended assess continued clinical competence as it relates to both general knowledge and technical skill. The review committee may wish to develop a recommendation in this area or consider adding this topic to the mandate/mission of a state-level center for patient safety should there be support for creation of such an entity.

**Implementation Steps: TBD, depends on recommendation(s) supported.**

**Cost: TBD, depends on recommendation(s) supported.**

**Implementation Target Date: TBD, depends on recommendation(s) supported.**

**Grade: TBD**

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**Reference List**

- <sup>1</sup> Testimony 829W:30-33  
<sup>2</sup> Testimony 812B:W135-136, W217-218  
<sup>3</sup> Testimony 204B:W103-106  
<sup>4</sup> Testimony 829W:30-33  
<sup>5</sup> Testimony 302B:O141-143  
<sup>6</sup> Testimony 302B:O144-146  
<sup>7</sup> Testimony 213W:8-10, 175-183  
<sup>8</sup> Testimony 302B:O130-133  
<sup>9</sup> Although this recommendation was not submitted through the testimony, it was an important strategy for improving safety through the professional licensure and disciplinary mechanism as identified by the Institute of Medicine, Missouri Commission on Patient Safety, and the Florida Commission on Excellence in Health Care.  
<sup>10</sup> Michigan Department of Community Health, retrieved 4.25.05 at <http://www.michigan.gov/mdch/0,1607,7-132-27417---,00.html>  
<sup>11</sup> Michigan Department of Community Health, retrieved 4.25.05 at [http://www.michigan.gov/mdch/0,1607,7-132-27417\\_28139\\_28150---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_28139_28150---,00.html)  
<sup>12</sup> Michigan Department of Community Health, retrieved 4.25.05 at [http://www.michigan.gov/mdch/0,1607,7-132-27417\\_28139\\_28150---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_28139_28150---,00.html)  
<sup>13</sup> Michigan Licensure Boards, Regulatory Authority and Professions

Board/ Regulatory Authority	Regulated Profession
<a href="#">Board of Chiropractic:</a>	Chiropractors
<a href="#">Board of Counseling:</a>	Licensed Professional Counselors, Limited Licensed Professional Counselors
<a href="#">Board of Dentistry:</a>	Dentists, Dental Specialists (Prosthodontists, Endodontists, Oral and Maxillofacial Surgeons, Orthodontists, Pediatrics, Periodontists and Oral Pathologists), Dental Hygienists, Dental Assistants
<a href="#">Board of Marriage &amp; Family Therapy:</a>	Marriage and Family Therapists
<a href="#">Board of Medicine:</a>	Medical Doctors
<a href="#">Board of Nursing:</a>	Registered Nurses, Licensed Practical Nurses, Trained Attendants, Nurse Specialists (Nurse Practitioner, Nurse Anesthetist and Nurse Midwife)
<a href="#">Board of Nursing Home Administrators:</a>	Nursing Home Administrators
<a href="#">Nurse Aides:</a>	Certified Nurse Aides
<a href="#">Board of Occupational Therapists:</a>	Occupational Therapists, Occupational Therapy Assistants
<a href="#">Board of Optometry:</a>	Optometrists
<a href="#">Board of Osteopathic Medicine and Surgery:</a>	Osteopathic Doctors

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<a href="#">Board of Pharmacy:</a>	Pharmacy Stores, Pharmacists, Manufacturer/Wholesalers, Clinical Thermometer Certification, Sodium Pentobarbital Facilities, Physician's Methadone Programs, Research Laboratories and Analytical Laboratories
<a href="#">Board of Physical Therapy:</a>	Physical Therapists
<a href="#">Physicians Assistants Task Force:</a>	Physicians Assistants
<a href="#">Board of Podiatric Medicine &amp; Surgery:</a>	Podiatrists
<a href="#">Board of Psychology:</a>	Psychologists, Limited Licensed Psychologists (Doctoral, Masters and Temporary)
<a href="#">Board of Social Work:</a>	Social Workers, Social Worker Technicians, Certified Social Workers
<a href="#">Sanitarians:</a>	Sanitarians
<a href="#">Board of Veterinary Medicine:</a>	Veterinarians, Veterinary Technicians

<sup>14</sup> Department of Labor and Economic Growth, State Office of Administrative Hearings and Rules, retrieved 4.25.05 at

[http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin\\_Num=33810101&Dpt=CH&RngHigh](http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=33810101&Dpt=CH&RngHigh)

<sup>15</sup> Michigan Department of Community Health, retrieved 4.25.05 at

[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27648\\_29876\\_29878-94426--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27648_29876_29878-94426--,00.html)

<sup>16</sup> Michigan Department of Community Health, retrieved 4.21.05 at

[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27648\\_29876\\_29878-94426--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27648_29876_29878-94426--,00.html).

