

SUNSET REVIEW: EVALUATION OF THE STATE BOARD OF PHYSICIANS AND THE RELATED ALLIED HEALTH ADVISORY COMMITTEES



DEPARTMENT OF LEGISLATIVE SERVICES NOVEMBER 2011

**Sunset Review:
Evaluation of the
State Board of Physicians and the Related
Allied Health Advisory Committees**

**Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland**

November 2011

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Warren G. Deschenaux
Director

November 7, 2011

The Honorable Thomas V. Mike Miller, Jr.
The Honorable Michael E. Busch
Honorable Members of the General Assembly

Ladies and Gentlemen:

The Department of Legislative Services (DLS) has completed its evaluation of the State Board of Physicians and the related allied health advisory committees as required by the Maryland Program Evaluation Act. This evaluation process is more commonly known as "sunset review" because the agencies subject to evaluation are usually subject to termination; typically, legislative action must be taken to reauthorize them. This report was prepared to assist the committees designated to review the board – the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee – in making their recommendations to the full General Assembly. The board is scheduled to terminate on July 1, 2013.

During this evaluation, DLS observed several positive trends. The board and its allied health advisory committees have dedicated members. The board continues to process licenses proficiently and has sufficient funds to support its activities. Also, the board has implemented several procedures in an effort to process complaints effectively and efficiently. However, significant challenges face the board and its advisory committees. There is a growing backlog of complaints and an ongoing increase in the timeline for complaint resolution. As new allied health professions are added to the jurisdiction of the board, questions regarding the relationship between the board and the advisory committees and the role of the advisory committees need to be addressed. Other challenges facing the board include how to balance the need for openness and transparency with the needs of licensees and how to best optimize the board's resources.

More significantly, DLS finds that the board has failed to implement key recommendations and requirements from previous sunset evaluations and currently fails to comply with statutory requirements in several areas such as public disclosure of board filing of charges and the Opening Meetings Act. The board fails to adopt regulations when required by law and does not update regulations to be consistent with current board practice. While there is no question that there is a continued need for the board and the allied health advisory committees, the purpose of this and past sunset evaluations is to provide recommendations to

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assist the board and its advisory committees in improving their ability to protect the public health and meet the challenges before them.

In total, DLS offers 46 recommendations relating to licensing, complaint resolution, board resources, and other issues. Some recommendations are more administrative in nature, such as altering the timing by which the board notifies licensees that they have been selected for the board's continuing medical education audit. However, others are more significant and serious in nature. For example, DLS recommends that budget language be adopted during the 2012 legislative session to withhold funds from the board until the board has adopted sanctioning guidelines for physicians and allied health professionals. DLS also recommends that the board assess its fee-charging practices and develop a long-term fiscal plan. Furthermore, DLS recommends that the board and the Department of Health and Mental Hygiene be required to jointly develop and implement a strategy for reducing the backlog of complaint cases.

Unfortunately, based on prior performance, DLS has significant concerns about whether the board will comply with the sunset recommendations contained in this report, especially those included in legislation. Therefore, DLS recommends that the termination date for the board and the related allied health advisory committees be extended by only one year to July 1, 2014, and that DLS be required to make a recommendation on further extension of the board based on the progress of the board in complying with the recommendations of this report and the submission of a follow-up report by the board. Draft legislation to implement the recommended changes is included as an appendix to this report.

We would like to acknowledge the cooperation and assistance provided by the board and the Department of Health and Mental Hygiene throughout the review process. The department and the board were provided a draft copy of the report for factual review and comment prior to its publication; both the department's and the board's written comments are included as appendices to this report.

Sincerely,

Warren G. Deschenaux
Director

WGD/JBC/mlm

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Executive Summary

Pursuant to the Maryland Program Evaluation Act, the Department of Legislative Services (DLS) has evaluated the State Board of Physicians (MBP), which is scheduled to terminate July 1, 2013, and the related allied health advisory committees. The 46 recommendations in this evaluation are summarized below.

Recommendation 1: The board should develop Managing for Results (MFR) goals for allied health professionals to report on consumer satisfaction and licensure processing goals. In its MFR submission, MBP reports consumer satisfaction data and licensure processing goals for initial physician licensure; however, similar measures related to allied health professionals are not reported.

Recommendation 2: To expedite the audit process and optimize board resources, the board should notify a licensee who has been selected for the continuing medical education (CME) audit in the renewal notice that the board is required to send each licensee. In the renewal notice, the board should advise such licensees who have been selected for the CME audit that they are required to send documentation of their CME to the board by December 31 of the renewal year. Licensees must meet CME requirements when renewing (or reinstating) their license. CME is on the honor system, with MBP doing a random audit of about 100 applications (slightly less than 1%) annually. Currently, there is a four-month delay between the end of the renewal period and the time when licensees are notified that they have been selected for the CME audit.

Although roughly 90% of licensees comply with the requirements, the board should expedite its current process.

Recommendation 3: The board should amend its regulations to reflect current fee levels. As a part of the board's sunset review, DLS discovered the board is charging an additional \$50 for initial physician licensure and reinstatement and an additional \$52 for physician licensure renewal over what is authorized for those activities in the board's regulations.

Recommendation 4: Statute should be amended to repeal the requirement that the board assess physician assistants a fee to fund the rehabilitation program for physicians and certain allied health professionals. Although the Maryland Physician Rehabilitation Program is available for physicians, physician assistants, and other allied health professionals licensed by the board, only physician assistants are still required to pay a fee to fund the program. Chapter 539 of 2007 repealed the requirement that physicians be assessed a separate fee to fund the physician rehabilitation program and peer review activities. Physician assistants should not be required to pay a fee for the program when no other profession under the board's jurisdiction has a similar requirement.

Recommendation 5: Uncodified language should be adopted requiring the board to recommend measures to increase the involvement of allied health advisory committees in complaint resolution and licensee discipline. The board should

consider the feasibility and efficacy of (1) allied health advisory committees handling all allied health complaint resolution functions currently handled by board members; or (2) having allied health advisory committee members perform certain complaint resolution functions, such as serving on the Investigative Review Panel (IRP) to review cases involving allied health professionals. Uncodified language should require that the recommendations be submitted by the board to DLS in a subsequent follow-up report. Allied health advisory committee members have expressed interest in having their committees more involved in resolving complaints against their peers. For cases involving certain grounds for discipline, such as a failure to meet appropriate standards for the delivery of care or practice beyond the authorized scope of practice, allied health advisory committee members have professional training, skills, and experience that could aid in assessing whether there is a violation and what sanction, if any, the board should impose. Any change in the involvement of allied health advisory committees in the disciplinary process would need to be made by amending statute.

Recommendation 6: MBP should report complaint data for allied health professionals in board annual reports and MFR data in the same manner as reported for physicians. In its annual reports and MFR submission, MBP reports allegations brought against physicians by each enumerated disciplinary ground and the number of days required to resolve each case. Similar measures are needed for allied health professionals so the board can monitor the time and resources required to

process complaints related to allied health professionals.

Recommendation 7: MBP should revise the expedited complaint process for CME cases to include (1) a ratification of the consent agreement or consent order by the board prior to the sanctions included in the agreement or order becoming effective; and (2) a mechanism for board review of more egregious cases before a consent agreement or consent order is offered to the licensee. MBP should also adopt regulations governing all expedited case resolution procedures. The amount of fines levied for failure to complete CME requirements should be reported in the board's annual report. The board has instituted an expedited complaint resolution process for CME cases. The expedited process results in a consent agreement or order, depending on the number of credits the licensee has failed to complete, that requires the licensee to complete the credits and pay a fine of \$100 per credit. There are several issues of concern regarding the process, including the lack of board involvement in the case.

Recommendation 8: MBP should review and adjust the expedited process for ground 21 and 24 disciplinary cases to address (1) the lack of involvement of the board; (2) the involvement of the executive director in determining appropriate sanctions; (3) the lack of a determination regarding legal sufficiency; and (4) the lack of clarity regarding the board's role in the expedited processing letter. Ground 21 and 24 cases occur when a licensee is disciplined by another jurisdiction for an act that would be grounds for discipline under the Maryland Medical Practice Act. Under the expedited process

for those cases, board staff prepares a consent order that includes sanctions that mirror those imposed by the other jurisdiction, unless the executive director determines that mirror sanctions may not be appropriate. IRP ratifies the consent order after it has been accepted by the licensee. The expedited process presents four major areas of concern, including that sanctions are being imposed without the vote of the full board and the lack of a determination regarding legal sufficiency of the case.

Recommendation 9: Uncodified language should be adopted requiring MBP and the Department of Health and Mental Hygiene jointly to develop and implement a strategy for reducing the backlog of complaint cases by December 31, 2012. Also, MBP should be required to include the strategy, as well as information regarding the effect of the strategy on the backlog and complaint resolution time, in a subsequent follow-up report that is submitted to DLS. Implementation of expedited case resolution processes appears to have had little to no effect on reducing the overall backlog and timeliness of the complaint resolution process. These expedited processes do not address the grounds for discipline that are the most violated and that result in the most lengthy complaint resolution times, such as standard-of-care violations.

Recommendation 10: MBP should (1) expand the complaint database to track the sanctions imposed in cases; (2) track the date the board voted to charge in a way that can be more easily accessed; and (3) institute steps that ensure that information recorded in the database is complete and accurate, including listing cases under all grounds

for which the licensee was charged and fully tracking the grounds for allied health cases. A clear picture for grounds for charging could not be developed due to the state of the information provided by the board, as information for many cases was either incomplete or inaccurate. The complaint database should include this information so the board can adequately monitor the complaint resolution process.

Recommendation 11: MBP should treat violations of probation and violations of orders as distinct, board-generated complaints and assign new complaint case numbers in these situations when the board learns of subsequent violations. Another factor that impedes the ability of MBP to accurately measure complaint resolution performance is the board's treatment of violation of probation cases or violation of order cases. These cases sometimes arise when the board completes a chart review as a condition of probation or termination of probation. Unlike other health occupations boards, the board often charges licensees in these situations using the same case number for which the licensee was put on probation, rather than considering the violation as a new, board-generated complaint with a new case number. This artificially lengthens the average case resolution time and undercounts the incidence of disciplinary actions against a licensee.

Recommendation 12: Budget bill language should be adopted during the 2012 legislative session to withhold funds from MBP until the board promulgates in regulations sanctioning guidelines for physicians and allied health professionals, as required by Chapters 533 and 534 of 2010. Furthermore, the Senate

Education, Health, and Environmental Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding. In the meantime, board staff should update sanctioning information provided in board books and include information related to allied health professionals. Although Chapters 533 and 534 of 2010 require all health occupations boards to adopt sanctioning guidelines, the recommendation that MBP adopt guidelines dates back to 2003 when the Office of the Attorney General (OAG) recommended that MBP adopt guidelines. It is unclear why MBP has been unable to adopt sanctioning guidelines in a timely manner in the eight-year period since sanctioning guidelines were first recommended for the board.

Recommendation 13: If unable to resolve a complaint within one year, MBP should comply with statute and include in the record of the complaint a detailed explanation of the reason for the delay. This statutory requirement is not being met. Along with improvements in maintaining the board's complaint database, adherence to this requirement will aid the board in identifying factors contributing to delays in complaint resolution.

Recommendation 14: MBP should comply with statute and disclose the filing of charges and notice of initial denial of a license application to the public. Statute should be amended to require MBP to disclose the information on the licensee profiles with a disclaimer stating that the charging document does not indicate a final finding of guilt by the board. After

filing charges against a physician licensee or notice of initial denial of a physician license application, MBP must disclose the filing to the public. MBP is not fully complying with this requirement. Initial denials of licensure and votes to charge are handled in closed session meetings of the board; therefore, they are not reflected in the public meeting minutes. The information is not included in licensee profiles on the MBP website and is generally not disclosed to a member of the public who contacts the board requesting the information, unless the individual is the complainant in the case.

Recommendation 15: Statute should be amended to require MBP to disclose the filing of charges against an allied health licensee and notice of initial denial of an allied health license application to the public, with a disclaimer stating that the charging document does not indicate a final finding of guilt by the board. There is no parallel requirement regarding the public disclosure of the filing of charges against an allied health licensee or the denial of an allied health license.

Recommendation 16: Statute should be amended to codify the requirement that MBP give the complainant in a case the opportunity to appear before the board during a case resolution conference. Board regulations should be updated to reflect this requirement. Uncodified language in Chapter 252 of 2003 requires MBP to give the complainant in a disciplinary case the opportunity to appear before the board during a case resolution conference. While MBP has been complying with this requirement, it remains uncodified. The requirement should be codified because it is an ongoing requirement, and placement in statute will

give licensees and the public notice of the requirement.

Recommendation 17: MBP should (1) adopt guidelines for reopening cases, especially sexual misconduct cases; (2) revise the advisory letter sent to licensees after an initial complaint involving sexual misconduct to include a statement notifying the licensee that the case may be reopened and charges may be issued if a pattern of behavior emerges; (3) institute a process for tracking sexual misconduct cases; and (4) reopen all relevant cases using the original case number. Board staff advises that the practice of reopening closed cases with new case numbers occurs whenever a pattern of behavior is discovered. Sexual misconduct cases can be hard to prove, and investigations may not result in sufficient evidence to sustain charges against the licensee. In those cases, the board closes the case with an advisory letter, which is nonpublic, informal board action; however, the board reopens the case under a new case number if a pattern of behavior emerges. Reopening sexual misconduct cases after a pattern is discovered is not unique to MBP; however, three issues of concern regarding specifics of the practice may be unique to MBP: consistency, clarity of the initial advisory letter sent to the licensees, and use of new case numbers.

Recommendation 18: When referring individuals to the Maryland Physician Rehabilitation Program, the board should no longer specify licensees are required to participate in the program for a specified time period. Instead, the length of participation in the Maryland Physician Rehabilitation Program should be based on the clinical need for participation and

whether the individual is still licensed in Maryland. All participants who are referred to the physician rehabilitation program by the board are typically required to participate in the program for five years, even if there is no longer a clinical need for participation. The board could benefit by deferring to the clinical judgment of the program when attempting to determine how long an individual should be monitored. There are also individuals participating in the program who are no longer practicing in the State; however, these participants cannot be discharged from the program due to specified monitoring periods delineated in their consent orders.

Recommendation 19: Statute should be amended to authorize MBP to seek a warrant for entry into private premises for the purpose of investigating formal complaints that allege a person is practicing, attempting to practice, or offering to practice medicine without a license and to require that MBP have a warrant before entering into private premises for those purposes. Chapter 539 of 2007 authorizes the executive director of MBP or an authorized agent or inspector of the board, on a formal complaint, to enter into private premises to investigate allegations that a person is practicing, attempting to practice, or offering to practice medicine without a license. When reviewing Chapter 539, OAG raised the concern that entry into private premises for this purpose is in part an entry to determine evidence of a crime. Because of that, both the Maryland Declaration of Rights and the U.S. Constitution require that the entry be supported by a warrant. MBP has not exercised the right to enter into private premises because of this, but the board continues to maintain that entry into private

premises is needed to adequately investigate allegations of unlicensed practice of medicine.

Recommendation 20: Due to the uncertainty surrounding the board's current fiscal condition, MBP should be required to assess its fee-charging practices, develop a long-term fiscal plan, and submit a report to DLS by December 31, 2012, so that these issues can be factored into consideration of the board's operating budget during the 2013 session of the General Assembly. Specifically, the assessment, plan, and report should include a description of the method the board uses to determine the amount of licensing fees that the board will charge licensees; the adequacy of the board's fund balance, including the board's projected fund balance based on fee levels specified in regulations; and the sufficiency of physician fee levels, including whether current fee levels need to be adjusted to reflect the costs associated with peer review and physician rehabilitation activities.

Recommendation 21: To enable the board to better approximate the cost associated with allied health expenditures and whether current fee levels for licensure are appropriate, MBP should budget allied health expenditures under a separate program code and report licensure revenues for physician assistants and radiographers with revenues derived from other allied health professionals. In reporting allied health revenues and expenditures separately, the board should monitor the revenues and expenditures of the Allied Health Unit to determine if additional personnel is needed to support the licensure of athletic trainers and

perfusionists in fiscal 2012 and 2014, respectively. Estimating the expenditures attributable to the Allied Health Unit is difficult because the board does not budget the unit under a separate program as it does with the board's legal services. Likewise, fee revenues related to licensing allied health professionals are not reported separately.

Recommendation 22: Although the board incurs numerous start-up costs when it begins to license a new profession, the board should examine the schedule of fees for allied health professionals and, if necessary, adjust licensure fees to more accurately reflect the ongoing cost of licensure amongst the various allied health professionals. The board should pay particular attention to initial application fees for athletic trainers, which seem relatively high for that profession. As part of the fee revision process, the board should determine the percentage of board activities dedicated to each allied health profession and adjust application and renewal fees accordingly by profession. When making any fee changes, the board should balance the need to maintain the current, reasonable surplus attributable to the Allied Health Unit, while considering new anticipated revenues from athletic trainers and perfusionists. Fee levels for initial licenses, license renewals, and licensure reinstatement differ amongst the various allied health professions. However, on a per-licensee basis, there does not appear to be a substantial difference in the amount of resources required to process license applications for each of the professions. It is unclear, therefore, whether the differing fee levels are justified and tailored to cover

licensure costs for the respective professions.

Recommendation 23: MBP should not use contractual employees to perform ongoing functions of the board – including policy research – or to perform functions that could be done by existing employees. While the board has successfully reduced its use of contractual employees, as recommended in the 2005 sunset review, the board is still using a contractual employee to perform ongoing allied health functions related to licensure and policy research that could be done by existing full-time employees.

Recommendation 24: To optimize current board resources, (1) board counsel, in conjunction with the executive director of the board, should establish clear guidance for board staff participation and attendance at closed meetings; and (2) the board should no longer require applicants for reinstatement who meet the requirements for reinstatement after a suspension to appear before the Reinstatement Inquiry Panel. While attending board meetings, DLS observed board staff, who have no duties related to the complaint resolution process, attending closed disciplinary hearings and meetings. This prevents staff from attending to their assigned duties. In addition, the board requires a licensee to appear before a Reinstatement Inquiry Panel when applying for reinstatement. If an individual has met all conditions for reinstatement after a suspension, the board must grant reinstatement and return the license to the licensee. Therefore, the Reinstatement Inquiry Panel serves no real role as the panel cannot deny reinstatement or require additional action by the applicant.

Requiring board members to attend the Reinstatement Inquiry Panel on a monthly basis not only unnecessarily diverts staff resources but also results in the board paying additional per diem rates to board members.

Recommendation 25: Statute should be amended to clarify that the board is required to provide online profiles on allied health licensees and require that allied health licensee profiles, to the extent possible, contain the same information that is provided on physician profiles, including, for the most recent 10-year period, a description of any disciplinary action taken by MBP and any final disciplinary action taken by a licensing board in any other state or jurisdiction against an allied health licensee. While statute does not require the board to provide online license profiles on allied health licensees, such profiles are provided by the board. The content of the profiles, however, is not uniform between allied health professionals and physicians. In addition, allied health profiles do not include a summary of final disciplinary action taken by a licensing board in any other state or jurisdiction within the most recent 10-year period as physician profiles do.

Recommendation 26: The board should improve the quality of its website for consumers and licensees so it is more user friendly. Furthermore, the board should improve its transparency to the public by posting all required disciplinary action on its website as well as posting open meeting agendas, open meeting minutes, board staff names, meeting cancellations, and contact information through which a person can receive information from the

board regarding medical malpractice settlements. These administrative changes will increase the board's transparency and openness to the public.

Recommendation 27: Board staff should standardize information and documents that are kept in the hard copy files and establish a system to ensure that the files are organized and information is readily accessible. Furthermore, hard copy complaint files should contain a checklist for documents included in the file, as well as dates corresponding with the steps in the complaint resolution process, such as when a board vote to charge occurred. DLS found the board's hard copy complaint files are disorganized. Furthermore, file review revealed inconsistencies and missing information in the electronic and hard copy files. Inconsistencies were also found in the type of information included in each file. A consistent file structure would make it easier to find documents in large complaint files and would facilitate the board's ability to move cases through the process.

Recommendation 28: Board staff should ensure that information included in the board's annual reports is consistent with information reported in its MFR submission and the board's complaint database. Likewise, when board staff prepares closed session minutes, staff should verify that case and licensure numbers are accurate and correspond to the appropriate licensee. Additional inaccuracies were found upon reviewing the board's annual reports and MFR performance measures related to licensure and compliance figures. Furthermore, minutes from the board's closed sessions included errors. This hinders the board's ability to track cases.

Recommendation 29: To enhance compliance with the Open Meetings Act, MBP should ensure that its members and staff receive training in the requirements of the Open Meetings Act from OAG and the Department of Health and Mental Hygiene (DHMH). Board counsel should review and approve the closed and open meeting agendas prior to monthly board meetings to maintain compliance with the Act. Furthermore, if the board begins to discuss a matter in closed session that violates the Act, board counsel should advise the board that it is violating the Act and the board should cease discussion. DLS noted that the board violated the Open Meetings Act by discussing specific topics in the board's closed sessions, including the board's position on legislation and politically sensitive topics, when statute requires those topics to be heard in an open setting. Board counsel did not appear to be sufficiently active in determining whether agenda items are appropriate for closed meetings.

Recommendation 30: MBP should continue to improve board member training by developing training in conjunction with DHMH, OAG, and the Office of Administrative Hearings on board procedures, including parliamentary procedures to expedite the disciplinary process. While attending closed board meetings, DLS observed board members lacked appropriate knowledge of parliamentary procedures, as well as the role of OAG. Since there are so many board regulations and policies to navigate, the board should continue to improve its existing training for board members.

Recommendation 31: Statute for each allied health advisory committee should include a requirement that the advisory committee submit an annual report to the board; the chair serve in an advisory capacity to the board as a representative of the committee; the board consider all recommendations of the advisory committee and provide a written explanation of the board's reasons for rejecting or modifying the committee's recommendation; the chair report to the board on a biannual basis and present to the board the committee's annual report; and the board provide to the advisory committee chair on a biannual basis a report on disciplinary matters involving allied health professionals. Also, board staff should ensure that the above allied health-related reporting requirements are met. There is a perception among certain allied health professionals that the board disregards the preferences of allied health committee members or has an incomplete understanding of professional practices, particularly in establishing requirements for licensure, defining scope of practice, or developing protocols. These changes to the allied health advisory committees should be adopted to further enhance board-committee communication and assist committees in addressing issues confronting their respective professions.

Recommendation 32: Uncodified language should be adopted requiring the board to develop and implement a plan by December 31, 2012, to improve the recruitment of allied health advisory committee members. The board should also be required to provide an update on implementation of that recruitment plan as well as study and report to DLS on several issues related to advisory

committee membership. Specifically the report should address (1) measures the board is taking to fill vacancies; solicit, identify, and appoint new members before a member's term expires; promptly reappoint members eligible and nominated to serve for an additional term; and ensure that committee chairs are elected in a timely manner and preside over committee meetings; (2) whether board members should sit on allied health advisory committees; (3) whether the number of licensees should be considered when determining the size of an allied health advisory committee; and (4) whether the size and composition of the advisory committees should be altered through statutory amendment to more effectively carry out oversight functions, including whether membership should be reduced after the regulatory framework for the affected profession has been developed. A number of allied health advisory committees have one or more vacancies in membership, or one or more members serving beyond the expiration of their term. Furthermore, one advisory committee is functioning without a chair elected from the committee membership.

Recommendation 33: As the board assumes responsibility to license new allied health professions, the board should adopt and appoint members, convene advisory committees, and develop and adopt regulations in a timely manner. The board was slow to appoint members to the Athletic Trainer Advisory Committee and promulgate regulations to govern the licensure of athletic trainers. MBP is required to license perfusionists by October 1, 2013. The board should be proactive in recruiting potential candidates

for the Perfusion Advisory Committee and completing any preparatory work so the board can promulgate regulations and begin issuing licenses in a timely manner.

Recommendation 34: To ensure that allied health advisory committee and board members exercise independent judgment in carrying out their responsibilities, statute should be amended to prohibit the appointment of an individual to an advisory committee or the board if the individual is providing or has provided services to the board for remuneration. Any individual currently serving on MBP or an advisory committee who has provided services to the board for remuneration should be replaced. Under board regulations, a member of the Physician Assistant Advisory Committee (PAAC) may be reappointed for a second term but may not serve more than two consecutive terms. One current member of PAAC, the committee chair, served two consecutive three-year terms from 1999 to 2006, left the committee and worked as a paid consultant to the board from 2006 to 2008, and was then reappointed to the committee for a third term. Employment by or service rendered to the board for remuneration, whether past or present, presents a conflict of interest.

Recommendation 35: The board should adopt and implement meeting procedures to ensure that nonmembers are clearly identified before addressing an allied health advisory committee or the board. While attending a PAAC meeting, DLS observed a representative of a professional association actively participating in deliberations on matters before the committee. Although the association representative did not vote on committee

matters and provided input that was invited by the committee, there was little indication that the representative, who was seated alongside of committee members, was not a member of the committee.

Recommendation 36: MBP should adopt regulations by December 31, 2012, that govern (1) exceptions to licensure for the purpose of consultation; (2) exemptions from licensure fees; and (3) mental health record subpoenas. If the board fails to adopt regulations as required, budget bill language should be adopted in the 2013 legislative session to withhold funds from MBP until the regulations are adopted. Furthermore, the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding. The Administrative Procedure Act requires MBP to adopt regulations that contain MBP guidelines and rules that have general application and future effect. However, MBP has failed to adopt regulations for the above procedures.

Recommendation 37: The board should institute a process for updating regulations when the board changes its practices. Uncodified language should be adopted requiring the board to amend its regulations to conform to current practice by December 31, 2012. If the board fails to update regulations as required, budget bill language should be adopted during the 2013 legislative session to withhold funds from MBP until the regulations are adopted. Furthermore, the Senate Education, Health, and Environmental

Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding. A review of board regulations showed that there were several outdated terms, references, and other information. Despite previous recommendations regarding the need for MBP to update and keep its regulations current, the board does not have a process for ensuring that necessary changes are made in a timely manner.

Recommendation 38: Statute should be amended to allow for current MBP practice regarding the requirement of postgraduate medical training for licensure and in cases of the failure to pass the required examination to be consistent with the Maryland Medical Practice Act. These two board regulations are inconsistent with statute. Given that no known problems have arisen due to the board's practice, statute should be amended to allow for current board practice in the above areas.

Recommendation 39: Statute should be amended to remove the requirement that physician-pharmacist agreements and protocols to be approved by the State Board of Pharmacy and MBP. Instead, participating pharmacists and physicians should be required to submit copies of all agreements and protocols to their respective board and to promptly submit any modifications. Furthermore, MBP should collaborate with the State Board of Pharmacy to submit a follow-up report to the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations

committees by October 1, 2013, on the impact of these modifications to the drug therapy management program, including the number of physician-pharmacist agreements and drug therapy management protocols on file with the boards. Participation in the drug therapy management program has been significantly low for several reasons. Among other things, the application process is onerous and time consuming, with some agreements and protocols awaiting approval for years. MBP and the State Board of Pharmacy disagree on the program's legislative intent, as well as the scope of the program and the types of diseases that should be treated under it. Furthermore, there is concern that MBP denies protocols that are authorized under the drug therapy management statute.

Recommendation 40: Uncodified language should be adopted requiring the board to work with the Maryland Insurance Administration, OAG, and DHMH's Office of the Inspector General to determine the appropriate entity for investigating and enforcing Maryland's Self-referral Law. Also, MBP should be required to report the findings to DLS in a subsequent follow-up report. It is unclear whether MBP is the most appropriate entity to be enforcing the self-referral law as the law applies to all health occupations, not just physicians or allied health professionals.

Recommendation 41: Statute should be amended to authorize MBP, rather than requiring the circuit courts, to impose civil fines against alternative health systems that fail to report as required so that the civil fine provisions related to reporting by hospitals and related institutions and alternative health systems

are the same. Statute should be amended to clarify how the court reporting requirement is to be enforced and place the requirement in a separate statutory section. The enforcement mechanisms regarding two sections of law are different. Not only is this an issue because there are inconsistent enforcement mechanisms for similar reporting requirements, but the enforcement mechanisms for the court reporting are conflicting.

Recommendation 42: Statute should be amended to clarify that all entities required to report to the board under §§ 14-413 and 14-414 of the Health Occupations Article are to report every six months even if the institution has not taken disciplinary action against a licensee or denied privileges to a licensee. The board should simplify its reporting form and conduct outreach with the facilities on this issue. Furthermore, the board should (1) exercise its authority to assess civil fines against an entity that does not report as required under § 14-413; and (2) create and post on the board's website a Report of Disciplinary Action form that may be used to report when a licensed allied health professional is disciplined or terminated. It is unclear whether hospitals, related institutions, and alternative health systems are not reporting as required or whether those facilities have not taken any action against physicians so there is nothing to report. Statute does not specify if the reporting requirement still applies if there have been no disciplinary actions taken in a given institution.

Recommendation 43: To accommodate the conventional practice of athletic training, statute should be amended to (1) clarify that a supervising physician

may authorize, in an evaluation and treatment protocol, an athletic trainer to accept an outside referral from a nonsupervising physician or licensed health care practitioner; (2) specify the licensed health care practitioners from whom an athletic trainer may accept referrals; and (3) clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer. Board-proposed regulations allow an athletic trainer to accept outside referrals from a nonsupervising physician or a licensed health care practitioner under certain circumstances. Although this is accepted conventional practice of athletic training, statute does not address whether, and the circumstances under which, an athletic trainer may accept outside referrals.

Recommendation 44: Uncodified language should be adopted requiring the board, with considerable input from PAAC, physician assistants, and supervising physicians from a variety of practice settings, to adopt regulations on or before December 31, 2012, for determining (1) what constitutes an advanced duty; and (2) how many successful procedures a physician assistant must perform to be deemed able to safely perform a delegated medical act. In the meantime, PAAC should (1) complete its work in refining the list of advanced duties the board has approved in the past; (2) post the list of advanced duties on the board's website; and (3) include the list as an attachment to both the addendum application and delegation agreement application to perform core duties. If there is a question as to whether a medical act in a delegation agreement filed with the board constitutes an advanced duty, PAAC as a

whole should make the determination. Physician assistants are prohibited from performing, attempting to perform, or offering to perform any delegated medical act beyond the scope of the license and which is consistent with a delegation agreement filed with the board. A supervising physician and physician assistant must obtain MBP approval of a delegation agreement that includes “advanced duties.” However, it is unclear what constitutes an advanced duty, how the board determines whether a procedure qualifies as an advanced duty, and how many procedures must be performed for a physician assistant to be qualified to perform a delegated duty.

Recommendation 45: Uncodified language should be adopted that requires the board to license individuals who were enrolled in an unaccredited radiation therapy, radiography, or nuclear medicine technology program on October 1, 2010, and who graduate by June 30, 2014, provided that the individuals meet all other requirements for licensure. In December 2010, the board adopted regulations that require an individual to successfully complete and graduate from an accredited program before being licensed to practice radiation therapy, radiography, or nuclear medicine. The regulations, under certain circumstances, grandfather individuals who were enrolled in an unaccredited program on April 1, 2010, and who graduated on or before June 30, 2011. However, individuals who enrolled in an unaccredited program in the fall of 2010 would not be able to be licensed even though the regulations, at the time they enrolled, would have allowed them to be licensed. As a matter of fair notice, the board should license these individuals if

they meet all other requirements for licensure.

Recommendation 46: Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2014. Further, uncodified language should be adopted to (1) require MBP to submit a follow-up report to DLS by June 1, 2013, that addresses the implementation of the recommendations made in this report, including any issues specifically noted for inclusion in the subsequent follow-up report; and (2) require DLS, by October 1, 2013, to make a recommendation to specified committees of the General Assembly regarding further extension of the termination dates based on the progress of MBP in complying with the recommendations of this report and the submission of the follow-up report by MBP. Although several positive trends were observed during the course of this evaluation, the board faces significant challenges moving forward, including the growing backlog of complaints and the ongoing increase in the timeline for complaint resolution. Also, based on past performance, DLS has significant concerns about whether the recommendations, especially those contained in legislation, will be complied with by MBP. The board failed to implement key recommendations and requirements of previous sunset evaluations and sunset legislation. Also, DLS found that MBP fails to comply with several statutory requirements, including public disclosure of board filing of charges, and compliance with the Open Meetings Act.

Chapter 1. Introduction and Background on the State Board of Physicians

The Sunset Review Process

This evaluation was undertaken under the auspices of the Maryland Program Evaluation Act (§ 8-401 *et seq.* of the State Government Article), which establishes a process better known as “sunset review” because most of the agencies subject to review are also subject to termination. Since 1978, the Department of Legislative Services (DLS) has evaluated about 70 State agencies according to a rotating statutory schedule as part of sunset review. In most cases, the review process begins with a preliminary evaluation conducted on behalf of the Legislative Policy Committee (LPC). Based on the preliminary evaluation, LPC decides whether to waive an agency from further (or full) evaluation. If waived, legislation to reauthorize the agency typically is enacted. Otherwise, a full evaluation typically is undertaken the following year. In select circumstances, the General Assembly forgoes a preliminary evaluation and instead subjects an entity to a direct full evaluation.

The State Board of Physicians (MBP) last underwent a full evaluation as part of sunset review in 2005. However, no legislation was adopted during the 2006 session to extend the board’s termination date. An update of the 2005 evaluation was completed during the 2006 interim. The 2005 evaluation and the 2006 update concluded that, while the board had made some progress, investigative caseloads remained too high and the complaint resolution process too lengthy. The reports made several recommendations to further enhance board operations and public protections in the areas of self-referral, sanctioning guidelines, public hearings, and employment or supervision of allied health professionals. Chapter 539 of 2007, among other things, extended the termination date of the board by six years to July 1, 2013. Chapter 539 also required a direct full evaluation of the board be conducted by July 1, 2012, necessitating a review in the 2011 interim.

This full evaluation was undertaken to provide the General Assembly with information in making the determination about whether to reauthorize the board and for what period of time. This report represents the fifth full evaluation of the board. Recommendations are made throughout this document.

Evaluation Methodology

In conducting this evaluation of MBP, DLS reviewed board-related statutes and regulations and internal board documents and files, including board minutes, financial records, and annual reports. **Exhibit 1.1** provides more details about the documents and files reviewed.

Exhibit 1.1
State Board of Physicians Sunset Evaluation:
Documents and Files Reviewed

<u>Material Reviewed</u>	<u>Period Under Review</u>	<u>Purpose of Review</u>
Board Minutes	All open and closed meeting minutes: fiscal 2007-2011 year-to-date	History of MBP action; assessment of procedures established by the board to carry out its administrative and disciplinary functions; and accuracy of minutes.
Initial Application Files	Random selection of files: fiscal 2010 and 2011	State of hard copy files.
Complaint and Discipline Material	Fiscal 2007-2011	Timeliness of processing of complaints; efficiency of disciplinary procedures; criteria for discipline; and identification of bottlenecks in complaint/disciplinary process.
Board Financial Records	Budget submissions: fiscal 2007-2011	Adequacy of budget; assessment of budget prioritization; and assessment of financial planning and resource availability.
Board Annual Reports and Newsletters	Fiscal 2007-2011	MBP history and background data.
New Physician Board Member Training Material	2011	MBP operations.

Source: Department of Legislative Services

In addition, DLS conducted interviews (personal and telephone) with an extensive range of interested parties including current and past board and allied health advisory committee members, key board staff, board counsel, a representative from the Office of the Attorney General (OAG), various staff of the Medical and Chirurgical Faculty of the State of Maryland (MedChi), staff from the peer review contractor, and other interested parties. These interviews focused on the implementation of recommendations from the 2005 sunset review and the 2006 update report, staff responsibilities, workload, disciplinary procedures, the board's relationship with professional associations, and board operations.

DLS also attended numerous board meetings, committee meetings, and disciplinary hearings to gain a better understanding of issues confronting the board, evaluate the procedures and processes developed by the board for appropriateness and effectiveness, and assess interactions among board members and between board members and board staff.

Report Structure

This report consists of six chapters. **Chapter 1** offers an overview of the sunset process, implementation of the recommendations from the 2005 sunset review and the 2006 update report, background on MBP, and legislative changes to the board since the last sunset review. **Chapter 2** discusses the licensing and renewal processes. Complaint and disciplinary issues are discussed in **Chapter 3**. **Chapter 4** discusses resource and administrative issues. **Chapter 5** discusses additional policy and regulatory issues, including the drug therapy management program and self-referral. **Chapter 6** is a brief conclusion.

