ARIZONA

NEW LAWS PROVIDE GREATER PHYSICIAN ASSISTANT AUTHORITIES

From a press release on the Arizona Medical Board Web site

SCOTTSDALE, Ariz. – New laws giving physician assistants greater medication prescribing and dispensing authorities went into effect in August. These new laws provide physician assistants meeting requirements for expanded prescribing and dispensing and receiving delegation from supervising physicians to prescribe schedule II and III controlled substances for up to 14 days—a significant increase from the previous 72-hour prescription law. Physician assistants may also prescribe schedule IV and V controlled substances from a period of 34 days to a maximum of five refills in a six-month period for each patient without the consent of the supervising physician.

“The expanded physician assistant prescribing privileges reflect the changing face of health care,” said Executive Director Barry A. Cassidy, Ph.D., P.A.-C. “In an age of managed care and budget cuts, physician assistants are increasingly relied upon to perform many essential health care tasks.”

There are several requirements physician assistants must fulfill prior to increasing their prescribing and dispensing practices. Physician assistants must certify to the Arizona Regulatory Board of Physician Assistants they have completed 45 hours of pharmacology, 45 hours of clinical management of drug therapy, or are currently certified by the National Commission on the Certification of Physician Assistants (NCCPA). The Board must also receive written delegation from the supervising physician for prescribing and dispensing authorities. Only physicians who are registered with the Arizona Medical Board to dispense may delegate dispensing privileges.

CALIFORNIA

BOARD PROPOSES NEW INFORMATION DISCLOSURE POLICY

From Action Report, a publication of the Medical Board of California

Last summer, the Medical Board of California appointed a Public Information Disclosure Committee, comprised of three physician and three public members. The purpose of the Committee was to comprehensively review the Board’s public disclosure policies and methods—not only what was considered public record, but how it was being presented.

From November 2001 through January 2002, the Committee held four public meetings statewide, taking testimony from organizations representing the public interest, organized medicine, malpractice insurers, and interested individuals.

As a result of these meetings and the Committee’s deliberations, the presentation on the board’s Web site of its individual physician records has been revamped to be more reader-friendly. A notice at the top of each record will make clear what information is and is not available from the board. Explanations of all enforcement-related terms will be provided, as will as a link to the Medical Practice Act. The disclaimers that put the information in context have been carefully rewritten to be more understandable. The gender of the physician will be added, and when the Board has information on practice specialty, additional postgraduate training information, and language proficiencies obtained via license application and renewal, these items also will be included.

At the meeting of the Board held May 11, 2002, the Committee recommended that additional information be disclosed by the board on its Web site and to callers about physicians. The board supported the Committee’s recommendations, which include:

- Malpractice settlement information reported to the board on all licensees. This information would be provided in context, given the physician’s specialty and size of the award so the public has a
picture of how the licensee’s malpractice track record fits into the context of that medical specialty area

- Misdemeanor convictions reported to the board that are substantially related to the qualifications, functions and duties of a physician
- Any public information in the possession of the board that may have an adverse impact on the safe delivery of medical care by a physician; e.g., physicians required to register as sex offenders
- The names of physicians whose fully investigated cases have been referred to the Office of the Attorney General for the filing of a formal accusation

NOTE: The final form of disclosure is subject to legislative approval.

The board views this vote as one important step in achieving its mission of consumer protection through public education. While the board recognizes the controversial nature of these proposals, it regards them as critical because it meets its first obligation — protection of health care consumers — by providing them with information that is vital to making important health care choices.

The board understands and appreciates that some people in the physician community are particularly concerned about the board’s proposal to disclose malpractice settlement information on its Web site. The information that would be provided already is public record. The board’s proposal simply makes such information available in a consolidated location rather than by requiring access of the civil index at multiple county clerks offices or superior courts to locate the same information.

Disclosure of malpractice settlements via the California medical board’s Web site is an idea that’s time is well upon us. Ten other states already provide such information. In this era of increasing information disclosure, California is, in fact, behind the pack. A study, published in January 2002 by the Pew Internet and American Life Project, found that the Internet has had a “significant” impact on health care decisions for more than 15 million Americans in the last two years. As use of the Internet continues to grow, so will the potential for such an impact and the need for credible information sources.

The Board now looks forward to continuing to work cooperatively with the legislature, consumers, physicians, insurers, and other interested parties to effectively implement these changes and find additional ways to ensure the public receives accurate, timely, and useful information when making decisions about health care services from California’s physicians.

GEORGIA

MEDICAL BOARD ACQUIRES NEW LICENSURE SOFTWARE PROGRAM

From The Examiner, a publication of the Georgia Composite State Board of Medical Examiners

In an effort to better serve the health care professions it regulates, the Georgia medical board, in cooperation with Georgia Better Health Care and the Georgia Department of Community Health, recently acquired a new licensure software system. In order to meet the increasing public demand for quality control over every aspect of the licensure process, the Department of Community Health, Office of Information Systems sought the latest technology on behalf of the medical board and Georgia Better Health Care.

With consumer protection in mind and looking toward the future of being able to deliver easier public access to information, a new software program called LicenseEase was chosen.

The new software system will allow flexibility and expandability for the medical board — able to easily adjust to changes in the regulatory business environment. The new system has three major programming components: application processing, license maintenance, and enforcement. The new system, once fully integrated over the course of the next several years, will allow interactivity with the medical board Web site, such as online renewals, downloading applications and complaint forms, as well as physician look-up. The e-commerce capability of the new system was one of its strongest selling points.

In 2000, 40% of all physician renewals were conducted through the medical board’s Web site. Physicians were the first group licensed by the medical board to experience online renewal capability. Online renewal was extended to all license types because it was such a huge success.
KENTUCKY

CHANGES IN MEDICAL PRACTICE ACT

From the Kentucky Board of Medical Licensure Newsletter

The 2002 Kentucky General Assembly passed legislation (HB617), which amended various provisions of the Medical Practice Act. These changes will assist the Board in its ability to more timely and effectively discipline physicians and will require physician assistants' scope of practice to be within that of their supervising physician.

According to the revisions, a physician may enter into supervision agreements with a maximum of four physician assistants, but shall not supervise more than two physician assistants at any one time. Other changes will require the supervising physician to submit an application for each physician assistant they wish to supervise. A physician who has been supervising a physician assistant may continue supervision and the physician assistant may continue to perform all medical services and procedures that were provided by the physician assistant. However, the supervising physician will be required to submit a new application and any supplemental application by October 15, 2002, as provided in these revisions.