Regarding pain management, retrieved 4.20.05: MCL 333.5655, Recommended medical treatment for advanced illness and the duty of physician to inform orally and in writing:

<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-5655&queryid=9872801&highlight=pain%20management>; MCL 333.16204a, Advisory committee

on pain and symptom management - at least once annually consults with all of the boards except veterinary to develop an integrated approach to understanding and applying pain and symptom management techniques (includes pain management educational curricula and continuing educational requirements for institutions providing health care education):

<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-16204a&queryid=9872801&highlight=pain%20management>; MCL 333.16204d, Information

booklet on pain to be developed by the department as part of educational program for health professionals. <http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-16204d&queryid=9872801&highlight=pain%20management>; MCL 333.16315, The pain

management education and controlled substances electronic monitoring and anti-diversion fund is established in the state treasury

<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-16315&queryid=9872801&highlight=pain%20management>; MCL 333.20155, At visits to health

facilities and agencies- adopt clinical process guidelines and compliance protocols with outcome measures: <http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-20155&queryid=9872801&highlight=pain%20management#1>

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- <sup>17</sup> Michigan Public Health Code, retrieved 4.21.05  
<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-16204&queryid=6989197&highlight=16204> accessed
- <sup>18</sup> Michigan Public Health Code, retrieved 4.25.05  
[http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin\\_Num=33810101&Dpt=CH&RngHigh](http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=33810101&Dpt=CH&RngHigh)
- <sup>19</sup> Michigan Public Health Code, retrieved 4.25.05  
[http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Department&Dpt=CH&Level\\_1=Bureau+of+Health+Professions](http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Department&Dpt=CH&Level_1=Bureau+of+Health+Professions)
- <sup>20</sup> Michigan Department of Community Health, retrieved 4.25.05  
[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_28139\\_28150---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_28139_28150---,00.html)
- <sup>21</sup> Testimony 302B:O130-133
- <sup>22</sup> Personal communication, Karen McCosky, April 21, 2005.
- <sup>23</sup> Michigan Department of Community Health, retrieved 4.25.05  
[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27529-43008--.,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27529-43008--.,00.html)
- <sup>24</sup> Michigan Department of Community Health, retrieved 4.25.05  
[http://www.michigan.gov/mdch/0,1607,7-132-27417\\_27529---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-27417_27529---,00.html)
- <sup>25</sup> GovTrack, retrieved 4.18.05 <http://www.govtrack.us/congress/billsearch.xpd>
- <sup>26</sup> Michigan Health & Hospital Association, retrieved 4.18.05  
<http://www.mha.org/mha/advocacy/Bill%20Tracking%2005-06.pdf> (pending bills are SB 10 (Health Care Provider Credentials – standardizes the credentialing process for health care providers), SB 204 (Occupations, Health Care Professions – provide for licensure of speech-language pathologists), HB 4325 (Occupations, Physicians – clarify performance of needle electromyography and the performance and interpretation of nerve conduction studies and who is authorized to perform), HB 4403 (Occupations, Physicians – Allow delegation of certain acts, tasks, or functions to a certified surgical technologist or certified surgical first assistant under certain circumstances), and HB 4439 (Occupations, Health Care Professions – provide for licensure of speech-language pathologists).
- <sup>27</sup> Michigan Public Health Code, 4.21.05 <http://www.legislature.mi.gov/documents/2005-2006/billintroduced/senate/pdf/2005-SIB-0231.pdf>
- <sup>28</sup> Department of Labor and Economic Growth, State Office of Administrative Hearings and Rules, retrieved 4.18.05 at <http://www.state.mi.us/orr/emi/rules.asp?type=dept&id=CH>
- <sup>29</sup> Testimony 829W:30-33
- <sup>30</sup> Testimony 812B:W217-218
- <sup>31</sup> American Dietetic Association, Commission on Dietetic Registration, state licensure and certification, retrieved 4.21.05 <http://www.cdmnet.org/certifications/licensure/index.htm>
- <sup>32</sup> Testimony 812B:W122-123
- <sup>33</sup> Testimony 812B:W124-126
- <sup>34</sup> Testimony 812B:W218-219
- <sup>35</sup> American Dietetic Association, retrieved 4.25.05  
[http://www.eatright.org/Public/GovernmentAffairs/98\\_12913.cfm](http://www.eatright.org/Public/GovernmentAffairs/98_12913.cfm)
- <sup>36</sup> Testimony 812B:W371-383
- <sup>37</sup> Center for Medicare and Medicaid Services, Transmittal AB-02-059
- <sup>38</sup> Testimony 812B:W213-215, W143-144, W151-158
- <sup>39</sup> American Dietetic Association, retrieved 4.25.05  
[http://www.eatright.org/Public/GovernmentAffairs/98\\_8723.cfm](http://www.eatright.org/Public/GovernmentAffairs/98_8723.cfm)