As supplements to the report, five appendices are included. **Appendix 1** contains draft legislation to implement the statutory recommendations contained in this report. **Appendix 2** contains a summary of recommendations from the 2005 full sunset review of MBP and the outcome of those recommendations, while **Appendix 3** contains a summary of recommendations and outcomes from the 2006 update report. MBP and the Department of Health and Mental Hygiene (DHMH) reviewed a draft of this report and provided the written comments included as **Appendix 4** and **Appendix 5**. Appropriate factual corrections and clarifications have been made throughout the document; therefore, references in written comments may not reflect this published version of the report.

Duties and Composition of the State Board of Physicians

Under the Maryland Medical Practice Act, physicians are granted the privilege to practice medicine by “diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual...” (§ 14-101(l)(2)(i) of the Health Occupations Article). However, in Maryland, the practice of medicine excludes the sale of nonprescription drugs or medicines, practice as an optician, or performing a massage or other manipulation by hand.

Regulation of medical practice in Maryland first began in 1788 and is conducted by MBP, which replaced the State Board of Physician Quality Assurance under Chapter 252 of 2003. The mission of MBP is to assure quality health care in Maryland through the efficient licensure and effective discipline of health providers under its jurisdiction, by protecting and educating clients/customers and stakeholders and enforcing the Maryland Medical Practice Act.

As shown in **Exhibit 1.2**, in fiscal 2011 the board issued a total of more than 27,000 new and renewal licenses to physicians, unlicensed medical practitioners (medical graduates

completing postgraduate training in the State), and multiple categories of allied health practitioners. Due to the biennial renewal cycle, the board actually had regulatory authority over 43,000 individuals in fiscal 2011. In that same year, the board dealt with more than 1,727 complaints.

Exhibit 1.2
Major Workload Indicators for the State Board of Physicians
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Physician Licenses					
New	1,533	1,508	1,541	1,575	1,560
Renewal	12,936	11,167	13,487	11,797	13,500
Unlicensed Medical Practitioners ¹	2,495	2,017	2,418	2,638	2,817
Allied Health Licenses					
New	924	962	885	967	941
Renewal	7,347	2,354	8,017	2,500	8,393
Total Licenses Issued	25,235	18,008	26,348	19,477	27,211
Total Complaints²	1,470	1,542	1,651	1,696	1,727

¹Unlicensed medical practitioners are medical graduates completing postgraduate training in the State.

²Total complaints includes complaints received in the fiscal year as well as complaints still pending from previous fiscal years.

Source: *Fiscal 2010, 2011, and 2012 Budget Books*, State Board of Physicians

MBP is composed of 21 members. By statute, the membership is drawn as follows:

- 11 practicing licensed physicians, including 1 doctor of osteopathy, appointed in accordance with a statutory nominating process;
- 1 practicing licensed physician appointed at the Governor's discretion;
- 1 practicing licensed physician with a full-time faculty appointment who then serves as a representative of an academic medical institution and is appointed from a list of names submitted by the Johns Hopkins University School of Medicine and the University of Maryland School of Medicine;

- 1 representative from DHMH nominated by the Secretary;
- 1 certified physician assistant appointed at the Governor's discretion in accordance with a statutory nominating process;
- 5 consumer members; and
- 1 public member knowledgeable in risk management or quality assurance matters appointed from a list submitted by the Maryland Hospital Association.

All board members serve staggered four-year terms. No member may serve more than two consecutive full terms. The board elects a chair and any other officers that the board considers necessary, and these positions are open to all members of the board.

Board Regulates Multiple Allied Health Professions

Statutory provisions place several allied health professions under the jurisdiction of MBP and establish allied health advisory committees that assist MBP in its oversight role. These committees are composed of representatives of the regulated professions, physicians, and consumers. The allied health professions under the jurisdiction of MBP include:

- **Physician assistants.** Physician assistants (PAs) practice medical acts delegated by and under the supervision of a licensed physician including taking patient histories, performing physical examinations, and exercising prescriptive authority under a delegation agreement with a supervising physician.
- **Radiographers, radiation therapists, nuclear medicine technologists, and radiologist assistants.** A radiographer uses ionizing radiation to assist in the diagnosis or localization of disease or injury or to perform tumor localization radiography. Radiation therapists perform tumor localization radiography and apply therapeutic doses of radiation. Nuclear medicine technologists prepare and administer radiopharmaceuticals to and conduct in vivo detection and measurement of radioactivity to assist in the diagnosis and treatment of disease or injury. Radiologist assistants are advanced practitioners of medical radiation technology licensed to perform fluoroscopy and selected radiology procedures, patient assessment, and patient management under the supervision of a radiologist.
- **Respiratory care practitioners.** Respiratory care practitioners evaluate, care for, and treat individuals who have deficiencies and abnormalities that affect the pulmonary system and associated aspects of the cardiopulmonary and other systems under the supervision of and in collaboration with a physician.

- **Polysomnographic Technologists.** Polysomnographic technologists monitor and record physiologic data during sleep under the supervision of a licensed physician, or use these data for the purposes of assisting a licensed physician in the diagnosis and treatment of sleep and wake disorders.
- **Athletic trainers.** Added to the jurisdiction of MBP in 2009, athletic trainers apply certain principles and methods, including injury prevention, for managing athletic injuries for athletes in good overall health under the supervision of a licensed physician.
- **Perfusionists.** Added to the jurisdiction of MBP in 2011, perfusionists perform functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, or respiratory systems or other organs to ensure the safe management of physiologic functions by monitoring and analyzing the parameters of the systems under an order and the supervision of a licensed physician. Regulation of perfusionists will begin October 1, 2012.

Exhibit 1.3 contains the membership composition and duties of the six allied health advisory committees. Each committee is subject to separate sunset review provisions requiring, with the exception of the Perfusion Advisory Committee, an evaluation by July 1, 2012. Review of the Perfusion Advisory Committee is required by July 1, 2021.

Exhibit 1.3

Allied Health Advisory Committees

<u>Committee</u>	<u>Membership Composition</u>	<u>Duties</u>
Physician Assistant Advisory Committee	<ul style="list-style-type: none"> • 3 physicians, including 1 who is a board member; • 3 physician assistants; and • 1 consumer member. 	Make recommendations to the board concerning physician assistant licenses and delegation agreements, as well as regulations governing physician assistants.
Radiation Therapy, Radiography, Nuclear Medicine Technology Advisory, and Radiology Assistance Committee	<ul style="list-style-type: none"> • 4 physicians; • 1 radiation therapist; • 1 radiographer; • 1 radiologist assistant; • 1 nuclear medicine technologist; • 1 consumer; and • 1 board member. 	Make recommendations to the board concerning a code of ethics, standards of care, and requirements for licensure for the practice of radiation therapy, radiography, nuclear medicine technology, and radiology assistance; on request, review applications for licensure and make recommendations to the board.
Respiratory Care Professional Standards Committee	<ul style="list-style-type: none"> • 3 physicians; • 3 respiratory care practitioners; and • 1 consumer member. 	Make recommendations to the board concerning applications for a license to practice respiratory care, as well as regulations governing the practice of respiratory care.
Polysomnography Professional Standards Committee	<ul style="list-style-type: none"> • 3 physicians; • 3 polysomnographic technologists; and • 1 consumer member. 	Make recommendations to the board concerning applications for licensure as a polysomnographic technologist, as well as regulations governing the practice of polysomnography.
Athletic Trainer Advisory Committee	<ul style="list-style-type: none"> • 3 athletic trainers; • 3 physicians; • 1 chiropractor; • 1 physical therapist; • 1 occupational therapist; and • 2 consumer members. 	Advise the board on regulations to govern the practice of athletic training and develop and recommend an evaluation and treatment protocol for use by an athletic trainer and a supervising physician.
Perfusion Advisory Committee	<ul style="list-style-type: none"> • 3 perfusionists; • 3 physicians; and • 1 consumer member. 	Advise the board on standards of care for the practice of perfusion, as well as regulations that govern the practice of perfusion.

Source: Department of Legislative Services

Board Has Committees with Strong Role

In addition to the allied health advisory committees, three other committees play a large role in the major functions of MBP, including licensing and discipline. The committees are:

- **Licensure/Practice of Medicine Committee**, composed of five board members who make determinations of eligibility for medical licensure and advise the board on licensure qualifications, questions of medical practice, and delegation;
- **Investigative Review Panel**, composed of seven board members, board counsel, and others, who review complaints, recommend full investigations or closure, and make recommendations for action on cases under investigation; and
- **Case Resolution Conference**, composed of five board members who make recommendations to the board with regard to the proposed disposition of disciplinary cases before a hearing.

Physicians appointed by MBP also sit on one committee within the State Board of Nursing and one committee within the State Board of Pharmacy:

- **Joint Committee on Nurse Midwifery**, which makes recommendations to the State Board of Nursing and MBP regarding approval of written agreements between nurse midwives and physicians; and
- **Joint Committee on Drug Therapy Management**, which makes recommendations to the State Board of Pharmacy and MBP regarding the approval of drug therapy management agreements between a physician and a pharmacist.

MBP previously had a role in approving written agreements between nurse practitioners and physicians. Since 2010, these agreements no longer need MBP approval. A copy of the agreement, however, is kept on file with the State Board of Nursing and must be provided to MBP on request.

Outstanding Issues Remain Regarding Implementation of Previous Sunset Review Recommendations

The 2005 sunset evaluation came not on the typical 10-year evaluation cycle, but rather only four years after the last full evaluation. The relatively short time between full evaluations was due to the fact that Chapter 252 of 2003 extended the termination date of the board by only four years to July 1, 2007. The same legislation also required a full evaluation of the board by July 1, 2006, necessitating a review in the 2005 interim. That review took place as required.

However, no legislation was adopted during the 2006 session to extend the board's termination date. An update of the 2005 evaluation was completed in 2006, which revised some of the recommendations made as a result of the 2005 evaluation. The outcome of each recommendation is shown in **Appendix 2** and **Appendix 3**.

Several recommendations that required statutory changes were fully implemented by Chapter 539 of 2007. These include extending the board's termination date, authorizing the board to impose a civil penalty against certain entities that fail to report a disciplinary action against certain allied health professionals, and authorizing the board to disclose certain information about licensees to the National Practitioner Data Bank. Other statutory recommendations were not adopted fully but were modified and included in Chapter 539. For example, rather than eliminate the distribution of physician fees to the general fund altogether, Chapter 539 set up a structure regarding what portion of the fees would go to the general fund and under what circumstances. Other statutory recommendations were not implemented, including the use of criminal background checks as a condition of licensure.

As shown in Appendix 1, several recommendations that required board action have not been implemented by the board to date, despite uncodified language in Chapter 539 requiring board action. In some cases, such as the adoption of sanctioning guidelines or exceptions to licensure regulations, the board agreed with the DLS recommendations. In other cases, the General Assembly chose to act on the recommendations over the objections of the board. The failure of the board to implement recommendations, even when required to, is especially concerning because issues that led to those recommendations are still present.

Legislative Changes Since the 2006 Update to the 2005 Full Sunset Review

Since the 2006 update report, several statutory changes have affected MBP, as shown in **Exhibit 1.4**. Chapters 533 and 534 of 2010 affected all health occupations boards, including MBP, by requiring them, among other things, to adopt sanctioning guidelines.

Exhibit 1.4 Legislative Changes Affecting the State Board of Physicians Since the 2006 Update to the 2005 Full Sunset Review

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2007	359	Makes practicing medicine without a license a felony subject to a fine of up to \$10,000 or imprisonment for up to five years or both, unless the violator is a licensee who failed to renew a license.

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2007	539	Extends the sunset date for MBP from July 1, 2007, to July 1, 2013, and makes substantial changes to the board (See Appendices 2 and 3).
2008	319	<p>Requires the State Board of Nursing and MBP to conduct a joint study to determine whether there is an appropriate alternative written protocol to replace the current requirement for a certified nurse-midwife to have a signed written collaborative agreement with a licensed physician.</p> <p>Requires the boards to report the results and recommendations of the study to specified committees of the General Assembly by December 1, 2009.</p>
2010	533/534	<p>Set standardized guidelines for all health occupations boards regarding disciplinary processes, board membership, and other administrative matters.</p> <p>Require each board to establish a disciplinary subcommittee to be responsible for the investigation of complaints and other aspects of the disciplinary process.</p> <p>Establish a six-year statute of limitations on the bringing of charges by a board against a licensee.</p> <p>Require boards to adopt sanctioning guidelines and post final public orders on the boards' websites.</p> <p>Require board membership to reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the State.</p> <p>Require boards to notify licensees of board vacancies.</p> <p>Require boards to develop a training process and materials for new board members.</p> <p>Require boards to collect racial and ethnic information about applicants.</p> <p>Authorize boards to establish a program that provides training, mentoring, or other forms of remediation to licensees who commit a single standard-of-care violation.</p> <p>Require the Secretary of Health and Mental Hygiene to confirm the appointment of an administrator or executive director to each board and establish goals for the timeliness of complaint resolution.</p>

Year Chapter Change

2010	709	Authorizes MBP to discipline a licensee if the licensee performs a cosmetic surgical procedure in an office or a facility that is not accredited by specified organizations or certified to participate in the federal Medicare program.
2011	215	Prohibits MBP from disciplining a licensee for providing a patient with a written statement, medical records, or testimony that, in the licensee's professional opinion, the patient is likely to receive therapeutic or palliative relief from marijuana.
	230/231	Authorize a health occupations board to discipline any health care practitioner under the board's jurisdiction who fails to comply with an order of the Governor to participate in disease surveillance, treatment, and suppression efforts or otherwise comply with directives of the Secretary of Health and Mental Hygiene or other designated official.
	308/309	Specify that the identities of individual physicians who are included in reports submitted by a hospital or related institution to the Health Services Cost Review Commission (HSCRC) may be disclosed to the Office of Health Care Quality (OHCQ) and a State or federal investigator.
		Require MBP to disclose any information contained in an MBP record to the Secretary of Health and Mental Hygiene, OHCQ, or HSCRC for the purpose of investigating quality or utilization of care in any entity regulated by OHCQ or HSCRC.
		Require MBP, the Secretary of Health and Mental Hygiene, and HSCRC jointly to adopt regulations for the efficient and secure transfer of any information in a MBP record that may indicate that an investigation of an entity may be appropriate.

Note: This chart does not include legislation affecting allied health professions, which is included in Exhibit 1.5.

Source: Laws of Maryland

Since the 2006 update report, several statutory changes, shown in **Exhibit 1.5**, have affected the practice of allied health professions under the board's authority. The board is now responsible for licensing and regulating three additional allied health professions: radiology assistance, athletic training, and perfusion. Statutory changes also affected the practice of respiratory care, radiation therapy, radiography, and nuclear medicine technology. In addition, Chapter 274 of 2010 resulted in significant changes to the practice and regulation of physician assistants.

Exhibit 1.5**Legislative Changes Affecting the Allied Health Professions Regulated by the Board of Physicians since the 2006 Update to the 2005 Full Sunset Review**

<u>Year</u>	<u>Chapter</u>	<u>Change</u>
2008	328	<p>Repeals MBP's authority to grant inactive status or issue temporary licenses to respiratory care practitioners.</p> <p>Requires a radiologist assistant to be licensed by MBP.</p> <p>Requires radiation therapists, radiographers, and nuclear medicine technologists to be licensed rather than certified by MBP.</p>
2009	268	<p>Delays the date by which a polysomnographic technologist must be licensed in order to practice in the State from October 1, 2011, to October 1, 2013.</p>
	529	<p>Defines and requires MBP to license and regulate the practice of athletic training.</p> <p>Requires individuals to be licensed to practice athletic training in the State on or after October 1, 2011, and establishes an 11-member Athletic Trainer Advisory Committee.</p>
2010	274	<p>Requires PAs to be licensed rather than certified by MBP to practice in the State.</p> <p>Removes the requirement that MBP approve a delegation agreement between a physician and PA before a PA may perform core duties.</p> <p>Removes the requirement that MBP approve a delegation agreement before a PA may perform advanced duties if the PA has been approved to perform advanced duties by a hospital or ambulatory surgical facility through a credentialing process.</p> <p>Expands grounds for disciplining PAs to align them with those for physicians and encompass violations of delegation agreements.</p>
2011	588	<p>Requires MBP to license and regulate the practice of perfusion in Maryland and establishes a seven-member Perfusion Advisory Committee to develop and recommend regulations, a code of ethics, standards of care, and continuing education requirements.</p>

Source: Laws of Maryland

Chapter 2. Licensing Issues

Board Generally Meets Licensing Performance Goals

Licensing is one of the core functions of the State Board of Physicians (MBP). With the authority to issue and revoke licenses, the board can enforce standards of care for physicians and allied health professionals. Thus, licensing allows the board to meet its statutory obligation to regulate and discipline physicians and allied health professionals. In addition to issuing licenses, the board also issues dispensing permits to physicians, and registers psychiatrist assistants. The board also regulates unlicensed medical practitioners (medical students completing clinical training and medical graduates completing postgraduate training in the State). These individuals are not subject to renewal since they are unlicensed.

As shown in **Exhibits 2.1** and **2.2**, the board issues a variety of licenses, which are renewed on a biennial basis. While the number of initial licenses issued to medical practitioners

Exhibit 2.1
Initial Licensing and Permit Applications Issued
By the State Board of Physicians
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Medical Practitioners	1,533	1,508	1,541	1,575	1,560
Unlicensed Medical Practitioners	2,495	2,017	2,418	2,638	2,200
Allied Health Professionals					
Physician Assistants	203	250	200	272	236
Radiographers	415	394	393	383	360
Nuclear Medicine Technologists	63	62	47	48	46
Radiation Therapists	14	30	26	39	31
Radiologist Assistants	0	0	0	2	0
Radiographers/Radiation Therapists	2	0	0	0	0
Respiratory Care Practitioners	227	226	200	199	200
Athletic Trainers	0	0	0	0	0
Polysomnographers	0	0	19	24	68
Total Allied Health	924	962	885	967	941
Dispensing Permits	271	229	316	255	330

Notes: Regulation of athletic trainers begins in fiscal 2012; polysomnographers were not licensed until fiscal 2009. Radiographers/radiation therapists are licensed to practice both radiography and radiation therapy. A dispensing permit is valid for a five-year period. Rather than renewing a dispensing permit, a physician must reapply for a permit at the end of the five-year period.

Source: State Board of Physicians

has remained constant since fiscal 2007, the number of initial licenses issued to allied health professionals has fluctuated from year to year. Overall, there has been a decline in the number of initial licenses issued to radiographers, nuclear medicine technologists, and respiratory care practitioners. In comparison, the number of new licenses issued to physician assistants, radiation therapists, and polysomnographers has increased.

Exhibit 2.2
Renewals and Reinstatements Issued
By the State Board of Physicians
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Medical Practitioners	12,936	11,167	13,487	11,797	13,500
Allied Health Professionals					
Physician Assistants	1,801	0	2,066	0	2,358
Radiographers	4,584	0	4,921	0	5,030
Nuclear Medicine Technologists	630	0	669	0	638
Radiation Therapists	252	0	292	0	303
Radiologist Assistants	0	0	0	0	2
Radiographers/Radiation Therapists	80	0	69	0	62
Respiratory Care Practitioners	0	2,338	0	2,448	0
Athletic Trainers	0	0	0	0	0
Polysomnographers	0	0	0	39	0
Psychiatrist Assistants	0	16	0	13	0
Total Allied Health	7,347	2,354	8,017	2,500	8,393

Notes: Regulation of athletic trainers begins in fiscal 2012; polysomnographers were not licensed until fiscal 2009. The board no longer offers initial registration for psychiatrist assistants. Therefore, individuals currently practicing as psychiatrist assistants are only subject to registration renewal.

Source: State Board of Physicians

As shown in Exhibit 2.2, since fiscal 2007, the number of renewal licensees has increased modestly due to growth within the allied health fields. Furthermore, the renewal patterns for physicians and allied health professionals fluctuate due to differences in board processes. For instance, the renewal period for physicians is staggered, so a physician whose last name begins with A-L is required to renew his/her license by September 30, in even-numbered years, while a physician whose last name begins with M-Z must renew his/her license by September 30, in odd-numbered years. In practice, the number of renewals issued for medical practitioners in odd-numbered years is only slightly higher than even-numbered years. Physician assistants, radiographers, nuclear medicine technologists, radiation therapists, and radiographers/radiation therapists renew in odd-numbered years, while respiratory care practitioners and psychiatrist assistants renew in even-numbered years. Licenses for allied health professionals expire on a

staggered basis (*i.e.*, in odd-numbered years all licenses for radiographers expire April 30, while all licenses for physician assistants expire June 30) to evenly distribute workload.

Initial Licensing

Application Process More Complex for Physicians

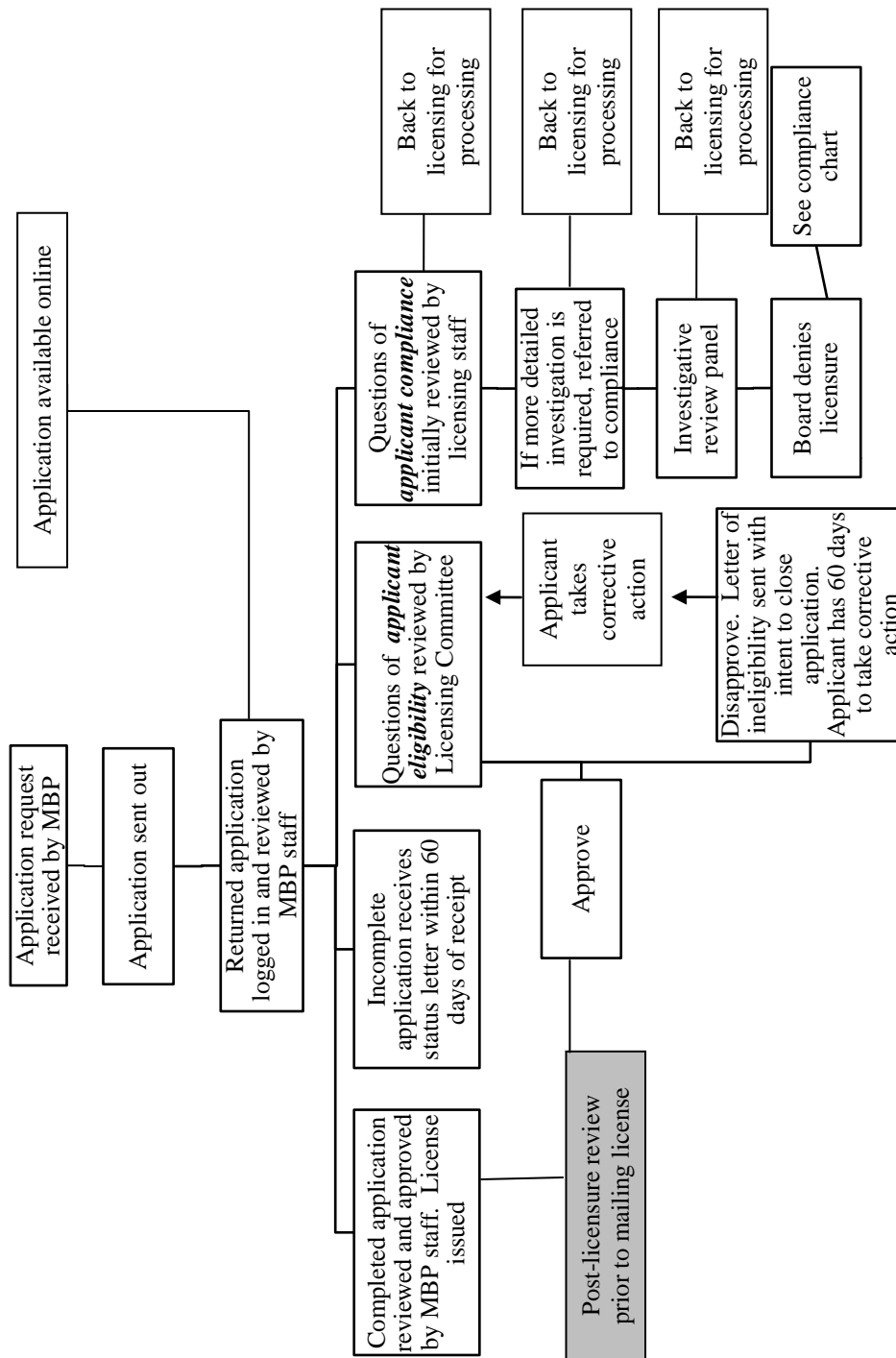
The initial licensing application process for physicians is detailed in **Exhibit 2.3**. The initial physician license application process is largely unchanged since the 2006 update report; however, the board has made one noteworthy change. The chief of the Licensure Unit now conducts a post-licensure review before the license is mailed for quality assurance purposes. In the event a problem is identified, the license is held back. Among other things, the initial physician application process contains a number of elements including the confirmation of postgraduate training and medical education, as well as medical licensing examination results (U.S. Medical Licensing Examination, USMLE). Disciplinary actions in other states are also verified through queries to the National Practitioner Data Bank, which was established by the U.S. Congress in 1986 to be a national repository of data concerning physicians. Data reported to the National Practitioner Data Bank include malpractice payments and adverse actions taken by medical boards, professional organizations, and health care organizations, including hospitals and health maintenance organizations. All of the information that is collected is crosschecked against the application form. Inconsistencies, incomplete applications, and affirmative responses to certain questions within the application trigger additional investigation by the Compliance Unit.

The process for obtaining an initial license as an allied health professional is less complex than that for a physician. To qualify for a license, all allied health professionals must be of good moral character, be at least 18 years old, and demonstrate oral and written competency in English. All of the allied health professions have continuing education requirements that must be fulfilled during the two-year period preceding expiration of a license. The number of continuing education hours that must be completed ranges from as many as 100 for physician assistants to as few as 16 for respiratory care practitioners.

Program Performance Focused on Efficient Processing

In terms of initial licensing program performance, two measures are important: (1) efficient processing of applications; and (2) ensuring that potentially problematic physicians and allied health professionals are not licensed. These two goals are competing rather than complementary. In terms of processing applications, one standard traditionally used by MBP is to license a qualified physician within 60 days of the receipt of the initial license application. On average, the board issues 71% of initial medical licenses within 60 days of receipt of the initial application. As shown in **Exhibit 2.4**, data reported by MBP reveal an increase in the percentage of applications being processed within 60 days of their receipt in fiscal 2011 compared to fiscal 2007. Physicians not licensed within 60 days are generally those with compliance issues based on responses to the character and fitness questions or other information identified during the licensure process.

Exhibit 2.3 Application Process for Physician Initial Licensure



Note: Shaded box indicates change since the 2006 update to the 2005 sunset review. For a more detailed explanation, see text.
Source: State Board of Physicians

Exhibit 2.4
Percent of Initial Medical Licenses Issued
Within 60 Days of Initial Application
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Physicians	68%	71%	67%	74%	74%

Source: State Board of Physicians, Department of Legislative Services

In comparison, **Exhibit 2.5** reveals that MBP consistently processes allied health licenses within 60 days of receipt. Since applicants and other entities provide less supporting documentation for allied health professionals, the Allied Health Unit is able to process licenses more quickly. It remains unclear if the board will be able to consistently meet the 60-day standard for initial allied health licensing as the board begins to license athletic trainers in fiscal 2012 and perfusionists in fiscal 2014.

Exhibit 2.5
Percent of Allied Health Licenses Issued
Within 60 Days of Initial Application
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Radiation Technologist	93%	95%	96%	96%	96%
Radiation Therapist	89%	97%	100%	100%	97%
Nuclear Medicine Technologist	95%	94%	96%	92%	100%
Physician Assistant	92%	96%	94%	97%	93%
Respiratory Care Practitioner	94%	93%	95%	95%	94%
Radiologist Assistant				100%	
Polysomnographer			100%	100%	100%

Notes: Radiologist assistants were not licensed until fiscal 2010, but no radiologist assistants applied for licensure in 2011. Polysomnographers were not licensed until fiscal 2009.

Source: State Board of Physicians, Department of Legislative Services

Because the issues that typically affect the processing of applications are beyond the control of board staff, MBP has developed another measure to assess licensing performance: to

issue initial medical licenses to 95% of qualified applicants within 10 days of receipt of the last qualifying document. This measure is also set forth in the board's Managing for Results (MFR) goals. In the 2001 sunset review of the board, it was noted that 97% of applications were processed within that timeframe. However, in the 2006 update report, the Department of Legislative Services (DLS) indicated that, in fiscal 2005, this figure had dropped to 75%. In fiscal 2010, this measure had returned to the 2001 level with 97% of applications processed within the MFR deadline.

In its MFR submission, MBP also reports consumer satisfaction data for the initial licensing process. Applicants rate the process on a scale of 1 to 20 (20 being the highest level of satisfaction). Ratings in fiscal 2010 averaged 16.5, slightly below the fiscal 2007 level of 17.1; however, the percentage of physicians expressing satisfaction actually increased to 97% in fiscal 2010 from 86% in fiscal 2007. This measure does not report on the consumer satisfaction for allied health professionals. It is noteworthy that the board continuously meets its MFR goals; however, similar MFR measures related to allied health professionals are not reported

Recommendation 1: The board should develop Managing for Results goals for allied health professionals to report on consumer satisfaction and licensure processing goals.

The second important performance measurement for the board involves an assessment of how successful the Licensure Unit is in screening out incompetent or unqualified practitioners. DLS interviews with different observers noted that they believed MBP is effective in this regard. However, this aspect of performance is difficult to measure. **Exhibit 2.6** details the disposition of initial medical license applications. Closed cases include license denials, withdrawals (often because of the need for additional information), and ineligible applications. With the exception of a decline in fiscal 2008, the number of closed cases varied little between fiscal 2007 and 2010. The board attributes a decline in the number of closed cases in fiscal 2008 to a reduction in licensure withdrawals and denials.

Exhibit 2.6
Disposition of Initial Medical License Applications
Fiscal 2007-2010

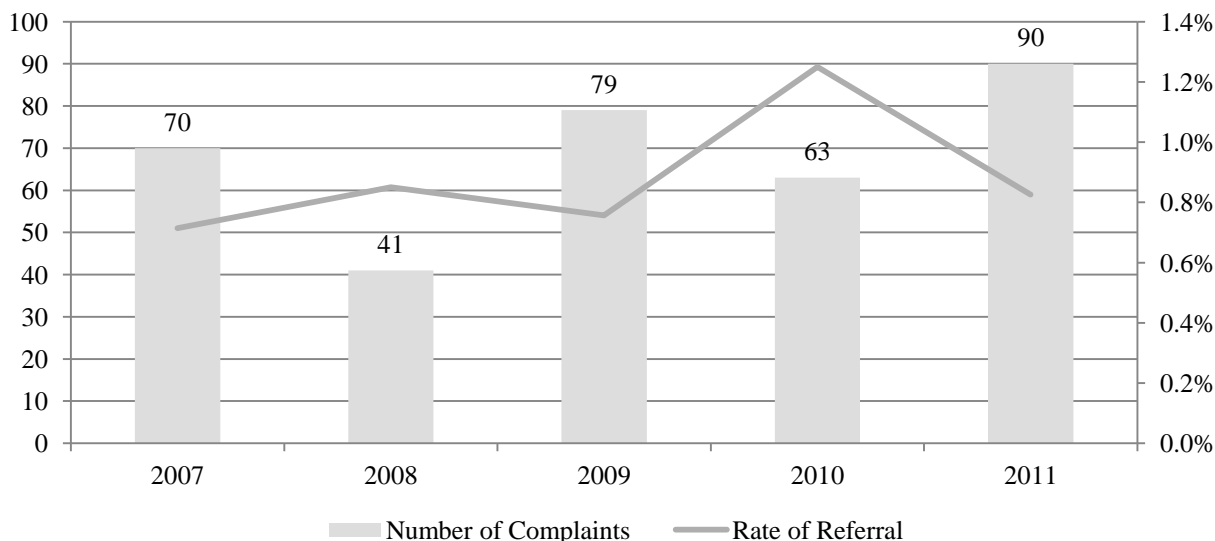
	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>
New Licenses Issued	1,533	1,508	1,541	1,575
Closed Cases	<u>52</u>	<u>26</u>	<u>44</u>	<u>52</u>
Total Applications Processed	1,585	1,534	1,585	1,627
Closed Cases as a % of Total Processed	3.3%	1.7%	2.8%	3.2%

Note: Closed cases include denials, withdrawals, and ineligible applications.

Source: State Board of Physicians, Department of Legislative Services

While the number of closed cases has shown little change, as detailed in **Exhibit 2.7**, the number of complaints referred from the Licensure Unit and the Allied Health Unit (generated from initial license applications and license renewals of physicians and license applications of allied health professionals) has increased by 22% since 2007. It is important to note that complaints referred from the units have fluctuated from fiscal 2007 to 2011 based on renewal (odd-numbered fiscal years) and nonrenewal (even-numbered fiscal years) years for allied health professionals.

Exhibit 2.7
MBP Complaints Referred from the Licensing and Allied Health Units
Fiscal 2007-2011



Source: State Board of Physicians

Licensure Renewal

All Physicians Now Renew Online

Since the 2006 update report, licensees have continued to utilize the online renewal system. As shown in **Exhibit 2.8**, the migration to online renewal of medical licenses has been striking, with 100% of licensees renewing online in fiscal 2010. As would be expected, online renewal has improved renewal processing times. In fiscal 2001, it was reported that the average number of days to process renewals was 4.9 days. With the exception of applicants who choose to pay by check, the majority of licensure renewals are processed within 24 hours. In the board's MFR submission for fiscal 2011, MBP's goal was to renew 100% of physicians online by June 30, 2012.

Exhibit 2.8
Percent of Physicians Using Electronic License Renewal
Fiscal 2007-2012

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>	<u>FY 2012</u>
Paper Renewal	16%	12%	10%	0%	0%	0%
Online Renewal	84%	88%	90%	100%	100%	100%

Source: State Board of Physicians

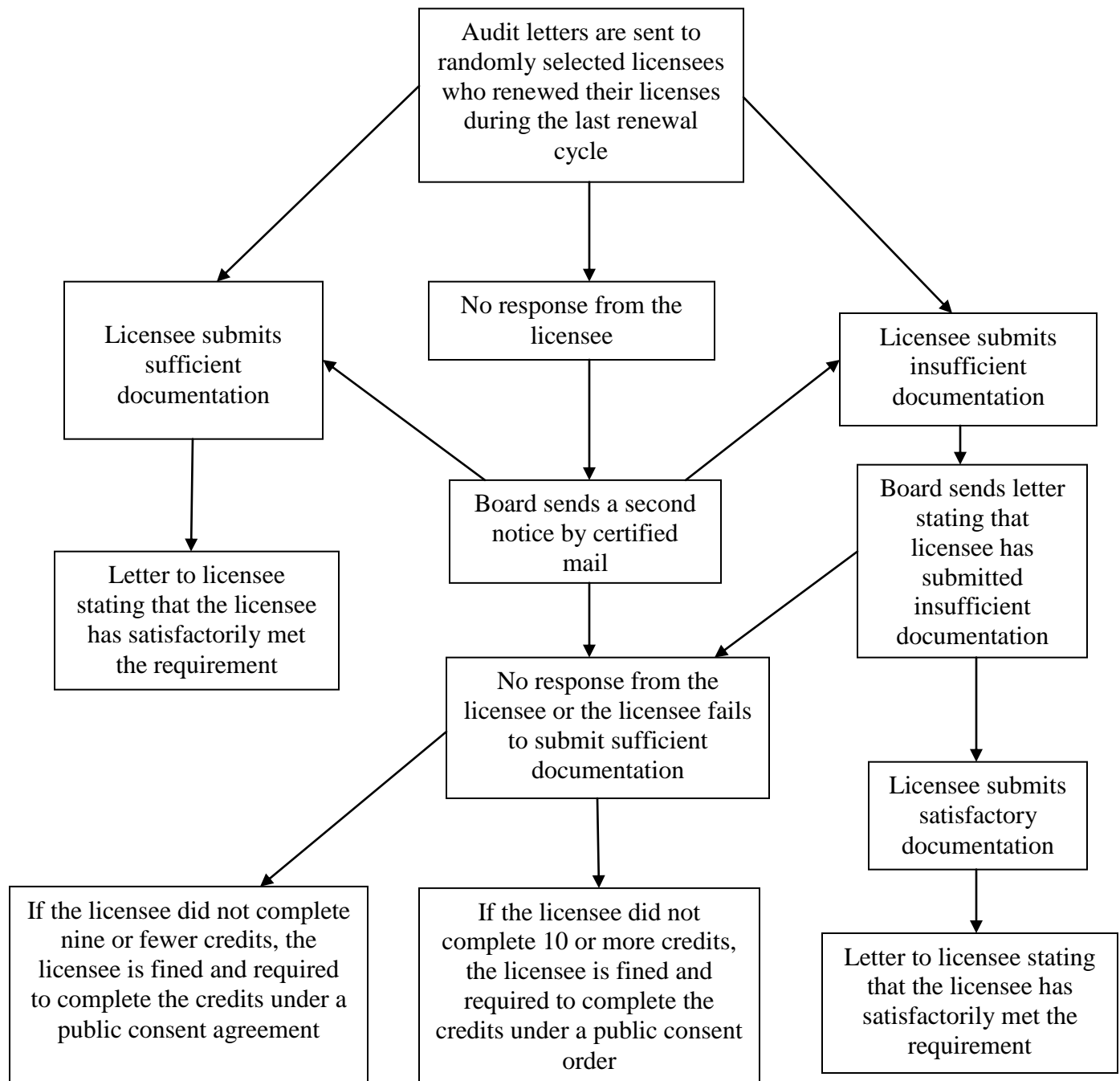
The physician licensure renewal process is straightforward. Renewal involves a fee, completion of a basic personal questionnaire, certification of continuing medical education (CME) requirements, and for first-time renewals, completion of the new physician orientation process. All complete applications are automatically renewed, even those with affirmative responses to character fitness questions concerning discipline in other states, substance abuse, and mental or physical impairment. However, these applications are sent to the Compliance Unit for review (see also Exhibit 3.7).

Automatic renewal of licenses sent to the Compliance Unit for review is troubling on the surface as a license would not be issued for a similar initial application until a compliance investigation were completed. However, automatic renewal of licenses has been standard practice for some time, as noted in the 2005 sunset review. As discussed previously in Exhibit 2.7, in practice, very few licensees are referred to the Compliance Unit for further investigation. Furthermore, as will be discussed in the next chapter, if MBP received a complaint against a licensee, the board would begin an investigation and the licensee would continue to practice until the investigations were closed. Therefore, the current process of automatic renewal appears to pose little additional threat to public health.

Board Audits Physician Compliance with Continuing Medical Education Requirements

Licensees must meet CME requirements when renewing (or reinstating) their license. Current CME requirements for physicians are 50 approved credit hours (per Code of Maryland Regulations 10.32.01.09). CME is on the honor system, with MBP doing a random annual audit of about 100 applications (slightly less than 1%) annually. This process is outlined in **Exhibit 2.9**. Currently, there is a four-month delay between the end of the renewal period and the time when licensees are notified that they have been selected for the a CME audit. The board actively works with licensees who are selected for the audit to obtain the proper CME documentation. Although roughly 90% of licensees comply with the requirements, to expedite the audit process, the board should notify licensees of selection for the audit in the renewal notices that the board is required to send out.

Exhibit 2.9
State Board of Physicians
Continuing Medical Education Audit Process



Source: State Board of Physicians, Department of Legislative Services

Recommendation 2: To expedite the audit process and optimize board resources, the board should notify a licensee who has been selected for the CME audit in the renewal notice that the board is required to send to each licensee. In the renewal notice, the board should advise such licensees who have been selected for the CME audit that they are required to send documentation of their CME to the board by December 31 of the renewal year.

Criminal History Records Checks Not Necessary at This Time

In order to increase the level of public protection, in the 2006 update report, DLS recommended that statute be amended to require the board to include national and State criminal history records checks in its initial application and licensure renewal process because data suggested a small number of physicians did not self-report criminal convictions as required on license application and renewal forms. However, MBP disagreed with this recommendation, stating criminal history records checks would increase the cost of licensure and cause unnecessary delays in the licensing process. Subsequently, this recommendation was amended out of the board's sunset legislation, and the board currently does not require criminal history records checks in its initial licensing or license renewal process. In practice, the board queries the Criminal Justice Information System (CJIS) when an applicant has an affirmative response to certain character fitness questions, including discipline taken in other states, substance abuse, and mental or physical impairment. The board advises that, from fiscal 2007 to 2011, there was only one instance in which a CJIS query revealed that a licensee did not self-report a serious criminal conviction on the application.

Chapter 390 of 2006 requires registered nurses, licensed practical nurses, certified nursing assistants, and electrologists to submit to criminal history records check as part of the initial license and certification application. The State Board of Nursing has established separate complaint and investigation units for nurses and certified nursing assistants. Criminal history records checks are conducted by the Federal Bureau of Investigation and CJIS. If either report comes back with a positive result (*i.e.*, a criminal history is identified), the board sends the report to the appropriate unit. The unit then contacts the prospective licensee or certificate holder for further documentation. In fiscal 2009, 8% of applicants to the State Board of Nursing had positive results that required investigation.

Reviewing criminal history records checks for initial licensure and certification applications has proved to create a significant workload for the State Board of Nursing. Ultimately, that board has dedicated one director and three additional staff to criminal history records checks. Similar criminal history records checks are also required for pharmacy technicians under the State Board of Pharmacy. This has significantly delayed the registration of pharmacy technicians. Based on the difficulties encountered by the State Board of Nursing and the State Board of Pharmacy in implementing criminal history records checks, and the likely low

level of licensees with positive records, there is not a need for MBP to require criminal history records checks at this time.

Review Revealed Problems with Certain Licensing Fees

Board Has Not Made Changes to Licensure Fees to Correspond with Statutory Change

Historically, licensure fees for health professionals were delineated in statute, but over time and with the shift to special funding for most of the health occupations boards, the General Assembly has given these boards the flexibility to raise fees through regulations. Statute authorizes MBP to “set reasonable fees for the issuance and renewal of licenses and its other services” (§ 14-207(b)(1) of the Health Occupations Article). Statute also requires that the fees charged be set “so as to approximate the cost of maintaining the [b]oard” (§ 14-207(b)(2) of the Health Occupations Article). Because the amount of the fees has a general application and future effect, MBP is required under the Administrative Procedure Act to set the specific fees it charges in regulations. The board has done this. However, as a part of the board’s sunset review, DLS discovered the board is charging fees for licensure that are above levels set in regulations. As shown in **Exhibit 2.10**, the board is charging an additional \$50 for initial physician licensure and reinstatement and an additional \$52 for physician licensure renewal.

The board advises that the additional \$50 charged for initial licensure and reinstatement, as well as \$50 of the additional \$52 charged for renewals, results from the board charging higher licensing fees to cover the costs of the physician rehabilitation program and peer review. Prior to 2007, the board was required by statute to charge a \$50 fee, separate from the licensing fees, to cover the cost of the board’s physician rehabilitation program and peer review activities. In the 2005 sunset review, DLS advised that fees associated with physician rehabilitation and peer review activities should be set according to the actual cost of the activities and not be set at a certain level in statute which may or may not reflect actual costs. Furthermore, DLS recommended that statute should be amended to eliminate the \$50 fee since those activities are part of the cost of licensing physicians and licensing fee levels overall are supposed to approximate the cost of licensure. The board agreed with this recommendation, and Chapter 589 of 2007 eliminated the \$50 statutory fee for physician rehabilitation and peer review activities; however, the separate fee remains listed in regulations.

During the current evaluation, board staff advised DLS that, even though the \$50 fee remained a separate fee listed in regulations, the board was no longer charging it and that the cost of those activities was instead subsumed in the licensing fees charged. It appears that the board never determined the actual cost of those activities; rather, the board continued to charge the same total amount in licensing fees. Additionally, the board’s regulations were never amended to reflect the changes in the fees associated with licensure.

Exhibit 2.10
Fee Levels for Physician Licensure

	<u>Fee Levels in COMAR</u>	<u>Fee Levels Charged By the Board</u>
Initial Licensure		
Licensure Application Fee	\$260	\$310
Physician License Fee	480	480
Licensure Renewal		
Biennial License Renewal	462*	514
Licensure Reinstatement		
Reinstatement (if physician was eligible for renewal in the previous year)	650	700
Reinstatement (if physician was not eligible for renewal in the previous year)	550	600

*Includes the \$26 Maryland Health Care Commission fee that MBP is required to charge.

Source: Code of Maryland Regulations, Board of Physicians

Recommendation 3: The board should amend its regulations to reflect current fees.

Requirement that the Board Charge Physician Assistants a Physician Rehabilitation Program Fee Should Be Repealed

The board, by statute and regulation, assesses physician assistants a \$25 fee to fund the physician rehabilitation program each time a physician assistant applies for an initial license or applies to renew or reinstate a license. Although this program is available for physicians, physician assistants, and other allied health professionals licensed by the board, only physician assistants are still required to pay a separate fee to fund the program. Chapter 539 of 2007 repealed the requirement that physicians be assessed a fee to fund the physician rehabilitation program and peer review activities. In light of this and the fund balance that the board is carrying with respect to licensing and discipline of allied health professionals, statute requiring the board to assess physician assistants a fee to fund the rehabilitation program should be repealed. Physician assistants should not be required to pay a separate fee for the program when no other profession under the board's jurisdiction has a similar requirement. All such costs should be reflected in the licensing fees charged.

Recommendation 4: Statute should be amended to repeal the requirement that the board assess physician assistants a fee to fund the rehabilitation program for physicians and certain allied health professionals.

Chapter 3. Complaint Resolution Issues

One of the State Board of Physicians' (MBP) most critical functions is to investigate complaints and take disciplinary action against individuals found to be in violation of the Maryland Medical Practice Act, laws governing allied health practitioners, and/or board regulations. The disciplinary work of the board is the area of operation that is the most visible and consequently the most scrutinized. This chapter reviews MBP's complaint resolution process and complaint activity, assesses the timeliness of complaint resolution, and identifies issues with complaint resolution that need to be addressed.

Complaint Resolution and Disciplinary Process Is Lengthy and Complex

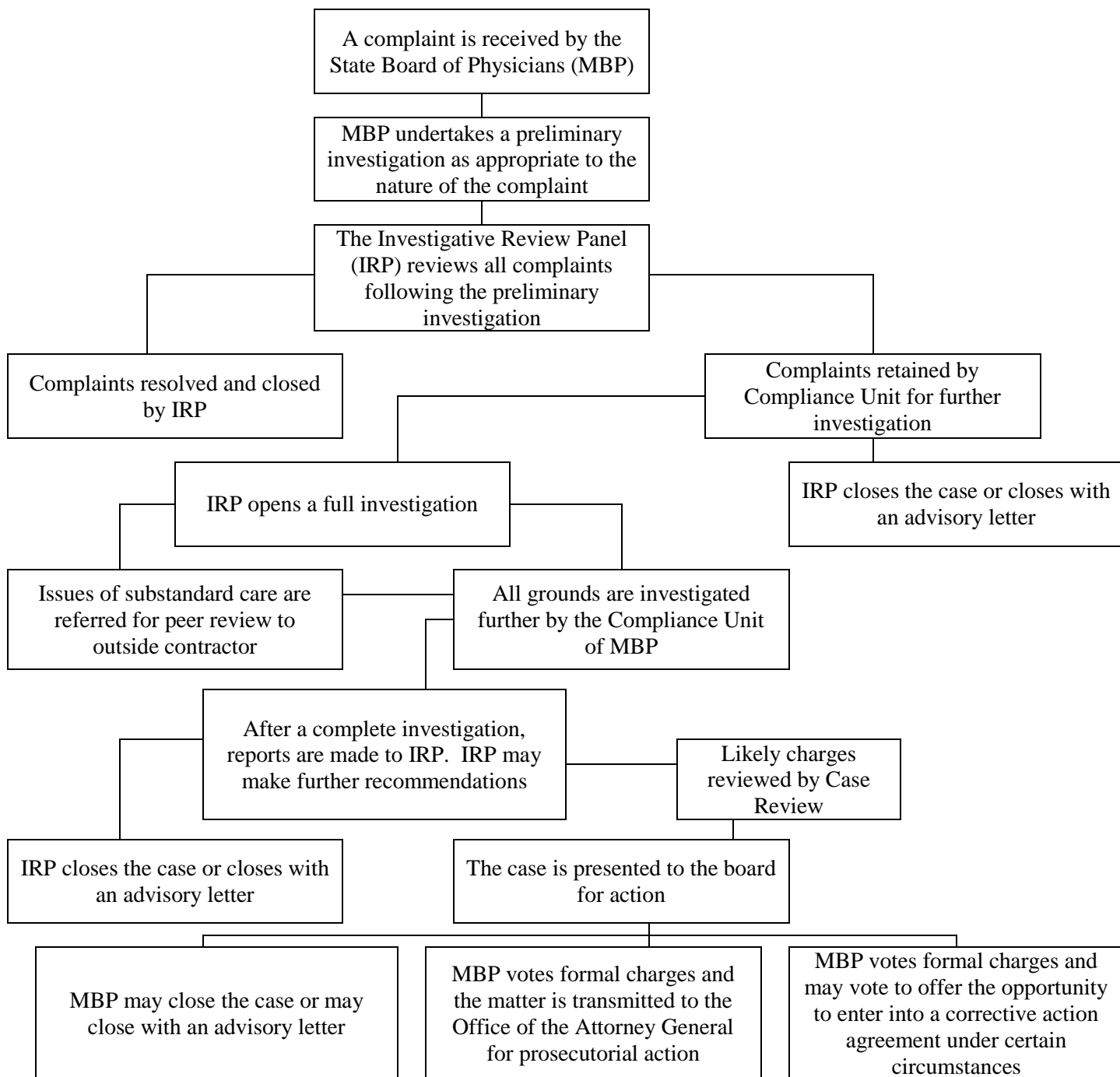
The board is charged with receiving, investigating, and responding to questions and complaints, monitoring licensees who are under board disciplinary orders, and reporting disciplinary actions to national databases. The board's Compliance Unit receives complaints from a variety of sources including consumers; hospital and health care facility adverse actions; other federal, State, and local agencies; the media; and referrals from other boards. An individual may obtain a complaint form from the board's website. Although the complaint form indicates that a complaint must be mailed to MBP, it may also be filed by fax, phone, in person, or via email. In some instances, a complaint is outside the board's jurisdiction, in which case, the complaint is referred to the appropriate authority.

MBP's complaint resolution process is a lengthy one and includes multiple levels of review by medical professionals, as well as professional investigators and State prosecutors. The process can be described as occurring in four stages. The board's complaint investigation process from receipt to resolution and board actions following the decision to charge a licensee are detailed in **Exhibit 3.1** and **3.2**. It should be noted that investigators in the Compliance Unit handles a complaint from the time it is received by the board until charges are issued in the case. Once charges are issued, the Probation Unit, a subunit of the Compliance Unit, handles the case though the rest of the process until the licensee meets and completes any conditions placed on the licensee in the board's order.

First Level: Investigation through the Investigative Review Panel

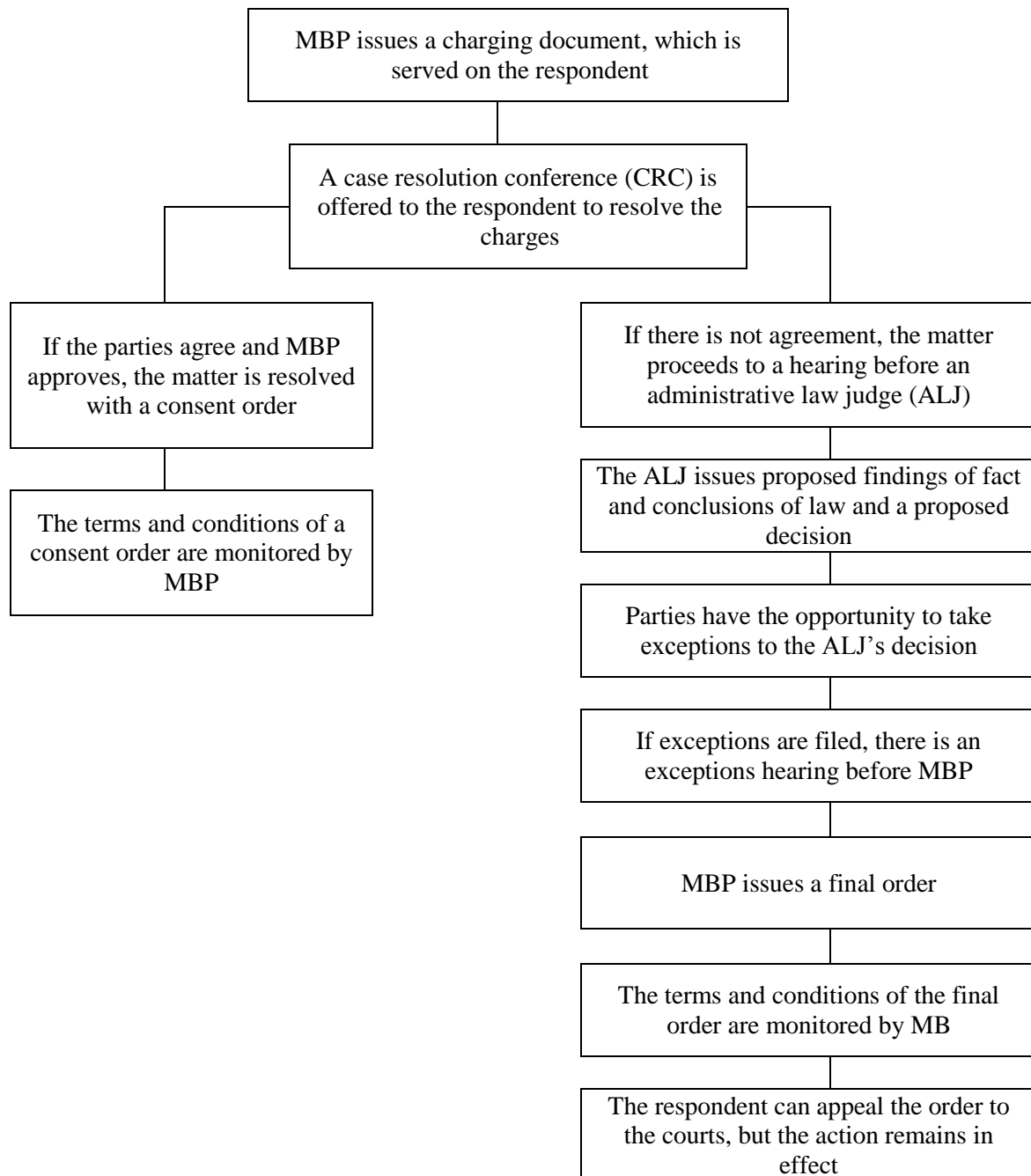
First, a complaint case undergoes a preliminary investigation including contact with the complainant and respondent by board staff. The investigation can also include the review of relevant medical records and hospital quality assurance files. MBP also utilizes in-house medical consultants. The case is presented to the Investigative Review Panel (IRP), which either votes to recommend closure of the case to the full board or to refer the case for further investigation. Cases involving standard of care and overutilization of health care services cases are referred for peer review. IRP may also recommend that a case be closed with an advisory letter. Most complaints are closed at this stage.

Exhibit 3.1
State Board of Physicians
Complaint Investigation Process from Receipt to Resolution



Source: State Board of Physicians, Department of Legislative Services

Exhibit 3.2
Actions Following State Board of Physicians' Vote to
Formally Charge a Licensee



Source: State Board of Physicians, Department of Legislative Services

Second Level: Full Investigation through Charging and Transmittal to the Office of the Attorney General

This stage includes drafting correspondence, including subpoenas for documents and testimony. All material received is handled pursuant to chain-of-custody protocol. Compliance analysts document in-depth and comprehensive interviews of individuals including the respondents, complainants, and relevant witnesses. Standard-of-care cases are sent for peer review.

Statute requires that complaints related to standard of care be reviewed by peer reviewers (§ 14-401(c)(2) of the Health Occupations Article). Until 2007, the board was only able to contract with nonprofit entities; however, with the passage of Chapter 539 of 2007, the board now has the option of contracting with either nonprofit or for-profit entities and directly with specialty groups for peer review services within that specialty. There are also specific qualifications required of the peer reviewer including board certification, a clean disciplinary record, and appropriate experience. Whenever possible, in-state physicians must be used as peer reviewers.

New peer review contracts began in fiscal 2009, and peer review cases related to psychiatry and anesthesiology were contracted to specialty groups. As shown in **Exhibit 3.3**, with the exception of calendar 2009, the average number of days to complete peer review has decreased by 12 days or 13% from 2007 to 2011. The lengthy review period in 2009 is largely attributed to a peer review entity the board ended its contract with due to poor performance.

Exhibit 3.3
Average Number of Days to Complete Peer Review
Calendar 2007-2011

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
Average Number of Days	89	84	135	86	77

Note: Calendar 2011 data only include cases sent to peer review from January through June.

Source: State Board of Physicians, Department of Legislative Services

Under current law, MBP must obtain two peer reviews for standard of care cases. The board uses a third peer reviewer if it is determined that one of the peer reviewers did an insufficient job and the other peer reviewer is adamant that the standard of care has been violated. Further investigation by DLS also revealed that, in some instances, staff in the Compliance Unit determines whether a third peer review is warranted, before a case is presented to the board.

Investigative findings of cases are presented to IRP. IRP may vote the case be closed with an advisory letter, or closed with no action, or recommend that the board issue charges. If IRP recommends that charges be issued, the case is then brought to the full board for a vote. If the board votes to charge, the case is then transmitted to the Office of the Attorney General (OAG).

Third Level: Transmittal to OAG to Final Board Action

Once the board votes to charge, OAG reviews the case, prepares a formal charging document, and is responsible for the prosecution of the case. A case resolution conference (CRC) is offered to the respondent. A CRC is a voluntary, informal, and confidential proceeding before a panel of board members. If no resolution is reached at a CRC or if the respondent does not want a CRC, the case goes before an administrative law judge (ALJ) in the Office of Administrative Hearings (OAH). The CRC process and/or administrative hearing process precedes final disposition by the board.

Board cases referred to OAH are assigned an ALJ to conduct a formal hearing as provided in the Administrative Procedure Act. Within 90 days of the conclusion of the hearing, the ALJ must issue findings of fact, conclusions of law, and recommend sanctions to the board. The board is not bound to adhere to the ALJ's findings, conclusions, or recommendations.

The board has a variety of sanctions and conditions available to it, some of which carry considerably more weight than others. These sanctions include denial of licensure, probation, reprimand, suspension, revocation, fines (which can also be combined with other actions), advisory letters, psychiatric evaluation and treatment, mandatory medical courses, restrictions on practice and practice environment, mandatory supervision, and mandated periodic peer reviews.

Fourth Level: Potential Judicial Review

As with all health occupations boards, statute provides for judicial review of the board's decision. Notably, an order of MBP (unlike most other health occupations boards) may not be stayed pending appeal, which means that the sanction imposed by the board is still in effect while the appeals process is taking place.

Board Now Handles More than 1,700 Complaints Annually

Exhibit 3.4 displays overall complaint volume and complaint disposition.

Exhibit 3.4
Complaint Volume and Disciplinary Activity
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
<u>Complaint Volume</u>					
Complaints "Pending" from a Previous Year	572	673	656	702	739
New Complaints	898	869	995	994	988
<i>Physicians</i>	792	777	905	885	861
<i>Allied Health Professionals</i>	53	64	57	58	81
<i>Other</i>	55	33	38	50	50
Total Complaints	1,470	1,542	1,651	1,696	1,727
<u>Disposition of Complaints</u>					
Closed with No Action	678	581	632	628	589
Closed with Advisory Opinion	189	234	222	227	167
Closed with Formal Action	52	71	95	102	136
<i>Physicians</i>	36	49	72	86	117
<i>Allied Health Professionals</i>	16	22	23	16	19
Total Complaints Closed	919	886	949	957	892
Complaints Still Open or "Pending"	551	656	702	739	835
<u>Formal Actions Taken</u>					
Closed with Formal Action	52	71	95	102	136
Other Disciplinary-related Actions	35	38	44	41	28
<i>New Termination Orders of Probation</i>	10	10	10	19	28
<i>Physicians</i>	10	9	9	18	24
<i>Allied Health Professionals</i>	0	1	1	1	4
<i>Other Formal Actions</i>	25	28	34	22	-
Total Formal Actions	87	109	139	143	164
Total Practitioners Under Monitoring					
Probationary Orders	95	103	110	110	120

Notes: The discrepancy between the number of complaints still pending at the end of fiscal 2007 and the number of complaints pending from a previous year listed for fiscal 2008 was present in the data provided by the board. The breakdown of new complaints against each type of practitioner was provided by the board and is included above for illustrative purposes only; however, the numbers **do not** sum to the total number of new complaints that was included in the budget books and is also reflected above.

Source: *Fiscal 2010, 2011, and 2012 Budget Books*; State Board of Physicians

A number of observations can be made from this exhibit:

- From fiscal 2007 through 2011, the number of complaints pending from a previous year grew from 572 in fiscal 2007 to 739 in 2011, an increase of 29%. As recently as fiscal 1998, MBP carried over less than 100 complaints from one year to the next.
- The board was taking more action on complaints from fiscal 2007 to 2010 with an increase in formal actions and advisory opinions. However, the number of cases closed dropped from 957 in fiscal 2010 to 892 in 2011, which reflects a significant drop in cases closed with an advisory opinion or closed with no action.
- The number of cases closed with formal actions as a percentage of total complaints closed rose between fiscal 2007 and 2011, from 6% to 15%.

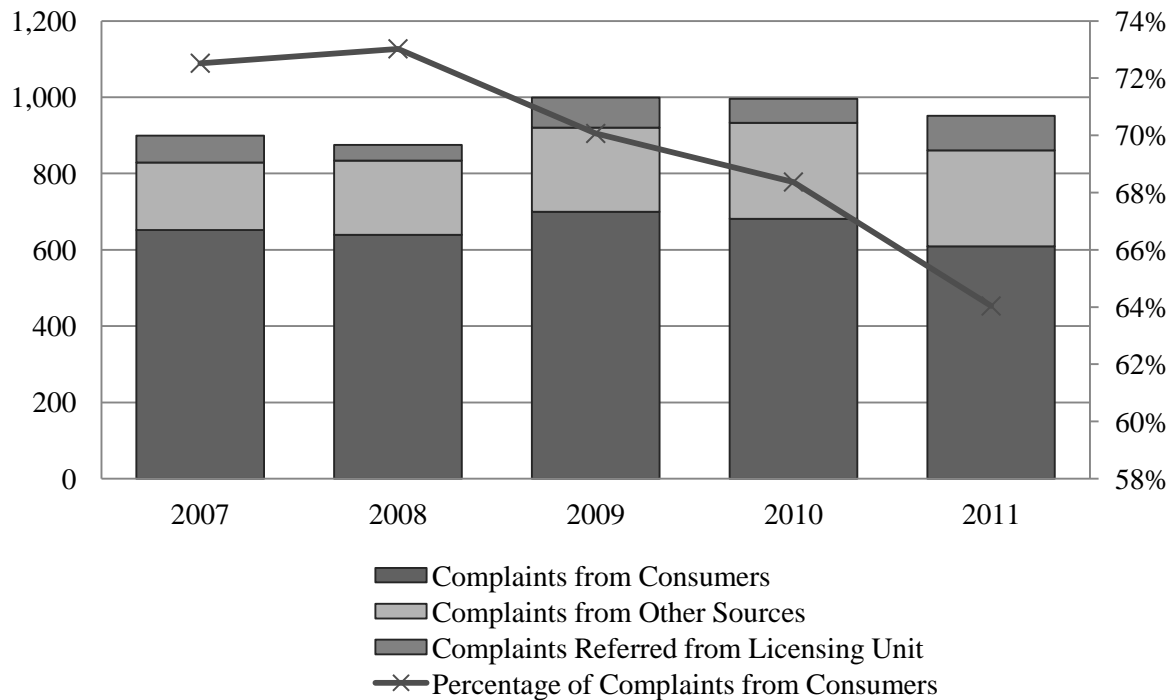
Complaints from Certain Sources Are Increasing

On average, the board receives approximately 944 complaints per year from a variety of sources. As indicated in **Exhibit 3.5**, just 64% of the complaints received in fiscal 2011 came from consumers.¹ In comparison, in fiscal 2007, 73% of board complaints came from consumers. Although total complaint volume has increased approximately 5.8% since fiscal 2007, complaints from sources other than consumers and the Licensure Unit have increased 42% over the same time period. Complaints referred from out-of-state boards constitute approximately half of this increase.

Complaints derived from out-of-state boards increased from 18 in fiscal 2007 to 58 in fiscal 2011. Although board staff is unsure what is driving this increase, it could stem from out-of-state boards either taking more disciplinary actions against individuals who are licensed in Maryland for events that occurred in the other states or being more active in reporting the disciplinary actions to national databanks. Another reason might be that more licensees are also being licensed in surrounding states.

¹Unless otherwise stated, complaint data refer to activities of the board against both physicians and allied health practitioners.

Exhibit 3.5
Complaints by Source
Fiscal 2007-2011



Source: State Board of Physicians, Department of Legislative Services

Complaints Investigated Primarily on Basis of Unprofessional Conduct and/or Failure to Meet Standard of Care

Statute specifies 41 different grounds for physician discipline (§ 14-404 of the Health Occupations Article). However, as shown in **Exhibit 3.6**, investigations of physicians typically focus on two grounds: immoral or unprofessional conduct in the practice of medicine and failure to meet standard of care as determined by peer review.

Grounds for discipline of allied health professionals are also included in statute (§§ 14-5A-17, 14-5B-14, 14-5C-17, 14-5D-14, 14-5E-16, and 15-314 of the Health Occupations Article). Although the board did provide the Department of Legislative Services (DLS) with a list of grounds for charging that included case numbers charged under the specific ground, the list was incomplete or incorrect regarding certain cases. For example, some cases were listed under grounds for which the practitioner was not charged in the case. Also, several allied health cases were listed under a general “other” category which did not specify the exact ground for

charging. The board's annual reports or Managing for Results data did not include full information regarding grounds for charging allied health professionals; therefore, conclusions regarding the most frequent grounds for these practitioners could not be made.

Exhibit 3.6
Investigations of Physicians by Ground for Charging
Fiscal 2007-2011

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>
Immoral or Unprofessional Conduct in the Practice of Medicine	436	410	502	527	484
Failure to Meet Standard of Care	338	292	376	382	342
Failure to Provide Medical Records to Another Physician or Hospital	58	55	60	55	65
Willfully Makes or Files a False Report or Record in the Practice of Medicine	20	22	46	28	57
Patient Abandonment	14	11	14	16	8
Grossly Overutilizes Health Care Services	9	6	12	6	10
Other Grounds for Charging	94	118	159	167	338
Total	969	914	1,169	1,181	1,304

Note: Numbers listed relate to investigations undertaken on each ground, not complaints received. Physicians may be investigated under multiple grounds.

Source: State Board of Physicians Annual Reports, State Board of Physicians

Allied Health Advisory Committees Lack Involvement in Complaint Resolution and Licensee Discipline

Allied health advisory committees are not involved in the investigation or resolution of complaints against allied health professionals. When the board receives a complaint against an allied health professional, the complaint is investigated and resolved by the board through the process shown earlier in Exhibits 3.1 and 3.2.

Allied health advisory committee members have expressed interest in having their committees more involved in resolving complaints against their peers. For cases involving certain grounds for discipline, such as a failure to meet appropriate standards for the delivery of care or practice beyond the authorized scope of practice, allied health advisory committee members have professional training, skills, and experience that could aid in assessing whether there is a violation and what sanction, if any, the board should impose. Moreover, by having committees involved in resolving complaints, committees may be able to provide better oversight by having greater awareness of patient care issues confronting the allied health professions.

However, the current process enables the board to assess and allocate responsibility for misconduct when a complaint involves licensees of different professions, such as a physician and a physician assistant. It may also yield more consistent decisions and sanctions than a process that distributes complaint resolution functions to several committees. Any change in the involvement of allied health advisory committees in the disciplinary process would need to be made by amending statute.

Recommendation 5: Uncodified language should be adopted requiring the board to recommend measures to increase the involvement of allied health advisory committees in complaint resolution and licensee discipline. The board should consider the feasibility and efficacy of (1) allied health advisory committees handling all allied health complaint resolution functions currently handled by board members; or (2) having allied health advisory committee members perform certain complaint resolution functions, such as serving on the Investigative Review Panel to review cases involving allied health professionals. Uncodified language should require that the recommendations be submitted by the board to the Department of Legislative Services in a subsequent follow-up report.

Timeliness of Complaint Resolution Still A Concern

Timeliness in complaint resolution is important for at least four reasons. First, consumers should not be exposed to physicians who are not practicing at an acceptable level and who, for the most part, continue to practice during the complaint resolution process. Second, hospitals and third-party insurers may be exposed to additional liability from physicians who continue to practice. Third, physicians should not have an ongoing disciplinary process hanging over them if the complaint is without merit. Finally, cases that are not resolved quickly lose the sense of urgency that might otherwise be attached to them.

The importance of timely complaint resolution is recognized in statute, which requires MBP to dispose of complaints “as expeditiously as possible and, in any event, within 18 months after the complaint was received by the board” (§ 14-401(k)(1) of the Health Occupations Article). This recognition is also seen in statute through the requirement that peer reviewers “shall have 90 days for completion of peer review,” (§ 14-401(f)(1) of the Health Occupations Article) although MBP may grant an extension. In practice, however, these statutory guidelines

have questionable value. Previous sunset evaluations have recommended that the statutory guidelines be repealed; however, the legislature retained those guidelines because they represented at the very least a goal as to how long a complaint should take to resolve.

Formal Actions Against Licensees on the Rise but No Drop in the Backlog

Overall, most complaints are dealt with relatively quickly. However, data from the board point to a complaint resolution process that continues to be under strain:

- The number of complaints carried over from a previous fiscal year grew from 572 in fiscal 2007 to 739 in fiscal 2011.
- The number of complaints closed with formal action more than doubled from 52 in fiscal 2007 to 136 in fiscal 2011.
- The percentage of complaints closed within the fiscal year fell from 63% in fiscal 2007 to 56% in fiscal 2010.
- The number of cases not resolved within 18 months, although falling from a high of 211 in fiscal 2007, remains at over 150 cases per fiscal year. This includes the majority of cases that go through the complete complaint resolution process.
- According to board minutes, the number of summary suspensions voted by the board has increased significantly from just 8 in calendar 2009 to 27 in calendar 2010.

Exhibit 3.7 summarizes data presented by MBP in its annual report concerning the average time taken to investigate allegations. Specifically, the exhibit focuses on the most frequent allegations resolved by the board during fiscal 2007 through 2010. The average number of days to resolve allegations has grown for the grounds with the highest number of allegations. For example, the average number of days to investigate allegations of immoral or unprofessional conduct has grown 17% from fiscal 2007 to 2010. Also, while the number of allegations concerning standard of care has decreased by 7% from fiscal 2007 to 2010, the average number of days to investigate those allegations has increased by 14%.

If complaint resolution times are increasing, the issue is where in the process cases appear to linger. **Exhibit 3.8** compares sample data from two separate periods for cases when MBP has recommended charges and the case has been transmitted to OAG. The exhibit includes 166 cases from between September 2002 and July 2006 and 221 cases from between January 2007 and June 2011.