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<sup>40</sup> American Dietetic Association, retrieved 4.25.05

[http://www.eatright.org/Public/GovernmentAffairs/98\\_11762.cfm](http://www.eatright.org/Public/GovernmentAffairs/98_11762.cfm)

<sup>41</sup> US Dept of Health and Human Services (1993). *Critical Literature Review: Clinical Effectiveness in Allied Health Practices*. DHHS (PHS, AHCPR): Washington, DC. Publication 94:0029.

<sup>42</sup> Hassell JT, Games AD, Shaffer B, Harkins LE (1994). Nutrition support team management of enterally fed patients in a community hospital is cost beneficial. *J Am Diet Assoc* 94:993-998.

<sup>43</sup> American Dietetic Association, retrieved 4.25.05

[http://www.eatright.org/Public/GovernmentAffairs/98\\_pgwrk02-03.cfm](http://www.eatright.org/Public/GovernmentAffairs/98_pgwrk02-03.cfm)

<sup>44</sup> Testimony 829W:30-33

<sup>45</sup> Testimony 829W 30-33

<sup>46</sup> American College of Radiology, retrieved 4.25.05

[http://www.acr.org/s\\_acr/sec.asp?CID=1848&DID=16053](http://www.acr.org/s_acr/sec.asp?CID=1848&DID=16053) The American College of Radiology periodically defines new practice guidelines and technical standards for radiologic practice to help advance the science of radiology and to improve the quality of service to patients throughout the United States. Existing practice guidelines and technical standards are reviewed for revision or renewal, as appropriate, or on their fifth anniversary or sooner. Each practice guideline and technical standard, representing a policy statement by the College, undergoes a thorough consensus process in which it has been subjected to extensive review, requiring the approval of the Commission on Quality and Safety as well as the ACR Board of Chancellors, the ACR Council Steering Committee, and the ACR Council. The practice guidelines and technical standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills, and techniques, as described in each document.

<sup>47</sup> Michigan Senate Bill No. 231, retrieved 4.25.05 <http://www.legislature.mi.gov/documents/2005-2006/billintroduced/senate/htm/2005-SIB-0231.htm>

<sup>48</sup> The Public Health Code specifies at 333.13521(3) that "the department shall promulgate rules specifying the minimum training and performance standards for an individual using a radiation machine for mammography as set forth in section 13523". Rule R 325.5601, which establishes requirements governing the use of x-radiation for mammography and apply to all persons who use x-radiation for mammography, does state that certain information must be supplied to the department: (b) Personnel information, including the education, training, experience, and certification of the mammography supervisor, any qualified radiation physicist who provides on-site consultation and evaluation of the mammography system, and any individual who actually performs mammography.

<sup>49</sup> Executive Order 1996-1 assigned responsibility for radioactive material regulation to the Department of Environmental Quality and assigned responsibility for x-ray machine regulation to the Dept of Consumer & Industry Services, which is now Dept of Community Health.