Exhibit 3.7
Average Time to Investigate Allegations Against Physicians
Fiscal 2007-2010

	Fiscal 2007		Fiscal 2008		Fiscal 2009		Fiscal 2010			
<u>Statutory Ground for Discipline</u>	<u>Number of Allegations</u>	<u>Days</u>	<u>Number of Allegations</u>	<u>Days</u>	<u>Number of Allegations</u>	<u>Days</u>	<u>Number of Allegations</u>	<u>Days</u>	<u>Percent Change in Number of Allegations 2007-2010</u>	<u>Percent Change in Number of Days 2007-2010</u>
Immoral or Unprofessional Conduct in the Practice of Medicine	409	236	413	226	448	270	495	286	17%	17%
Patient Abandonment	12	199	11	120	14	182	13	276	8%	28%
Willfully Makes or Files a False Report or Record in the Practice of Medicine	22	588	21	373	34	460	31	494	29%	-19%
Failure to Provide Medical Records to Another Physician or Hospital	66	112	68	126	45	90	57	39	-16%	-187%
Grossly Overutilizes Health Care Services	7	516	9	632	7	1,129	6	846	-17%	39%
Failure to Meet Standard of Care	358	387	327	390	359	464	336	452	-7%	14%

Source: State Board of Physicians Annual Reports

Exhibit 3.8
Number of Days Taken to Process Cases
In Which Board Recommends Charges¹

	September 2002-July 2006		January 2007-June 2011		Percent Change
	<u># of Cases</u>	<u>Avg. # of Days Taken</u>	<u># of Cases</u>	<u>Avg. # of Days Taken</u>	
Date Case Opened to Vote to Charge and Transmittal to OAG	166	566	221	640	13%
Date Case Transmitted to OAG to Formal Charges Signed/Executed	142	151	221	176	17%
Date Formal Charges Signed to Board Consent Order			164	153	
Date Formal Charges Signed to Board Final Order			49	367	
Date Formal Charges Signed to Final Board Action	105	202	213	198	-2%
Date Case Opened to Final Board Action	105	955	221	1,013	6%

¹As cases progress, fewer cases are used to calculate the average times shown because some cases do not go through the entire process. Therefore, the average time taken from case opening to resolution does not sum to the various parts of the process.

Note: Data for September 2002-July 2006 were presented in the 2006 update report. These data were not broken down into cases that resulted in a consent order versus a final order. Data are based on 221 cases for which full information regarding the various steps of the complaint resolution process was available.

Source: State Board of Physicians, Department of Legislative Services

As shown in Exhibit 3.8, the time taken from case opening to final board action has increased by 6% or 58 days. Within the process, the time taken to get cases to OAG and the time taken to get formal charges signed and executed have both lengthened, while the time from the signing and execution of formal charges to final board action has minimally decreased.

Allied Health Case Processing Times Are Longer than Expected Given Volume and Level of Complexity

A review of cases resulting in final board action indicates that cases involving allied health professionals generally took less time to resolve than cases involving physicians. **Exhibit 3.9** compares processing times for such cases.

Exhibit 3.9
Number of Days to Process Complaint Cases – Physician vs. Allied Health
January 2007 – June 2011

	Physician Cases		Allied Health Cases		Difference	
	<u># of Cases</u>	<u>Avg. # of Days Taken</u>	<u># of Cases</u>	<u>Avg. # of Days Taken</u>	<u>Days</u>	<u>%</u>
Date Case Opened to Vote to Charge and Transmittal to OAG	185	667	26	507	-160	-24
Date Case Transmitted to OAG to Formal Charges Signed/Executed	185	181	26	117	-64	-35
Date Formal Charges Signed to Board Consent Order	136	149	18	162	12	8
Date Formal Charges Signed to Board Final Order	42	375	7	319	-56	-15
Date Formal Charges Signed to Final Board Action	178	197	25	206	9	4
Date Case Opened to Final Board Action	185	1,044	26	826	-218	-21

Note: Data are based on 221 cases for which full information regarding the various steps of the complaint resolution process was available.

Source: State Board of Physicians, Department of Legislative Services

As shown in Exhibit 3.9, cases involving allied health professionals took less time to investigate, with fewer days elapsing from the date the case was opened until transmittal to OAG. In addition, OAG took less time to develop charging documents for allied health cases

than for physician cases, as shown by the fewer days involved in progressing a case from transmittal to OAG to the signing or execution of formal charges. However, in taking an average 826 days to progress from case opening to final board action, allied health cases still took a significant amount of time to resolve. A substantial number of physician cases required peer review to address allegations that a physician failed to meet the standard of care. Information provided in board annual reports indicates that this ground was charged with considerably less frequency in allied health cases. With peer review adding an extra and often lengthy step in the investigation process, one might expect to see allied health cases resolved in a shorter time period than has occurred.

It is difficult, however, to draw any conclusions from the relatively small number of allied health cases referenced in Exhibit 3.9. Of the 26 allied health cases, 8 took more than three years to resolve. One lengthy case involved a practitioner who violated terms of a consent order. Because the board does not assign a new case number for such cases, a matter discussed later in this chapter, the time to resolve this case includes all of the days to investigate and resolve the initial case that gave rise to the consent order. Accordingly, these cases elevate the average number of days taken to resolve allied health cases. Nonetheless, of the 26 cases referenced, only 5 were resolved within 18 months. Board staff maintains that allied health cases generally take less time to resolve because these cases often involve allegations of substance abuse, a ground that is typically less complicated to investigate. Yet only 4 of the 26 cases in Exhibit 3.8 appear to have involved an allegation of substance abuse.

As the board handles a steady and potentially increasing number of disciplinary cases involving allied health professionals due to its oversight of new professions, the board may need to devote more attention to measures and resources required to timely and effectively resolve these cases. At minimum, the board needs to maintain and present in its annual report complete and accurate data on allegations brought against allied health professionals by each enumerated disciplinary ground and the number of days required to resolve these cases.

Recommendation 6: MBP should report complaint data for allied health professionals in board annual reports and Managing for Results data in the same manner as reported for physicians.

Several Factors Contribute to Backlog

The board and OAG advised DLS that many factors affect the backlog of cases and complaint resolution time. Specifically:

- Compliance analysts are preparing more complete investigative reports. While more complete investigative reports reduce the time a case is in OAG and lessen the need for OAG to send a case back to the board for additional investigation, the time it takes for board staff to prepare these reports increases. Moreover, cases continue to take longer to move through the disciplinary process.

- The board has a policy of prioritizing cases that result in compliance analysts focusing on newer cases that appear to involve patient welfare issues at the expense of older cases. This has the benefit of action being taken on more recent cases that appear to involve patient safety, but it simply adds to the time it takes to resolve older cases.
- In fiscal 2009, the board's peer review contractor was noncompliant, resulting in lengthy peer review processing times. This issue is discussed later in this chapter.
- The number of cases referred to OAG for charging has increased, while the number of prosecutors assigned to the board has not. According to OAG, in calendar 2005, 54 cases were referred for formal charges compared with 84 cases in 2009 and 133 cases in 2010. Currently, five full-time and two part-time prosecutors work on the board's cases.
- The number of summary suspensions referred to OAG has significantly increased as well. This affects the ability of OAG to work on cases because the nature of the case requires the prosecutor to begin work on it immediately and basically stop working on all other cases. A summary suspension case ties up a prosecutor for at least three months.
- The complexity of cases and the involvement of defense attorneys in the process has increased. Since there is potentially so much at stake for the licensee in a disciplinary proceeding, the tendency is to constantly fight actions at every step. This lengthens the process of resolving cases at the CRC stage and can lead to more cases going through OAH.

Board staff has also frequently cited the number of compliance analysts and a high average caseload for the backlog of cases. At the end of August 2011, the average caseload was approximately 37 cases. While that amount is above the optimal caseload of 25, the average caseload has actually decreased from 56 in 2005. Despite more analysts and a lower average caseload, the backlog of cases and the length of time it takes for a full investigation to be completed continue to increase.

Board Has Targeted Reduction Efforts to Certain Phases of the Process and Certain Types of Cases

Since the 2006 update report, the board has implemented plans for reducing its backlog of complaint cases. Board staff has altered the way cases are monitored and processed during the investigation stage. Also, cases that involve failure of licensees to meet continuing medical education (CME) requirements and those that involve licensees being disciplined by other jurisdictions (ground 21 and 24 cases) are placed on expedited case resolution tracks. While the board should be commended for putting these processes into place, the backlog continues to grow, and the expedited case resolution tracks have presented additional problems.

Monitoring and Processing of Cases During the Investigative Stage

Board staff has implemented procedures to more effectively monitor and process cases during the investigative stage and reduce the backlog of cases. Compliance analysts are assigned to teams with a lead investigator as the head of the team. These teams hold meetings to monitor case progress. Monthly Compliance Unit meetings are held. During these meetings, staff attempts to identify any backlog cases, hurdles to case resolution, and investigative strategies. The compliance chief regularly reviews case tracking data. Analysts complete investigation summaries and strategies that are reviewed by the team leader and the head of compliance. Checklists for complaint intake staff are used to ensure that sufficient information is received at the beginning stages of a case. In January of each year, board staff identifies cases that are projected to be backlogged by June 30. For this purpose, a case is considered backlogged if it has taken more than 18 months to resolve. Once the cases are identified, the Compliance Unit begins working to resolve those cases. A different prosecutor is assigned each month to aid the board with any legal issues that arise during the investigation. This prosecutor also handles any summary suspension cases that are identified. Cases are reviewed by a prosecutor for legal sufficiency before going to the board for charging. If there are legal deficiencies, the case is retained by the Compliance Unit for further investigation.

Expedited Complaint Resolution Process for Continuing Medical Education Cases

Statute authorizes MBP to impose a civil penalty of up to \$100 per CME credit in lieu of reprimand, probation, revocation, or suspension for first-time offenses (§ 14-316(d)(4) of the Health Occupations Article). It is the practice of the board to impose a fine of \$100 per credit. Since these straightforward cases require little, if any, investigation into whether the licensee met the requirement, MBP has instituted an expedited complaint resolution process to deal with these cases. When MBP determines that a licensee has failed to meet the CME requirement, MBP opens a case against the licensee. A letter is then sent by a compliance analyst offering the licensee an opportunity to resolve the case by entering into a consent agreement (for failure to complete 9 or fewer credits) or a consent order (for failure to complete 10 or more credits). In any case, the licensee would be required to pay the fine and complete the missing credits. If the licensee elects not to accept the consent agreement or consent order, the board continues the investigation.

Although this expedited process was instituted in an effort to deal with more routine disciplinary matters more quickly, the process itself presents issues of concern, in addition to the fact that this process is not in regulations, as discussed in **Chapter 2** of this report. One issue is that at no point during the expedited process are these cases brought before the board. The lack of involvement by the board in individual CME cases may be inappropriate for three reasons. First, a consent order or agreement is a public action of the board; however, the board does not take formal action relating to the specific case. The board does not even vote to ratify the order or agreement after it has been accepted by the licensee. Second, by not having the cases presented to the board, nuances of cases may be missed and the board does not have an opportunity to determine whether more egregious cases related to the reason for not complying

with the requirement warrant a harsher sanction. For example, other than the amount of the fine, licensees who have willfully disregarded the CME requirement, even for years, are treated the same as licensees who have failed to complete one CME credit. Third, regulations require the board to adjudicate the failure of a physician to notify the board of a name or address change according to the board's hearing procedures (COMAR 10.32.02.06D). CME cases are similar cut-and-dry cases; however, the board is not adjudicating them in the same way.

Also, the letter that is sent to the licensee does not state the procedure or the rights of the licensee as clearly as it could. This can cause issues because this procedure is not in the board's regulations and conflicts with the hearing procedures that are in regulations.

Recommendation 7: MBP should revise the expedited complaint process for CME cases to include (1) a ratification of the consent agreement or consent order by the board prior to the sanctions included in the agreement or order becoming effective; and (2) a mechanism for board review of more egregious cases before a consent agreement or consent order is offered to the licensee. MBP should also adopt regulations governing all expedited case resolution procedures (COMAR 10.32.02.06D). The amount of fines levied for failure to complete CME requirements should be reported in the board's annual report.

Expedited Complaint Process for Cases Involving Disciplinary Action Taken by Another Jurisdiction

Ground 21 and 24 cases arise when a physician is disciplined by another jurisdiction for an act that would be grounds for discipline under the Maryland Medical Practice Act (§ 14-404(a)(21) and (24) of the Health Occupations Article). Because these cases usually do not entail additional investigation by the board, the board has approved an expedited complaint resolution process for these cases. Once the board receives notice from the Federation of State Medical Boards that action has been taken against a licensee by another jurisdiction, board staff prepares a letter of procedures and a consent order. The consent order contains sanctions that mirror the sanctions imposed by the other jurisdiction; however, if the executive director determines that mirror sanctions may not be appropriate, the case is referred to IRP for instruction on how to proceed on the case. If the licensee accepts the consent order, the consent order is presented to IRP for ratification. If the licensee elects not to sign the consent order, the board schedules a meeting with the licensee and provides the licensee with another opportunity to sign the order. If the licensee declines, board staff conducts a full investigation, and the case is taken out of the expedited process. If the licensee does not respond to the letter, a default order is entered and presented to IRP for ratification.

In addition to the fact that this process is not in the board's regulations, there are four other major areas of concern. First, and perhaps the most serious, is that, by using this process, sanctions are being imposed without the vote of the full board. The only involvement of the board is through IRP. The ratification of the consent orders in these cases is done by the vote of the majority of IRP members at a meeting. This could result in sanctions being imposed in some cases through the affirmative vote of only three board members (a quorum of IRP is four

members). When this issue was raised to board staff, the response was that statute does not cover how charges are to be issued, and the board has delegated its authority to sanction to IRP. Although board staff is correct in stating that there is no statutory requirement regarding the issuance of charges, regulations do require the board, once an investigation has been completed, to vote on how to proceed on a case, whether that be dismissing the case, charging the licensee with a violation, or taking other action (COMAR 10.32.02.03C(1)). With regard to the sanctioning of a physician, statute states that “the board, on affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license” if the licensee takes action that violates any of the grounds listed, which includes both grounds 21 and 24 (§ 14-404(a) of the Health Occupations Article). A vote of IRP would not constitute an affirmative vote of a majority of the board quorum. Statute does not contain any authority for the board to delegate this function to a committee of the board. Also, the use of this process violates other regulatory requirements. For example, the board does not offer the respondent an opportunity to participate in a CRC.

Second, the executive director, rather than the board or even a committee of the board, is making the determination of whether mirror sanctions are appropriate. IRP only sees the case before a consent order is issued if the executive director determines that a mirror sanction may not be appropriate. This is a concern for two reasons. The executive director may not have the medical expertise needed in understanding the nuances of a case to determine what sanction is appropriate. Also, the lack of MBP sanctioning guidelines, combined with the fact that the board’s complaint database does not contain the sanctions imposed in cases, makes it difficult to ensure that mirror sanctions in a case are consistent with what the board has done historically in similar cases.

Third, the board accepts the legal sufficiency of the case as determined by the other jurisdiction. Legal sufficiency of the case against the physician is only determined by OAG if the physician contests the consent order. With other cases, a prosecutor determines whether there is legal sufficiency before the case is presented to the board for charging. That is not done in these cases.

Finally, the letter that is sent out in these cases does not outline all of the options available to the physician and may not fully inform the physician regarding the board’s role in the expedited process. For example, the letter does not state that the physician has an option to meet with board staff regarding the case, although this is what happens if the physician elects not to sign the consent order. The letter only states that, if the consent order is not signed, the board will continue its investigation into the offense, as well as any other related matters. Also, the letter indicates that the board is conducting an investigation – although at the point when the letter is sent, the board has completed the preliminary investigation and no other investigation occurs unless the consent order is contested. The letter also states that the board has decided to impose a reciprocal sanction against the physician; however, at the point the letter is sent out, there has been no action taken by the board.

Recommendation 8: MBP should review and adjust the expedited process for ground 21 and 24 disciplinary cases to address (1) the lack of involvement of the board; (2) the involvement of the executive director in determining appropriate sanctions; (3) the lack of a determination regarding legal sufficiency; and (4) the lack of clarity regarding the board's role in the expedited processing letter.

Implementation of expedited case resolution processes appears to have had little to no effect on reducing the overall backlog and timeliness of the complaint resolution process. These expedited processes do not address the grounds for discipline that are the most violated and that result in the lengthy complaint resolution time, such as standard-of-care violations. For example, in fiscal 2011, 12 cases went through the expedited CME case track, and 10 cases went through the expedited ground 21 and 24 case track. This is a mere fraction of the number of cases investigated by MBP.

Recommendation 9: Uncodified language should be adopted requiring MBP and the Department of Health and Mental Hygiene jointly to develop and implement a strategy for reducing the backlog of complaint cases by December 31, 2012. Also, MBP should be required to include the strategy, as well as information regarding the effect of the strategy on the backlog and complaint resolution time, in a subsequent follow-up report that is submitted to the Department of Legislative Services.

Measuring Performance and Results in Complaint Resolution Hindered by Poor Data Maintenance

Tracking complaint data and measuring performance in complaint resolution are important for several reasons. First, it is important for the board to be able to accurately report information on disciplinary activity in its annual reports and Managing for Results data. Second, tracking various stages of the complaint process allows the board to accurately measure the timeliness of the complaint resolution process and identify parts of the process that are causing delays and reasons for the delay. Third, tracking complaint data helps to ensure consistency in sanctioning. Several factors impede the board's ability to accurately measure its performance in complaint resolution.

Database Issues

As part of this evaluation, DLS requested various data from the complaint database maintained by MBP. The requests centered on cases in which the board issued charges or denied licenses, cases that were referred for peer review, grounds for charging, and sanctions imposed by the board. The board was unable to provide a list of sanctions imposed for each case because the complaint database does not contain that information. Other information provided by the board was incomplete or inaccurate.

Cases in Which the Board Issued Charges or Denied Licenses

The board provided information on approximately 510 cases in which the board recommended charges or license denial. The case information, however, was incomplete. For example, not every case had a date for when consent orders were signed. Also, cases for which there was a final order were not included. The board also did not provide information on when cases were transmitted to OAG. DLS used board minutes and license profiles to fill in missing information. DLS also reviewed hard copy files to fill in missing information; however, it became clear that, due to the state of many of the hard copy files, it would not be possible to fill in missing information. In the end, complete information from multiple sources was only available for 221 cases of the nearly 600 cases that were originally provided by the board and/or included in board minutes.

Through the process of reconciling data from all available sources, inaccuracies in the data provided were uncovered. For example, an order on a licensee profile might indicate that the consent order was signed on one date, but the date included in the complaint database was a few days earlier or later. Also, approximately 71 cases included in board minutes indicated the board had voted to charge but were not included in the information provided by the board. It is unclear why these cases were not included. The database does appear to contain the dates the board voted to charge but evidently not in a format that a query would yield that information.

Additionally, the information provided by the board contained approximately 124 cases in which consent orders or final orders were issued by the board, but for which there was no corresponding board vote to charge contained in board minutes. Some of these cases went through the expedited case resolution processes; such cases do not go to the full board for a vote. However, a significant number of those cases did not go through expedited processes; rather, they are cases involving standard of care, sexual misconduct, and crimes of moral turpitude, for which the expedited processes do not apply. Although these cases appear to be in the database, board staff was unable to provide reasons why these cases were not included in board minutes.

Cases Referred for Peer Review

Not all peer review cases provided included the date MBP decided to send the case to peer review, the date on which the case was actually sent to peer review, and the date on which the board received the case back from peer review. Furthermore, not all peer review cases sent during the time period for which information was requested were included in the information provided to DLS. For example, only two cases from fiscal 2007 were included; however, more than 300 standard-of-care cases were charged during fiscal 2007.

Grounds for Charging

A clear picture for grounds for charging could not be developed due to the state of the information provided by the board, as information for some cases was either incomplete or inaccurate. For example, the ground for several cases listed was not charged on that ground,

according to board minutes. Also, several cases were charged on multiple grounds, but only one ground was indicated in the data provided. For allied health professions, it appears that, for some cases, the database does not contain specific information regarding the grounds for charging; rather, it just indicates that it was charged on grounds other than those for physicians.

Recommendation 10: MBP should (1) expand the complaint database to track the sanctions imposed in cases; (2) track the date the board voted to charge in a way that can be more easily accessed; and (3) institute steps that ensure that information recorded in the database is complete and accurate, including listing cases under all grounds for which the licensee was charged and fully tracking the grounds for allied health cases.

Broader Issue of Assigning Case Numbers Prevents Board from Accurately Determining Complaint Resolution Times

Another factor that impedes the ability of MBP to accurately measure complaint resolution performance is the board's treatment of violation of probation cases or violation of order cases, which normally arise when the board completes a chart review as a condition of probation or termination of probation. Unlike other health occupations boards, the board often charges licensees in these situations using the same case number for which the licensee was put on probation, rather than considering the violation as a new, board-generated complaint with a new case number. By not assigning new case numbers, cases appear to be open for years without any board action. This has the affect of artificially lengthening the average case resolution time. By not assigning a new case number in these situations, the board is undercounting the incidence of disciplinary actions. Except for the licensee being on probation or the chart review being completed because of the previous case, there is no other link between the new violations and the previous case. The new violations are separate and distinct; therefore, new complaint case numbers should be assigned when the board learns of these types of violations.

The board recognizes that issues arise by not assigning new cases numbers, especially regarding the length of time a complaint appears to be unresolved. The board plans to institute a new monitoring case number system to address these problems, which will involve assigning a unique number to a case when it is transferred to the Probation Unit, the part of the Compliance Unit that handles cases once charges have been issued. This number will be used for tracking the licensee during the sanction and probation period. However, this plan does not address core issues. When calculating the time it takes to resolve violations of probation or violations of orders, the date that the new monitoring case number is assigned will be used. This method will not accurately reflect the time it takes the board to resolve the violation because the date the Probation Unit received the case will be used, rather than the date the board learns of the violation. Also, because the board does not plan to assign a new complaint number nor count these as board-generated complaints, the complaint data will continue to inaccurately reflect the number of distinct violations the board is handling.

Recommendation 11: MBP should treat violations of probation and violations of orders as distinct, board-generated complaints and assign new complaint case numbers in these situations when the board learns of subsequent violations.

Statutory Issues

Board Has Not Adopted Sanctioning Guidelines

Chapters 533 and 534 of 2010 require all health occupations boards to adopt sanctioning guidelines. While the board has begun working on sanctioning guidelines, these guidelines have not yet been adopted. The adoption of sanctioning guidelines for physicians and allied health professionals is imperative for several reasons. First, sanctioning guidelines will inform licensees and the public more specifically about action the board can take when a licensee violates a specific ground for discipline. Second, the guidelines will help ensure that the board is imposing consistent sanctions. Third, information provided in board books, which contain the material provided to board members for a board meeting, regarding sanctioning is outdated and does not include any information regarding sanctioning of allied health professionals.

During this evaluation, two issues arose regarding the board's process of drafting sanctioning guidelines. First, the draft guidelines provided to DLS would apply only to physicians and not to allied health professionals. According to board staff, there are no plans to draft sanctioning guidelines for allied health professionals. Board staff indicated that drafting may begin once the guidelines for physicians are finished but expressed skepticism as to how valuable guidelines for allied health professionals would actually be since most discipline cases involve physicians. However, DLS finds that because several of the allied health professions have been added to the jurisdiction of the board relatively recently and there is basically no participation by the allied health advisory committees in the disciplinary process, it is even more important that sanctioning guidelines for allied health professionals be adopted. Second, statute requires that the sanctioning guidelines include "a range of sanctions that is based on historical data or a normative process for each type of violation" (§ 1-606(a)(1) of the Health Occupations Article). During this evaluation, it became unclear how the board is ensuring that the sanctioning guidelines meet this requirement, especially in light of the fact that the complaint database does not track the sanctioning outcome of individual cases. Issues with recordkeeping and database maintenance prohibit the board from using historical data for drafting guidelines. Board staff advised DLS that the individuals involved in the drafting of the guidelines are long-term staff of the board and that the board believes that institutional memory is sufficient to meet the statutory requirement.

Although Chapters 533 and 534 of 2010 require all health occupations boards to adopt sanctioning guidelines, as noted in the 2005 full evaluation, the recommendation that MBP adopt guidelines dates back to 2003 when OAG recommended that MBP adopt guidelines. OAG suggested that disciplinary guidelines may make the disciplinary process more efficient by decreasing the time it takes for new board members to understand the disciplinary process. It

was also noted that disciplinary guidelines under certain circumstances could positively impact the efficiency, cost, and consistency of the disciplinary process. Furthermore, in the 2005 full evaluation, DLS recommended that MBP, in conjunction with OAG, adopt sanctioning guidelines that are voluntary, with the intent to be used as a resource which would allow the board to retain the ability to use its discretion on a case-by-case basis. Despite these recommendations, the board did not begin to develop sanctioning guidelines until fiscal 2011 in response to Chapters 533 and 534 of 2010. Also, Chapters 533 and 534 of 2010 require the health occupations boards to submit a report to certain committees of the General Assembly by December 31, 2011, on progress in meeting the requirements of the Acts; however, MBP is not close to meeting the sanctioning guidelines requirement.

It is important to note that, as of November 4, 2011, five health occupations boards – the State Acupuncture Board, the State Board of Dental Examiners, the State Board of Examiners of Psychologists, the State Board of Examiners of Nursing Home Administrators, and the State Board of Physical Therapy Examiners – have submitted regulations for sanctioning guidelines to the Joint Committee on Administrative, Executive, and Legislative Review (AELR). The State Board for Certification of Residential Child Care Program Professionals has also developed sanctioning guidelines but has not yet submitted them to the AELR Committee. Several other boards are anticipated to adopt sanctioning guidelines by the end of the calendar year. While these boards have a less complicated disciplinary process than MBP, it remains unclear why MBP has been unable to adopt sanctioning guidelines in a timely manner in the eight-year period since sanctioning guidelines were first recommended for the board.

Recommendation 12: Budget bill language should be adopted during the 2012 legislative session to withhold funds from MBP until the board promulgates in regulations sanctioning guidelines for physicians and allied health professionals, as required by Chapters 533 and 534 of 2010. Furthermore, the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding. In the meantime, board staff should update sanctioning information provided in board books and include information related to allied health professionals.

Board Ignores Statutory Requirement Regarding the Notation of Reason for Delay in Completion of Complaint Cases

If the board is unable to resolve a complaint within one year, it must include in the record of the complaint a detailed explanation of the reason for the delay (§ 14-401(k)(2) of the Health Occupations Article). This statutory requirement is not being met. Along with improvements in maintaining the board's complaint database, adherence to this requirement will aid the board in identifying factors contributing to delays in complaint resolution.

Recommendation 13: If unable to resolve a complaint within one year, MBP should comply with statute and include in the record of the complaint a detailed explanation of the reason for the delay.

Board Fails to Publicly Disclose the Filing of Charges or Denial of a License as Required

After filing charges against a physician licensee or notice of initial denial of a physician license application, MBP must disclose the filing to the public (§ 14-411(i) of the Health Occupations Article). MBP is not fully complying with this requirement. Initial denials of licensure and votes to charge are handled in closed session meetings of the board; therefore, they are not reflected in the public meeting minutes. The information is not included in licensee profiles on the MBP website and is not disclosed to a member of the public who contacts the board requesting the information, unless the individual is the complainant in the case. The board indicates that requests for written verification of licensure do, however, include information about charges against a licensee. The reason given for not routinely providing such information is concern that licensees would lose patients and suffer harm to their reputations because of unfounded allegations. However, the filing of charges only occurs when the board determines that there is sufficient evidence that the licensee violated the law. Also, from fiscal 2007 through 2010, the board filed charges in an average of 6% of total complaints, which accounts for less than 0.02% of physician licensees. To facilitate disclosure to the public and address concerns of the board, this information should be disclosed on the licensee profiles with a disclaimer that states that the charging document does not indicate a final finding of guilt by the board.

Recommendation 14: MBP should comply with statute and disclose the filing of charges and notice of initial denial of a license application to the public. Statute should be amended to require MBP to disclose the information on the licensee profiles with a disclaimer stating that the charging document does not indicate a final finding of guilt by the board.

There is no parallel requirement regarding the public disclosure of the filing of charges against an allied health licensee or the denial of an allied health license.

Recommendation 15: Statute should be amended to require MBP to disclose the filing of charges against an allied health licensee and notice of initial denial of an allied health license application to the public, with a disclaimer stating that the charging document does not indicate a final finding of guilt by the board.

Board Offers Complainants Opportunity to Appear Before the Case Resolution Conference Committee

Uncodified language in Chapter 252 of 2003 requires MBP to give the complainant in a disciplinary case the opportunity to appear before the board during a case resolution conference. While MBP has been complying with this requirement, it remains uncodified. The requirement

should be codified because it is an ongoing requirement, and placement in statute will give licensees and the public notice of the requirement.

Recommendation 16: Statute should be amended to codify the requirement that MBP give the complainant in a case the opportunity to appear before the board during a case resolution conference. Board regulations should be updated to reflect this requirement.

Other Issues

Board Lacks Guidelines for Reopening of Sexual Misconduct Cases

Board staff advises that the practice of reopening closed cases with new case numbers occurs whenever a pattern of behavior is discovered. However, concerns about this practice were identified following DLS' review of cases that involved sexual misconduct. Sexual misconduct cases can be hard to prove, and investigations may not result in sufficient evidence to sustain charges against the licensee. In those cases, the board closes the case with an advisory letter, which is nonpublic, informal board action. Reopening sexual misconduct cases after a pattern is discovered is not unique to MBP; however, three issues of concern regarding specifics of the practice may be unique to MBP: consistency, clarity of the initial advisory letter sent to licensees, and use of new case numbers.

The board is not consistent regarding how many similar complaints need to be received before closed cases are reopened and lacks guidelines regarding when to reopen closed sexual misconduct cases based on the receipt of additional, similar complaints. For example, in one instance, the board reopened two cases after the receipt of a third complaint, but in another instance, a case was reopened after the receipt of a second complaint. In the first instance, however, the complaints included similar allegations of more egregious behavior of the licensee than the allegations in the second instance.

Unlike the practice of other health occupations boards, the advisory letter sent to a licensee after the initial sexual misconduct complaint does not state that the case may be reopened and charges may be issued by the board if a pattern of behavior becomes apparent. The letter states that the board has closed that case and that no action is pending against the licensee.

Further, when the board reopens a case, a new case number is assigned. Although this can be helpful in determining the complaint resolution time once the case has been reopened, it has the detrimental effect of making it appear that more allegations have been lodged against the licensee than actually have been and inflates the case numbers of the board. Such cases should be reopened under the original case number.

Recommendation 17: MBP should (1) adopt guidelines for reopening cases, especially sexual misconduct cases; (2) revise the advisory letter sent to licensees after an initial

complaint involving sexual misconduct to include a statement notifying the licensee that the case may be reopened and charges may be issued if a pattern of behavior emerges; (3) institute a process for tracking sexual misconduct cases; and (4) reopen all relevant cases using the original case number.

Length of Participation in Physician Rehabilitation Program Is Not Determined by Clinical Need

Like all states, Maryland has a physician rehabilitation program. The program is intended to evaluate and provide assistance to impaired physicians and allied health professionals in need of treatment for alcoholism; chemical dependency; and other physical, emotional, or mental conditions.

Chapter 539 of 2007 required the board to issue a request for proposals (RFP) from nonprofit entities to operate the board's physician rehabilitation program by January 1, 2008. If no responsive proposal was received, the board had the option to provide those services in house. Bids were requested in 2008 and 2009; however, a responsive proposal was not received. In fiscal 2010, the board continued to directly administer the physician rehabilitation program until December 2009. In September 2009, a third RFP was issued and the Center for a Healthy Maryland – an affiliate of the Medical and Chirurgical Faculty of the State of Maryland (MedChi) – was awarded the contract. Center for a Healthy Maryland continues to administer the board's program, now known as the Maryland Professional Rehabilitation Program (MPRP). The contract term is from January 1, 2010, to December 31, 2014. MPRP offers information, evaluation, and referral for treatment. The current contract caps the number of participants at 50 enrollees; however, the program has averaged 35 participants per year from fiscal 2007 to 2011. Since October 1, 2007, pursuant to Chapter 539 of 2007, MPRP only provides services to individuals whom the board refers in writing. Referrals can include any individual licensed or certified by the board or applicants for licensure or certification.

Both board staff and representatives from MPRP advise the current program is operating more efficiently than in prior years. In part, this can be attributed to improved communication between the board and MPRP. Board staff meets with MPRP quarterly to review data regarding board-known participants. This meeting also serves as a forum to discuss procedural and policy issues. Furthermore, the RFP issued in September 2009 was more specific than prior RFPs, creating more accountability within MPRP and the board and clearly defining the relationship between the two entities.

While the physician rehabilitation program has improved, a few problems remain. For instance, all participants who are referred to MPRP by the board are typically required to participate in the program for five years, even if there is no longer a clinical need for

participation.² The board could benefit from the clinical judgment of MPRP by deferring to the program when attempting to determine how long an individual should be monitored. An open-ended monitoring period would allow for clinical judgment. As of October 2011, there were two board-known participants in MPRP who were no longer licensed in the State, as well as four board-known individuals who were monitored by an out-of-state entity, as opposed to direct monitoring under MPRP. Since these individuals are no longer practicing in the State, it remains unclear as to why the board is continuing to monitor these individuals through MPRP. However, these participants cannot be discharged from the program due to specified monitoring periods delineated in their consent orders.

Recommendation 18: When referring individuals to the Maryland Physician Rehabilitation Program, the board should no longer specify licensees are required to participate in the program for a specified time period. Instead, the length of participation in the Maryland Physician Rehabilitation Program should be based on the clinical need for participation and whether the individual is still licensed in Maryland.

Authority for Board to Enter into Private Premises Needs Revision

Chapter 539 of 2007 authorizes the executive director of MBP or an authorized agent or inspector of the board, on a formal complaint, to enter into private premises to investigate allegations that a person is practicing, attempting to practice, or offering to practice medicine without a license. When reviewing Chapter 539, OAG raised the concern that entry into private premises for this purpose is in part an entry to determine evidence of a crime. Because of that, both the Maryland Declaration of Rights and the U.S. Constitution require that the entry be supported by a warrant. MBP has not exercised the right to enter into private premises because of this, but the board continues to maintain that entry into private premises is needed to adequately investigate allegations of unlicensed practice of medicine.

Recommendation 19: Statute should be amended to authorize MBP to seek a warrant for entry into private premises for the purpose of investigating formal complaints that allege a person is practicing, attempting to practice, or offering to practice medicine without a license and to require that MBP have a warrant before entering into private premises for those purposes.

²The length of time a licensee is required to participate in MPRP is delineated in a consent order produced by the board. Therefore, MPRP is unable to discharge an individual from the program prior to the date specified in the consent order.

Two Issues from Previous Evaluations Linger

Sexual Contact by a Health Care Professional in the Practice of a Health Occupation

The 2005 sunset review recommended that nonconsensual sexual contact with a patient on the part of any health care professional should be made a sexual offense in the third degree due to the nature of the relationship between a health care professional and a patient and the effect of the statute of limitations on the ability of prosecutors to prosecute nonconsensual contact with a patient. Two bills, Senate Bill 422 and House Bill 290, were introduced in the 2006 session that would have addressed this recommendation; however, both bills failed. Thus, the issue was not a focus of the current evaluation. Even so, because concerns continue to be expressed regarding this issue, especially concerning effect of the statute, the General Assembly may wish to reconsider amending statute to make nonconsensual sexual contact with a patient on the part of any health care professional a sexual offense in the third degree.

Use of the Office of Administrative Hearings

In an effort to improve the complaint resolution process, the 2005 sunset evaluation recommended that MBP be authorized to refer any cases for a formal hearing to a subcommittee of the board rather than solely to OAH. Alternatively, the review recommended that consideration be given to authorize the board to refer only standard-of-care cases for a formal hearing to a subcommittee of the board. Chapter 539 of 2007 required the Chief Administrative Law Judge to designate a pool of ALJs to hear cases referred to it by MBP. The law also required MBP to provide training at least annually to OAH personnel on medical terminology, medical ethics, and to the extent practicable, descriptions of basic medical and surgical procedures currently in use. MBP did meet with OAH, but a pool of judges has not been appointed. To date, only three training sessions have occurred, most recently in October 2011. Because this issue was intended to facilitate complaint resolution, MBP may wish to work with OAH to assess whether further actions should be taken related to adjudicating cases through OAH.

Chapter 4. Resource and Administrative Issues

Although the Department of Legislative Services (DLS) found that the State Board of Physicians (MBP) has implemented changes to improve certain aspects of board operations, several issues still warrant further discussion. This chapter reviews the fiscal condition of the board, staffing levels, the adequacy of licensure fees, the transparency of the board, file maintenance, the training of new board members, and the role of the allied health advisory committees.

Fiscal Condition and Fund Balances

Like all but two health occupations boards, MBP is special funded. The board derives its support from fees. Fees are deposited in the Board of Physicians Fund, with the exception of the set-aside of 12% of the fees for the Health Personnel Shortage Incentive Grant and the Janet L. Hoffman Loan Assistance Repayment programs. These programs are intended to encourage individuals to enter critical health profession shortage fields or repay loans for physicians and medical residents willing to work in established Health Professional Shortage Areas. As specified in Chapter 252 of 2003, interest on the MBP Fund now accrues to the benefit of the fund.

License fee levels are supposed to approximate the cost of maintaining the board. On average, board fee revenues are \$9.2 million annually. However, due to the biennial renewal cycle for allied health professionals, board revenues are roughly \$1.7 million higher in odd-numbered fiscal years than even-numbered fiscal years. Despite this trend, revenues in fiscal 2009 were lower than anticipated in comparison to fiscal 2007 since the number of licensees under the board's jurisdiction had increased (see **Exhibit 4.1**). In comparison, in fiscal 2011, board fee revenues were \$1.1 million higher than revenues in fiscal 2009. In part, this spike in revenues can be attributed to \$400,000 in funds returned to the board from a peer review contractor due to the entity's inability to meet the contract's stipulations. However, it remains unclear why revenues have fluctuated as much as they have from year to year.

As shown in Exhibit 4.1, from fiscal 2007 through 2012, board expenditures are projected to increase by 46% or \$2.7 million. The big jump in expenditures between fiscal 2007 and 2008 can be attributed to one-time costs associated with the board's new database and higher indirect costs paid to the Department of Health and Mental Hygiene. Otherwise, approximately one-third of increased spending since fiscal 2007 can be attributed to salaries and wages, including contractual employees.³ The remaining growth in costs can be attributed to the board's contracts for peer review and physician rehabilitation services, increases in per diem rates for board members, and increased rent as the board has acquired additional office space. Despite

³Expenditure growth in fiscal 2012 is largely attributed to increased personnel costs due to the elimination of service reduction days and furloughs.

Exhibit 4.1
State Board of Physicians Fiscal History
Fiscal 2007-2012

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>	<u>Est. FY 2012</u>
Authorized Positions	78.00	72.00	75.00	72.00	68.00	68.00
Contractual Positions	17.10	0.78	0.99	2.06	2.53	3.60
Beginning Fund Balance	\$5,084,874	\$8,178,461	\$7,502,277	\$5,590,521	\$4,753,666	\$5,123,172
Revenues Collected	9,960,769	8,122,268	9,423,133	8,161,955	10,536,616	8,640,261
Total Funds Available	15,045,643	16,300,729	16,925,410	13,752,476	15,287,726	13,763,433
Total Expenditures	5,938,671	8,092,953	7,120,043	7,443,296	7,800,646	8,640,261
Transfer to Scholarship Fund	928,511	705,449	1,014,846	1,027,895	1,231,738	1,018,042
Transfer to General Fund			3,200,000	527,619	1,132,170	
Ending Fund Balance	\$8,178,461	\$7,502,327	\$5,590,521	\$4,753,666	\$5,123,172	\$4,105,130
Target Balance as % of Expenditures	20%	20%	20%	20%	20%	20%
Actual Balance as a % of Expenditures	137.72%	92.70%	78.52%	63.90%	65.70%	47.51%

Notes: Excludes the Maryland Health Care Commission assessment collected by MBP as a pass-through. Board expenditures include direct and indirect costs. It is unclear why the fiscal 2008 year-end fund balance is \$50 greater than the beginning fund balance reflected for fiscal 2009.

Source: Department of Health and Mental Hygiene, Department of Legislative Services

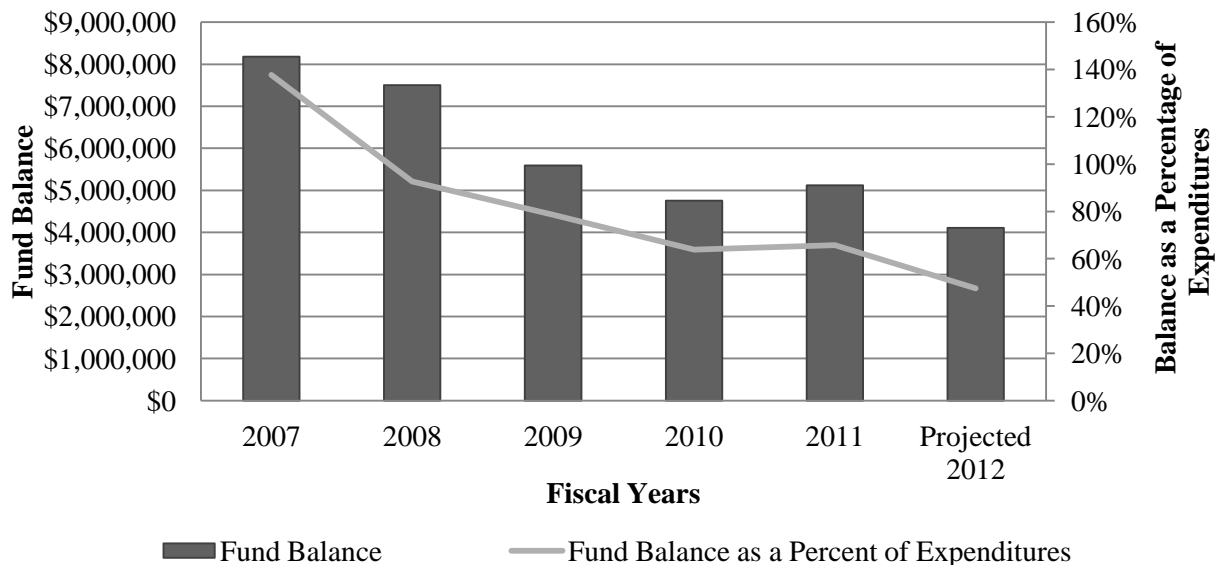
increasing costs, board revenues have consistently been sufficient to cover the board's expenditures as the board maintains a healthy fund balance – an indication that current fee levels are more than sufficient to cover the board's operating costs.

Transfers to the General Fund Due to High Fund Balance

As noted in the 2005 sunset review, MBP began accruing a fund balance in 2001, and the board's fund balance consistently has remained above the recommended 20% threshold for health occupations boards of its size. While the board's ending fund balance has gradually become a smaller percentage of the board's expenditures, decreasing from 138% in fiscal 2007 to 66% in fiscal 2011 (see **Exhibit 4.2**), this reduction is primarily due to transfer of funds to the general fund through the Budget Reconciliation and Financing Act (BRFA). Collectively, a total of \$4.7 million has been transferred between fiscal 2008 and 2011. As noted in **Chapter 2**, since 2007 the board has continued to charge an additional \$50 for physician licensure to support peer review and physician rehabilitation activities even though the statutory authority to charge such a fee was repealed. The board did not determine how the costs associated with those activities affect the total cost of licensure and modify its fee structure accordingly, as was intended. From fiscal 2007 through 2011, the board has collected \$3.5 million associated with these activities from physician licensees, an amount equivalent to 74% of funds transferred through the BRFA over the same time period. Thus, the fees charged clearly have not reflected actual costs and have instead simply added to the board's fund balance.

In fiscal 2012, the board has *projected* that its fund balance will continue to decline, representing 47.5% of the board's expenditures. However, it remains unclear if the board's fund balance will *actually* continue to decrease as board revenues are anticipated to increase in future years with licensure of athletic trainers in fiscal 2012 and perfusionists in fiscal 2014. Revenues are also projected to grow due to a recent increase in licensure fees for physician assistants. However, board revenues are primarily derived from the licensure of physicians, and it is unclear if the board's revenue projections include fees that are charged in excess of what is permitted by regulations. If the board ends the practice of charging additional fees for physician licensure, MBP may begin to spend down its fund balance. Furthermore, a few factors could negatively affect the board's fund balance in future years. First, personnel costs will likely increase at a faster pace due to the elimination of service reduction days and furloughs in fiscal 2012. In addition, the board's expenditures will increase to the extent the board receives new positions to support the licensing activities for athletic trainers and perfusionists. Both of these factors could erode the board's fund balance. In the start-up phase, these increased licensing responsibilities could be more costly; however, fees associated with these new licensees should be sufficient to cover costs in the long term. Nevertheless, the board has not been able to satisfactorily answer questions on the fees it has been charging, and it is, therefore, unclear what impact any corrections might have on MBP's fund balance.

Exhibit 4.2
State Board of Physicians Year-end Fund Balance
Fiscal 2007-2012



Note: The fiscal 2012 year-end fund balance is an estimate.

Source: Department of Health and Mental Hygiene, Department of Legislative Services

Recommendation 20: Due to the uncertainty surrounding the board's current fiscal condition, MBP should be required to assess its fee-charging practices, develop a long-term fiscal plan, and submit a report to the Department of Legislative Services by December 31, 2012, so that these issues can be factored into consideration of the board's operating budget during the 2013 session of the General Assembly. Specifically, the assessment, plan, and report should include:

- a description of the method the board uses to determine the amount of licensing fees that the board will charge licensees;
- the adequacy of the board's fund balance, including the board's projected fund balance based on fee levels specified in regulations; and
- the sufficiency of physician fee levels, including whether current fee levels need to be adjusted to reflect costs associated with peer review and physician rehabilitation activities.

Allied Health Licensure Fees Cover the Costs Attributable to the Allied Health Unit

Maintaining a fund balance is important to allow the board to keep fees at the same level for several years. This way fees do not have to be raised for each renewal period to keep pace with inflation. However, the board has indicated that the additional responsibilities of licensing allied health professionals over the past decade have drained board resources as there are numerous start-up costs associated with licensing a new profession. This makes it important that licensure fees for allied health professionals accurately reflect the costs associated with licensure, including disciplinary actions.

Further, because MBP's licensure activity for allied health professionals occurs on a biennial basis, fee revenues are alternately high in one year and low in another. Accordingly, revenues and expenditures associated with allied health should be assessed on a two-year basis. Estimating the expenditures attributable to the Allied Health Unit is difficult because the board does not budget the unit under a separate program as it does with the board's legal services. Likewise, fee revenues related to licensing allied health professionals are not reported separately. Currently, revenues for initial licensure for physician assistants and radiographers are reported with initial licensure revenues for physicians, while all other fee revenues for the remaining allied health professionals are reported together. Consequently, it is not easy to track revenues and expenditures related to the licensure of allied health professionals. Thus, DLS used licensure figures to estimate revenues associated with initial licensure for physician assistants and radiographers as they are reported separately from other allied health revenues. Expenditure estimates were based on figures reported in the board's budget.

Recommendation 21: To enable the board to better approximate the cost associated with allied health expenditures and whether current fee levels for licensure are appropriate, MBP should budget allied health expenditures under a separate program code and report licensure revenues for physician assistants and radiographers with revenues derived from other allied health professionals. In reporting allied health revenues and expenditures separately, the board should monitor the revenues and expenditures of the Allied Health Unit to determine if additional personnel is needed to support the licensure of athletic trainers and perfusionists in fiscal 2012 and 2014, respectively.

As shown in **Exhibit 4.3**, a closer look at revenues and expenditures for the Allied Health Unit in fiscal 2010 and 2011 suggests that current fee levels accurately reflect the costs associated with licensing and disciplining allied health professionals. In fact, the board has a small surplus of funds (\$195,006) that represents approximately 15% of allied health expenditures for fiscal 2010 and 2011, indicating the board's excessive fund balance in recent years is primarily attributable to the licensure fees for physicians. Revenues derived from allied health licensure fees are anticipated to increase with the licensure of athletic trainers in fiscal 2012 and perfusionists in fiscal 2014.

Exhibit 4.3
Fiscal Condition of Allied Health Unit
Fiscal 2010-2011

	<u>FY 2010</u>	<u>FY 2011</u>	<u>Totals</u>
Allied Health Revenues	\$261,066	\$1,197,720	\$1,458,786
Allied Health Expenditures	653,357	610,423	1,263,780
Fund Balance Attributable to Allied Health Revenues	(\$392,291)	\$587,297	\$195,006

Note: Allied health expenditures reflect salaries, wages, and contractual spending attributed to the Allied Health Unit. Expenditures also reflect the salary for an investigator who undertakes investigations concerning allied health professionals. Expenditures reflect costs associated with communication, travel, supplies and materials, equipment, and fixed charges. With the exception of salaries and contractual spending, expenditures were estimated on a per-employee basis.

Source: State Board of Physicians, Department of Legislative Services

Not Clear Whether Allied Health Licensure Fees Have Been Set in Accordance with the Costs of Licensure or in an Equitable Manner

As stated previously, allied health licensure fees appear to approximate the costs associated with the Allied Health Unit. It is unclear, however, whether fee levels amongst the various allied health professions appropriately reflect the effort associated with the licensure of each profession. As shown in **Exhibit 4.4**, fee levels for initial licenses, license renewals, and license reinstatements differ amongst the various allied health professions. Physician assistants, respiratory care practitioners, polysomnographic technologists, and athletic trainers are assessed higher fees for an initial license and to reinstate a license than are radiologist assistants, radiation therapists, nuclear medicine technologists, and radiographers. However, on a per-licensee basis, there does not appear to be a substantial difference in the amount of resources required to process license applications for each of the professions.

Exhibit 4.4
Allied Health Licensure Fees and Median Wages
Fiscal 2012

<u>Profession</u>	<u>Licensees</u>	<u>Initial</u>	<u>Renewal</u>	<u>Reinstatement</u>	<u>Delegation Agreement/ Protocol</u>	<u>Median Annual Wage</u>
Physician Assistant	2,866	\$200	\$135	\$200	\$200	\$81,230
Radiologist Assistant	4	150	135	150		103,000
Radiation Therapist	373	150	135	150		72,910
Nuclear Medicine Technologist	732	150	135	150		66,660
Radiographer	5,773	150	135	150		52,210
Respiratory Care Practitioner	2,847	200	150	200		52,200
Polysomnographic Technologist	131	200	150	200		47,000
Athletic Trainer	600	200	135	200	100	39,640

Notes: The number of licensees reflects all initial and renewal licenses issued in fiscal 2010 and 2011. Renewal fees do not include a \$26 assessment to the Maryland Health Care Commission. The board is planning to waive the fee for an initial athletic trainer E&T protocol. The annual wage listed for radiologist assistants is the average annual wage, not the median annual wage, as information regarding the median annual wage was not available. Fees for athletic trainers are based on fees pending in regulations and the number of licensees reflects an estimate, not actual licensure figures.

Source: Code of Maryland Regulations; *Maryland Register*; State Board of Physicians; U.S. Bureau of Labor Statistics, May 2008; Washington Metro Institute of Sleep Technology; American Society of Radiologic Technologists; Department of Legislative Services

One wonders, therefore, whether the differing fee levels are justified and tailored to cover licensure costs for the respective professions. The Allied Health Unit devotes additional resources to processing delegation agreements, particularly delegation agreement addendums requesting board approval of advanced duties for physician assistants. Additional resources will be required, moreover, to process evaluation and treatment (E&T) protocols for athletic trainers. However, the board charges licensees a separate filing fee to cover the cost of processing these items. It should be noted that the board incurs start-up costs to establish advisory committees, draft regulations, and put in place processes to implement licensure when it begins to license a new profession, such as athletic training. However, in light of the apparent fund balance

attributable to revenues from allied health professionals, fee levels may be sufficient to absorb these up-front costs over time.

In addition, it is unclear if current fee levels present a barrier to entry for certain allied health professionals. For instance, Exhibit 4.4 demonstrates the three allied health professions under the board's jurisdiction with the lowest median annual wage (respiratory care, polysomnography, and athletic training) are assessed higher initial and reinstatement licensure fees than four of the five other allied health professions for which the board has set fee levels. Concerns have been expressed that the licensing fees proposed for athletic trainers are unreasonably high. Athletic trainers will be assessed the same fees as physician assistants, a profession with a median annual wage that is double that earned by athletic trainers. In comparison, licensure requirements for physician assistants are also more stringent than those for athletic trainers. To relieve the financial burden on athletic trainers, the board has agreed to waive the fee to file the initial E&T protocol. This measure will improve the inconsistent fee structure that the board currently utilizes to license allied health professionals.

Recommendation 22: Although the board incurs numerous start-up costs when it begins to license a new profession, the board should examine its schedule of fees for allied health professionals and, if necessary, adjust licensure fees to more accurately reflect the ongoing cost of licensure amongst the various allied health professionals. The board should pay particular attention to initial application fees for athletic trainers, which seem relatively high for that profession. As part of the fee revision process, the board should determine the percentage of board activities dedicated to each allied health profession and adjust application and renewal fees accordingly by profession. When making any fee changes, the board should balance the need to maintain the current, reasonable surplus attributable to the Allied Health Unit, while considering new anticipated revenues from athletic trainers and perfusionists.

Staffing Levels Are Down

The 2005 sunset review of the board indicated that, beginning in fiscal 2005, with the improvement in MBP's fiscal condition, the board began to replenish staffing levels. DLS also noted that, even with 83.1 full-time equivalent (FTE) regular employees in fiscal 2006, the staffing level of the board was still below that found in fiscal 1996. Immediately thereafter, however, MBP began to lose positions. As shown in **Exhibit 4.5**, in fiscal 2012, the board has a total of 68 FTEs and 3.6 contractual employees. These staffing levels include positions authorized in MBP's budget – both those housed with the board and those assigned to the Office of the Attorney General (OAG) to work on behalf of the board. Between fiscal 2007 and 2012, MBP lost 10 FTE employees assigned to the board. Half of the abolished positions were administrative positions. Other areas of the board's operations that were impacted by the reductions included compliance analyst and data processing positions. Two FTEs were

abolished through the Voluntary Separation Program, and an additional position was transferred to the Governor's Office.

Over the same period, the board also lost 14 contractual employees. The reduction in contractual employees, which began in fiscal 2008, came as a result of a recommendation from the 2005 sunset review that indicated the board should limit its use of contractual employment for ongoing functions. It is important to note that, while the board has reduced staffing levels, it has benefitted from certain efficiencies such as automation of licensure renewal for allied health professionals and physicians and the transition to electronic board books, which will be discussed later in this chapter. While the board has successfully reduced its use of contractual employees, a few problems still persist as the board is using a contractual employee to perform ongoing allied health functions related to licensure and policy research that could be done by existing full-time employees.

Exhibit 4.5
State Board of Physicians Staffing Levels:
Number of Full-time Equivalent Positions
Fiscal 2007-2012

	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 2011</u>	Projected <u>FY 2012</u>
Authorized Positions	78.00	72.00	75.00	72.00	68.00	68.00
Contractual Positions	17.10	0.78	0.99	2.06	2.53	3.60

Source: Department of Health and Mental Hygiene, Department of Legislative Services

Recommendation 23: MBP should not use contractual employees to perform ongoing functions of the board – including policy research – or to perform functions that could be done by existing employees.

Vacancy Rate Still High Even Though It Has Decreased in Recent Years

The board's vacancy rate has decreased from 15% in fiscal 2007 to 9% in fiscal 2010, a decrease of 6 percentage points. Despite this reduction, the vacancy rate at the board remained at 6.54 positions (higher than its budgeted turnover rate of 3%) for fiscal 2010. In part, high vacancy rates are attributable to the statewide hiring freeze, which requires MBP to submit a hiring freeze exception form to the Department of Budget and Management prior to filling a vacant position. Further, the board has lost three positions to the Voluntary Separation Plan and another position to meet department-wide personnel reductions.

Board Gained Four Additional Compliance Analysts Since Fiscal 2004

In the 2006 update report, DLS documented that MBP was experiencing difficulties in hiring and retaining compliance analysts due to a relatively low salary (Grade 13/14, or an entry-level salary of \$32,788/\$34,870) available for a position that requires significant skill levels. Since the 2006 update report, compliance analyst positions have been reclassified to a higher grade (Grade 16/17, or \$41,071/\$43,725), and the board has experienced lower vacancy rates than in prior fiscal years. Furthermore, the total number of compliance analysts at the board has increased from 12 in fiscal 2004 to 16 in fiscal 2012. As of October 2011, each compliance analyst had an average of 37.4 cases, as opposed to 56 cases in fiscal 2005. However, despite an increase in the number of compliance analysts and a decrease in the average caseload, these staffing enhancements do not appear to have had an impact on complaint processing times.

Board Could Take Many Actions to Optimize Resources

Presently, the problem for MBP is not necessarily a lack of financial resources but rather personnel inefficiencies in certain areas. As indicated earlier in this chapter, the board has been able to meet licensure goals for both physicians and allied health professionals; however, numerous problems persist related to the board's compliance process. Furthermore, the board advises it is understaffed. Also, the board's complaint backlog continues to grow, despite the reclassification of board compliance analysts, an overall increase in the number of such analysts, and new efforts to expedite the processing of certain cases. It remains unclear if the board is in need of more compliance analysts or if current board processes are inefficient.

Reducing the complaint backlog aside, the board could take a number of approaches to optimize its current resources. For instance, while attending board meetings, DLS observed board staff, who have no duties related to the complaint resolution process, attending closed disciplinary hearings and meetings. Furthermore, staff has been distracting at the board meetings and, in some instances, has participated in board hearings, which unnecessarily prolongs the disciplinary process. To optimize board resources, attendance of board staff at closed meetings should be limited to staff directly involved in the complaint resolution process. This would free up staff to attend to their assigned duties.

As discussed in Chapter 2, the board requires a licensee to apply to the board for reinstatement after the license has been suspended. In addition to submitting an application, the licensee is also required to appear before the Reinstatement Inquiry Panel, which is the Case Resolution Conference Committee sitting as the Reinstatement Inquiry Panel. The panel is held each month. Although it appears that board members believe that they can deny a reinstatement of a suspended license even if the licensee has met all conditions for reinstatement, this is not the case. If an individual has met all conditions for reinstatement after a suspension, the board must grant reinstatement and return the license to the licensee per §§ 14-407(c) and 14-409(a) of the

Health Occupations Article. Therefore, the Reinstatement Inquiry Panel serves no real role as the panel cannot deny reinstatement or require additional action by the applicant. Furthermore, requiring board members to attend the Reinstatement Inquiry Panel on a monthly basis not only unnecessarily diverts staff resources but also results in the board paying additional per diem rates to board members.

The board has taken steps to optimize board resources in certain areas. In preparation for board meetings, staff is required to compile board books for each board member. These books are several hundred pages and include investigative files for disciplinary cases, draft regulations, and pending applications to be approved at the board meeting. Compiling board books diverts staff from assigned duties and represents an additional drain on fiscal resources as board books must be sent overnight to board members. In order to remedy this matter, MBP is transitioning to electronic board books in January 2012.

Recommendation 24: To optimize current board resources, (1) board counsel, in conjunction with the executive director of the board, should establish clear guidance for board staff participation and attendance at closed meetings; and (2) the board should no longer require applicants for reinstatement who meet the requirements for reinstatement after a suspension to appear before the Reinstatement Inquiry Panel.

Administrative Issues

Board Could Improve the Availability of Information for Licensees and the Public

The board provides a valuable service to both the public and the professionals it regulates, and the board's website is an important resource for licensees and consumers. While the board's website includes applications for licensure, disciplinary sanctions, declaratory rulings, and meeting schedules, it also lacks critical information, which decreases the board's transparency and openness to the public. Moreover, the board's website is disorganized and difficult to navigate. Therefore, the information that is currently provided is difficult to access.

Specifically, the website does not include open meeting agendas, open meeting minutes from prior board and allied health advisory committee meetings, and a listing of board staff. Furthermore, the website does not note when allied health advisory committee meetings are cancelled; the board routinely cancels these meetings but does not notify the public. Although required by Chapter 539 of 2007, MBP does not include on its website contact information through which a person can receive information from the board regarding medical malpractice settlements involving a licensee. In addition, some online licensee profiles are missing disciplinary information. Consent orders are not consistently posted on profiles; neither is information regarding summary suspensions. Sometimes the letters of permanent license

surrender that are posted do not include a copy of the charges, as the letter states is attached, which leads to an unclear picture of the actions that led to the permanent surrender.

It should be noted that, while statute does not require the board to provide online license profiles on allied health licensees, such profiles are provided by the board. The content of profiles, however, is not uniform between allied health professionals and physicians. Specifically, while profiles for allied health professionals usually contain a link to the consent or final order, there is no summary of the action taken as there is on physician profiles. In addition, allied health profiles do not include a summary of final disciplinary action taken by a licensing board in any other state or jurisdiction within the most recent 10-year period, as physician profiles do.

Recommendation 25: Statute should be amended to clarify that the board is required to provide online profiles on allied health licensees and require that allied health licensee profiles, to the extent possible, contain the same information that is provided on physician profiles, including, for the most recent 10-year period, a description of any disciplinary action taken by MBP and any final disciplinary action taken by a licensing board in any other state or jurisdiction against an allied health licensee.

Recommendation 26: The board should improve the quality of its website for consumers and licensees so it is more user friendly. Furthermore, the board should improve its transparency to the public by posting all required disciplinary action on its website as well as posting open meeting agendas, open meeting minutes, board staff names, meeting cancellations, and contact information through which a person can receive information from the board regarding medical malpractice settlements.

Board Recordkeeping Needs Improvement

Accurate recordkeeping is essential to help the board monitor the licensure status of physicians and allied health professionals and track complaint cases. With the exception of the online renewal process, almost all licensing information and disciplinary information comes to the board in hard copy form. Once board staff receives the information, a file is created and housed in the Licensure Unit if it pertains to an application or in the Compliance Unit if it pertains to a disciplinary case. Then staff enters the licensing or complaint information into the board's database. To maintain accurate files, the contents of the hard copy file must correspond to the information in the electronic file. Files that are no longer maintained by the board are sent off-site to a microfiche scanning service to archive files.

DLS found the board's hard copy complaint files are disorganized. Furthermore, file review revealed inconsistencies and missing information in the electronic and hard copy files. For instance, dates corresponding to various steps in the complaint resolution process, such as a board vote to charge, were not consistently included in hard copy or electronic records. Additionally, when dates corresponding to the board's vote to charge were included in hard copy

files, the date noted in the file did not always match the date noted in the board's electronic records. In some instances, there were cases included in the board's electronic database for which board minutes did not indicate that the board ever voted to charge the licensee. Inconsistencies were also found in the type of information included in each file. In some cases, the hard copy complaint files were missing key documents, such as new and old consent orders. It is important to note it was also difficult to find correspondence between the board and the licensee or complainant. This could be attributed to the large size of the compliance files that the board keeps. However, a consistent file structure would make it easier to find key documents in large complaint files and would facilitate the board's ability to move cases through the process.

Additional inaccuracies were found upon reviewing the board's annual reports and Managing for Results (MFR) performance measures related to licensure and compliance figures. Furthermore, minutes from the board's closed sessions included errors. This hinders the ability of the board to track cases.

Recommendation 27: Board staff should standardize information and documents that are kept in the hard copy files and establish a system to ensure that the files are organized and information is readily accessible. Furthermore, hard copy complaint files should contain a checklist for documents included in the file, as well as dates corresponding with the steps in the complaint resolution process, such as when a board vote to charge occurred.

Recommendation 28: Board staff should ensure that information included in the board's annual reports is consistent with information reported in its Managing for Results submission and the board's complaint database. Likewise, when board staff prepares closed session minutes, staff should verify that case and licensure numbers are accurate and correspond to the appropriate licensee.

Board Has Not Complied with the Open Meetings Act

DLS noted that the board has violated the Open Meetings Act by discussing specific topics in the board's closed sessions, including the board's position on legislation and politically sensitive topics, when statute requires those topics to be heard in an open setting. Board counsel did not appear to be sufficiently active in determining whether agenda items are appropriate for closed meetings.

Recommendation 29: To enhance compliance with the Open Meetings Act, MBP should ensure that its members and staff receive training in the requirements of the Open Meetings Act from the Office of the Attorney General and the Department of Health and Mental Hygiene. Board counsel should review and approve the closed and open meeting agendas prior to monthly board meetings to maintain compliance with the Act. Furthermore, if the board begins to discuss a matter in closed session that violates the Act, board counsel should advise the board that it is violating the Act and the board should cease discussion.

Board Should Improve Training for New Members

When new board members are appointed, they receive a brief training that DHMH provides to new board members of all health occupations boards. To supplement that training and to provide information specific to MBP, the board created training materials for new board members that contains the board's annual report, the most recent sunset legislation, a calendar of meetings, an MBP directory and organizational chart, updated regulations, and ethics information including a financial disclosure statement. While attending closed board meetings, however, DLS observed board members lacked appropriate knowledge of parliamentary procedures, as well as the role of the Office of Administrative Hearings (OAH) and the Open Meetings Act. DLS recognizes that much of what board members have to learn is best learned "on the job" and requires time. However, since there are so many board regulations and policies to navigate, the board should continue to improve its existing training for board members.

Recommendation 30: MBP should continue to improve board member training by developing training in conjunction with DHMH, OAG, and OAH on board procedures, including parliamentary procedures to expedite the disciplinary process.

Matters Specific to Allied Health Administration

With the addition of athletic trainers and perfusionists, the board now has oversight over several allied health professional categories. There are, among other administrative issues, matters requiring attention concerning the advisory committees that assist the board in its oversight role of the allied health professions. The allied health advisory committees are established by statute to develop and recommend to the board regulations and to provide the board with recommendations concerning the practice of their respective professions.

The committees differ in the frequency and regularity in which they meet. Some of the committees, specifically the Athletic Trainer Advisory Committee (ATAC) and Physician Assistant Advisory Committee (PAAC), have met monthly and have generally convened meetings as scheduled. PAAC must regularly review delegation agreements. Other committees meet infrequently and have meetings cancelled on a regular basis. For example, the Respiratory Care Professional Standards Committee met three times in 2007, once in 2008, twice in 2009, once in 2010, and once in 2011 (as of September 2011). Similarly, the Polysomnography Professional Standards Committee met three times in 2007, four times in 2008, twice in 2009, twice in 2010, and twice in 2011 (as of September 2011).

While the advisory committees meet with greater frequency during the initial months after their formation to develop and recommend regulations establishing requirements for licensure, committees typically meet more sporadically as time goes on. At the initiative of board staff, scheduled meetings are convened when there are pending scope of practice or other issues and cancelled when there are no issues to address.

Board and Allied Health Advisory Committee Communication Needs Improvement

There is a perception among certain allied health professionals that the board disregards preferences of committee members or has an incomplete understanding of professional practices, particularly in establishing requirements for licensure, defining scope of practice, or developing protocols. All of the allied health advisory committees are established by statute to make recommendations to the board concerning regulations and other matters. Some committees, however, have additional statutory reporting and advisory requirements. Although it has yet to comply with this requirement, the Polysomnography Professional Standards Committee is required by statute to submit an annual report to the board. Statute establishing PAAC includes an added requirement – the chair has to serve in an advisory capacity to the board as a representative of the committee. Statute also requires the board to consider all recommendations of that committee and provide a written explanation of the board's reasons for rejecting or modifying the committee's recommendation. These statutory requirements are important to establish and maintain channels of communication between the board and the advisory committees and should be consistent for all of the allied health advisory committees under the board's purview.

To further enhance board-committee communication, the chair of each committee should report to the board on a biannual basis and present to the board the committee's annual report. The board is responsible for handling disciplinary matters involving allied health professionals; the committees do not play a role in this process. As a consequence, committee members have limited awareness of complaints and disciplinary actions involving their professional peers. Some committee members would like their committees to be more involved in handling disciplinary matters involving members of their profession. While DLS finds this to be worthy of further inquiry, in the near term, the board should likewise provide to the committee chairs on a biannual basis a report on disciplinary matters involving allied health professionals, including the numbers and types of complaints and formal actions taken against allied health professionals. This information could assist the committees in addressing issues confronting their profession through training or guidance to practitioners in advisory letters, newsletters, or on the board's website.

Recommendation 31: Statute for each allied health advisory committee should include a requirement that:

- **the advisory committee submit an annual report to the board;**
- **the chair serve in an advisory capacity to the board as a representative of the committee;**
- **the board consider all recommendations of the advisory committee and provide a written explanation of the board's reasons for rejecting or modifying the committee's recommendation;**

- **the chair report to the board on a biannual basis and present to the board the committee's annual report; and**
- **the board provide to the advisory committee chair on a biannual basis a report on disciplinary matters involving allied health professionals.**

Also, board staff should ensure that the above allied health-related reporting requirements are met.

Board Needs to Prioritize and Improve Its Allied Health Advisory Committee Member Recruitment and Appointment Efforts

As shown in **Exhibit 4.7**, a number of allied health committees have one or more vacancies in membership, or one or more members are serving beyond the expiration of their term. Many of these vacancies are for physician and consumer members, member categories that regularly have been difficult to fill. In addition, the board is required by statute to appoint a board member to serve on PAAC and the Radiation Therapy, Radiography, Nuclear Medicine Technology Advisory, and Radiology Assistance Committee (Rad Tech Advisory Committee). However, both of these positions have been vacant for some time. Board members already devote a substantial amount of time to fulfilling other board duties, including preparation for and participation in the board's monthly full-day board meeting. These meetings require review of a large volume of disciplinary hearing and other materials. Board members also serve on licensure and medical practice or compliance committees, such as the Investigative Review Panel. Because of these commitments, it is a challenge to fill vacant board member positions on the advisory committees for allied health.

In addition, one committee, ATAC, is currently functioning without a chair elected from the committee membership, which is a statutory requirement. ATAC has not elected a chair since it began meeting in February 2011. Board staff has presided over ATAC meetings during an important period in which the committee developed and recommended to the board regulations and an E&T protocol.

In view of these vacancies in membership, expired terms, and chair vacancy, the board must prioritize and improve its allied health advisory committee member recruitment efforts. The board should develop and implement a plan to address a persistent challenge in recruiting and appointing physician and consumer members to serve on the allied health advisory committees.

Exhibit 4.7
Allied Health Advisory Committee Vacancies as of October 2011

<u>Committee</u>	<u>Size of Committee</u>	<u>Members Serving Beyond Expiration of Term</u>	<u>Vacancies</u>	<u>Member Vacancy Category</u>
Athletic Trainer Advisory Committee	11	1	3	<ul style="list-style-type: none"> • 2 consumers • 1 chiropractor
Physician Assistant Advisory Committee	7	2	1	<ul style="list-style-type: none"> • 1 physician member of the board
Polysomnography Professional Standards Committee	7	1	0	
Radiation Therapy, Radiography, Nuclear Medicine Technology Advisory, and Radiology Assistance Committee	10	2	3	<ul style="list-style-type: none"> • 1 board member • 1 radiologist (who supervises a radiology assistant) • 1 radiologist assistant
Respiratory Care Professional Standards Committee	7	1	2	<ul style="list-style-type: none"> • 1 thoracic surgeon • 1 pulmonary medicine specialist

Notes: Excludes the seven-member Perfusion Advisory Committee, which has not yet been appointed.

Source: State Board of Physicians

Recommendation 32: Uncodified language should be adopted requiring the board to develop and implement a plan by December 31, 2012, to improve the recruitment of allied health advisory committee members. The board should also be required to provide an update on implementation of that recruitment plan as well as study and report to the Department of Legislative Services on several issues related to advisory committee membership. Specifically, that report should address:

- measures the board is taking to (1) fill vacancies; (2) solicit, identify, and appoint new members before a member's term expires; (3) promptly reappoint members eligible and nominated to serve for an additional term; and (4) ensure that

committee chairs are elected in a timely manner and preside over committee meetings;

- whether board members should sit on allied health advisory committees;
- whether the number of licensees should be considered when determining the size of an allied health advisory committee; and
- whether the size and composition of the advisory committees should be altered through statutory amendment to more effectively carry out oversight functions, including whether membership should be reduced after the regulatory framework for the affected profession has been developed.

Board Needs to Appoint Allied Health Advisory Committees and Adopt Regulations in a Timely Manner

Chapter 529 of 2009 requires an individual to be licensed by the board by October 1, 2011, to practice athletic training in the State. Statute established the 11-member ATAC to develop and recommend regulations, continuing education requirements, and an E&T protocol into which an athletic trainer must enter with a licensed physician. Although the athletic trainer statute was passed in 2009, the board did not begin the process of appointing members to the committee until the summer of 2010, which met for the first time in February 2011. Due to this delay in appointing members and convening the committee, the board did not vote to approve regulations governing the practice of athletic training until July 2011. As a consequence, the board had to request that the proposed regulations be adopted as emergency regulations to enable the board to begin licensing athletic trainers by October 2011.

It is important to note that the Maryland Perfusion Act, which takes effect October 1, 2012, will require MBP to license perfusionists by October 1, 2013. The board should be proactive in recruiting potential candidates for the Perfusion Advisory Committee and completing any preparatory work so the board can promulgate regulations and begin issuing licenses in timely manner.

Recommendation 33: As the board assumes responsibility to license new allied health professions, the board should appoint members, convene advisory committees, and develop and adopt regulations in a timely manner.