<sup>50</sup> American Society of Radiologic Technologists, retrieved 4.25.05

[http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient\\_Safety.aspx](http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient_Safety.aspx)

<sup>51</sup> American Society of Radiologic Technologists, retrieved 4.25.05

[http://www.asrt.org/content/GovernmentRelations/LegislativeNews/StateWrap-up/State\\_Legislation.aspx](http://www.asrt.org/content/GovernmentRelations/LegislativeNews/StateWrap-up/State_Legislation.aspx)

<sup>52</sup> American Society of Radiologic Technologists, retrieved 4.25.05

[http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient\\_Safety.aspx](http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient_Safety.aspx)

<sup>53</sup> American Society of Radiologic Technologists, retrieved 4.25.05

[http://www.asrt.org/media/pdf/licensure\\_table.pdf](http://www.asrt.org/media/pdf/licensure_table.pdf)

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- <sup>54</sup> American Society of Radiologic Technologists, retrieved 4.25.05  
[http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient\\_Safety.aspx](http://www.asrt.org/content/GovernmentRelations/CAREBill/Patient_Safety.aspx)
- <sup>55</sup> Florida Department of Health and Agency for Health Care Administration. (2001). *Florida Commission on Excellence in Health Care Report: A Comprehensive Statewide Strategy for Improving the Health Care delivery System through Meaningful Reporting Standards, Data Collection and Review, and Quality Measurement*, retrieved 4.10.05 at  
<http://www.floridahealthstat.com>
- <sup>56</sup> Testimony 204B:W103-106
- <sup>57</sup> Testimony 829W:W30-33
- <sup>58</sup> Testimony 204B:W96-100, W103-106
- <sup>59</sup> Finocchio LJ, Dower CM, Blick NT et al. (1998). *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*. San Francisco, CA: Pew Health Professions Commission.
- <sup>60</sup> Finocchio, *ibid.*, executive summary.
- <sup>61</sup> Finocchio, *ibid.*, executive summary.
- <sup>62</sup> Kohn LT, Corrigan JM and Donaldson M (eds.). (2000). *To Err is Human: Building a Safer Health System*. Washington, DC: Institute of Medicine.
- <sup>63</sup> Kohn, *ibid.*, pg. 132.
- <sup>64</sup> Kohn, *ibid.*, pg. 134.
- <sup>65</sup> Kohn, *ibid.*, pg. 135.
- <sup>66</sup> Kohn, *ibid.*, pg. 141.
- <sup>67</sup> Missouri Commission on Patient Safety. (2004). *Missouri Commission on Patient Safety: Report Presented to Governor Bob Holden, July 2004*. Page iv.
- <sup>68</sup> Missouri Commission, *ibid.*, pg 20.
- <sup>69</sup> Missouri Commission, *ibid.*, pg 22.
- <sup>70</sup> Missouri Commission, *ibid.*, pg. 22. Green J. (2001). Effectiveness of continuing education as a means to improve the safety of patient care was demonstrated by a group of radiologists in Pennsylvania regarding stroke diagnosis error rates. New approach uses CME to reduce medical errors. *AMNews*, retrieved 04.10.05 at [www.ama-assn.org/amednews/2001/02/19/prsa0219.htm](http://www.ama-assn.org/amednews/2001/02/19/prsa0219.htm) .
- <sup>71</sup> Missouri Commission, *ibid.*, pg. 22.
- <sup>72</sup> Florida op cit., pg. 24.
- <sup>73</sup> Testimony 213W:175-183.
- <sup>74</sup> Testimony 302B:O130-133.
- <sup>75</sup> Although this recommendation was not submitted through the testimony, it was an important strategy for improving safety through the professional licensure and disciplinary mechanism as identified by the Institute of Medicine, Missouri Commission on Patient Safety, and the Florida Commission on Excellence in Health Care.
- <sup>76</sup> Testimony 302B:O144-146.
- <sup>77</sup> Testimony 302B:W406-408.
- <sup>78</sup> Testimony 213W:8-10, 10-11, 133-135.
- <sup>79</sup> Finocchio, op cit., executive summary.
- <sup>80</sup> Finocchio, op cit., executive summary.
- <sup>81</sup> Finocchio, op cit., executive summary.
- <sup>82</sup> Missouri Commission, op cit., pg. 26.
- <sup>83</sup> Kohn, op cit., pg. 134.