Individuals Who Provide Services to the Board for Remuneration Should Be Prohibited from Serving as Committee or Board Members

Under board regulations, a member of PAAC may be reappointed for a second term but may not serve more than two consecutive terms. One current member of PAAC, the committee chair, served for two consecutive three-year terms from 1999 to 2006, left the committee and worked as a paid consultant to the board from 2006 to 2008, and was then reappointed to the committee for a third term. While serving as a consultant, this individual actively participated in committee deliberations and, on one occasion, was asked by board staff to facilitate a meeting due to the absence of a chair and in the absence of the secretary.

It is essential that allied health advisory committee members and board members exercise independent judgment in carrying out their responsibilities. Employment by or service rendered to the board for remuneration, whether past or present, presents a conflict of interest.

Recommendation 34: To ensure that allied health advisory committee and board members exercise independent judgment in carrying out their responsibilities, statute should be amended to prohibit the appointment of an individual to an advisory committee or the board if the individual is providing or has provided services to the board for remuneration. Any individual currently serving on MBP or an advisory committee who has provided services to the board for remuneration should be replaced.

Nonmembers Should Be Clearly Identified When Invited to Address a Committee or the Board

As noted above, PAAC has involved a nonmember in presiding over meetings and in deliberations on matters before it. In addition, DLS observed while attending a meeting of this advisory committee a representative of a professional association actively participate in deliberations on matters before the committee. Although the association representative did not vote on committee matters and provided input that was invited by the committee, there was little indication that the representative, who was seated alongside of committee members, was not a member of the committee. To ensure that committee matters are decided by committee members, the board should clearly identify a nonmember before such an individual addresses a committee.

Recommendation 35: The board should adopt and implement meeting procedures to ensure that nonmembers are clearly identified before addressing an allied health advisory committee or the board.

Chapter 5. Additional Policy and Regulatory Issues

This chapter highlights additional policy and regulatory issues that affect the State Board of Physicians (MBP) and are related to MBP's mission to protect the health and safety of the citizens of Maryland.

Regulatory Issues

Board Fails to Adopt Regulations as Required by Law

The Administrative Procedure Act (APA) requires MBP to adopt regulations that contain MBP guidelines and rules that have general application and future effect. However, MBP has failed to adopt regulations for various procedures, including exceptions to licensure for the purpose of consultation, mental health records subpoenas, and postdisciplinary reinstatement of a license.

Exceptions to Licensure for the Purpose of Consultation

MBP has the authority to allow certain individuals to practice medicine in the State without a license. Specifically, "a physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in the State" may practice medicine without a license "subject to the rules, regulations, and orders of the board" (§ 14-302(2) of the Health Occupations Article). An example of this is a physician who is an expert in a certain field who comes into the State to consult with a Maryland physician regarding the treatment of a patient.

To be approved for an exception to licensure, the Maryland licensed physician must submit an application to the board that includes information about him or herself and the unlicensed physician with whom he or she will be consulting. With the application, the Maryland licensed physician must include (1) a curriculum vitae of the unlicensed physician; and (2) evidence that the teaching/learning institution where the unlicensed physician will practice medicine has credentialed the physician to perform the medical acts. When the board receives an application for an exception from licensure, licensing staff reviews the license of the sponsoring Maryland physician to verify licensure and to check for any compliance issues. The board also completes a search of the National Practitioner Data Bank for information related to the unlicensed physician. If the request is for 30 days or less, licensing staff can approve the application, and the board is notified of the approval at the next board meeting. If the request is for more than 30 days, the board must approve the request.

In addition to APA requiring that regulations be adopted on this MBP procedure, MBP was also required by Chapter 539 of 2007 to adopt these regulations by September 1, 2007. The board did not meet that deadline and has yet to adopt the regulations, in part because it was not a board priority. With a pending disciplinary case, MBP opted to postpone the adoption of the

regulations due to a concern about potential negative impacts on MBP disciplinary proceedings in the case.

The pending disciplinary case serves as a prime example of why adoption of regulations by MBP regarding an exception to licensure for the purpose of consultation is crucial. Not only would the adoption of regulations serve to protect MBP, it also would assist the regulated community in knowing its responsibilities. While the board's concern about potentially compromising an important disciplinary case is understandable, one case should not delay the adoption of regulations that could guide licensees and protect patients from the performance of unauthorized medical acts.

Exemptions from Licensure Fees

MBP is required to issue a license free of charge to a physician who (1) provides *pro bono* medical services; (2) is not engaged in the private practice of medicine; and (3) otherwise qualifies for a license. To receive the exemption from licensure fees, the physician is required to submit an application to MBP in which the physician provides information relating to whether the physician qualifies for the exemption. MBP also requires the administrator of the agency where the physician provides or will provide the free medical services to certify in writing the specific arrangement. Although this procedure is required by APA to be in regulations, MBP has not adopted such regulations.

Mental Health Record Subpoenas

As part of investigating complaints, MBP often issues subpoenas for patient medical records. Information included in patient medical records can be sensitive, especially when the patient is seeking treatment from a psychiatrist for mental health issues. As a result, MBP attempts to balance the need for patient confidentiality with the need to protect the public's health and welfare. In attempting to balance those sometimes conflicting needs, MBP considers the factors outlined by the Court of Special Appeals in *Dr. K v. Board of Physician Quality Assurance*,⁴ when determining whether to issue a mental health records subpoena. Those factors are (1) the type of record requested; (2) information contained in the record; (3) the potential for harm in subsequent nonconsensual disclosure; (4) the injury in the disclosure to the relationship for which the record is created; (5) the adequacy of safeguards to prevent unauthorized disclosure; (6) the government's need to access; (7) an express statutory mandate; (8) articulated public policy; and (9) other public interest in favor of access to the records.

The board submitted regulations in January 2008 that required the full board to review an investigative subpoena that involves mental health records if the psychiatrist who is the subject of a standard of care complaint requests that the subpoena be reviewed. Those regulations, however, were later withdrawn and have not been resubmitted.

⁴98 Md.App. 103 (1993).

Recommendation 36: MBP should adopt regulations by December 31, 2012, that govern (1) exceptions to licensure for the purpose of consultation; (2) exemptions from licensure fees; and (3) mental health record subpoenas. If the board fails to adopt regulations as required, budget bill language should be adopted during the 2013 legislative session to withhold funds from MBP until the regulations are adopted. Furthermore, the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding.

MBP Fails to Update Regulations to Reflect Current Board Practice

In order to give proper notice and comment of changes to board processes and procedures, MBP needs to continually assess current regulations and update them as necessary. If the regulations are inconsistent with MBP practices, a conflict of authority may arise as to the legality of MBP actions. In addition, physicians and allied health practitioners rely on the regulations to comply with the rules. Thus, if regulations are out of date, the regulated community may be relying on incorrect information as to MBP procedures.

Chapter 539 of 2007 required MBP to update its regulations to conform to current practice by September 1, 2007. The language also required MBP to adopt regulations to implement the recommendations made in the 2004 *Report on the Maryland Board of Physicians' Investigative Processes and Optimal Caseloads*, which specifically recommended changing the regulations to replace the Weekly Review Panel with the Investigative Review Panel, require respondents to file answers to all factual allegations of the charging document, and extend the time period for a petition for reinstatement following license revocation. However, these changes were not made by September 2007. In January 2008, MBP submitted amendments to its hearings regulations that included the changes but withdrew them at the request of the Secretary of Health and Mental Hygiene due to pending legislation. Although the legislation that finally passed in 2010 did not affect the validity of many of the changes as contemplated by Chapter 539, the board has not resubmitted the regulations.

A review of board regulations showed that there were several outdated terms, references, and other information. Despite previous recommendations regarding the need for MBP to update and keep its regulations current, the board does not have a process for ensuring that necessary changes are made in a timely manner. Board staff indicated that changing outdated terms and references is done when the board submits substantive changes to MBP regulations. However, this means that terms and references may continue to be in MBP regulations long after they become outdated, which can cause confusion regarding actual MBP practices.

Recommendation 37: The board should institute a process for updating regulations when the board changes its practices. Uncodified language should be adopted requiring the board to amend its regulations to conform to current practice by December 31, 2012. If the

board fails to update its regulations as required, budget bill language should be adopted during the 2013 legislative session to withhold funds from MBP until the regulations are adopted. Furthermore, the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees should advise the Senate Budget and Taxation and the House Appropriations committees on whether they support the recommendation to withhold funding.

Several Regulatory Provisions Are Inconsistent with Statute

Inconsistencies between statutory and regulatory provisions are a cause of concern for two main reasons. First, inconsistent provisions are confusing to licensees. Second, inconsistent provisions can call into question the actions of the board and whether those actions are valid. For those reasons, it is important that board regulations be consistent with the board's governing statutes.

However, two board regulations are inconsistent with statute. First, the Maryland Medical Practice Act requires that an applicant for a physician's license submit evidence to MBP of the successful completion of one year of training in a postgraduate medical training program accredited by an accrediting organization that MBP recognizes in its regulations (§ 14-307(d) of the Health Occupations Article). MBP regulations include provisions recognizing the accrediting organization; however, the regulations also specify that MBP, on a case-by-case basis, may consider full-time teaching at an accredited medical school in the United States or practice in another state in the United States or Canada as an alternative to the accredited postgraduate clinical medical education that would otherwise be required (COMAR 10.32.01.03E and F). Second, although statute requires an applicant who fails the required examination or any part of the examination three or more times to submit evidence of having completed additional clinical training (§ 14-307(g) of the Health Occupations Article), board regulations authorize MBP, on a case-by-case basis, to consider licensure of the applicant if the applicant can demonstrate, for example, that the failures resulted from a physical, emotional, or mental condition or learning disability under certain circumstances (COMAR 10.32.01.03G(7)). In those circumstances, no additional training is required.

Even though board regulations are inconsistent with statute, no known problems have arisen due to the board's practice. Therefore, statute should be amended to allow for current board practice in the above areas.

Recommendation 38: Statute should be amended to allow for current MBP practice regarding the requirement of postgraduate medical training for licensure and in cases of the failure to pass the required examination to be consistent with the Maryland Medical Practice Act.

Drug Therapy Management Program Has Been Underutilized

According to the American Pharmacists Association, as of 2008, 45 states had authorized collaborative drug therapy management between a pharmacist and a physician. Generally, authority to practice drug therapy management is incorporated in state pharmacy practice acts within the definition of a pharmacist's scope of practice.

In Maryland, Chapter 249 of 2002 created the Drug Therapy Management Program, which authorizes a physician and a pharmacist to enter into a therapy management contract that specifies treatment protocols that may be used to provide care to a patient. Therapy management contracts allow pharmacists to help manage a patient's medications in collaboration with a physician. A pharmacist may order laboratory tests and other patient care measures related to monitoring or improving the outcomes of drug or device therapy based on disease-specific, mutually agreed-upon protocols. The program was initially set to terminate on May 31, 2008; however, Chapter 650 of 2008 extended the termination date to September 30, 2010, and Chapters 44 and 45 of 2010 ultimately repealed the termination date, making the program permanent.

Administrative Process Is Onerous

Before collaborating on drug therapy management, a pharmacist and a physician must apply to the State Board of Pharmacy for a physician-pharmacist agreement and approval of each individual protocol to be used. Each pharmacist must be approved by the State Board of Pharmacy to participate in a therapy management contract. To qualify, a pharmacist must have a doctoral degree or equivalent training, may not have any public final disciplinary orders within the previous five years, and must meet significant relevant advanced training and experience requirements as set in regulation. An applicant pays a \$250 application fee, which includes review and disposition of the physician-pharmacist agreement and one protocol. Additional protocols require a fee of \$50.

Once a pharmacist is approved, all application materials and protocols are sent to the Joint Committee on Drug Therapy Management, which consists of two members of MBP and two members of the State Board of Pharmacy. The Joint Committee reviews and makes recommendations regarding the final approval of the agreement and protocol(s) to MBP and the State Board of Pharmacy. Both boards must approve the physician-pharmacist agreement. Agreements are valid for two years and may be renewed for a fee of \$200.

Chapter 249 of 2002 required the Department of Health and Mental Hygiene (DHMH) to assess outcomes achieved by drug therapy management contracts. The department contracted with the University of Maryland to evaluate the program from 2007 to 2009. The University of Maryland found that applying for a physician-pharmacist agreement typically took six months and involved significant paperwork and strict oversight by both boards. The evaluation noted that physicians and pharmacists had been reluctant to expend the time and expertise necessary to

prepare protocols and application materials because they were onerous (and, at the time, the program was scheduled to terminate).

Participation in Drug Therapy Management Is Low

According to the boards, there are currently only nine physician-pharmacist agreements in Maryland: three are specific to metabolic syndrome; three to antithrombosis (management of patients on anticoagulants or blood thinners); two to tobacco use and dependence; and one to anxiety. The Department of Legislative Services (DLS) identified several potential reasons why participation in the drug therapy management program continues to be low. First, statute and regulations outlining the Drug Therapy Management Program are lengthy and complex. Second, as reflected in the University of Maryland evaluation of the program, the application process is onerous and time consuming, with some agreements and protocols awaiting approval for *years*. Third, based on DLS observations of Joint Committee proceedings, the pharmacy and physician boards disagree on the program's legislative intent, as well as the scope of the program and the types of diseases that should be treated under it. This leads to disagreements on and significant delays in the approval process. Furthermore, there is concern that MBP denies protocols that are authorized under the drug therapy management statute, which both hinders collaborative practice and further prolongs the approval process by requiring repeated resubmissions and revisions.

Joint Approval Inconsistent with Other Boards and Other States

In addition to identifying obstacles to participation, DLS also notes that the requirement that physician-pharmacist agreements and individual drug protocols be approved by both boards appears inconsistent with similar agreements regulated by other health occupations boards and with the drug therapy management laws in other states.

MBP and State Board of Nursing No Longer Approve Nurse Practitioner Agreements. A similar joint committee structure was historically used by MBP and the State Board of Nursing to govern agreements between nurse practitioners and physicians. However, Chapters 77 and 78 of 2010 eliminated joint board approval of such agreements. Instead, nurse practitioners may practice independently if they have an approved attestation that they have a collaboration agreement in place with a licensed physician and will refer to and consult with physicians as needed. Neither board approves such attestations, but the State Board of Nursing must maintain approved attestations and make them available to MBP upon request.

Only Eight Other States Require Approval of Drug Therapy Agreements. To obtain additional information about drug therapy management in other states, DLS contacted the National Association of Boards of Pharmacy and conducted an informal survey of other state boards of pharmacy. DLS found that only 8 of the 45 states that authorize drug therapy management require agreements (or protocols) to be approved. Arizona, Nevada, Montana, and Washington require the agreements to be approved by the board of pharmacy only, while West Virginia and Louisiana require approval by both the pharmacy and physician boards. In

Wyoming, while both boards jointly review applications and protocols, approval is conducted by the pharmacy board only. New Hampshire requires approval of protocols by the board of pharmacy only. In addition to these states, Virginia requires approval of protocols that are “outside the standard of care”; however, in practice no such protocols have ever been submitted for approval.

The remaining states generally allow qualified pharmacists and physicians to enter into drug therapy management contracts and establish drug therapy management protocols that follow established statutory and regulatory guidelines without any board approval or notice.

Requirement for Joint Approval of Agreements and Protocols Should Be Repealed. Based on DLS observations and findings, if the General Assembly wishes to foster collaborative drug therapy management between pharmacists and physicians (as can be inferred from the removal of the termination date on the program in 2010), the program could benefit from revision. Simplification of the governing statute and regulations and removal of current barriers to participation may be first steps. In particular, the Maryland law should be amended to repeal the dual board approval requirement as well as the boards’ authority to charge fees for the program.

Recommendation 39: Statute should be amended to remove the requirement that physician-pharmacist agreements and protocols be approved by the State Board of Pharmacy and MBP. Instead, participating pharmacists and physicians should be required to submit copies of all agreements and protocols to their respective board and to promptly submit any modifications. Furthermore, MBP should collaborate with the State Board of Pharmacy to submit a follow-up report to the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees by October 1, 2013, on the impact of these modifications to the drug therapy management program, including the number of physician-pharmacist agreements and drug therapy management protocols on file with the boards.

DLS notes that this recommendation is also included in the full sunset evaluation of the State Board of Pharmacy, and the statutory language to implement the recommendation is included in the draft legislation with that report.

MBP May Not Be Most Appropriate Entity to Enforce Self-referral Law

The Maryland Self-referral Law (§ 1-300 *et seq.* of the Health Occupations Article), enacted in 1993, regulates patient referrals by a health care practitioner to a health care entity in which the practitioner has a financial interest. One of the primary reasons the self-referral law was enacted was growing concern that unnecessary diagnostic tests were adding to the State’s rising medical costs and physicians were profiting. Specifically, the law:

- prohibits health care practitioners from making referrals to a health care entity with which the practitioner or an immediate family member has a “compensation arrangement” or a health care entity in which the practitioner or an immediate family member holds a beneficial interest;
- defines a compensation arrangement as “any arrangement or system involving any remuneration between a health care practitioner or the immediate family member of the health care practitioner and a health care entity;” and
- establishes that a practitioner who fails to comply with the provisions of the law “shall be subject to disciplinary action by the appropriate regulatory board.”

The Maryland self-referral law does contain some exceptions. Regulations implementing the self-referral provisions took effect June 25, 2001.

In December 2006, MBP issued a Declaratory Ruling under the Maryland Self-referral Law on referrals made by physicians for magnetic resonance imaging (MRI) scans when the physician has a financial interest in the performance of that scan.⁵ The Declaratory Ruling determined that a certain referral by an orthopedic physician for an MRI to be performed on or by an MRI machine owned or leased by the orthopedic practice is an illegal self-referral within the meaning of the Maryland Self-referral Law. The Declaratory Ruling was upheld by the Court of Appeals in January 2011.⁶ Since then, MBP has worked to gather information by surveying more than 140 licensees regarding their referral practices. MBP provided the licensees 90 days to reorganize their practices to comply with the self-referral law before imposing sanctions for noncompliance.

One of the recommendations from the 2006 update report was that the Maryland Insurance Administration should investigate self-referral cases because the cases require very specific knowledge of business ownership, financial relationships, and the investigation of fraudulent practices, which the Maryland Insurance Administration has. That recommendation, however, was not adopted by the General Assembly. Instead, Chapter 539 of 2007 required DHMH and the Office of the Attorney General (OAG) to review the process for investigating self-referral cases by health occupations boards and to make recommendations to revise the process. In the report submitted by DHMH in October 2007, DHMH supported the continuing enforcement of the self-referral laws by MBP with the provision of additional resources, including additional staff.

Despite the conclusion of the 2007 DHMH report, whether MBP is the most appropriate entity to be enforcing the self-referral law continues to be a question for the following reasons:

⁵State Board of Physicians, Declaratory Ruling No. 2006-1. Eight orthopedic medical practices whose referrals had been questioned by CareFirst and the Injured Workers’ Insurance Fund joined the Declaratory Ruling.

⁶*Potomac Valley Orthopedic Assocs. v. Maryland State Board of Physicians*, 417 Md. 622 (2011).

- Both MBP and OAG have expressed concerns regarding the time and expertise needed to enforce this law. These cases can be very complex, and statute can be difficult to interpret. Although MBP recently hired an individual with a nursing background to investigate these cases, MBP has frequently expressed the belief that a forensic accountant would be required to investigate self-referral cases. As also noted in the October 2007 DHMH report, MBP compliance analysts are trained to investigate cases involving the practice of medicine and not cases that involve accounting and other business-related issues.
- In an interview with OAG, it was made clear that OAG does not have the resources or the expertise to prosecute self-referral cases. OAG believes that a position should be created in its office to work on self-referral cases from MBP and other health occupations boards.
- The main purpose of prohibiting self-referral is not the protection of public health, as is the purpose of MBP; rather, it is the prevention of what has been deemed as an inappropriate and self-serving method of gaining economic benefits.
- The power to grant a waiver under the self-referral law is vested in the Secretary of Health and Mental Hygiene, not with the individual health occupations boards.
- The self-referral law applies to all health occupations, not just physicians or allied health practitioners.

Recommendation 40: Uncodified language should be adopted requiring the board to work with the Maryland Insurance Administration, the Office of the Attorney General, and the Department of Health and Mental Hygiene's Office of the Inspector General to determine the appropriate entity for investigating and enforcing Maryland's Self-referral Law. Also, MBP should be required to report the findings to the Department of Legislative Services in a subsequent follow-up report.

Reporting by Hospitals and Other Entities

Inconsistent Enforcement Mechanisms among Facility Types

Under § 14-413 of the Maryland Medical Practice Act, each hospital and related institution in the State is required to report every six months to MBP regarding (1) disciplinary action taken against licensed physicians who are employed by the entity; or (2) denials of privileges to licensed physicians. Alternative health systems are required to submit similar reports to the board under § 14-414 of the Maryland Medical Practice Act. Both sections also require a court to report to MBP each conviction or entry of a plea of guilty or *nolo contendere* by a physician for any crime involving moral turpitude.

However, as can be seen in **Exhibit 5.1**, the enforcement mechanisms regarding these two sections of law are different. Under § 14-413, the board has authority to impose a civil fine for failure to report. The imposition of the civil fine is not mandatory and is at the discretion of the board. In contrast, authority to impose a civil fine against alternative health systems for failure to report under § 14-414 lies with the circuit courts of the State and is mandatory. Not only is this an issue because there are inconsistent enforcement mechanisms for similar reporting requirements, but the enforcement mechanisms for the court reporting are conflicting.

Exhibit 5.1 Reporting Requirements

	<u>Hospitals and Related Institutions</u>	<u>Alternative Health Systems</u>	<u>Courts</u>
Governing Statute	§ 14-413 of the Health Occupations Article	§ 14-414 of the Health Occupations Article	§§ 14-413 and 14-414 of the Health Occupations Article
Reporting Requirements	<ul style="list-style-type: none"> • Every 6 months • Action taken against licensed physicians 	<ul style="list-style-type: none"> • Every 6 months • Action taken against licensed physicians 	Convictions or entries of plea of guilty or <i>nolo contendere</i> by a physician for any crime involving moral turpitude
Enforcement	Board may impose civil penalty of up to \$5,000	Circuit court of the State must impose a civil penalty of up to \$5,000	1) Board may impose civil penalty of up to \$5,000 2) Circuit court of the State must impose a civil penalty of up to \$5,000

Source: §§ 14-413 and 14-414 of the Health Occupations Article

Recommendation 41: Statute should be amended to authorize MBP, rather than requiring the circuit courts, to impose civil fines against alternative health systems that fail to report as required so that the civil fine provisions related to reporting by hospitals and related institutions and alternative health systems are the same. Statute should be amended to clarify how the court reporting requirement is to be enforced and place the requirement in a separate statutory section.

Compliance with Reporting Requirement Is Low

While MBP has previously engaged and provided training to hospitals regarding the reporting requirements, since fiscal 2007, the board has only received 49 reports (36 from hospitals and 13 from other entities). Statute also requires hospitals, related institutions, alternative health systems, and employers to file a report with the board if a licensed respiratory care practitioner, radiation therapist, radiographer, radiologist assistant, nuclear medicine technician, polysomnographic technologist, physician assistant, or perfusionist is disciplined or terminated. This requirement is similar to the aforementioned requirement related to physicians.

It is unclear whether hospitals, related institutions, and alternative health systems are just not reporting as required or whether those facilities have not taken any action against physicians so there is nothing to report. Statute does not specify if the reporting requirement still applies if there have been no disciplinary actions taken in a given institution. Due to the low compliance rate, additional outreach may be warranted. Furthermore, the board has statutory authority to impose a civil fine against hospitals and related institutions for failure to report. In practice, however, the board has never issued such a fine. Board staff indicates this is because most of the entities that are not reporting are nursing homes and other smaller nonhospital entities that experience changes in ownership or go out of business. However, the reporting requirement does not depend on the ownership of an entity. Third, the board does not have a Report of Disciplinary Action form that may be retrieved and filed for allied health professionals that have been disciplined or terminated.

Recommendation 42: Statute should be amended to clarify that all entities required to report to the board under §§ 14-413 and 14-414 of the Health Occupations Article are to report every six months even if the institution has not taken disciplinary action against a licensee or denied privileges to a licensee. The board should simplify its reporting form and conduct outreach with the facilities on this issue. Furthermore, the board should (1) exercise its authority to assess civil fines against an entity that does not report as required under § 14-413; and (2) create and post on the board's website a Report of Disciplinary Action form that may be used to report when a licensed allied health professional is disciplined or terminated.

Regulation of Athletic Trainers Should Accommodate Conventional Practice

By statute, a licensed athletic trainer must enter into, and obtain board approval of, a written evaluation and treatment (E&T) protocol with a licensed physician to practice athletic training. The E&T protocol must include specified information, such as the settings where the athletic trainer may practice, physician supervision mechanisms that the physician will use to give direction to the athletic trainer, and the treatment procedures that the athletic trainer may perform. Statute specifies, moreover, that nothing in the title governing the practice of athletic training “may be construed to authorize an athletic trainer to practice except under the

supervision of a licensed physician and in an approved setting” (§ 14-50-11(a) of the Health Occupations Article). “Supervision” is defined as the “responsibility of a physician to provide ongoing and immediately available instruction that is adequate to ensure the safety and welfare of a patient and is appropriate to the setting” (§ 14-50-01(n) of the Health Occupations Article).

To reflect and accommodate the conventional practice of athletic training, the Athletic Trainer Advisory Committee and board have proposed regulations which allow an athletic trainer to accept an “outside referral” from a “nonsupervising physician” or other “licensed health care practitioner” if (1) the supervising physician specifies in the E&T protocol that the athletic trainer may accept referrals from nonsupervising physicians or other licensed health care practitioners; (2) the nonsupervising physician or licensed health care provider has seen the athlete and has written an order for the care; and (3) the “duties” are among the duties delegated in the E&T protocol. The proposed regulations define a “licensed health care practitioner” as an individual licensed under the Health Occupations Article. An “outside referral” is defined as a “request for treatment from a licensed health care practitioner, other than the supervising physician or designated alternate supervising physician of that athletic trainer.”

Statutes governing the practice of athletic training do not address whether, and the circumstances under which, an athletic trainer may accept a referral from a nonsupervising physician or licensed health care practitioner. By accepting a request for treatment from a nonsupervising physician or other licensed health care practitioner, an athletic trainer would seemingly be providing treatment under the direction of a practitioner with whom the athletic trainer has not entered into an E&T protocol. The proposed regulations attempt to resolve this by requiring a supervising physician to provide general authorization for referrals, making the supervising physician ultimately responsible for providing ongoing and immediately available instruction to an athletic trainer for treatment requested by another individual. It is unclear, however, whether this general authorization in an E&T protocol, and potentially arms-length supervision, is allowed under statute. If there are questions or issues relating to treatment, an athletic trainer would presumably consult the nonsupervising physician or other licensed health care practitioner requesting treatment and not the supervising physician who has not seen the patient or may be less familiar with the patient’s condition. In this circumstance, the supervising physician would provide minimal, if any, direction to the athletic trainer.

The reference to a “licensed health care practitioner” is particularly problematic for similar reasons. By allowing an athletic trainer to accept an outside referral from a licensed health care practitioner with minimal, if any, direct involvement of a supervising physician, the regulations may be authorizing an athletic trainer to practice athletic training without sufficient supervision of a licensed physician. There are, moreover, a variety of health care professionals licensed under the Health Occupations Article, such as chiropractors, nurses, occupational therapists, physician assistants, and podiatrists. Due to the spectrum of health care providers licensed under this article, DLS believes that the athletic trainer statute should be amended to specify whether an athletic trainer may accept an outside referral, the circumstances under which this may be done, and the licensed health care providers from whom an athletic trainer may accept referrals.

The DLS analysis of the proposed regulations for the Joint Committee on Administrative, Executive, and Legislative Review (AELR) echoes some of these concerns and raises additional issues. In that analysis, DLS notes that the regulations allow supervision by a physician in the form of “continuous availability to the athletic trainer” by one or more of the following means: on-site supervision, written instructions, electronic means, verbal orders, and designation of an “alternate supervising physician.”⁷ It is unclear, however, whether this kind of “continuous availability” – particularly by electronic means – is acceptable in light of the statutory definition of supervision, which is the responsibility to provide “ongoing and *immediately available* instruction that is adequate to ensure the safety and welfare of a patient and is appropriate to the setting.” (Emphasis added.) Board staff maintains that the supervision contemplated by statute is not “standard” supervision because a supervising physician is not responsible for what the athletic trainer actually does. Regulations allowing supervision by email, outside referrals, or the appointment of an alternate supervising physician in an emergency do not, therefore, conflict with statute. While this may be a credible interpretation, statutes should be amended to clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer.

Recommendation 43: To accommodate the conventional practice of athletic training, statute should be amended to (1) clarify that a supervising physician may authorize, in an E&T protocol, an athletic trainer to accept an outside referral from a nonsupervising physician or licensed health care practitioner; (2) specify the licensed health care practitioners from whom an athletic trainer may accept referrals; and (3) clarify the acceptable mechanisms that a physician may use to supervise an athletic trainer.

Board Should Clarify the Duties a Physician Assistant May Perform without Additional Approval by the Board

Section 15-401(b) of the Health Occupations Article prohibits a physician assistant (PA) from performing, attempting to perform, or offering to perform any delegated medical act beyond the scope of the license and which is consistent with a delegation agreement filed with the board. A delegation agreement is a document executed by a primary supervising physician and a PA that contains specified information, including (1) a description of the qualifications of the primary supervising physician and PA; (2) the settings in which the PA will practice; and (3) the delegated medical acts that are within the primary or alternate supervising physician’s scope of practice and require specialized education or training that is consistent with accepted

⁷As with the reference to referrals from a nonsupervising physician or a licensed health care practitioner, statutes governing athletic training also do not address whether, and the circumstances under which, a supervising physician may designate an alternate supervising physician. The proposed regulations establish that a designated alternate supervising physician may assume the role of the supervising physician by submitting a new E&T protocol to the board within 15 days in the event of a sudden departure, incapacity, or death of a supervising physician. As DLS suggests in the analysis to the AELR Committee, the proposed regulations should be revised to clarify that an athletic trainer is able to work, without interruption, during the 15-day period following the triggering event. The board should consider, moreover, whether an initial E&T protocol must identify the designated alternate supervising physician and include a signed acknowledgment of the designation by the alternate supervising physician.

medical practice. A supervising physician and PA must obtain additional board approval of a delegation agreement that includes “advanced duties.”

Chapter 274 of 2010 made significant changes to the process through which delegation agreements are reviewed and approved by the board. Prior to Chapter 274, a PA could not perform delegated medical acts until a delegation agreement received a favorable recommendation by the Physician Assistant Advisory Committee (PAAC) and the board had reviewed and approved agreement. Under Chapter 274, however, a PA need only file with the board an executed delegation agreement and receive acknowledgment of its receipt by the board to begin working if the agreement does not authorize a PA to perform advanced duties. Unlike before, PAAC no longer reviews delegation agreements that authorize a PA to perform core duties. Review of such agreements is performed by board staff.

Under Chapter 274, a delegation agreement to perform advanced duties must still be reviewed and approved by PAAC and the board before a PA may begin working. However, if a PA works in a hospital or ambulatory surgical facility and has been approved by the facility to perform advanced duties through the facility’s credentialing process, the PA is not required to obtain prior approval by PAAC and the board. A PA may begin work after the board receives the request to perform advanced duties and acknowledges receipt of the request to perform advanced duties. The board requires PAs in all practice settings to file a request to perform advanced duties as an addendum to the delegation agreement.

By statute, the board may disapprove any delegation agreement if it “believes” that the agreement does not meet statutory requirements or the PA is “unable to perform safely the delegated duties.” In recently adopted regulations, the board defines an “advanced duty” as a medical act that requires additional training beyond the basic PA education program required for licensure.⁸ Beyond this definition, which is also referenced on the board’s website and in its standard Delegation Agreement Addendum for Advanced Duties, there is little, if anything, to guide a PA in determining whether a medical act is an “advanced duty.” As a consequence, it is unclear when a PA must file an addendum request to perform advanced duties, and some PAs who merely file a delegation agreement to perform core duties may be performing medical acts outside of the scope of their agreement.

PAAC and board staff use an internal list of duties approved in the past to determine whether a requested duty requires additional PAAC and board review and approval. The internal list of advanced duties includes redundancies (procedures that differ in the manner they are described, but involve the same technique). Concerns have been expressed, moreover, that the process for determining whether a procedure is advanced is arbitrary and that a number of procedures deemed to be advanced are generally accepted as being within scope of a PA’s core training. Critics also expressed concern that the number of successful procedures required by PAAC and the board to demonstrate sufficient training to perform certain advanced procedures is

⁸In these regulations, the board also proposed to define “core duties” to mean “medical acts that are included in the standard curricula of accredited physician assistant education programs.”

arbitrary. PAAC has determined, for example, that the insertion of a central vein catheter is an advanced duty and that a PA must perform 15 successful procedures to demonstrate proficiency. Intubation of a patient, a procedure commonly performed by emergency medical technicians, has also been criticized as procedure deemed to be “advanced” for a PA.

PAAC is currently reviewing and revising its internal list of advanced duties to appropriately and consistently include duties that require additional training. PAAC and the board should complete the work necessary to refine this list. To guide PAs in determining whether to file an addendum and obtain board approval to perform a medical act, the board should post the list of advanced duties on the board’s website and include the list as an attachment to both the addendum application and delegation agreement application to perform core duties. If there is a question as to whether a medical act in a delegation agreement filed with the board constitutes an advanced duty, PAAC as a whole should make this determination. Board staff should refrain from the current practice of informally obtaining an opinion from the PAAC chair when making this determination. Moreover, PAAC and the board should adopt, with considerable input from PAs and supervising physicians from a variety of practice settings, regulations for determining what constitutes an advanced duty and how many successful procedures a PA must perform to be deemed able to safely perform a procedure.

Recommendation 44: Uncodified language should be adopted requiring the board, with considerable input from PAAC, physician assistants, and supervising physicians from a variety of practice settings, to adopt regulations on or before December 31, 2012, for determining (1) what constitutes an advanced duty; and (2) how many successful procedures a physician assistant must perform to be deemed able to safely perform a delegated medical act. In the meantime, PAAC should (1) complete its work in refining the list of advanced duties the board has approved in the past; (2) post the list of advanced duties on the board’s website; and (3) include the list as an attachment to both the addendum application and delegation agreement application to perform core duties. If there is a question as to whether a medical act in a delegation agreement filed with the board constitutes an advanced duty, PAAC as a whole should make the determination.

Regulations Should Allow Licensure of Specified Graduates of Unaccredited Radiation Therapy, Radiography, or Nuclear Medicine Technology Programs

The Radiation Therapy, Radiography, Nuclear Medicine Technology Advisory, and Radiology Assistance Committee (Rad Tech Advisory Committee) has statutory authority to review applications for licensure and make recommendations to the board. Exercising its authority, the Rad Tech Advisory Committee has regularly reviewed and approved educational credentials of individual students from unaccredited programs to provide a pathway to licensure. Of the several radiologic technology, radiation therapy, or nuclear medicine technology programs in the State, two programs are not currently accredited: Frederick Community College, which has a nuclear medicine technology program, and Howard Community College, which has a radiologic technology program.

In December 2010, the board adopted regulations (Code of Maryland Regulations, 10.32.10.04) that require an individual to successfully complete and graduate from a program which has been accredited by the Joint Review Committee on Education in Radiologic Technology (JRCERT) to obtain a license to practice radiation therapy or radiography. The regulations, similarly, require an individual to successfully complete and graduate from a program accredited by the Joint Review Committee on Educational Programs in Nuclear Medicine Technology (JRCNMT). The regulations grandfather individuals who were enrolled in an unaccredited program on April 1, 2010, and who graduated on or before June 30, 2011, if the board determines the program to be equivalent to programs meeting certain accreditation standards.

According to the director of the radiologic technology program at Howard Community College, students typically take four years to complete prerequisite, general education, and radiologic technology clinical courses. Frederick Community College's program has similar course requirements. Because these programs typically require four years to complete, students who enrolled in one of these unaccredited programs in the fall of 2010 will be unable to obtain a license when they graduate, though the regulations in place at the time they enrolled provided a pathway to licensure. As a matter of fair notice, students who enrolled in the fall of 2010 and have graduated from their programs in a timely manner should be afforded an opportunity to obtain a license to practice radiation therapy, radiography, or nuclear medicine technology in the State.

Recommendation 45: Uncodified language should be adopted that requires the board to license individuals who were enrolled in an unaccredited radiation therapy, radiography, or nuclear medicine technology program on October 1, 2010, and who graduate by June 30, 2014, provided that the individuals meet all other requirements for licensure.

Chapter 6. Conclusion

Several positive trends have been observed concerning the State Board of Physicians (MBP) and its related allied health advisory committees. Dedicated board and allied health advisory committee members continue to support MBP and its committees. Processing of licenses continues to be done efficiently. Also, the board has sufficient funds to support its activities. MBP has implemented several procedures regarding its complaint resolution process, such as more fully investigating complaints, which aids in the effective prosecution of those complaints, in an attempt to process complaints more efficiently and effectively.

Despite the progress made by MBP, significant challenges face MBP and its allied health advisory committees. Perhaps most significant is the growing backlog of complaints and the ongoing increase in the timeline for complaint resolution. The addition of new allied health professions to the jurisdiction of MBP raises the question of what the relationship between MBP and the respective allied health advisory committees and the role of the committees in regulating allied health professions should be. Another challenge facing the board is how effectively it balances the need for openness and transparency with the needs of licensees. Finally, whether the board is using its resources in the best way to meet these challenges continues to be an issue.

MBP plays a key role in protecting the public health and welfare, and there is no question that MBP and its allied health advisory committees should continue to exist. The purpose of this report and its recommendations is to help MBP and its committees improve their ability to protect the public health and welfare and meet the challenges facing them. However, based on past performance, the Department of Legislative Services (DLS) has significant concerns about whether the recommendations, especially those contained in legislation, will be complied with by MBP. The board has failed to implement key recommendations and requirements from previous sunset evaluations and sunset legislation. Also, DLS found that MBP fails to comply with several statutory requirements regarding (1) complaint investigation files; (2) provision of contact information on the board website regarding medical malpractice information; (3) obtaining peer review reports; (4) public disclosure of board filing of charges; and (5) compliance with the Open Meetings Act. The board additionally fails to adopt regulations even when required by law.

Based on these findings, DLS recommends that the termination dates of MBP and its allied health advisory committees only be extended for one year until July 1, 2014. Also, any statutory changes recommended in this evaluation should be implemented through legislation adopted in the 2012 session of the General Assembly. In the meantime, DLS should be required to make a recommendation regarding further extension to the Senate Education, Health, and Environmental Affairs and the House Health and Government Operations committees by October 1, 2013. The recommendation should be determined based on the progress of MBP in complying with the recommendations of this report and the submission of a follow-up report by MBP to DLS.

Recommendation 46: Statute should be amended to extend the termination date for the State Board of Physicians and the related allied health advisory committees until July 1, 2014. Further, uncodified language should be adopted to (1) require MBP to submit a follow-up report to the Department of Legislative Services by June 1, 2013, that addresses the implementation of the recommendations made in this report, including any issues specifically noted for inclusion in the subsequent follow-up report; and (2) require the Department of Legislative Services, by October 1, 2013, to make a recommendation to the Senate Education, Health, and Environmental Affairs and House Health and Government Operations committees regarding further extension of the termination dates based on the progress of MBP in complying with the recommendations of this report and the submission of the follow-up report by MBP.

Appendix 1. Draft Legislation

Bill No.: _____

Requested: _____

Committee: _____

Drafted by: Chilson

Typed by: Carol

Stored – 11/08/11

Proofread by ☒ _____Checked by ☒ _____By: **Leave Blank**

A BILL ENTITLED

1 AN ACT concerning

2 **State Board of Physicians and Allied Health Advisory Committees – Sunset**
 3 **Extension and Program Evaluation**

4 FOR the purpose of continuing the State Board of Physicians and certain allied health
 5 advisory committees in accordance with the provisions of the Maryland
 6 Program Evaluation Act (Sunset Law) by extending to a certain date the
 7 termination provisions relating to the statutory and regulatory authority of the
 8 Board and the committees; altering to a certain date the termination provision
 9 related to the Perfusion Advisory Committee; prohibiting an individual from
 10 being appointed to the Board or an allied health advisory committee under
 11 certain circumstances; repealing a certain provision of law regarding entry onto
 12 private premises for a certain purpose; authorizing the Board's executive
 13 director to apply for a certain search warrant under certain circumstances;
 14 specifying that the application for the warrant must meet certain requirements;
 15 authorizing a judge who receives a certain search warrant application to issue a
 16 warrant under certain circumstances; specifying that a certain search warrant
 17 must include certain information and be executed and returned to a certain
 18 person within a certain period of time; authorizing the Board to waive, under
 19 certain circumstances, certain training required for licensure; codifying the
 20 requirement that the Board provide certain individuals an opportunity to
 21 appear before the Board under certain circumstances; requiring the Board to
 22 disclose the filing of charges and initial denials of licensure on the Board's Web

 EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 site; requiring that physician license profiles include a summary of charges filed
2 against the physician and a copy of the charging document under certain
3 circumstances; requiring that license profiles include a certain disclaimer;
4 requiring the Board to include certain information on a license profile within a
5 certain time period; specifying that a certain report that certain entities are
6 required to file with the Board include certain information; authorizing the
7 Board to impose a certain civil penalty on an alternative health system that
8 fails to file a certain report; requiring the Board to remit a certain penalty to the
9 General Fund of the State; repealing the requirement that a circuit court of the
10 State impose a civil penalty on an alternative health system that fails to file a
11 certain report; specifying that a certain court reporting requirement is to be
12 enforced by the imposition of a certain fine by a circuit court of the State;
13 requiring the chairs of certain committees to serve in an advisory capacity to
14 the Board, report to the Board a certain number of times a year, and present to
15 the Board certain annual reports; requiring certain committees to submit an
16 annual report to the Board; requiring the Board to consider all
17 recommendations of certain committees, provide a certain explanation to the
18 committees under certain circumstances, and provide a certain report to the
19 committees a certain number of times each year; requiring the Board to create
20 and maintain a certain profile on certain licensees; requiring the profiles to
21 contain certain information; requiring the Board to forward a written copy of
22 certain profiles to a person under certain circumstances; requiring the Board to
23 maintain certain profiles on the Board's Web site; requiring the Board to
24 provide a mechanism for correcting errors in certain profiles; requiring the
25 Polysomnography Professional Standards Committee to elect a chair every
26 certain number of years; defining certain terms related to the practice of
27 athletic training in the State; altering a certain definition related to the practice
28 of athletic training in the State; authorizing an athletic trainer to accept an
29 outside referral from certain individuals under certain circumstances; repealing
30 the requirement that the Board assess a certain fee under certain
31 circumstances; requiring the Board and the Department of Health and Mental
32 Hygiene to develop and implement a certain strategy on or before a certain date;
33 requiring the Board to assess certain practices and submit a certain long-term
34 fiscal plan to the Department of Legislative Services on or before a certain date;
35 requiring the Board to develop and implement a certain recruitment plan on or
36 before a certain date; requiring the Board to amend the Board's regulations to
37 reflect the procedures of the Board on or before a certain date; requiring certain
38 entities to determine the appropriate entity to investigate and enforce certain

provisions of law on or before a certain date; requiring the Board, in consultation with certain persons, to adopt certain regulations on or before a certain date; requiring the Board to issue a license to an individual under a certain provision of law under certain circumstances; requiring the Board to submit a certain report to the Department of Legislative Services on or before a certain date; requiring the Department of Legislative Services to make certain recommendations to certain committees of the General Assembly on or before a certain date; providing for the effective date of certain provisions of this Act; and generally relating to the State Board of Physicians and the related allied health advisory committees.

BY adding to

Article – Health Occupations

Section 14–202(l), 14–206.1, 14–401(l), 14–416, 14–5A–06(e), 14–5A–18.1, 14–5B–05(f), 14–5B–15.1, 14–5C–06(d) and (e), 14–5C–18.1, 14–5D–05(f), 14–5D–16.1, 15–202(f), and 15–316.1

Annotated Code of Maryland

(2009 Replacement Volume and 2011 Supplement)

BY repealing and reenacting, with amendments,

Article – Health Occupations

Section 14–206(d)(1), 14–307(d) and (g), 14–411(i), 14–411.1(b), (c)(2), and (f), 14–413, 14–414, 14–5A–06(d), 14–5A–07, 14–5A–25, 14–5B–05(c), 14–5B–06, 14–5B–21, 14–5C–07, 14–5C–25, 14–5D–01, 14–5D–05(e), 14–5D–06, 14–5D–11, 14–5D–20, 14–702, 15–202(e), 15–205, and 15–502

Annotated Code of Maryland

(2009 Replacement Volume and 2011 Supplement)

BY repealing

Article – Health Occupations

Section 15–310(e)

Annotated Code of Maryland

(2009 Replacement Volume and 2011 Supplement)

BY repealing and reenacting, with amendments,

Article – Health Occupations

Section 14–5E–06(d), 14–5E–07, and 14–5E–25

Annotated Code of Maryland

(2009 Replacement Volume and 2011 Supplement)
(As enacted by Chapter 588 of the Acts of the General Assembly of 2011)

BY adding to
Article – Health Occupations
Section 14–5E–06(e) and 14–5E–18.1
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)
(As enacted by Chapter 588 of the Acts of the General Assembly of 2011)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
MARYLAND, That the Laws of Maryland read as follows:

Article – Health Occupations

14–202.

**(L) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE BOARD IF THE
INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD FOR
REMUNERATION.**

14–206.

(d) (1) If the entry is necessary to carry out a duty under this title, the
Board’s executive director or other duly authorized agent or investigator of the Board
may enter at any reasonable hour:

(i) A place of business of a licensed physician; **OR**

(ii) [Private premises where the Board suspects that a person
who is not licensed by the Board is practicing, attempting to practice, or offering to
practice medicine, based on a formal complaint; or

(iii)] Public premises.

14–206.1.

(A) THE BOARD'S EXECUTIVE DIRECTOR MAY APPLY TO A JUDGE OF THE DISTRICT COURT OR A CIRCUIT COURT FOR A SEARCH WARRANT TO ENTER PRIVATE PREMISES WHERE THE BOARD SUSPECTS THAT A PERSON WHO IS NOT LICENSED BY THE BOARD IS PRACTICING, ATTEMPTING TO PRACTICE, OR OFFERING TO PRACTICE MEDICINE, BASED ON A COMPLAINT RECEIVED BY THE BOARD.

(B) AN APPLICATION FOR A SEARCH WARRANT SHALL:

(1) BE IN WRITING;

(2) BE VERIFIED BY THE APPLICANT; AND

(3) DESCRIBE THE PREMISES TO BE SEARCHED AND THE NATURE, SCOPE, AND PURPOSE OF THE SEARCH.

(C) A JUDGE WHO RECEIVES AN APPLICATION FOR A SEARCH WARRANT MAY ISSUE A WARRANT ON A FINDING THAT:

(1) THE SCOPE OF THE PROPOSED SEARCH IS REASONABLE;

(2) THE REQUEST FOR A SEARCH WARRANT IS BASED ON A COMPLAINT RECEIVED BY THE BOARD; AND

(3) OBTAINING CONSENT TO ENTER THE PREMISES MAY JEOPARDIZE THE ATTEMPT TO DETERMINE WHETHER A PERSON WHO IS NOT LICENSED BY THE BOARD IS PRACTICING, ATTEMPTING TO PRACTICE, OR OFFERING TO PRACTICE MEDICINE.

(D) (1) A SEARCH WARRANT ISSUED UNDER THIS SECTION SHALL SPECIFY THE LOCATION OF THE PREMISES TO BE SEARCHED.

(2) A SEARCH CONDUCTED IN ACCORDANCE WITH A SEARCH WARRANT ISSUED UNDER THIS SECTION MAY NOT EXCEED THE LIMITS SPECIFIED IN THE WARRANT.

(E) A SEARCH WARRANT ISSUED UNDER THIS SECTION SHALL BE EXECUTED AND RETURNED TO THE ISSUING JUDGE:

**(1) WITHIN THE PERIOD SPECIFIED IN THE WARRANT, WHICH
MAY NOT EXCEED 30 DAYS FROM THE DATE OF ISSUANCE; OR**

**(2) WITHIN 15 DAYS AFTER THE WARRANT IS ISSUED, IF NO
PERIOD IS SPECIFIED IN THE WARRANT.**

14-307.

**(d) (1) Except as provided in § 14-308 of this subtitle AND PARAGRAPH
(2) OF THIS SUBSECTION, the applicant shall:**

[(1)] (i) 1. Have a degree of doctor of medicine from a medical
school that is accredited by an accrediting organization that the Board recognizes in
its regulations; and

[(ii)] 2. Submit evidence acceptable to the Board of successful
completion of 1 year of training in a postgraduate medical training program that is
accredited by an accrediting organization that the Board recognizes in its regulations;
or

[(2)] [(i)] (II) 1. Have a degree of doctor of osteopathy from a
school of osteopathy in the United States, its territories or possessions, Puerto Rico, or
Canada that has standards for graduation equivalent to those established by the
American Osteopathic Association; and

[(ii)] 2. Submit evidence acceptable to the Board of successful
completion of 1 year of training in a postgraduate medical training program accredited
by an accrediting organization that the Board recognizes in its regulations.

**(2) THE BOARD MAY WAIVE THE POSTGRADUATE MEDICAL
TRAINING REQUIREMENT IF THE APPLICANT HAS:**

**(I) TAUGHT FULL TIME IN A MEDICAL SCHOOL IN THE
UNITED STATES THAT IS ACCREDITED BY AN ACCREDITING ORGANIZATION
THAT THE BOARD RECOGNIZES IN ITS REGULATIONS; OR**

1 **(II) PRACTICED CLINICAL MEDICINE IN ANOTHER STATE OF**
2 **THE UNITED STATES OR CANADA.**

3 (g) **(1) [An] EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS**
4 **SUBSECTION, AN** applicant who has failed the examination or any part of the
5 examination 3 or more times shall submit evidence of having completed 1 year of
6 additional clinical training in an approved postgraduate training program following
7 the latest failure.

8 **(2) THE BOARD MAY WAIVE THE ADDITIONAL CLINICAL TRAINING**
9 **REQUIREMENT IF THE APPLICANT CAN DEMONSTRATE THAT:**

10 **(I) THE FAILURES RESULTED FROM A PHYSICAL,**
11 **EMOTIONAL, OR MENTAL CONDITION OR LEARNING DISABILITY;**

12 **(II) THE INDIVIDUAL HAS PRACTICED CLINICAL MEDICINE**
13 **IN ANOTHER STATE OF THE UNITED STATES OR CANADA; OR**

14 **(III) THE INDIVIDUAL IS CERTIFIED BY A CERTIFYING**
15 **ORGANIZATION THAT THE BOARD RECOGNIZES IN ITS REGULATIONS.**

16 14-401.

17 **(L) THE BOARD, IN CONDUCTING A CASE RESOLUTION CONFERENCE,**
18 **OR ITS SUCCESSOR, UNDER COMAR 10.32.02.03 SHALL PROVIDE AN**
19 **OPPORTUNITY TO APPEAR BEFORE THE BOARD TO BOTH THE LICENSEE WHO**
20 **HAS BEEN CHARGED AND THE INDIVIDUAL WHO HAS FILED THE COMPLAINT**
21 **AGAINST THE LICENSEE GIVING RISE TO THE CHARGE.**

22 14-411.

23 (i) Following the filing of charges or notice of initial denial of license
24 application, the Board shall disclose the filing to the public **ON THE BOARD'S WEB**
25 **SITE.**

26 14-411.1.

(b) The Board shall create and maintain a public individual profile on each licensee that includes the following information:

(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE THAT INCLUDES A COPY OF THE CHARGING DOCUMENT, UNTIL THE BOARD HAS TAKEN ACTION UNDER § 14-404 OF THIS SUBTITLE BASED ON THE CHARGES OR HAS RESCINDED THE CHARGES.

(2) A description of any disciplinary action taken by the Board against the licensee within the most recent 10-year period that includes a copy of the public order;

[(2)] (3) A description in summary form of any final disciplinary action taken by a licensing board in any other state or jurisdiction against the licensee within the most recent 10-year period;

[(3)] (4) The number of medical malpractice final court judgments and arbitration awards against the licensee within the most recent 10-year period for which all appeals have been exhausted as reported to the Board;

[(4)] (5) A description of a conviction or entry of a plea of guilty or nolo contendere by the licensee for a crime involving moral turpitude reported to the Board under § 14-413(b) of this subtitle; and

[(5)] (6) Medical education and practice information about the licensee including:

(i) The name of any medical school that the licensee attended and the date on which the licensee graduated from the school;

(ii) A description of any internship and residency training;

(iii) A description of any specialty board certification by a recognized board of the American Board of Medical Specialties or the American Osteopathic Association;

(iv) The name of any hospital where the licensee has medical privileges as reported to the Board under § 14-413 of this subtitle;

(v) The location of the licensee's primary practice setting; and

(vi) Whether the licensee participates in the Maryland Medical Assistance Program.

(c) In addition to the requirements of subsection (b) of this section, the Board shall:

(2) Include a statement on each licensee's profile of information to be taken into consideration by a consumer when viewing a licensee's profile, including factors to consider when evaluating a licensee's malpractice data **AND A DISCLAIMER STATING THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT BY THE BOARD**; and

(f) The Board shall include information relating to **CHARGES FILED AGAINST A LICENSEE BY THE BOARD** AND a final disciplinary action taken by the Board against a licensee in the licensee's profile within 10 days after **THE CHARGES ARE FILED OR** the action becomes final.

14-413.

(a) (1) Every 6 months, each hospital and related institution shall file with the Board a report that:

(i) Contains the name of each licensed physician who, during the 6 months preceding the report:

1. Is employed by the hospital or related institution;

2. Has privileges with the hospital or related institution;

and

3. Has applied for privileges with the hospital or related institution; [and]

(ii) States whether, as to each licensed physician, during the 6 months preceding the report:

1 1. The hospital or related institution denied the
2 application of a physician for staff privileges or limited, reduced, otherwise changed, or
3 terminated the staff privileges of a physician, or the physician resigned whether or not
4 under formal accusation, if the denial, limitation, reduction, change, termination, or
5 resignation is for reasons that might be grounds for disciplinary action under § 14–404
6 of this subtitle;

7 2. The hospital or related institution took any
8 disciplinary action against a salaried, licensed physician without staff privileges,
9 including termination of employment, suspension, or probation, for reasons that might
10 be grounds for disciplinary action under § 14–404 of this subtitle;

11 3. The hospital or related institution took any
12 disciplinary action against an individual in a postgraduate medical training program,
13 including removal from the training program, suspension, or probation for reasons
14 that might be grounds for disciplinary action under § 14–404 of this subtitle;

15 4. A licensed physician or an individual in a
16 postgraduate training program voluntarily resigned from the staff, employ, or training
17 program of the hospital or related institution for reasons that might be grounds for
18 disciplinary action under § 14–404 of this subtitle; or

19 5. The hospital or related institution placed any other
20 restrictions or conditions on any of the licensed physicians as listed in items 1 through
21 4 of this subparagraph for any reasons that might be grounds for disciplinary action
22 under § 14–404 of this subtitle; AND

23 **(III) STATES THAT NO ACTION WAS TAKEN AGAINST THE**
24 **LICENSED PHYSICIAN IF THE HOSPITAL OR RELATED INSTITUTION DID NOT**
25 **TAKE ACTION AGAINST THE LICENSED PHYSICIAN DURING THE PERIOD**
26 **COVERED BY THE REPORT.**

27 (2) The hospital or related institution shall:

28 (i) Submit the report within 10 days of any action described in
29 paragraph (1)(ii) of this subsection; and

(ii) State in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned.

(3) The Board may extend the reporting time under this subsection for good cause shown.

(4) The minutes or notes taken in the course of determining the denial, limitation, reduction, or termination of the staff privileges of any physician in a hospital or related institution are not subject to review or discovery by any person.

[(b) (1) Each court shall report to the Board each conviction of or entry of a plea of guilty or nolo contendere by a physician for any crime involving moral turpitude.

(2) The court shall submit the report within 10 days of the conviction or entry of the plea.]

[(c)] (B) The Board may enforce this section by subpoena.

[(d)] (C) Any person shall have the immunity from liability described under § 5–715(d) of the Courts and Judicial Proceedings Article for giving any of the information required by this section.

[(e)] (D) A report made under this section is not subject to subpoena or discovery in any civil action other than a proceeding arising out of a hearing and decision of the Board under this title.

[(f)] (E) (1) The Board may impose a civil penalty of up to \$5,000 for failure to report under this section.

(2) The Board shall remit any penalty collected under this subsection into the General Fund of the State.

14–414.

(a) (1) Every 6 months, each alternative health system as defined in § 1–401 of this article shall file with the Board a report that:

(i) Contains the name of each licensed physician who, during the 6 months preceding the report:

1. Is employed by the alternative health system;
2. Is under contract with the alternative health system;
- and
3. Has completed a formal application process to become under contract with the alternative health system; [and]

(ii) States whether, as to each licensed physician, during the 6 months preceding the report:

1. The alternative health system denied the formal application of a physician to contract with the alternative health system or limited, reduced, otherwise changed, or terminated the contract of a physician, or the physician resigned whether or not under formal accusation, if the denial, limitation, reduction, change, termination, or resignation is for reasons that might be grounds for disciplinary action under § 14–404 of this subtitle; or
2. The alternative health system placed any other restrictions or conditions on any licensed physician for any reasons that might be grounds for disciplinary action under § 14–404 of this subtitle; AND

(III) STATES THAT NO ACTION WAS TAKEN AGAINST THE LICENSED PHYSICIAN IF THE ALTERNATIVE HEALTH SYSTEM DID NOT TAKE ACTION AGAINST THE LICENSED PHYSICIAN DURING THE PERIOD COVERED BY THE REPORT.

(2) The alternative health system shall:

- (i) Submit the report within 10 days of any action described in paragraph (1)(ii) of this subsection; and
- (ii) State in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned.

(3) The Board may extend the reporting time under this subsection for good cause shown.

(4) The minutes or notes taken in the course of determining the denial, limitation, reduction, or termination of the employment contract of any physician in an alternative health system are not subject to review or discovery by any person.

[(b) (1) Each court shall report to the Board each conviction of or entry of a plea of guilty or nolo contendere by a physician for any crime involving moral turpitude.

(2) The court shall submit the report within 10 days of the conviction or entry of the plea.]

[(c)] (B) The Board may enforce this section by subpoena.

[(d)] (C) Any person shall have the immunity from liability described under § 5–715(d) of the Courts and Judicial Proceedings Article for giving any of the information required by this section.

[(e)] (D) A report made under this section is not subject to subpoena or discovery in any civil action other than a proceeding arising out of a hearing and decision of the Board under this title.

[(f)] (E) (1) [Failure to report pursuant to the requirements of this section shall result in imposition of a civil penalty of up to \$5,000 by a circuit court of this State] **THE BOARD MAY IMPOSE A CIVIL PENALTY OF UP TO \$5,000 FOR FAILURE TO REPORT UNDER THIS SECTION.**

(2) THE BOARD SHALL REMIT ANY PENALTY COLLECTED UNDER THIS SUBSECTION INTO THE GENERAL FUND OF THE STATE.

14–416.

(A) (1) EACH COURT SHALL REPORT TO THE BOARD EACH CONVICTION OF OR ENTRY OF A PLEA OF GUILTY OR NOLO CONTENDERE BY A PHYSICIAN FOR ANY CRIME INVOLVING MORAL TURPITUDE.

1 **(2) THE COURT SHALL SUBMIT THE REPORT WITHIN 10 DAYS OF**
2 **THE CONVICTION OR ENTRY OF THE PLEA.**

3 **(B) FAILURE TO REPORT PURSUANT TO THE REQUIREMENTS OF THIS**
4 **SECTION SHALL RESULT IN IMPOSITION OF A CIVIL PENALTY OF UP TO \$5,000**
5 **BY A CIRCUIT COURT OF THE STATE.**

6 14-5A-06.

7 (d) **(1)** From among its members, the Committee shall elect a chair once
8 every 2 years.

9 **(2) THE CHAIR SHALL:**

10 **(I) SERVE IN AN ADVISORY CAPACITY TO THE BOARD AS A**
11 **REPRESENTATIVE OF THE COMMITTEE;**

12 **(II) REPORT TO THE BOARD TWICE A YEAR ON THE**
13 **ACTIVITIES OF THE COMMITTEE; AND**

14 **(III) PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL**
15 **REPORT.**

16 **(E) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF**
17 **THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD**
18 **FOR REMUNERATION.**

19 14-5A-07.

20 **(A)** In addition to the powers set forth elsewhere in this subtitle, the
21 Committee shall:

22 (1) Develop and recommend to the Board regulations to carry out the
23 provisions of this subtitle;

24 (2) Develop and recommend to the Board a code of ethics for the
25 practice of respiratory care for adoption by the Board;

(3) If requested, develop and recommend to the Board standards of care for the practice of respiratory care;

(4) Develop and recommend to the Board the requirements for licensure as a respiratory care practitioner;

(5) Evaluate the credentials of applicants as necessary and recommend licensure of applicants who fulfill the requirements for a license to practice respiratory care;

(6) Develop and recommend to the Board continuing education requirements for license renewal;

(7) Provide the Board with recommendations concerning the practice of respiratory care;

(8) Develop and recommend to the Board criteria related to the practice of respiratory care in the home setting; [and]

(9) Keep a record of its proceedings; AND

(10) SUBMIT AN ANNUAL REPORT TO THE BOARD.

(B) THE BOARD SHALL:

(1) CONSIDER ALL RECOMMENDATIONS OF THE COMMITTEE AND PROVIDE A WRITTEN EXPLANATION OF THE BOARD'S REASONS FOR REJECTING OR MODIFYING THE COMMITTEE'S RECOMMENDATIONS; AND

(2) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT ON THE DISCIPLINARY MATTERS INVOLVING LICENSEES.

14-5A-18.1.

(A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL DENIAL OF A LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO THE PUBLIC ON THE BOARD'S WEB SITE.

1 **(B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL**
2 **PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:**

3 **(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE**
4 **THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS**
5 **TAKEN ACTION UNDER § 14-5A-17 OF THIS SUBTITLE BASED ON THE CHARGES**
6 **OR HAS RESCINDED THE CHARGES;**

7 **(2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE**
8 **BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD**
9 **THAT INCLUDES A COPY OF THE PUBLIC ORDER;**

10 **(3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL**
11 **DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR**
12 **JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR**
13 **PERIOD;**

14 **(4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF**
15 **GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING**
16 **MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 14-5A-17(C) OF THIS**
17 **SUBTITLE; AND**

18 **(5) THE PUBLIC ADDRESS OF THE LICENSEE.**

19 **(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS**
20 **SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S**
21 **PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER**
22 **WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING**
23 **THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT**
24 **BY THE BOARD.**

25 **(D) THE BOARD:**

26 **(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S**
27 **PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE**
28 **PROFILE TO THE PERSON; AND**

(2) SHALL MAINTAIN A WEB SITE THAT SERVES AS A SINGLE POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE TO THE PUBLIC ON THE INTERNET.

(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S PROFILE.

(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES FINAL.

14-5A-25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14-702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2013] **2014**.

14-5B-05.

(c) (1) From among its members, the Committee shall elect a chair once every 2 years.

(2) THE CHAIR SHALL:

(I) SERVE IN AN ADVISORY CAPACITY TO THE BOARD AS A REPRESENTATIVE OF THE COMMITTEE;

(II) REPORT TO THE BOARD TWICE A YEAR ON THE ACTIVITIES OF THE COMMITTEE; AND

(III) PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL REPORT.

1 **(F) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF**
2 **THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD**
3 **FOR REMUNERATION.**

4 14-5B-06.

5 **(A)** In addition to the powers set forth elsewhere in this subtitle, the
6 Committee shall:

7 (1) Make recommendations to the Board on regulations necessary to
8 carry out the provisions of this subtitle;

9 (2) Make recommendations to the Board on a code of ethics for the
10 practice of radiation therapy, the practice of radiography, the practice of nuclear
11 medicine technology, and the practice of radiology assistance for adoption by the
12 Board;

13 (3) On request, make recommendations to the Board on standards of
14 care for the practice of radiation therapy, the practice of radiography, the practice of
15 nuclear medicine technology, and the practice of radiology assistance;

16 (4) Make recommendations to the Board on the requirements for
17 licensure as a radiation therapist, radiographer, nuclear medicine technologist, or
18 radiologist assistant;

19 (5) On request, review applications for licensure as a radiation
20 therapist, radiographer, nuclear medicine technologist, or radiologist assistant and
21 make recommendations to the Board;

22 (6) Develop and recommend to the Board continuing education
23 requirements for license renewal;

24 (7) Advise the Board on matters related to the practice of radiation
25 therapy, the practice of radiography, the practice of nuclear medicine technology, and
26 the practice of radiology assistance; [and]

27 (8) Keep a record of its proceedings; **AND**

1 **(9) SUBMIT AN ANNUAL REPORT TO THE BOARD.**

2 **(B) THE BOARD SHALL:**

3 **(1) CONSIDER ALL RECOMMENDATIONS OF THE COMMITTEE AND**
4 **PROVIDE A WRITTEN EXPLANATION OF THE BOARD'S REASONS FOR REJECTING**
5 **OR MODIFYING THE COMMITTEE'S RECOMMENDATIONS; AND**

6 **(2) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT ON**
7 **THE DISCIPLINARY MATTERS INVOLVING LICENSEES.**

8 **14-5B-15.1.**

9 **(A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL**
10 **DENIAL OF LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO**
11 **THE PUBLIC ON THE BOARD'S WEB SITE.**

12 **(B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL**
13 **PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:**

14 **(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE**
15 **THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS**
16 **TAKEN ACTION UNDER § 14-5B-14 OF THIS SUBTITLE BASED ON THE CHARGES**
17 **OR HAS RESCINDED THE CHARGES;**

18 **(2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE**
19 **BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD**
20 **THAT INCLUDES A COPY OF THE PUBLIC ORDER;**

21 **(3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL**
22 **DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR**
23 **JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR**
24 **PERIOD;**

25 **(4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF**
26 **GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING**
27 **MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 14-5B-14(c) OF THIS**
28 **SUBTITLE; AND**

(5) THE PUBLIC ADDRESS OF THE LICENSEE.

(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT BY THE BOARD.

(D) THE BOARD:

(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE PROFILE TO THE PERSON; AND

(2) SHALL MAINTAIN A WEB SITE THAT SERVES AS A SINGLE POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE TO THE PUBLIC ON THE INTERNET.

(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S PROFILE.

(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES FINAL.

14-5B-21.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, and subject to the termination of this title under § 14-702 of this title, this subtitle and all rules and regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2013] **2014**.

14-5C-06.

1 **(D) (1) FROM AMONG ITS MEMBERS, THE COMMITTEE SHALL ELECT**
2 **A CHAIR ONCE EVERY 2 YEARS.**

3 **(2) THE CHAIR SHALL:**

4 **(I) SERVE IN AN ADVISORY CAPACITY TO THE BOARD AS A**
5 **REPRESENTATIVE OF THE COMMITTEE;**

6 **(II) REPORT TO THE BOARD TWICE A YEAR ON THE**
7 **ACTIVITIES OF THE COMMITTEE; AND**

8 **(III) PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL**
9 **REPORT.**

10 **(E) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF**
11 **THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD**
12 **FOR REMUNERATION.**

13 14-5C-07.

14 **(A) In addition to the powers set forth elsewhere in this subtitle, the**
15 **Committee shall:**

16 (1) Develop and recommend to the Board regulations to carry out the
17 provisions of this subtitle;

18 (2) Develop and recommend to the Board a code of ethics for the
19 practice of polysomnography for adoption by the Board;

20 (3) Develop and recommend to the Board standards of care for the
21 practice of polysomnography;

22 (4) Develop and recommend to the Board the requirements for
23 licensure as a polysomnographic technologist, including:

24 (i) Criteria for the educational and clinical training of licensed
25 polysomnographic technologists; and

1 (ii) Criteria for a professional competency examination and
2 testing of applicants for a license to practice polysomnography;

3 (5) Develop and recommend to the Board criteria for licensed
4 polysomnographic technologists who are licensed in other states to practice in this
5 State;

6 (6) Evaluate the accreditation status of education programs in
7 polysomnography for approval by the Board;

8 (7) Evaluate the credentials of applicants and recommend licensure of
9 applicants who fulfill the requirements for a license to practice polysomnography;

10 (8) Develop and recommend to the Board continuing education
11 requirements for license renewal;

12 (9) Provide the Board with recommendations concerning the practice
13 of polysomnography;

14 (10) Develop and recommend to the Board criteria for the direction of
15 students in clinical education programs by licensed polysomnographic technologists
16 and licensed physicians;

17 (11) Keep a record of its proceedings; and

18 (12) Submit an annual report to the Board.

19 **(B) THE BOARD SHALL:**

20 **(1) CONSIDER ALL RECOMMENDATIONS OF THE COMMITTEE AND**
21 **PROVIDE A WRITTEN EXPLANATION OF THE BOARD'S REASONS FOR REJECTING**
22 **OR MODIFYING THE COMMITTEE'S RECOMMENDATIONS; AND**

23 **(2) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT ON**
24 **THE DISCIPLINARY MATTERS INVOLVING LICENSEES.**

25 **14-5C-18.1.**

(A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL DENIAL OF LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO THE PUBLIC ON THE BOARD'S WEB SITE.

(B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:

(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS TAKEN ACTION UNDER § 14-5C-17 OF THIS SUBTITLE BASED ON THE CHARGES OR HAS RESCINDED THE CHARGES;

(2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD THAT INCLUDES A COPY OF THE PUBLIC ORDER;

(3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD;

(4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 14-5C-17(C) OF THIS SUBTITLE; AND

(5) THE PUBLIC ADDRESS OF THE LICENSEE.

(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT BY THE BOARD.

(D) THE BOARD:

(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE PROFILE TO THE PERSON; AND

(2) SHALL MAINTAIN A WEB SITE THAT SERVES AS A SINGLE POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE TO THE PUBLIC ON THE INTERNET.

(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S PROFILE.

(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES FINAL.

14-5C-25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14-702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2013] **2014**.

14-5D-01.

(a) In this subtitle the following words have the meanings indicated.

(b) "Athlete" means an individual who participates in an athletic activity.

(c) "Athletic activity" means exercise, recreation, sport, competition, or game that:

(1) Requires physical strength, range of motion, flexibility, control, speed, stamina, or agility; and

(2) Is associated with an educational institution or a professional, amateur, or recreational sports club or athletic organization.

(d) “Athletic injury” means an injury that affects an athlete’s participation or performance in an athletic activity.

(e) “Board” means the State Board of Physicians.

(f) “Committee” means the Athletic Trainer Advisory Committee established under § 14–5D–04 of this subtitle.

(g) “Educational institution” includes:

(1) The schools in the public elementary and secondary education system of the State;

(2) A noncollegiate educational institution governed under § 2–206 of the Education Article; and

(3) An institution of higher education as defined in § 10–101 of the Education Article.

(h) “Evaluation and treatment protocol” means a document that is executed by a physician and an athletic trainer that meets the requirements of § 14–5D–11 of this subtitle.

(i) “License” means a license issued by the Board to practice athletic training.

(j) “Licensed athletic trainer” means an individual who is licensed by the Board to practice athletic training.

(K) “LICENSED HEALTH CARE PRACTITIONER” MEANS:

(1) A CHIROPRACTOR LICENSED UNDER TITLE 3 OF THIS ARTICLE;

1 (2) A NURSE PRACTITIONER CERTIFIED UNDER TITLE 8 OF THIS
2 ARTICLE;

3 (3) A PHYSICAL THERAPIST LICENSED UNDER TITLE 13 OF THIS
4 ARTICLE; OR

5 (4) A PHYSICIAN ASSISTANT LICENSED UNDER TITLE 15 OF THIS
6 ARTICLE.

7 [(k)] (L) “National certifying board” means the National Athletic Trainers’
8 Association Board of Certification, Inc., or its successor organization.

9 (M) “NONSUPERVISING PHYSICIAN” MEANS A PHYSICIAN LICENSED BY
10 THE BOARD WHO IS NOT THE SUPERVISING PHYSICIAN OF THE LICENSED
11 ATHLETIC TRAINER.

12 (N) “OUTSIDE REFERRAL” MEANS A REQUEST FOR TREATMENT FROM A
13 NONSUPERVISING PHYSICIAN OR LICENSED HEALTH CARE PRACTITIONER.

14 [(l)] (O) (1) “Practice athletic training” means application of the
15 following principles and methods for managing athletic injuries for athletes in good
16 overall health under the supervision of a licensed physician:

17 (i) Prevention;

18 (ii) Clinical evaluation and assessment;

19 (iii) Immediate care; and

20 (iv) Treatment, rehabilitation, and reconditioning.

21 (2) “Practice athletic training” includes:

22 (i) Organization and administration of an athletic training
23 program; and

24 (ii) Instruction to coaches, athletes, parents, medical personnel,
25 and community members regarding the care and prevention of athletic injuries.

(3) “Practice athletic training” does not include:

(i) The practice of:

1. Chiropractic, including adjustments, manipulation, or high velocity mobilizations of the spine or extremities;

2. Massage therapy;

3. Medicine;

4. Occupational therapy; or

5. Physical therapy;

(ii) The reconditioning of systemic neurologic injuries, conditions, or disease; or

(iii) Except for the conditioning of an athlete under the supervision of a treating physician, the treatment, rehabilitation, or reconditioning of nonathletic injuries or disease.

[(m)] (P) “Setting” means a:

(1) Location where an athletic activity, as defined in subsection (c) of this section, is being held;

(2) Health or fitness club;

(3) Clinic or hospital;

(4) Corporation; or

(5) Government agency.

[(n)] (Q) “Supervision” means the responsibility of a physician to provide ongoing and immediately available instruction, **IN PERSON, BY TELEPHONE, OR BY**

1 **OTHER ELECTRONIC MEANS**, that is adequate to ensure the safety and welfare of a
2 patient and is appropriate to the setting.

3 14-5D-05.

4 (e) (1) From among its members, the Committee shall elect a chair every
5 2 years.

6 (2) **THE CHAIR SHALL:**

7 (I) **SERVE IN AN ADVISORY CAPACITY TO THE BOARD AS A**
8 **REPRESENTATIVE OF THE COMMITTEE;**

9 (II) **REPORT TO THE BOARD TWICE A YEAR ON THE**
10 **ACTIVITIES OF THE COMMITTEE; AND**

11 (III) **PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL**
12 **REPORT.**

13 (F) **AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF**
14 **THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD**
15 **FOR REMUNERATION.**

16 14-5D-06.

17 (A) In addition to the powers set forth elsewhere in this subtitle, the
18 Committee shall:

19 (1) Develop and recommend to the Board regulations to carry out this
20 subtitle;

21 (2) Develop and recommend to the Board continuing education
22 requirements for license renewal;

23 (3) Provide the Board with recommendations concerning the practice
24 of athletic training;

(4) Develop and recommend to the Board an evaluation and treatment protocol for use by an athletic trainer and the physician with whom the athletic trainer practices;

(5) Provide advice and recommendations to the Board on individual evaluation and treatment protocols when requested; [and]

(6) Keep a record of its proceedings; AND

(7) SUBMIT AN ANNUAL REPORT TO THE BOARD.

(B) THE BOARD SHALL:

(1) CONSIDER ALL RECOMMENDATIONS OF THE COMMITTEE AND PROVIDE A WRITTEN EXPLANATION OF THE BOARD'S REASONS FOR REJECTING OR MODIFYING THE COMMITTEE'S RECOMMENDATIONS; AND

(2) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT ON THE DISCIPLINARY MATTERS INVOLVING LICENSEES.

14-5D-11.

(a) Nothing in this title may be construed to authorize an athletic trainer to practice except under the supervision of a licensed physician and in an approved setting **OR AS PROVIDED IN SUBSECTION (D) OF THIS SECTION.**

(b) Before an athletic trainer may practice athletic training, the athletic trainer shall:

(1) Obtain a license under this subtitle;

(2) Enter into a written evaluation and treatment protocol with a licensed physician; and

(3) Obtain Board approval of the evaluation and treatment protocol.

(c) An evaluation and treatment protocol shall:

(1) Describe the qualifications of the licensed physician and licensed athletic trainer;

(2) Describe the settings where the athletic trainer may practice;

(3) Describe the physician supervision mechanisms that the physician will use to give direction to the athletic trainer; and

(4) Specify the treatment procedures the athletic trainer may perform.

(D) AN ATHLETIC TRAINER MAY ACCEPT AN OUTSIDE REFERRAL FROM A NONSUPERVISING PHYSICIAN OR LICENSED HEALTH CARE PRACTITIONER IF:

(1) THE SUPERVISING PHYSICIAN SPECIFIES IN THE EVALUATION AND TREATMENT PROTOCOL THAT THE ATHLETIC TRAINER MAY ACCEPT REFERRALS FROM A NONSUPERVISING PHYSICIAN OR LICENSED HEALTH CARE PRACTITIONER;

(2) THE NONSUPERVISING PHYSICIAN OR LICENSED HEALTH CARE PRACTITIONER HAS SEEN THE ATHLETE AND HAS WRITTEN AN ORDER FOR THE CARE OF THE ATHLETE; AND

(3) THE TREATMENT PROCEDURES TO BE USED BY THE ATHLETIC TRAINER ARE:

(I) WITHIN THE SCOPE OF PRACTICE OF AN ATHLETIC TRAINER; AND

(II) INCLUDED IN THE EVALUATION AND TREATMENT PROTOCOL THAT THE ATHLETIC TRAINER HAS ENTERED INTO WITH THE SUPERVISING PHYSICIAN.

14-5D-16.1.

(A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL DENIAL OF LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO THE PUBLIC ON THE BOARD'S WEB SITE.

1 **(B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL**
2 **PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:**

3 **(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE**
4 **THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS**
5 **TAKEN ACTION UNDER § 14-5D-14 OF THIS SUBTITLE BASED ON THE CHARGES**
6 **OR HAS RESCINDED THE CHARGES.**

7 **(2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE**
8 **BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD**
9 **THAT INCLUDES A COPY OF THE PUBLIC ORDER;**

10 **(3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL**
11 **DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR**
12 **JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR**
13 **PERIOD;**

14 **(4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF**
15 **GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING**
16 **MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 14-5D-14(B) OF THIS**
17 **SUBTITLE; AND**

18 **(5) THE PUBLIC ADDRESS OF THE LICENSEE.**

19 **(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS**
20 **SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S**
21 **PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER**
22 **WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING**
23 **THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT**
24 **BY THE BOARD.**

25 **(D) THE BOARD:**

26 **(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S**
27 **PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE**
28 **PROFILE TO THE PERSON; AND**

1 **(2) SHALL MAINTAIN A WEB SITE THAT SERVES AS A SINGLE**
2 **POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE**
3 **TO THE PUBLIC ON THE INTERNET.**

4 **(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION**
5 **AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S**
6 **PROFILE.**

7 **(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES**
8 **FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION**
9 **TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE**
10 **WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES**
11 **FINAL.**

12 14-5D-20.

13 Subject to the evaluation and reestablishment provisions of the Maryland
14 Program Evaluation Act and subject to the termination of this title under § 14-702 of
15 this title, this subtitle and all rules and regulations adopted under this subtitle shall
16 terminate and be of no effect after July 1, [2013] **2014.**

17 14-702.

18 Subject to the evaluation and reestablishment provisions of the Program
19 Evaluation Act, this title and all rules and regulations adopted under this title shall
20 terminate and be of no effect after July 1, [2013] **2014.**

21 15-202.

22 (e) The chairperson shall:

23 **(1) [serve] SERVE** in an advisory capacity to the Board as a
24 **representative of the Committee;**

25 **(2) REPORT TO THE BOARD TWICE A YEAR ON THE ACTIVITIES OF**
26 **THE COMMITTEE; AND**

1 **(3) PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL**
2 **REPORT.**

3 **(F) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF**
4 **THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD**
5 **FOR REMUNERATION.**

6 15–205.

7 (a) In addition to the powers set forth elsewhere in this title, the Committee,
8 on its initiative or on the Board's request, may:

9 (1) Recommend to the Board regulations for carrying out the
10 provisions of this title;

11 (2) Recommend to the Board approval, modification, or disapproval of
12 an application for licensure or a delegation agreement;

13 (3) Report to the Board any conduct of a supervising physician or a
14 physician assistant that may be cause for disciplinary action under this title or under
15 § 14–404 of this article; and

16 (4) Report to the Board any alleged unauthorized practice of a
17 physician assistant.

18 **(B) THE COMMITTEE SHALL SUBMIT AN ANNUAL REPORT TO THE**
19 **BOARD.**

20 **[(b)] (C)** (1) In addition to the duties set forth elsewhere in this title, the
21 Board shall adopt regulations to carry out the provisions of this title.

22 (2) The Board shall:

23 (i) Consider all recommendations of the Committee; **[and]**

24 (ii) Provide a written explanation of the Board's reasons for
25 rejecting or modifying the Committee's recommendations; **AND**

**(III) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT
ON THE DISCIPLINARY MATTERS INVOLVING LICENSEES.**

(3) The Board may:

(i) Investigate any alleged unauthorized practice of a physician assistant;

(ii) Investigate any conduct that may be cause for disciplinary action under this title; and

(iii) On receipt of a written and signed complaint, including a referral from the Commissioner of Labor and Industry, conduct an unannounced inspection of the office of a physician assistant, other than an office of a physician assistant in a hospital, related institution, freestanding medical facility, or freestanding birthing center, to determine compliance at that office with the Centers for Disease Control and Prevention's guidelines on universal precautions.

(4) If the entry is necessary to carry out a duty under this subtitle, including an investigation or determination of compliance as provided under paragraph (3) of this subsection and an audit to determine compliance with the Board's requirements with respect to physician assistant practice, the Executive Director of the Board or other duly authorized agent or investigator may enter at any reasonable hour a place of business of a licensed physician or a licensed physician assistant or public premises.

(5) (i) A person may not deny or interfere with an entry under this subsection.

(ii) A person who violates any provision of this subsection is guilty of a misdemeanor and on conviction is subject to a fine not exceeding \$100.

15-310.

[(e) The Board shall assess each applicant for a license or the renewal of a license to practice as a physician assistant, a fee set by the Board sufficient to fund the activities of the Board's rehabilitation program under § 14-401(g) of this article in conducting a physician assistant rehabilitation program.]

15-316.1.

(A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL DENIAL OF LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO THE PUBLIC ON THE BOARD'S WEB SITE.

(B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:

(1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS TAKEN ACTION UNDER § 15-314 OF THIS SUBTITLE BASED ON THE CHARGES OR HAS RESCINDED THE CHARGES;

(2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD THAT INCLUDES A COPY OF THE PUBLIC ORDER;

(3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD;

(4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 15-314(B) OF THIS SUBTITLE; AND

(5) THE PUBLIC ADDRESS OF THE LICENSEE.

(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT BY THE BOARD.

(D) THE BOARD:

(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE PROFILE TO THE PERSON; AND

(2) SHALL MAINTAIN A WEB SITE THAT SERVES AS A SINGLE POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE TO THE PUBLIC ON THE INTERNET.

(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S PROFILE.

(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES FINAL.

15-502.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act, this title and all regulations adopted under this title shall terminate and be of no effect after July 1, [2013] **2014**.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health Occupations

14-5E-06.

(d) (1) From among its members, the Committee shall elect a chair every 2 years.

(2) THE CHAIR SHALL:

1 (I) SERVE IN AN ADVISORY CAPACITY TO THE BOARD AS A
2 REPRESENTATIVE OF THE COMMITTEE;

3 (II) REPORT TO THE BOARD TWICE A YEAR ON THE
4 ACTIVITIES OF THE COMMITTEE; AND

5 (III) PRESENT TO THE BOARD THE COMMITTEE'S ANNUAL
6 REPORT.

7 (E) AN INDIVIDUAL MAY NOT BE APPOINTED TO THE COMMITTEE IF
8 THE INDIVIDUAL IS PROVIDING OR HAS PROVIDED SERVICES TO THE BOARD
9 FOR REMUNERATION.

10 14-5E-07.

11 (A) In addition to the powers set forth elsewhere in this subtitle, the
12 Committee shall:

13 (1) Develop and recommend to the Board:

14 (i) Regulations to carry out the provisions of this subtitle;

15 (ii) A code of ethics for the practice of perfusion for adoption by
16 the Board;

17 (iii) Recommendations concerning the practice of perfusion,
18 including standards of care for the practice of perfusion; and

19 (iv) Continuing education requirements for license renewal;
20 [and]

21 (2) Keep a record of its proceedings; AND

22 (3) SUBMIT AN ANNUAL REPORT TO THE BOARD.

23 (B) THE BOARD SHALL:

1 (1) CONSIDER ALL RECOMMENDATIONS OF THE COMMITTEE AND
2 PROVIDE A WRITTEN EXPLANATION OF THE BOARD'S REASONS FOR REJECTING
3 OR MODIFYING THE COMMITTEE'S RECOMMENDATIONS; AND

4 (2) PROVIDE TO THE COMMITTEE TWICE A YEAR A REPORT ON
5 THE DISCIPLINARY MATTERS INVOLVING LICENSEES.

6 14-5E-18.1.

7 (A) FOLLOWING THE FILING OF CHARGES OR NOTICE OF INITIAL
8 DENIAL OF LICENSE APPLICATION, THE BOARD SHALL DISCLOSE THE FILING TO
9 THE PUBLIC ON THE BOARD'S WEB SITE.

10 (B) THE BOARD SHALL CREATE AND MAINTAIN A PUBLIC INDIVIDUAL
11 PROFILE ON EACH LICENSEE THAT INCLUDES THE FOLLOWING INFORMATION:

12 (1) A SUMMARY OF CHARGES FILED AGAINST THE LICENSEE
13 THAT INCLUDES A COPY OF THE CHARGING DOCUMENT UNTIL THE BOARD HAS
14 TAKEN ACTION UNDER § 14-5E-16 OF THIS SUBTITLE BASED ON THE CHARGES
15 OR HAS RESCINDED THE CHARGES.

16 (2) A DESCRIPTION OF ANY DISCIPLINARY ACTION TAKEN BY THE
17 BOARD AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR PERIOD
18 THAT INCLUDES A COPY OF THE PUBLIC ORDER;

19 (3) A DESCRIPTION IN SUMMARY FORM OF ANY FINAL
20 DISCIPLINARY ACTION TAKEN BY A LICENSING BOARD IN ANY OTHER STATE OR
21 JURISDICTION AGAINST THE LICENSEE WITHIN THE MOST RECENT 10-YEAR
22 PERIOD;

23 (4) A DESCRIPTION OF A CONVICTION OR ENTRY OF A PLEA OF
24 GUILTY OR NOLO CONTENDERE BY THE LICENSEE FOR A CRIME INVOLVING
25 MORAL TURPITUDE REPORTED TO THE BOARD UNDER § 14-5E-16(C) OF THIS
26 SUBTITLE; AND

27 (5) THE PUBLIC ADDRESS OF THE LICENSEE.

(C) IN ADDITION TO THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION, THE BOARD SHALL INCLUDE A STATEMENT ON EACH LICENSEE'S PROFILE OF INFORMATION TO BE TAKEN INTO CONSIDERATION BY A CONSUMER WHEN VIEWING A LICENSEE'S PROFILE, INCLUDING A DISCLAIMER STATING THAT A CHARGING DOCUMENT DOES NOT INDICATE A FINAL FINDING OF GUILT BY THE BOARD.

(D) THE BOARD:

(1) ON RECEIPT OF A WRITTEN REQUEST FOR A LICENSEE'S PROFILE FROM ANY PERSON, SHALL FORWARD A WRITTEN COPY OF THE PROFILE TO THE PERSON; AND

(2) SHALL MAINTAIN A WEBSITE THAT SERVES AS A SINGLE POINT OF ENTRY WHERE ALL LICENSEE PROFILE INFORMATION IS AVAILABLE TO THE PUBLIC ON THE INTERNET.

(E) THE BOARD SHALL PROVIDE A MECHANISM FOR THE NOTIFICATION AND PROMPT CORRECTION OF ANY FACTUAL INACCURACIES IN A LICENSEE'S PROFILE.

(F) THE BOARD SHALL INCLUDE INFORMATION RELATING TO CHARGES FILED AGAINST A LICENSEE BY THE BOARD AND A FINAL DISCIPLINARY ACTION TAKEN BY THE BOARD AGAINST A LICENSEE IN THE LICENSEE'S PROFILE WITHIN 10 DAYS AFTER THE CHARGES ARE FILED OR THE ACTION BECOMES FINAL.

14-5E-25.

Subject to the evaluation and reestablishment provisions of the Maryland Program Evaluation Act and subject to the termination of this title under § 14-702 of this title, this subtitle and all regulations adopted under this subtitle shall terminate and be of no effect after July 1, [2022] 2014.

SECTION 3. AND BE IT FURTHER ENACTED, That, on or before December 31, 2012, the State Board of Physicians and the Department of Health and Mental Hygiene jointly shall develop and implement a strategy for reducing the backlog of complaint cases.

1 SECTION 4. AND BE IT FURTHER ENACTED, That, on or before December
2 31, 2012, the State Board of Physicians shall assess its fee-charging practices and
3 submit to the Department of Legislative Services a long-term fiscal plan that includes:

4 (1) a description of the method the Board uses to determine the
5 amount of licensing fees that the Board will charge licensees;

6 (2) the adequacy of the Board's fund balance, including the Board's
7 projected fund balance based on fee levels specified in regulations; and

8 (3) the sufficiency of physician fee levels, including whether current
9 fee levels need to be adjusted to reflect costs associated with peer review and physician
10 rehabilitation activities.

11 SECTION 5. AND BE IT FURTHER ENACTED, That, on or before December
12 31, 2012, the State Board of Physicians shall develop and implement a plan to improve
13 the recruitment of allied health advisory committee members.

14 SECTION 6. AND BE IT FURTHER ENACTED, That, on or before December
15 31, 2012, the State Board of Physicians shall amend its regulations to reflect the
16 procedures of the Board.

17 SECTION 7. AND BE IT FURTHER ENACTED, That, on or before December
18 31, 2012, the State Board of Physicians, the Maryland Insurance Administration, the
19 Office of the Attorney General, and the Department of Health and Mental Hygiene's
20 Office of the Inspector General shall jointly determine the appropriate entity for
21 investigating and enforcing Title 1, Subtitle 3 of the Health Occupations Article.

22 SECTION 8. AND BE IT FURTHER ENACTED, That, on or before December
23 31, 2012, the State Board of Physicians, in consultation with the Physician Assistant
24 Advisory Committee and physician assistants and supervising physicians from a
25 variety of practice settings, shall adopt regulations for determining:

26 (1) what constitutes an advanced duty; and

27 (2) how many successful procedures a physician assistant must
28 perform to be deemed able to safely perform a medical act.

1 SECTION 9. AND BE IT FURTHER ENACTED, That the State Board of
2 Physicians shall issue a license to an individual under § 14–5B–10 of the Health
3 Occupations Article if the individual:

4 (1) was enrolled in an unaccredited radiation therapy, radiography, or
5 nuclear medicine technology program on October 1, 2010, and graduates by June 30,
6 2014; and

7 (2) meets all other requirements for licensure.

8 SECTION 10. AND BE IT FURTHER ENACTED, That, on or before June 1,
9 2013, the State Board of Physicians shall submit a report to the Department of
10 Legislative Services. The report shall address the status of the implementation of the
11 recommendations made by the Department of Legislative Services in the November
12 2011 publication “Sunset Review: Evaluation of the State Board of Physicians and the
13 Related Allied Health Advisory Committees”. The report shall include:

14 (1) recommendations for measures to increase the involvement of
15 allied health advisory committees in complaint resolution and licensee discipline,
16 including the feasibility and efficacy of:

17 (i) allied health advisory committees handling all allied health
18 complaint resolution functions currently handled by the Board; or

19 (ii) having allied health committee members perform certain
20 complaint resolution functions, including whether allied health committee members
21 should serve on any panel established by the Board to review disciplinary cases
22 involving allied health licensees;

23 (2) with respect to the allied health advisory committees, measures
24 the Board is taking to:

25 (i) fill vacancies;

26 (ii) solicit, identify, and appoint new members before a
27 member’s term expires;

(iii) promptly reappoint members eligible and nominated to serve for an additional term; and

(iv) ensure that committee chairs are elected in a timely manner and preside over committee meetings;

(3) whether board members should sit on allied health advisory committees;

(4) whether the number of licensees should be considered when determining the size of an allied health advisory committee;

(5) whether the size and composition of the allied health advisory committees should be altered through statutory amendment to effectively carry out the committees' oversight functions, including whether the membership of allied health advisory committees should be reduced after the initial regulations governing the allied health profession have been adopted by the Board;

(6) the findings regarding the appropriate entity for investigating and enforcing Title 1, Subtitle 3 of the Health Occupations Article; and

(7) the strategy implemented by the Board as required by Section 3 of this Act and the effect of the strategy on the backlog of complaints and complaint resolution time.

SECTION 11. AND BE IT FURTHER ENACTED, That, on or before October 1, 2013, the Department of Legislative Services shall make recommendations to the Senate Education, Health, and Environmental Affairs Committee and the House Health and Government Operations Committee regarding further extension of the termination dates of the State Board of Physicians and the related allied health advisory committees and any related changes to § 8-403 of the State Government Article that would be required.

SECTION 12. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect October 1, 2012, the effective date of Chapter 588 of the Acts of the General Assembly of 2011. If the effective date of Chapter 588 is amended, Section 2 of this Act shall take effect on the taking effect of Chapter 588.

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1 SECTION 13. AND BE IT FURTHER ENACTED, That, except as provided in
2 Section 12 of this Act, this Act shall take effect June 1, 2012.

Appendix 2.
Summary of Recommendations and Outcomes
from the 2005 Sunset Review:
Evaluation of the State Board of Physicians

<u>Recommendation</u>		<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
1.	Extend the termination date for the board to July 1, 2013, and conduct the next sunset review without a preliminary evaluation.	Statutory	Adopted	Chapter 539 of 2007
2.	Allow the State Board of Physicians (MBP) to provide for a physician rehabilitation program that is either operated by MBP or through a contract. Amend the statute regarding reporting on physicians in the physician rehabilitation program to conform to current practice.	Statutory	Modified	Chapter 539 requires MBP, on or before January 1, 2008, to issue a request for proposals and enter into a written contract with a nonprofit entity to provide rehabilitation services. MBP may provide rehabilitation services directly if unable to contract with a nonprofit entity. Chapter 539 repealed the requirement that a physician who has been noncompliant with the Physician Rehabilitation Committee for 60 days be reported to MBP.
3.	Require MBP and the courts to develop a procedure to facilitate court reporting to the board of information regarding the conviction of or entry of a plea of guilty or <i>nolo contendere</i> by a physician for any crime of moral turpitude.	Statutory	Rejected	
4.	Encourage MBP to request authorization for a permanent full-time consumer assistant position.	Administrative	Rejected	MBP has not taken action on this recommendation because it is not a priority of the board to reallocate existing resources to provide for this position.
5.	Require MBP to amend current regulations to reflect current practice and to implement the recommendations made in the <i>Report on the Maryland Board of Physicians' Investigative Processes and Optimal Caseloads</i> .	Statutory	Accepted, but not implemented by MBP	Chapter 539 required that the regulations be amended by September 1, 2007. MBP published proposed hearing regulations in January 2008 that contained these changes, but the regulations were withdrawn due to pending legislation. Regulations have not been repropoed.

<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
6. Encourage MBP to change the process currently in place for a physician to obtain an exception from licensure and adopt regulations detailing the procedures for exceptions from licensure for purposes of "consultation."	Administrative/Regulatory	Rejected	Although MBP agreed with this recommendation and was required to adopt these regulations by Chapter 539, no action has been taken.
7. Require DLS to prepare a report on the efficacy of MBP's complaint resolution process by November 1, 2007.	Statutory	Rejected	This recommendation was included in the 2006 sunset legislation (SB 398/HB 121) that failed. The recommendation was not repeated in the 2006 update and was not included in Chapter 539.
8. Authorize MBP to refer any cases for a formal hearing to a subcommittee of the board rather than solely to the Office of Administrative Hearings (OAH) or give consideration to authorizing MBP to refer only standard-of-care cases for a formal hearing to a subcommittee of MBP.	Statutory	Modified	Chapter 539 requires the Chief Administrative Law Judge to designate a pool of administrative law judges to hear cases referred to it by MBP. This appears not to have been done. MBP is also required to provide training at least annually to OAH personnel on medical terminology, medical ethics, and to the extent practicable, descriptions of basic medical and surgical procedures currently in use.
9. Require the departments of Health and Mental Hygiene (DHMH) and Budget and Management to review job classifications for investigators at MBP specifically and health occupations boards generally.	Statutory	Modified	Chapter 539 requires the Secretary of Health and Mental Hygiene, on or before July 1, 2007, to standardize job classifications for investigators at the State Board of Physicians by increasing the base salary grade to Grade 16. The job classifications were standardized.
10. Encourage MBP to limit its use of contractual employment for positions that are performing ongoing functions, and encourage MBP and DHMH to request contractual conversion of such employees.	Administrative	Accepted	The contracts for individuals performing ongoing functions of the board were converted to permanent positions in 2007.

<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
11. Require MBP and DHMH to report to specified committees of the General Assembly by July 1, 2006, with details on a jointly developed strategy to reduce investigative caseloads and complaint backlogs. Require MBP to reduce investigative caseloads and complaint backlogs by July 1, 2007.	Statutory	Rejected	Although Chapter 539 did not include this requirement, MBP has continued to work to reduce investigative caseloads and complaint backlogs.
12. Require DHMH, in conjunction with the Office of the Attorney General (OAG), to review the process for the investigation of self-referral cases and make recommendations of an existing central unit that can provide additional resources and support for the health occupations boards to pursue self-referral cases and report the recommendations to specified committees of the General Assembly by July 1, 2006.	Statutory	Modified	Required by Chapter 539, the report was submitted as required.
13. Encourage MBP, in conjunction with OAG, to adopt voluntary sanctioning guidelines.	Administrative	Rejected	Although not adopted in response to the sunset review, MBP is currently working with OAG to adopt sanctioning guidelines as required by Chapters 532 and 533 of 2010.
14. Require that disciplinary proceedings following formal charging by MBP be open to the public, providing that the licensee or the complainant may, for good cause shown, request the proceeding be closed.	Statutory	Rejected	Although MBP agreed with this recommendation in principle, there were concerns about patient privacy and whether opening up the disciplinary process would have a chilling effect on board deliberations and impact board members' willingness to serve.
15. Make nonconsensual sexual contact with a patient on the part of any health care professional a sexual offense in the third degree.	Statutory	Rejected	Chapter 539 did not include this language. Two bills, Senate Bill 422 and House Bill 290, were introduced in the 2006 session that would have addressed this recommendation; both failed.

<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
16. Require MBP's website to include an additional statement explaining the potential inconsistency in medical malpractice claims and settlement information on individual licensee profiles and provide a clear directive for the user on how to access the disclaimer.	Administrative	Modified	Chapter 539 requires MBP to provide on its website notification that a person may contact MBP to find out whether the number of medical malpractice settlements involving a particular licensee totals three or more with a settlement amount of \$150,000 or greater within the most recent five-year period. This information is not on the board's website; however, the individual licensee profiles do have a disclaimer statement regarding medical malpractice information.
17. Include hospitals, related institutions, alternative health systems, or employers in the prohibition against employing uncertified radiation oncology/therapy technologists, medical radiation technologists, or nuclear medicine technologists. MBP should be authorized to impose a civil penalty of up to \$1,000 against such entities for employing uncertified radiation oncology/therapy technologists, medical radiation technologists, or nuclear medicine technologists.	Statutory	Accepted	Chapter 539
18. Authorize MBP to impose a civil penalty of up to \$1,000 against a hospital, related institution, alternative health system, or employer for failing to report a disciplinary action against a certified radiation oncology/therapy technologist, certified medical radiation technologist, certified nuclear medicine technologist, or licensed respiratory care practitioner.	Statutory	Accepted	Chapter 539
19. Repeal the requirement that MBP elect a secretary-treasurer.	Statutory	Accepted	Chapter 539
20. Cross reference the requirement for a physician to register before performing acupuncture in the State.	Statutory	Accepted	Chapter 539

<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
21. Eliminate the distribution of fees to the general fund under the Maryland Physician Assistants Act.	Statutory	Modified	Chapter 539 requires 12% of the fees collected to be distributed to the Office of Student Financial Assistance if the Governor does not include in the State budget at least \$750,000 for the operation of certain grant and loan repayment assistance programs, with the balance of fees distributed to the Board of Physicians Fund. If at least \$750,000 is included in the State budget, all fees are distributed to the fund.
22. Eliminate the \$50 fee that funds physician rehabilitation and peer review activities.	Statutory	Accepted	Chapter 539 eliminated the fee; however, the fee is still listed in board regulations.
23. Replace the reference to MedChi regarding certain confidential records or transactions with a reference to the entity or entities that have contracted with MBP to provide further investigation and physician peer review.	Statutory	Modified	Chapter 539 replaces the reference to MedChi with a reference to the entity or <i>individual</i> that contracts with MBP.

Source: State Board of Physicians, Department of Legislative Services

Appendix 3.
Summary of Selected Recommendations and Outcomes
from the 2006 Update to the
2005 Full Sunset Review of the State Board of Physicians

	<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
6.	Require the State Board of Physicians (MBP) to include national and State criminal background checks in its initial application and license renewal process.	Statutory	Rejected	MBP disagreed with the recommendation. The board felt that it would add to the cost of applying for a license and that it would delay the licensing process for little gain.
7.	Allow MBP to disclose certain identifying information about licensees to the National Practitioner Data Bank in order to monitor licensing and disciplinary activities.	Statutory	Accepted	Chapter 539 of 2007
8.	Authorize MBP to develop a pilot program incorporating a clinical assessment center or other entity to perform competence reviews of licensees. Encourage MBP to work with the State's teaching hospitals in the development of the program.	Statutory	Rejected	MBP disagreed with the recommendation. The board felt that the establishment of a center would be very costly and time-consuming.
10.	Modify the minimum qualifications for licensure to exclude any applicant with an active disciplinary order in another state for probation, suspension, revocation, or special conditions.	Statutory	Rejected	
12.	Broaden eligibility for the provision of peer review service to include for-profit and nonprofit entities.	Statutory	Accepted	Chapter 539 of 2007
15.	Require the Maryland Insurance Administration to investigate whether any claim, bill, or other demand or request for payment for health care services was provided as a result of a prohibited referral.	Statutory	Rejected	In August of 2011, the board received a position that is assigned to self-referral.

	<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
16.	Make criteria for the reporting of medical malpractice claims and settlement information consistent with the approach recommended by the Federation of State Medical Boards.	Statutory	Rejected	The requirement to report medical malpractice settlements was repealed in its entirety in the final version Chapter 539. However, information regarding medical malpractice settlements is still reported by MBP on its website.
20.	Authorize MBP to enter premises where MBP suspects, based on a formal complaint, that medicine is being practiced by an unlicensed individual.	Statutory	Accepted	This was included in Chapter 539 of 2007; however, in reviewing the legislation, the Office of the Attorney General recommended that this provision be repealed or amended to require a warrant.
21.	Repeal statutory provisions requiring MBP to adopt regulations regarding the specific experience or training qualifications required to demonstrate the ability of a physician to treat and manage opiate-dependent patients in an office-based setting; instead, qualify a physician for MBP certification to apply for a federal Substance Abuse and Mental Health Services Administration waiver to practice office-based, medication-assisted opioid addiction therapy.	Statutory	Modified	Chapter 539 repeals the requirement that MBP adopt regulations and instead authorizes MBP to adopt regulations regarding experience or training qualifications required to qualify a physician to practice office-based, medication-assisted opioid addiction therapy.
24.	Authorize the Physicians' Rehabilitation Committee to evaluate the allied health professionals under MBP's regulatory authority if they request participation in the program or require monitoring by MBP.	Statutory	Accepted	Chapter 539 of 2007
25.	Extend the termination date for the Polysomnography Professional Standards Committee to July 1, 2013, requiring a full evaluation by July 1, 2012.	Statutory	Accepted	Chapter 539 of 2007

	<u>Recommendation</u>	<u>Type of Change</u>	<u>Status</u>	<u>Comments</u>
31.	Authorize MBP to impose a civil penalty of up to \$100 for a first offense, per continuing medical education credit, for failure to obtain the credits required by MBP.	Statutory	Modified	Chapter 539 authorizes MBP to impose a civil penalty of up to \$100 for a first offense, per continuing medical education credit, <i>in lieu of a sanction for a first offense</i> , for failure to obtain the credits required by MBP.

Note: The chart does not include recommendations made in the 2006 update report that were identical to or substantially the same as recommendations made in the 2005 sunset review.

Source: State Board of Physicians, Department of Legislative Services

Appendix 4. Written Comments of the State Board of Physicians



STATE OF MARYLAND

DHMH

Board of Physicians

Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue • Baltimore, Maryland 21215-2299

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 4, 2011

Mr. Warren G. Deschenaux, Director
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, MD 21401

Dear Mr. Deschenaux:

The Maryland State Board of Physicians (the Board) views the Sunset Review process to be a very important component of the legislative process through which the Board derives its' authority to serve and protect the people of Maryland; and, by extension, a very serious matter with which the Board must contend. We also appreciate both the importance of the observations made by the Sunset reviewers and the importance of responding to those observations in a timely and concise manner. In that spirit, I very much regret that the timing of the "Exposure Draft" being made available to the Board; the lack of an opportunity to have preliminary discussions with the reviewers prior to the draft being finalized; and the timing of end of the year Board meetings have created a condition in which I have not been able to develop a consensus of the Board vis-à-vis a response to the forty-six (46) discussion points made by the reviewers by the November 4, 2011, extended deadline.

Nevertheless, as Chairman of the Board, I have had the opportunity to review the "Exposure Draft" with Board staff and some individual Board members. Following that preliminary review (and reserving the right to modify; amplify; and/or abridge the following) I would like to offer the following as a preliminary response from the Board:

- The Board will concur with recommendations: 1; 6; 9; 10; 11; 13; 16; 23; 26; 28; 30; 33; 34; 38; 41; and 43;
- The Board will mostly concur (i.e. with some reservations) with recommendations: 7; 8; and 17; and
- After initial review the Board does not concur with recommendations: 2; 3; 4; 5; 12; 14; 15; 18; 19; 20; 21; 22; 24; 25; 27; 29; 31; 32; 35; 36; 37; 39; 40; 42; 44; 45; and 46.

Additionally, after initial review, we believe that there are numerous factual findings represented in the "Exposure Draft" that require some discussion. We have forwarded those for review in the attached enclosure.

In conclusion I want to again note that the Board believes that the Sunset Review process is an important tool to be used to help the Board fulfill its mission of protecting the people of Maryland. To that end it is critical that I be afforded the time to engage all Board members in the process. The next Board meeting will be held on November 16, 2011, and I anticipate that I will be able to provide a more comprehensive response regarding the posture of the Board on these matters after that meeting. More specifically, I will be able to make a more concise response at the hearing scheduled for November 30, 2011.

Thank you for your understanding and patience in these matters.

Sincerely,

A handwritten signature in dark ink, appearing to read "P.T. Elder M.D.", written in a cursive style.

Paul T. Elder, M.D.

Appendix 5. Written Comments of the Department of Health and Mental Hygiene



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

November 4, 2011

Warren G. Deschenaux
Director
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, MD 21401

Dear Mr. Deschenaux:

Thank you for the opportunity to review an exposure draft of the sunset evaluation of the Board of Physicians, prepared by the Department of Legislative Services. We commend your staff for its examination of the Board's processes and review of the Board's work.

The Board of Physicians exists to protect the public's health. The Board is responsible for protecting Marylanders from incompetent and dangerous individuals who are practicing or are seeking to practice medicine in our state. The Board also provides important licensing services to thousands of Maryland professionals who provide lifesaving care to Maryland residents.

The report identifies a number of important concerns about the Board of Physicians' operation. These include the time to resolve cases, the lack of sanctioning guidelines, inconsistencies between regulations and practice, and a range of other administrative and oversight issues.

It is my view that the sunset evaluation's findings justify a thorough outside review and a new operational plan. I will make such a recommendation when I meet with the Board of Physicians at its meeting on November 16.

We look forward to updating you and the General Assembly on the Board's progress.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: Paul Elder, M.D.